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Situating Health Experiences: A Culture-Centered Interrogation

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ABSTRACT

Culture-centered studies of health communication de-center the theorization of health as an individual behavior and reveal the structural conditions that shape inequalities in health outcomes. The present study examines the ways in which space and housing shape experiences of health in a low-income site in Auckland undergoing radical redevelopment. We draw from a culture-centered project undertaken in 2018–2021 predominantly among Māori and Pasifika peoples involving 60 initial in-depth interviews, seven focus groups, a series of filmed interviews, and 32 additional in-depth interviews conducted during the COVID-19 pandemic. The residents' narratives foregrounded the detrimental health impact of inadequate housing, financial constraints, transience, and displacement that severs ties to place and community. These findings reveal the relationship between housing challenges, economic marginalization, and neoliberal capitalism, highlighting the need for policy interventions to address housing as a fundamental determinant of health disparities among marginalized communities.

This article demonstrates the ways in which space and housing shape experiences of health. Culture-centered studies have shown how meanings of health are culturally grounded, de-centering the theorization of health as an individual behavior (Dutta, 2004, 2005; Sastry et al., 2021). Moreover, cultural meanings of health are (re)constructed against structural inequalities, with culture-centered studies documenting how meanings of health play out in the inaccessibility of local resources (e.g., Dutta, 2007; Dutta & Basu, 2008). Although there has been some theorization around the interconnection of local health meanings with land (e.g., Basu & Dutta, 2007; Dutta-Bergman, 2004; Pal & Dutta, 2013), what is missing in the previous culture-centered work is the centering of space as the site through which health is produced, circulated, and disrupted, and how this is set against a history of displacement among Indigenous peoples.

This article is based on a culture-centered project undertaken in 2018–2021 predominantly among Māori (Indigenous population of Aotearoa) and Pasifika peoples (referring to the Indigenous populations of the Pacific Islands) in a low-income site in Auckland undergoing radical redevelopment. Land has been depicted as a central component of a Māori cultural model of health (e.g., Mark & Lyons, 2010), but our initial fieldwork and interviews showed how community members enact agency in their health meanings in interaction with the unaffordability of healthcare, healthy foods, and housing (Elers et al., 2021b). In the present article, we extend our initial ethnographic findings by demonstrating the consistent theme of how space and housing shape experiences of health, drawing upon supplementary culture-centered engagements.

We report on the findings from the 60 initial qualitative interviews reported in 2021, as well as seven community

advisory board focus groups, a series of filmed interviews, and 32 additional qualitative interviews conducted during the COVID-19 pandemic. The gentrification of place formed the backdrop against which low-income households negotiated their further alienation from land. Residents' narratives foregrounded the lack of access to adequate housing, situated against housing transience and financial hardship. The findings reveal the relationship between housing challenges, economic marginalization, and neoliberal capitalism and highlight the need for policy interventions to address housing as a fundamental determinant of health disparities among marginalized communities.

The culture-centered approach: principles and applications

Dutta's (2008, 2018) culture-centered approach involves working with communities situated in the "margins of the margins", those missing from dominant discursive spaces, to identify issues to health and wellbeing that are locally meaningful. The approach situates individual and community agency against two intersecting concepts: culture, denoting shared understandings and practices, and structure, denoting the frameworks that regulate resource accessibility mediated through power (Dutta, 2008). A culture-centered project in rural Bengal, for example, revealed how Santali cultural health beliefs are polymorphic and intertwined with nature, which plays out within an environment of structural threats from modernization through deforestation and urbanization (Dutta-Bergman, 2004). Another culture-centered project among Afghan refugees in Aotearoa showed how constructions of health are articulated within narratives of support and

how COVID-19 lockdown restrictions posed critical challenges to their health through structural barriers in accessing information (Elers et al., 2023).

