CHAPTER 3

The COVID-19 Pandemic's Impact on the Health of Rohingya Refugees

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The flows of COVID-19 across global terrains work unequally, impacting disproportionately the margins of global spaces. Refugees constitute the "margins of the margins" of globalization, constituted in spaces without access to rights and pathways of citizenship, and living through the effects of violence targeted at them (Dutta & Zoller, 2009, Dutta, 2021; Dutta et al., 2020). Systematically erased from the infrastructures of claiming the "rights to have rights," refugees negotiate the challenges of health and well-being amidst crowded living arrangements, lack of adequate sanitation, and lack of access to healthcare, often living lives that bear the burdens of traumas inflicted by violence and yet disconnected from structures for addressing the effects of violence (Elers et al., 2021). This essay draws on the culture-centered approach (CCA) to theorize the negotiations of health among Rohingya refugees in Aotearoa New

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Zealand, depicting the interplays of communicative inequality and structural inequalities of health. We note that Rohingya refugees constitute the extremes of marginalization in the contemporary context of global organizing, having been subject to over six decades of violence organized by the infrastructures of hate, and violently erased from the infrastructures of recognition in modern democracies.

The communicative inequalities experienced by Rohingya refugees across the globe are tied to the structural and health inequalities experienced by Rohingya people and Rohingya communities. COVID-19 works to further deepen this interpenetrating relationship between communicative and structural inequalities, expressed in the accelerated threats to human health and well-being and the everyday negotiations of the structural challenges to health. The forms of structural inaccess and silencing that make up the everyday experiences of erasure in Rohingya communities are multiplied manifold by the top-down decision-making processes imposed as pandemic responses. This is particularly salient in Aotearoa New Zealand where the overarching hegemonic narrative of kindness, immersed in whiteness, fails to account for the lived experiences at the "margins of the margins." How did these top-down decisions, albeit positioned as scientifically based and clearly communicated, impact the everyday lived experiences of health and well-being among Rohingya communities? Particularly salient in this chapter is the juxtaposition of the New Zealand model of COVID-19 response that has been celebrated as a model for pandemic response in the backdrop of the health challenges and communicative gaps negotiated by Rohingya refugees.

COVID-19 and Refugee Health

Aotearoa New Zealand has a long history of settling refugees, beginning in the 1940s (Marlowe, 2021a). Since then, more than 35,000 refugees have been resettled in New Zealand (INZ, 2021a). The country established a formal annual quota for the resettlement of refugees in 1987 and from July 2020. Aotearoa New Zealand increased its annual quota of refugees to 1500 from 1000. Because of the COVID-19 pandemic, the refugee intake by New Zealand has been put on hold for almost a year from March 2020 to January 2021, but resumed the resettlement process in February 2021 (Walls, 2021). The family members of refugees may also come to New Zealand through the refugee family support category. Every year, the country allows 300 places for eligible refugees residents

to sponsor family members to join them (INZ, 2021b). Besides that, Aotearoa New Zealand approves asylum seekers who apply for refugee status from within its borders due to fears of persecution if they were to return home. For the last 10 years, Aotearoa New Zealand approved an average of 106 asylum seekers a year to gain refugee status from 375 applicants (Marlowe, 2021b).

Through the United Nations third country settlement process, refugees coming from different countries to New Zealand are at first accommodated temporarily for 6 weeks at the Mangere Refugee Resettlement Centre (MRRC) of Auckland for orientation programs to prepare them for life in a new country. Alongside a range of other support, a Refugee Health Screening Service (RHSS) to identify and treat personal health conditions that may adversely affect a refugee's resettlement process. Refugees generally suffer from various physical, psychological, and social experiences as they flee conflict and persecution. Therefore, specific focus on their health challenges is very much a crucial process to resettling in a new country. Refugee families also need additional support and guidance as the health system of the resettled country is often very different compared to their homeland and previous experiences in refugee camps or home countries.

