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EXPLORING CHALLENGES:
A CULTURE-CENTRED APPROACH (CCA) PROJECT IN GLEN INNES

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ABOUT CARE

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Prof Mohan J Dutta is the Director of CARE and author of books such as Neoliberal Health Organizing, Communicating Health, and Voices of Resistance.

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INTRODUCTION

This study explores the challenges experienced by residents in Glen Innes, Auckland. The findings have assisted in the identification of local problems and corresponding solutions, including the 'Poverty is Not Our Future' campaign, which has served as anchor for residents to challenge dominant structures and, at the same time, communicate their everyday realities of poverty.

While this study is focused on Glen Innes, material hardship continues to be a significant issue in Aotearoa New Zealand, with research determining that 13 percent of children lived in households that experienced material hardship in the 2017/18 financial year (Statistics New Zealand, 2019) and that children born into disadvantage in Aotearoa New Zealand have a significant likelihood of remaining disadvantaged (New Zealand Treasury, 2016a, 2016b; Templeton, 2016).

Glen Innes is situated 10 km east of Auckland's central business district and it is as an urban site with high material deprivation. Although the area covers three suburbs, residents who were interviewed deemed the area as one community and did not delineate between the neighbouring suburbs. Glen Innes was developed as a state housing area in the 1950s by the Labour government with the vision of providing adequate housing to all (Kearns, Smith, & Abbott, 1991), and the population is unfavourably represented in terms of income, employment, and education (Statistics New Zealand, 2014a, 2014b). The area is encircled by more affluent and largely owner-occupied housing (Gordon, Collins, & Kearns, 2017) with a much higher standard of living (Scott, Shaw, & Bava, 2010). Glen Innes has received significant media coverage over the last decade, due to redevelopment, which some analysts consider to be a form of gentrification (e.g., Gordon et al., 2017).

This study draws from in-depth interviews conducted with 60 residents in 2018 and 2019. While the findings discussed should be considered as part of a broader context tied to colonisation, urbanisation, and detribalisation, this study provides insight into the lived experiences and needs of those with low incomes in Aotearoa New Zealand, which could inform stakeholder decision-making and improve local support services. This study is part of an ongoing project that facilitates participation with community members in defining localised problems and corresponding solutions to improve their lives.

METHODOLOGY

60 interviews, lasting on average one-hour duration, were undertaken with residents in Glen Innes from December 2018 to February 2019. A semi-structured interview design (Chantler, 2014) was utilised, whereby open-ended questions concerning the challenges in the area and potential localised solutions provided entry points for in-depth discussion. This research is part of a broader project that is grounded in a cultured-centred approach (Dutta, 2008).

The cultured-centred approach emphasises the need to understand localised, culture-centred views of health and poverty with attention given to the voices of the target population (Dutta, 2008). As Dutta (2018) explained, "The overarching objective is to shift the decision-making capacities into the hands of the community... The community is seen as the appropriate owner of the problem configuration and the corresponding solutions" (p. 245).

Participants were recruited using purposive sampling that specifically attends to inviting the voices of the marginalised within the community, using direct approaches in the area, snowball sampling. They were asked open-ended questions relating to experiences and potential solutions relating to poverty, health, education, food, and housing within the area.

Most participants identified as being unemployed (45%) or unable to work due to disability (25%). There was a higher proportion of participants who reported being of Māori of ethnicity compared to the general population of the areas, and a lower proportion of participants who reported being of Pacific or New Zealand European ethnicity. The demographics of the participants are outlined in Table 1 below.

Table 1: Demographics of Interview Participants

Demographic	Number of Participants	%
Ethnicity*		
Māori	41	68.3
Pacific	19	32.0
NZ European	7	11.7
Other	1	1.7
Gender		
Male	25	41.7
Female	35	59.3
Occupational Status*		
Employed full time	4	6.7
Employed part-time	2	3.3
Unemployed	27	45.0
Homemaker/looking after children	11	18.3
Unable to work due to disability	15	25.0
Student	2	3.3
Age		
18-25	8	13.3
26-35	11	18.3
36-45	13	21.7
46-55	17	28.3
56-65	11	18.3
66+	0	0

* Participants could identify as multiple ethnicities and occupations

KEY CHALLENGES

Food

Although there was a desire to consume healthy foods expressed by a large proportion of participants, the cost of these foods and the dominance of local stores providing unhealthy foods presented as barriers. Furthermore, sharing and consuming unhealthy foods appeared to be part of local collective practices. Some younger participants discussed experiences of not having enough food or relying on local charitable groups to access food, and it seems that the unhealthy diet has become intergenerationally embedded. As one participant stated:

> *"That is hard aye to cut the habit aye of coming out of [our upbringing]. But you know why? Because that, the oily food, was the cheapest to get. It's sad but it's the truth. We can't get a chicken breast and feed everybody. What's that? One person at least."*

As this participant indicated, eating unhealthy foods is not part of their traditional Pacific culture, but it is rather reflective of intergenerational poverty and financial hardship encroaching on the enactment of their cultural practices. Another participant discussed this in relation to poor health outcomes:

> *"The only option is the cheaper diet, which is takeaways and all that... but then you find yourself in the doctors... Mum, she has diabetes... so she's been on the pill for a long time and it's just, they're [health practitioners] like 'oh just, if you just change your diet and exercise more'... they make it seem easy. But for the ones who can't really afford, you know, good healthy food, will just remain sick."*

Again, this quote highlights the intergenerational nature of the unhealthy diet and corresponding health outcomes, for while this participant references her mother's situation, she also manages Type 2 Diabetes and has been advised to improve her diet. Central to her conversation is fundamental misunderstanding by the healthcare provider of the local social, cultural, and community contexts of collectivism and economic struggle.