Contrary to neoliberal narratives that have represented migration and mobility as symbols of agency and empowerment, culture-centered work has revealed how migration can interwork with structural disenfranchisement for communities situated in the margins (e.g., Dutta, 2017; Dutta & Kaur-Gill, 2018). For example, Dutta and Kaur-Gill (2018) found that negotiating space among foreign domestic workers in Singapore is tied to racism and threats to dignity. Foreign domestic workers also encounter immobility from human trafficking and of displacement and erasure from urban development (Dutta & Kaur-Gill, 2018). Such development is often marked by the proletarianization of labor (Dutta, 2011) while simultaneously contributing to the displacement of communities through rising market rents and property (Gordon et al., 2017).

The disjuncture between narratives that associate migration with opportunity and the actual lived experiences of being precarious were made newsworthy through the rise of COVID-19 (Dutta & Elers, 2020). Processes of migration amplified existing structural inequalities during the pandemic, as witnessed through migrant communities struggling to access resources (e.g., Elers et al., 2023, Kumar et al., 2021). The uptake of COVID-19 policy responses was constituted in relation to structural inequalities, with residents in emergency and transitional housing in South Auckland reporting difficulties with social distancing due to close living quarters and shared facilities (Franks, 2022). It also played out within existing cultural norms and health beliefs with some communities not conceiving COVID-19 as being threatening within their contexts (e.g., Heemskerk et al., 2022) and ethnic minority groups having higher hesitancy of COVID-19 interventions (Niño et al., 2021), including the uptake of COVID-19 vaccines among Māori (Ministry of Health, 2022).

In Aotearoa, the poor condition of housing has been related to inequitable health outcomes (Howden-Chapman et al., 2012), but it is not the only determinant of health, which is tied to broader historical and contemporary contexts that create and maintain inequalities. While cultural models have provided valuable insights into Māori and Pasifika holistic constructions of health that contrast with biomedical frameworks (e.g., Cammock et al., 2014; Durie, 1985; Mark & Lyons, 2010), Dutta has shown how health is constituted amidst structural inequalities (e.g., Dutta, 2007; Dutta & Basu, 2008). However, space and displacement has not been centered in culture-centered work to date, which we contribute to addressing in the present study. We extend the findings from our initial fieldwork (Elers et al., 2021b) situated within the context of a large-scale redevelopment to examine:

RQ: *What are the ways in which space and housing shape experiences of health?*

The geographical area

The culture-centered approach has shown how inequality in the distribution of voice infrastructures is intricately tied to material

inequalities (Dutta, 2008). Our study is based in Glen Innes, a suburban site with statistically high material deprivation (Exeter et al., 2020) situated 10 km east of Auckland's central business district. Glen Innes was developed as a state-housing area in the 1950s (Kearns et al., 1991) when there was significant growth in Māori and Pacific migration to the area (Gordon et al., 2017). The geographic location is symbolic of an economic divide in Auckland, with Glen Innes being negatively represented in terms of income, employment, and education (Statistics New Zealand, 2020a, 2020b) and encircled by affluent and largely owner-occupied housing (Gordon et al., 2017).

This growth reflected a broader trend from the 1950s in which there was an increasing urbanization of Māori (Walker, 1996). Colonization brought forth a structure imposing the integration of Māori into the New Zealand European population through sustained policy efforts by the Crown (Hill, 2010). Many Māori who moved to urban areas “became isolated from the social support fabric of whānau [extended family] and hapū [kindship group]” (Reid et al., 2017, p. 43), although research has also shown how particular cultural practices were maintained in these settings (e.g., King, 2019, King et al., 2018). For instance, Borell (2005) documented how Māori youth express meaningful associations to local land in South Auckland. The migration of Pasifika peoples transformed Auckland into the largest Polynesian city in the world (Kearns et al., 1991), yet as “occupants of some of the city's poorest and least health-promoting housing” (Cheer et al., 2002, p. 497).

Over the last decade, Glen Innes has become a site undergoing radical redevelopment based on the concept of a social mix, which provides state, social, and market-based housing (Gordon et al., 2017). The redevelopment was driven by a need to accommodate housing growth, high land costs, and a lack of political will to pepper pot social housing in other parts of the city (Scott et al., 2010). Residents have reported that Māori and Pasifika families have been forced out of the area (Boynton, 2018; Johnston, 2018), and from 2006 to 2013, Māori and Pacific residents declined by 693, while New Zealand European residents increased (Gordon et al., 2017). Despite various protests by residents, 2500 of the approximately 2800 state-owned homes in Tāmaki (comprising Glen Innes) will be demolished in 10–20 years and 7500 homes will be built (Gibson, 2018). Against this backdrop, our research contributes to the extant CCA scholarship (see Sastry et al., 2021) that theorizes linkages between settler colonialism and neoliberal capitalism in expelling communities at the margins from land that disrupts attachments to place and community.