Refugees can access free general healthcare and pay a subsidized cost to visit a doctor (General Practitioner-GP) or get prescriptions from a pharmacy in Aotearoa New Zealand. But COVID-19, especially during the lockdown, placed refugees at greater risk of getting appropriate healthcare services because of communicative and structural barriers (Elers et al., 2021; Jayan & Dutta, in press). The COVID-19 pandemic created a double emergency for refugees—difficulties in avoiding contracting the virus, on the one hand, and problems in accessing basic needs and livelihoods, on the other due to lockdown measures (Kirisci & Yavcan, 2020). Many refugees in Aotearoa New Zealand often depend on low paying and contractual jobs or depend on benefits/allowances they get from the state. However, because of COVID-19 pandemic many of them were laid off temporarily or permanently (Mortensen, 2020) but their benefits were not increased. During the lockdown, refugees were not able to access masks and hand sanitizers as well because shops were closed, the lack of supplies, and from the high costs of health safety products such as sanitizers and masks.

Furthermore, approximately 16% of New Zealanders do not have access to the internet, with the a refugee populations over-represented

in this group (StatsNZ, 2020). During the lockdown, general physicians (GPs) and other health workers provided their services mainly through online platforms. Refugee participants could not communicate with them because of difficulties with using mobile phones, not having internet facilities, and experiencing language barriers. Refugees also experienced long waiting times as a structural issue throughout the processes of receiving healthcare during the COVID-19 lockdowns. They faced problems during their medical consultations over phones as the GPs were not always available, from the lack of availability of interpreters, and having to wait for a longer period during the COVID-19 lockdowns. The refugees also experienced more restricted access to routine but critical healthcare services, including visits for primary care-responsive conditions like asthma, hypertension, heart failure, diabetes, cancer screening, and maternal and childcare visits (San Lau et al., 2020).

Rohingya Health

Rohingyas are the world's largest stateless population from enduring state-sponsored discrimination, persecution, violence, and genocide in their homeland Myanmar (Burma) for decades. Since the 1970s, when the army took control of power in Myanmar, the Rohingyas fled persecution and violence to various neighboring countries including Bangladesh, India, Pakistan, Thailand, and to other Muslim countries including Saudi Arabia, Malaysia, and Indonesia. As a result, over 3.5 million Rohingya Muslims are now distributed throughout the world (Albert & Maizland, 2020) and the largest number of Rohingyas, more than 1.1 million, are now living in various makeshift camps of Bangladesh (Rahman et al., 2021). In the 2000s, the refugees of Myanmar commonly known as Burmese refugees (including some Rohingya refugees), living in various countries of the world, had opportunities to resettle to Aotearoa New Zealand.

Initially from 2005, Rohingya refugees started to settle in Aotearoa New Zealand as Burmese refugees mainly from Thailand (UNHCR, 2007) and then between 2006 and 2010 some Rohingya families from Bangladesh had the opportunity of third country settlement including in Aotearoa New Zealand (Azad & Jasmin, 2013). But from 2010 Bangladesh has stopped the third country settlement for Rohingyas out of fear that it may promote other Rohingyas still living in Myanmar to come to Bangladesh (Rahman et al., 2021). From 2014–2015 the

Rohingya refugees of Myanmar living either in Malaysia or Thailand too started to resettle in Aotearoa New Zealand (INZ, 2019). Now, there are an estimated 1,500 Rohingyas living in Aotearoa New Zealand coming under the UNHCR-initiated third country settlement process.

Under the third country resettlement process, all refugees including Rohingya people received New Zealand Permanent Residence (PR) visas and can, therefore, access the same publicly funded health and disability services as all citizens of Aotearoa New Zealand. However, during COVID-19 pandemic, Rohingya refugees faced unmet health challenges, especially when they were bound to stay at home during the lockdowns. Aotearoa New Zealand had reported its first case of the virus on 28 February 2020 and went into lockdown on 25 March 2020. The lockdown lasted two months and was lifted on 13 May 2020. Then again, the emergence of the Delta variant of the virus, Aotearoa New Zealand went into lockdown from 18 August 2021, lasting another two months. Most of the Rohingya refugees living in New Zealand had been struggling to survive on benefits and allowances of Work and Income, New Zealand (WINZ), as they did not find any suitable jobs as new resettled people in the country.