Healthcare Inaccessibility

Health inequity was certainly reflected in the sites; with a large proportion of participants discussing personal physical or mental illness or the prevalence of this within the area. This was coupled with widespread addiction and substance abuse, which exacerbated financial instability, for, as participants discussed, "it's all those, all those bloody drugs that are out aye, and those drugs and the alcohol" and "when ugh benefits are paid, they'll be, they'll be waiting to you know, they'll buy the cheapest and nastiest bottle of liquor or cans of beer and stuff... but you're stuck in that cycle".

Participants experienced difficulty accessing health services, particularly prescriptions or health consultations due to cost. It seems that despite the impression that healthcare in Aotearoa New Zealand is "universal" (Ministry of Health, 2018a, para. 2), and that there is a high preforming healthcare system (OECD, 2017), the lived realities for the participants in navigating healthcare was often based on financial inaccessibility. Prescriptions are subsidised in Aotearoa New Zealand, usually with a five-dollar surcharge, but as one participant stated: "Who the hell wants to go and pay five-dollars... That can buy a bread and a milk... what are you going to do when you have none of those... in your cupboards?" For patients over 13, general practices charge co-payment within a certain threshold that varies by area (Ministry of Health, 2018b), but cost was still a barrier for participants, such as a participant who stated, "Yeah, I don't see them [GPs], oh, due to a financial problem" even though he manages Type 2 Diabetes.

The long waiting lists to access specialist care and elective procedures was also discussed by participants to the point where some participants gave up and stopped seeking care. Furthermore, not having access to transportation to medical appointments outside of Glen Innes. Participants discussed the inevitable impact of having inadequate access to healthcare, including fatal consequences, for as one participant stated, "I know people that have fucking died, oh sorry, excuse me, that have died just recently from a simple – they couldn't get an inhaler and they had asthma attacks".

Housing

Most of the participants lived in state housing, some of which were in friends of family's tenancies (sometimes against the state housing regulations), although some participants lived in emergency accommodation or homeless on the street and in a van. The housing conditions and homelessness directly impacted the

participants' lived experiences of poverty. Most participants felt that the state housing in Glen Innes that would be demolished was in poor condition, and, at the time of the interviews, no participants lived in new housing.

Participants shared stories of the houses being cold, damp, and mouldy, sewerage lines frequently blocking. Participants knew that living in these conditions could be detrimental to their health, and some participants had experienced this detriment first-hand. However, participants also expressed their gratitude to have state housing, and the increasing homelessness in Glen Innes was discussed by many participants.

In spite of the challenges experienced, most participants said that they want to remain in Glen Innes and that it has a strong sense of community, with statements like, "I wouldn't like to stay anywhere else but here. Because I feel safer here" and "this is home. I'll always come back home". It is this very culture and community that many participants felt is being threatened by the housing redevelopment. Although a small proportion of participants did not have any issue with the development, the most widespread view was that the redevelopment is a form of gentrification, making statements like: "they're just pushing the ones who's less fortunate out of the community into a real harder environment" and "I just think that they just want to get rid of us".

Employment

At the time of the interviews, most residents received an income benefit for being unemployed or unable to work due to sickness or caring for children. The only potential employment perceived was generally unskilled and frequently physical labour, and poor health presented as a barrier, with residents being on a benefit for being unable to work due to disability and others discussing how their health condition limits their choices of potential employment.

Participants discussed various barriers to gaining employment, including not having enough experience or education, the need for travel or a driver's license, and family or relationship barriers. For example, one participant stated, "I was working there. For six years, but I had to chuck it in because I had, with the kids, the mother, the mother she left so... so she gave me the kids, a couple of kids". Another significant barrier discussed was a criminal history, which was perceived to lower the chance of successful employment. For example, one participant stated,

> *"WINZ [Work and Income New Zealand] with employment can't really help. They, they're kinda um restricted by the same situation, like ugh, if you say a person has a criminal conviction, um there's no a lot they can do about that."*

In spite of the challenges experienced, some participants described positive experiences or impressions of employment, and it was viewed by many participants as a way to increase incomes and as a potential solution for the poverty experienced in Glen Innes. As one participate stated, "If there's gonna be a solution to any of this, it's for WINZ to put them into work... keep, keep them busy, keep them occupied... At least they're doing something". In consistence with the other findings, descriptions of gaining employment tended to be through personal contacts and support services. For example, one participant stated:

> *"It was through friends that helped me out knowing, like, when I lost my last job I was on the benefit and my mate's mum asked me if I wanted work and she took me in for a trial and then, yeah. Since then I've been there."*

CONCLUSION

It is hoped that this paper will serve as an entry point to listening to the voices of residents in Glen Innes to inform stakeholder decision-making and local support services. Our analysis of 60 in-depth interviews with residents in Glen Innes indicated the complexity and multidimensional nature of the challenges encountered that is intertwined with individual, cultural, and structural factors.
The following key findings can be deduced:

- Structural conditions relating to financial constraints directly impacted participants' capacities to purchase and consume healthy foods, live in healthy accommodation and access adequate healthcare.
- However, financial barriers were not the only cause of the challenges experienced. For example, residents discussed the widespread addiction and substance abuse in the area, which exacerbated financial instability, and the low motivation to pursue employment.
- The strong sense of community and collectivist practices of caring emerged as a form of 'safety net' and a local resource in the negotiation of local structures, although many participants felt that this was being threatened by the redevelopment.

Before closing, we need to acknowledge that our study has some limitations. With the nature of qualitative research, our findings are limited to the 60 participants interviewed and to the time in which the research was undertaken. In spite of these limitations, through listening to community voices, we gained rich, detailed insight into the lived experiences and the needs of residents living in Glen Innes.

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