Method

Study design

Approval through Massey University's ethics procedures was sought and gained on a phase-by-phase basis. All participants were provided with information sheets, completed consent forms, and were required to be at least 18-years old and fluent in English. In the first phase, sixty individual in-depth interviews were undertaken with residents in 2018–2019. These residents were recruited through purposive sampling through direct approaches within the area and snowball sampling. They were asked open-ended

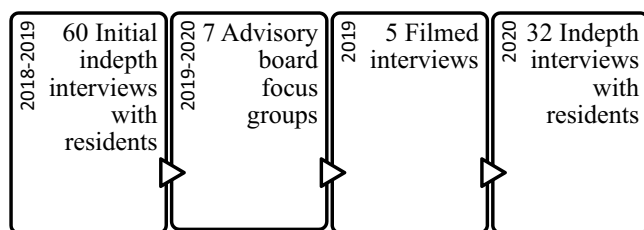


Figure 1. Summary of the methods.

questions concerning meanings of health, challenges to being healthy, including regarding housing, and potential solutions. In the second phase, the interview participants who consented to be contacted again were invited to form an advisory board. The first advisory board focus group in 2019 was attended by 15 participants and in total, seven advisory board focus groups were undertaken in 2019–2020 and attended by 24 participants. The advisory board focus groups discussed the research findings and co-developed a media campaign, Poverty is Not Our Future, to draw attention to challenges in the area (Elers et al., 2021a). In the third phase, five filmed interviews in 2019 were undertaken about the challenges in the area as part of the campaign, comprising six participants. In the final phase, 32 in-depth interviews were undertaken in 2020 about experiences during the COVID-19 pandemic, including residents' living situations, necessitated by the rise of the pandemic. Recruitment was again through purposive and snowball sampling, by initially inviting residents who were previously involved in the project. The four phases of the project are illustrated in Figure 1.

The interviews and focus groups in the first three phases were undertaken in person, but in the fourth phase, we used a mixture of phone interviews (16/32) and in-person interviews undertaken by a community researcher (16/32) due to the university's travel restrictions during the COVID-19 pandemic. Our

recruitment approach meant that some residents participated in more than one phase of the research, as outlined in Table 1. Our approach also resulted in a higher representation of unemployed and Māori and Pasifika participants compared to the population in Glen Innes (see Statistics New Zealand, 2020a, 2020b). Most of the 60 participants initially interviewed resided in state housing, although some resided in emergency accommodation (3 participants), in street homelessness (3 participants) and one participant resided in a van.

Data analysis

The interviews and focus groups were recorded, transcribed, and analyzed using grounded theory throughout the four phases of the project, guided by Charmaz (2000). This involved the researchers engaging in the reflective process of memo writing after each interview, listening to recordings for familiarization and documenting impressions, and transcribing the interviews verbatim. Following on from this was an iterative process, involving line-by-line open coding of the interview transcripts that identified initial concepts and, subsequently, discrete concepts related to a phenomenon were grouped under conceptual categories. Axial coding then involved the formulation of relationships within and among the categories, before achieving selective coding through theoretical integration. We carried out constant comparison throughout the interviewing process, with particular data points emergent across the open, axial and selective coding processes being constantly compared to other data points in order to generate categories and concepts. The first author initially coded interviews, and the codes were checked by the second author, as well as two members of the broader research team. Disagreements at any stage of the coding process were resolved through dialogue. For instance, while conducting selective coding, the research team engaged in

Table 1. Participant demographic information.