Culture-Centered Approach

The culture-centered approach (CCA) situates health amidst the interplay of culture, structure, and agency (Dutta, 2004, 2021; Dutta et al., 2020; Kim & Dutta, 2009). Culture refers to the contextually situated values, narratives, and norms that guide communication. Structure refers to the forms of organizing, the rules and roles that shape and constrain access to resources of health and well-being. Agency refers to the capacity of individuals, families, and collectives to make sense of health, negotiate structures, and seek to change them. Through the voicing of meanings of health, communities at the margins co-create theories of health and well-being, in dialogue with theories of communication (Dutta & Zoller, 2009). For instance, culture-centered interventions co-created with precarious migrant workers at the "margins of the margins" builds communicative infrastructures owned by the workers, and these infrastructures emerge as spaces where solutions to health and well-being are foregrounded (Dutta & Jamil, 2013). By foregrounding the struggle amidst migration structures, the migrant worker voices dismantle the

whiteness of health communication that encloses health into preventive behaviors defined within the ambits of parochial US-centrism. This ongoing dismantling of what forms health is a key element of the CCA, situating the definitions and scope of what is health communication in the hands of communities at the "margins of the margins." Therefore, we ask, what are the meanings of health constructed by Rohingya refugees in Aotearoa New Zealand amidst COVID-19?

Method

This chapter reports on participant observations, in-depth interviews, and systematic analysis of the literature (both published and gray). One of us has been working with Rohingya refugees in camps in Malaysia and India since 2018, seeking to develop a culture-centered framework for advocacy. The other has been working with Rohingya refugee crisis as a journalist since 2017 Rohingya genocide. He still works with Rohingya people while working with CARE (Center for Culture-Centered Approach to Research and Evaluation) at Massey University and was involved with conducting in-depth interviews of Rohingya refugees living in Aotearoa New Zealand.

Based on the CCA, a total of 20 in-depth interviews with Rohingya refugees were conducted between November 2020 and February 2021. Each of the in-depth interviews lasted between 40 and 70 min and was undertaken with the help of a community researcher, who is also a part of the Rohingya refugee community of Aotearoa New Zealand. All the interviews were conducted in the Rohingya language, and then translated and transcribed. The interviews were then examined microscopically through line-by-line open coding to identify concepts before forming relationships between the concepts, and then providing theoretical integration.

Findings

The initial lockdown in 2020 in Aotearoa New Zealand exacerbated the challenges experienced by Rohingya refugees, especially those who entered New Zealand just before the lockdown. After entering a new country, they were stuck without access to resources. When the lockdown was declared in 2020 and 2021, amidst the uncertainty of how long the lockdown would last, shortage of goods, including healthcare items, had resulted in panic buying (Hall et al., 2021). Rohingya refugees struggled

with finding the required items like masks, hand sanitizers, etc. to buy. They noted that if the items were available, the cost was too high.

During the lockdown as the prices of daily commodities and health items were raised, Rohingya refugees faced difficulty in purchasing these items. Rohingya refugees articulated that during the lockdown of 2020, Ramadan (the fasting month of Muslims) was observed and on certain days, they could not find anything to from the shortage of money and closed shops. They had to continue fasting without consuming food at night, when needing to break their fast. Rohingya refugees also faced difficulties using debit and credit cards during lockdown as they were used to purchasing food with cash. During the lockdown, the participants noted that no cash could be used in shops, and one needed to purchase food only by using digital transactions. This created challenges for Rohingya refugees as they did not have debit or credit cards and did not know how to use them. These struggles were constituted amidst the struggles in accessing healthcare, with long waiting times, technologically mediated telephone conversations, and communication gaps that were exacerbated by the lockdown.

Struggles with Food

Across participant narratives, we hear the struggles with securing adequate, decent, and culturally anchored food. The everyday struggles with food experienced by Rohingya refugees were exacerbated by the structures of the COVID-19 lockdown, with the contacts into the community disrupted and participants largely experiencing information vacuums. For the first few days of the lockdown, participants experienced anxiety and confusion, not knowing how to arrange access to food. Participants note that when the lockdown was announced, they struggled to secure access to food because they were disconnected from the services that served as nodes of connection into resources.