	Initial interviews (n = 60) ^a		Advisory board meetings (n = 22, new = 11) ^a		Filmed interviews (n = 6, new = 5) ^a		COVID-19 interviews (n = 32, new = 18) ^a	
	n(%)	n(%)	new(%)	n(%)	new(%)	n(%)	new(%)	
Age								
18–25	8(13.3)	4(18.1)	3(13.6)	0(0.0)	0(0.0)	3(9.4)	0(0.0)	
26–35	11(18.3)	6(27.2)	2(9.1)	2(33.3)	0(0.0)	11(34.4)	4(22.2)	
36–45	13(21.7)	1(4.5)	0(0)	2(33.3)	0(0.0)	4(12.5)	1(5.6)	
46–55	17(28.3)	5(22.7)	2(9.1)	1(16.7)	0(0.0)	6(18.8)	6(33.3)	
56–65	11(18.3)	3(13.6)	1(4.5)	0(0.0)	0(0.0)	6(18.8)	5(27.8)	
66 +	0(0.0)	0(0.0)	0(0.0)	0(0.0)	0(0.0)	2(6.3)	2(11.1)	
Missing	0(0.0)	3(13.6)	3(13.6)	1(16.7)	1(100)	0(0)	0(0.0)	
Occupational Status ^b								
Employed	6(10)	2(9.1)	1(4.5)	0(0)	0(0)	10(31.3)	7(38.9)	
Unemployed	27(45)	14(63.6)	9(40.9)	4(66.7)	0(0)	13(40.6)	6(33.3)	
Homemaker	11(18.3)	3(13.6)	1(4.5)	0(0)	0(0)	6(18.8)	4(22.2)	
Student	2(3.3)	1(4.5)	0(0)	0(0)	0(0)	1(3.1)	1(5.6)	
Unable to work due to disability	15(25)	3(13.6)	0(0)	1(16.7)	0(0)	2(6.3)	0(0.0)	
Retired	0(0)	0(0)	0(0)	0(0)	0(0)	1(3.1)	1(5.6)	
Missing	0(0)	0(0)	0(0)	1(16.7)	1(100)	0(0)	0(0.0)	
Ethnicity ^b								
Māori	41(68.3)	18(81.8)	9(40.9)	4(66.7)	0(0)	10(31.3)	5(27.8)	
Pacific	19(32.0)	10(45.4)	4(18.2)	2(33.3)	0(0)	21(65.6)	11(61.1)	
NZ European	7(11.7)	4(18.1)	2(9.1)	1(16.7)	0(0)	4(12.5)	0(0.0)	
Other	1(1.7)	2(9.1)	2(9.1)	0(0.0)	0(0)	2(6.3)	2(11.1)	
Missing	0(0)	0(0)	0(0)	1(16.7)	1(100)	0(0)	0(0.0)	

^an = total number of residents who participated, new = total number of residents who participated in this phase and had not previously been involved in the project

^bParticipants could identify as multiple ethnicities and occupations

dialogue regarding the significance of situating the participants' reliance on state housing within the broader context of financial challenges posed by both state-provided housing and private rentals in keeping with the culture-structure-agency framework. The recruitment of participants for the in-depth interviews continued until data saturation had been achieved. The grounded theory analysis placed in conversation with the concepts of culture, structure, and agency guiding the CCA foregrounded the ways in which space and place constitute the struggles with health at the margins of settler colonialism.

Results

In response to open-ended questions about meanings of health, residents foregrounded the lack of access to adequate housing and displacement from place and community. The financial barriers to adequate housing and transient nature of housing significantly impacted the precarious lives of residents, shaping their everyday understanding of health. The advisory board focused on housing as a key determinant of health, building a community-led advocacy campaign around housing (Elsers et al., 2021a). Our findings attend to the cost of housing and the instability brought about by ongoing displacement, which in turn constitute the everyday negotiations of health and wellbeing. The grounded theory analysis, co-created through the participation of the advisory board in building sensitizing concepts that shaped the emergent health advocacy, foregrounded housing at the interplays of colonialism and capitalism.

Physical wellbeing

Housing, it's, um, the welfare of the people. That, um, that a family need to be in a safe environment. . . Then quickly, when people are starting to be evicted, you see, where else, what else . . . and then we ended up in the, in crowded houses . . . People stay and sleep in garages. (56–65-year-old Pacific man)

Consistent with Māori and Pasifika holistic cultural models of health (e.g., Cammock et al., 2014; Durie, 1985; Mark & Lyons, 2010), residents' narratives foregrounded housing and the broader environment within local constructions of health and wellbeing. However, the structure of housing inaccessibility was experienced as a barrier to enacting agency in their health, such as through evictions and overcrowding as described in the above quotation. Moreover, this structured housing inadequacy further manifested in the poor condition of the government housing slated for demolition in the redevelopment. Researchers observed and residents commonly reported these dwellings as being “cold,” “damp,” and “mouldy,” illustrating unsafe and unhealthy conditions that could detriment the health and wellbeing of residents. For instance, during the COVID-19 pandemic, a resident stated:

Mould and stuff like that, it's unstable, like breathing . . . We are so vulnerable. In every house, there might be ten or more people in it . . . I really believe that, yeah, our community has suffered. [26–35-year-old Pacific woman]

The above excerpt reveals how the housing conditions could be detrimental to residents' physical health and the vulnerability to illness that could stem from these conditions, including

during the COVID-19 pandemic. Furthermore, some residents' stories relayed how the state housing agency did not have compassion for them or their housing situations, whereby: “They're not like compassionate . . . They don't care . . . We feel like they're not listening” (18–25-year-old Pacific woman). Another resident discussed how she would not contact the state housing agency for future issues after waiting for an extended time to have her pantry door repaired:

I'm not gonna say anything . . . I'll just accept it . . . Our food got maggots in it cos the door, the pantry door, cos the flies kept coming in and I had to clean up our food, chuck the foods . . . They don't see that hazard, nor did they care. It's just a blimin' job to them, but to us, but to us it's life. (25–31-year-old Pacific woman)

This resident's account highlights how a lack of responsiveness from the state housing agency profoundly impacted her perspective on seeking assistance in the future. Her narrative reflects a sense of resignation and diminished agency, conveyed through her decision not to report future issues despite experiencing significant problems with her pantry door. What this quotation depicts, like others, was a sense of disempowerment and a loss of agency shaped by the interactions with the state housing structure. With housing and the broader environment being central within local constructions of health and wellbeing, residents knew some of the living conditions were unsafe, had few avenues to improve their situation.

For some residents, the unsafe living conditions became further embedded as barriers to being healthy in the COVID-19 “lockdowns” when people were restricted to staying indoors and were socially distanced from local relational networks of support. Consider the following description of a COVID-19 lockdown: “we [my child and I] had to stay at my sister's house which was severely overcrowded. We were sleeping in the lounge, and it was just, it wasn't convenient, wasn't healthy, wasn't safe, nothing” (18–25-year-old Pacific/NZ European woman). The potential for COVID-19 transmission intensified the hazard of living in overcrowded conditions, particularly given that Māori and Pasifika peoples statistically face higher risks of severe illness from COVID-19 compared to the national population (Ministry of Health, 2023), grounded in historical and ongoing inequities (Waitangi Tribunal, 2021). Residents reported further delays in processing state housing requests and fixing issues within the houses during the pandemic.

Ultimately, the participants' emphasis on the inaccessibility to safe housing and its toll on the health and wellbeing of individuals and families reveal systemic barriers embedded within socio-economic structures. The poor condition of the government housing slated for demolition in the redevelopment and the lack of responsiveness from the state housing agency perpetuate a cycle of housing precarity. This can amplify health risks and exacerbate challenges faced by communities during crises like the COVID-19 pandemic.