> When we got the news that the City Council will supply us food, we phoned the City Council and informed them that we wanted halal Food. Then they sent us the Halal food. But sometimes some food also came which was not halal. Then we only kept the halal food and other foods were given to our neighbor. Just after one year of coming to New Zealand the lockdown started and so we faced a lot of problems like shopping and buying food etc.

Some Rohingya participants came just some months before the COVID-19 lockdown started. They did not know the system, rules, regulations, shopping places, and environment of the new country. But, when the lockdown started they could not go outside whenever they needed to, which hampered a lot of their daily living.

> We were new at that time of lockdown. We did not know what to do. We were scared a lot by the COVID-19. We could not go to school (ETC). We did not understand what to do. We faced the problem of collecting or purchasing food as maximum shops were closed. We all were in trouble in COVID-19lockdown.

Articulation of another Rohingya male participant:

> As we are Asian, we cannot lead life like kiwis. But during the lockdown the Asian shops could not supply food as per our requirements and so we faced problems. We could not purchase food according to our wish or according to our kids' needs.

Notes another Rohingya participant, "during the lockdown the prices of commodities were higher."

Struggles Accessing Masks and Hand Sanitizers

The initial COVID-19 pandemic and lockdown caused a surge in demand for face masks, alcohol-based hand rubs (hand sanitizers), medical gloves, etc. that created shortage of these items during the lockdown period. Rohingya refugees faced problems getting face masks and hand sanitizers. One Rohingya participant mentioned finding no masks when he went outside. He then used an old mask he had from Malaysia. He mentioned:

> I had a mask I had taken from Malaysia and that mask I used to wear to go to the market. I always had to wear masks in my job in Malaysia and during my journey to this country I took 2-3 masks from that country and those masks helped me in New Zealand also. During lock down no family members went outside, I only went outside wearing Malaysian masks.

Without access to masks, sometimes Rohingya refugees went outside without wearing masks. Sometimes, they mentioned wearing clothes as masks when they wish to enter into markets.

> ... I did not find face masks to purchase. So, without masks sometimes I had to go to the shop and at that time I used a separate cloth as mask as I did not find any masks to buy, or anyone did not provide me the masks. Some people asked me why I use clothes as masks. Then I replied that I could not find masks from any sources or even could not buy them. Then they told me to keep my distance from them while I was in the shop.

Scarcity of Rohingya Interpreters for Communication

The Rohingya refugees could speak only in their mother tongue, Rohingya language. So, whenever they make an appointment with a GP, a Rohingya interpreter is needed to facilitate the interaction. The participants note there is a scarcity of Rohingya interpreters in New Zealand and so sometimes, the GPs try to take help from the interpreters based in Australia. This creates a problem to get the GPs' service in time. During the lockdown, with a number of GP services closed or only offering phone consultations, this problem was exacerbated. Getting healthcare consultation through phones was difficult for the Rohingya refugees as most of them could not speak English and there were no alternative sources for accessing healthcare during the lockdown period.

One Rohingya refugee who came from Malaysia and now lives in Aotearoa New Zealand mentions that when he lived in Malaysia, he did not need to get any appointment. However, in New Zealand, without any appointment, he could not visit a doctor. Again, after queueing for a long period, he secured an appointment, but then faced problems with the lack of Rohingya interpreters.

> In Auckland, in Australia, there are enough Rohingya interpreters, but in Palmerston North, there is scarcity of Rohingya interpreters. And during the lockdown we even did not find any Rohingya interpreter to help us. We face several problems here in New Zealand. To get a hospital appointment, we have to wait for two to three days. But in Malaysia, it was good. No need to make an appointment in a hospital in Malaysia. Here we do not find an interpreter and again we have to wait a long time for an appointment. We are facing many problems here.

Participants noted that after reaching New Zealand, Rohingya refugees received help through the Red Cross. A caseworker is appointed for every refugee family for their resettlement needs in the new country.