Unaffordability

Housing, it doesn't belong to us . . . [We] pay rent. We can't own anything. We can't call this land our home anymore, cos it feels like we're just being shifted around . . . Like everyone's just doing it

for the money . . . Not doing it for, um, to help people. (26-35-year-old Pacific woman)

The above excerpt captures a sense of disempowerment from housing displacement and transience, indicating how systemic factors and market-driven motives can undermine stability and a sense of belonging. The disconnection with land, emphasized in the statement “We can’t call this land our home anymore,” carries profound implications, given the emphasis on housing and the broader environment within local constructions of health and Māori and Pacific models (e.g., Cammock et al., 2014; Durie, 1985; Mark & Lyons, 2010). The notion of paying rent but being unable to own anything reflects the economic barriers perpetuated by neoliberal capitalism by prioritizing profit over housing as a fundamental human need. Unaffordable housing emerged as a common theme among many residents whereby: “The rent is so bad, it’s shocking” (46–55-year-old Māori woman) and “people on, like me for example, of very low incomes generally can’t afford the rentals” (56–65-year-old European-other man). Being poor coupled with the relative unaffordability of housing had a flow-on effect whereby residents struggled to afford primary healthcare, healthy foods, internet, and children’s educational materials. The pandemic exacerbated this challenge for some residents who encountered unemployment or experienced reduced working hours.

The structural housing unaffordability compelled several residents to live in others’ (often overcrowded) residencies, while awaiting the possibility of securing state housing, which was significantly cheaper than private rentals. Being poor and unable to access state housing had an immense social and mental toll on residents, particularly those living in transience or street homelessness. A young woman cried when she was asked about her living situation, stating “I’m homeless. . . So I’m a good person to question about the poverty . . . It’s just hard” (26–31-year-old Māori woman) and another recalled living in a van with her siblings, stating: “My older sister she was about five or six months pregnant and we were sleeping in our van . . . [We would] cry and just pray and just ask God to please help” (26–31-year-old Pacific woman). These emotive stories point to the human cost of housing unaffordability and insecurity.

Narratives about the state housing allocation structure highlighted a paradox in addressing housing affordability while perpetuating financial challenges for its residents. While state housing served as a vital refuge by being more affordable than market rent, a “God-sent” (26–31-year-old Pacific woman) for some, it was still considered expensive, with those residing in state housing continuing to struggle financially. The means-tested nature of state housing, adjusted in accordance with income, inadvertently created a dilemma wherein obtaining employment risked rendering housing more unaffordable as: “by the time we get a job, it’s easier not to even have it cos we can’t even afford the home we live in” (25–36-year-old Māori woman). Thus, although the state housing allocation structure reduced the financial inaccessibility to housing, it simultaneously created the inability to secure access to decent income while retaining access to this structure. The intergenerational nature of this predicament

became apparent as residents described the “cycle of poverty” whereby, “her mother brought up her family in social housing and [name removed] went on, and her daughter and so forth” (56–65-year-old Māori woman), illustrating how structural inadequacies can have a long-lasting impact in communities.

Within this framing, state housing, despite often being celebrated for its affordability, could paradoxically perpetuate financial constraints among some residents, diminishing residents’ agency. Altogether, the collective narratives of the residents portray the human toll caused by housing unaffordability, restricting residents’ access to healthcare, education, and dignified living. This suggests a need for systemic reforms that prioritize safe and accessible housing, which could significantly impact residents’ stability and agency in their health and well-being.

Displacement and instability

Housing means to me, something you stay in, but you’re not sure when you’re going to move out or how long you’re going to stay. (26-31-year-old Pacific man)

The lack of security and the threat of displacement are evident in the above quotation, illustrating the unsettled and transitory nature of residents’ living conditions. Residents’ descriptions of moving to Glen Innes were further grounded in stories of displacement; some were of their family’s travel directly from the Pacific Islands or their tribal lands to seek employment or education, while others depicted harrowing circumstances, such as street homelessness (four participants), incarceration (two participants), abusive relationships (two participants), and being “pretty much pushed” (36–45-year-old Māori woman) from state housing in recently gentrified neighboring areas (four participants). For some residents, space and housing “means somewhere stable to be able to live, not where you have to move every couple of months . . . You need that stability” (56–65-year-old European-other man).

The instability that arose from transience flowed on to other areas of social life, such as education and employment which requires: “getting myself stable first . . . It’s hard to commit to something when you’re living out of your bag” (26–35-year-old Māori woman). Yet despite some residents frequently being moved within Glen Innes, for most of those who had resided in the area for a significant time, Glen Innes was “home” and relationships in the community served as *whānau* [extended family]. Residents stated: “I reckon us as GI [Glen Innes], we all stick up for each other . . . We love where we are, where we live. You can never take someone’s hood away from them” (18–25-year-old Pacific woman), “this is home. I’ll always come back home” (46–55-year-old Pacific woman), and:

Glen Innes in Auckland is like my village . . . I find it hard to leave my village, cos I can walk out there now and I can see someone and they’ll greet me in their tongue and I’ll greet them in my tongue. So, even though we’re from different Islands, we’re still a community. So, I feel like this is my village. This is my hapū [sub-tribe] . . . My heart is with Glen Innes. (46-55-year-old Māori-NZ European woman)

This excerpt reveals a deep-rooted connection and sense of belonging toward Glen Innes. Depicting it as a “village” and “*hapū* [sub-tribe]” while recognizing the ethnic diversity in her statement, “we’re from different Islands” indicates a shared sense of identity and belonging, intertwining familial ties and cultural identity within the geographical space. The sense of community within Glen Innes became a social structure inherited within cultural norms for residents’ enacting agency in their health and wellbeing, such as through sharing resources and supporting one another.

However, residents expressed concern that this sense of community was under threat due to the housing redevelopment. Residents had witnessed local housing being demolished, friends, and families leaving the area, and “outsiders” moving in, and there was a feeling of uncertainty of if or when they too would move. This resulted in an unsettling feeling of uncertainty about their own future and potential displacement. Although some residents (approximately seven in the preliminary interviews) voiced no apprehensions about the redevelopment, a widespread view was that it was a form of gentrification, in which: “they’re just pushing the ones who’s less fortunate out of the community into a real harder environment” (36–45-year-old Māori woman) and “they just want to get rid of us” (36–45-year-old Māori man). In a video interview, a resident described how this was making the community suffer, stating:

My 33-years, I was born and raised here. . . They’re just targeting us from all corners, from all areas, cos they just wanna get all the shit out of here, which means us, the ones that are hurt, and move us somewhere else . . . You want a beautiful, a strong community, you start with the people, not with claiming the land. Too much claiming the land, that’s making us suffer. (26–35-year-old Māori woman)

The above excerpt suggests a feeling of being targeted and marginalized as part of a larger scheme of being pushed out to make way for a wealthier demographic, reflective of the consequences of gentrification – a situation intertwined with neoliberal capitalist policies. The resident’s assertion that focusing on the people rather than “claiming the land” is essential for building a vibrant community highlights a disillusionment with the redevelopment for the well-being of the residents. Yet in spite of the strong opinions expressed against the redevelopment by many residents, it was generally considered to be inevitable – with participants noting that they “can’t really do much about it” (56–65-year-old Māori woman) and “whatever I says, or somebody else’s says, it’s not gonna . . . change . . . in the next two years they may kick me out somewhere else because it is guarantee I’m not gonna be in GI [Glen Innes]” (46–55-year-old Pacific man), again indicating a loss of agency in the pursuit of local constructions of health and wellbeing.

Discussion

Building on preliminary culture-centered fieldwork carried out in Glen Innes (Elsers et al., 2021b), our study inverts the hegemonic approach to health communication that narrowly defines health in the realm of individualized behavior,

contributing to culture-centered scholarship that documents the role of structures in constituting the everyday experiences of health amidst poverty and deprivation (e.g., Dutta, 2007; Dutta & Basu, 2008). The participant narratives conceptualize evictions and housing precarity as an organizing feature of settler colonial neoliberalism that threatens health at the “margins of the margins.” Moreover, we theorize the interplays of space, colonization, and neoliberal urbanization to depict the intertwined relationship among land alienation of Māori, ongoing displacement brought about by neoliberal gentrification. We attend to the organizing role of space as a manifestation of the interrelationship between settler colonialism and neoliberal urban expansionism.

The parochial definition of health as situated within the confines of pre-determined constructs of health behaviors and interactions within biomedical health settings is disrupted by Dutta’s (2008) culture-centered approach in turning to the defining question, “what does health mean to you?” The participation of communities at the global margins in articulating health by drawing on their everyday lived experiences and struggles opens the interpretive frames around health, creating registers for community participation in mobilizing toward health (Dutta-Bergman, 2004). In Glen Innes, residents foregrounded housing and place in constructions of health, attending to access to healthy housing, and ongoing experiences of displacement amidst the accelerated gentrification and neoliberal urban reorganization. The emergent health intervention, the “Poverty is Not Our Future” campaign, grows out of the culture-centered process and takes the form of resisting eviction, rather than behavior change solutions (Elsers et al., 2021a). Dutta (2007) distinguished between cultural sensitivity and culture-centered approaches; this study delineates that differentiation, demonstrating the ways in which culture-centered health organizing challenges the colonial-capitalist structure that constitutes urban housing. On one hand, participants foreground the ways in which poor quality housing is at the root of the challenges to health. On the other hand, they situate their experiences of poor housing amidst the transience of housing in the neighborhood.

For Māori, the displacement is manifold, beginning with the theft of land by the settler colonial state that constituted large-scale urban migration. The loss of land through colonization was an assault on the essence of the traditional Māori culture, as relationships with the land were built across generations and permeated Indigenous life. The alienation from land shaped the loss of livelihood, which in turn, catalyzed the mass-scale movement of Māori to urban spaces in search of income (Durie, 2003; Walker, 1996). The neoliberal reforms aggressively pursued in Aotearoa New Zealand since the 1980s commoditized land and turned it into the key site of profiteering (Murphy, 2008). This took the form of urban expansion projects that further displaced already displaced Māori and Pasifika peoples from their spaces of community, living and livelihood (Friesen, 2009). As Banerjee (2011) described, “the development state did not necessarily translate into forms of local sovereignty for these [Indigenous] communities who bore the brunt of development . . . technologies of extraction, exclusion and expulsion lead to dispossession . . . ” (p. 323).

Glen Innes is a neighborhood that anchored the everyday meanings and negotiations of health for community members. At the time of carrying out this culture-centered intervention, the concepts of *whānau* [extended family] and *hapū* [subtribe] that participants had attached to their local community in Glen Innes were being threatened by the development agenda of the neoliberal state. Expelled and alienated from their relationship with land that anchors traditional practices, Māori resettled into urban spaces developed *hapū* and *whānau* concepts and relationships within the urban space. Cultural meanings embedded in context offered the scripts and interpretive frames for defining the neighborhood and attaching meanings to it. The neighborhood as the basis for the *hapū* and *whānau* anchored relationships, which in turn, formed the basis of securing health amidst structural deprivation.

Note here the interplay of culture and structure, with structure working to erase cultural claims to connection with land, expressed through sustainable housing, rooted in sustained relationship with the neighborhood. Structure simultaneously creates the conditions of disenfranchisement through its framework of means testing in the state housing allocation, rooted in the neoliberal ideology. Participants articulate that employment is not worthwhile within the means testing criteria, which in turn, perpetuates the cycle of poverty. This is situated in the backdrop of the high price rise in housing in Aotearoa, making housing inaccessible for households struggling to make a living (Cheer et al., 2002; Fernandez, 2020). The neoliberal ideology constructs the deserving subject, perpetuating the state of disenfranchisement, which is reflected in the everyday experiences of health.

Amidst housing insecurity, households turned to the broader *whānau* [extended family] infrastructure to support each other and to secure health, often the extended family living within the same household (Elers et al., 2021b). The challenge of overcrowding within this urban context renders visible the violence of the interpenetrating forces of settler colonialism and capitalism. Overcrowding therefore is a feature produced by the neoliberal settler colonial structure rather than being an outcome of poor behavior of individual households. The structure conditions the negotiation of culture, shaping the interpretive frames through which individuals, households, and communities relate to health and wellbeing. The struggles to secure housing are constituted within a neoliberal structure that positions housing as temporary. For households struggling with poverty, the access to decent quality housing is juxtaposed in opposition to rootedness in community. Health is negotiated amidst the temporariness of housing, and the loss of relationships and community connections that serve as key pathways for securing health. This construction of health serves as the basis of the Poverty is Not Our Future campaign in resistance to the gentrification in Glen Innes (Elers et al., 2021a).

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