Besides, Red Cross volunteers also work on the resettlement process of the refugees. The caseworker and volunteers work through reducing the communication gap between the refugees and Govt. agencies. During COVID-19 lockdown, the accessibility to the caseworker and volunteers was also restricted as they too had to stay home, which in turn hampered the resettlement process for the newly arrived Rohingya families.

One Rohingya woman articulated that she had to wait in a lift of a hospital for more than 30 min as she did not know how to use the lift at that time. As she was pregnant, the Rohingya woman had to visit a doctor and she went to the hospital with the help of a Red Cross volunteer, but the volunteer only helped her to reach the hospital. After reaching the hospital, the Rohingya woman had to visit the doctor by herself. The pregnant Rohingya woman could enter the lift, but she did not know how she could get out of the lift. As a result, she was stuck in the lift for more than 30 min and at last with the help of an Asian provider, she could get out of the lift. She mentioned:

> During lockdown, I was pregnant. I faced difficulties finding a volunteer to help me. At that time, I did not find any midwives either. Diabetes was also observed during my pregnancy and so I had to visit the hospital at a regular interval. But during the lockdown I faced difficulty finding a volunteer. At that time, I did not know how to use the lift. One day a volunteer just took me to the hospital and left me alone there. I had to go to the 2nd floor and so I got myself in the lift, but I did not know where or on which floor I should get off. On that day I was in the lift for more than 30 minutes as I did not understand how I could get off from the lift. I could not also ask anyone as I do not know English. At last an Indian Nurse/Doctor asked me in Hindi why I was in the lift for more than 30 minutes. She helped me to get off the lift. That was a terrible scenario for me.

The same Rohingya woman described that she could not convey her message clearly to the gynecologist about the delivery date of her last child born in New Zealand. As a result, the child was born 10 days before the maturity date. The Rohingya woman felt sorry for her struggles with expressing her health needs in English, which in turn resulted in her child's early delivery. She observes:

> The last child of mine was born in New Zealand. But my last child was born 10 days before the maturity of my child, I think. As I could not speak

> English properly and I could not communicate clearly with the doctor, my child was born ten days before the delivery time. The doctor prescribed medicine and mentioned that as I have diabetes, they made the delivery of my child 10 days before the actual delivery time. That happened against my wish and I did not feel good and still I feel sorry thinking why the doctor had to deliver my child before 10 days of actual delivery time. And during lockdown I had to wait 5-6 hours in the hospital which was difficult as I was carrying (pregnant) at that time.

An elderly Rohingya woman observed that during the COVID-19 lockdown she experienced fever and cough, symptoms of COVID-19. Her neighbor and friends advised her to take the COVID-19 test. Then her family members communicated with the GP and she tested negative for COVID-19. Due to her inability to speak English, she herself could not communicate with the GP. She was not advised by her provider about quarantining despite her symptoms mimicking that of COVID-19 symptoms. She mentioned:

> During lockdown, I felt sick, got a fever and coughing. Then my family members and the ETC (English Teaching College) teachers also asked to check the COVID-19 test. Then my family members talked to the GP and after getting the paper from the GP I went to take the COVID-19 test. I could not drive the car and then my daughter helped to take me to the testing centre for COVID-19 test. The testing centre people took samples from my nose and gave the result after two days. During these two days or after feeling sick, I did not maintain quarantine in my house and the GP did not also instruct me to do any isolation. That time was scary as I was asked to take the COVID-19 test. After two days, I got the test result and the result was COVID-19 negative. Then the GP advised and prescribed fever and coughing medicines that were bought by family members from the Palmerston North Pharmacy.

Long Waiting Time

Long waiting times to receive health care services were one of the most significant issues pertaining to health challenges of Rohingya refugees in Aotearoa New Zealand. Rohingya people have to wait for hours in the hospital to get the required services and sometimes some people have to return back as they were unable to wait for a longer period of time due to their health conditions. Not only in the hospital, Rohingya refugees faced

long waiting times to see the GP. Various factors such as the inability of Rohingyas to speak in English, unavailability of GPs, etc. exacerbated the situation. Some Rohingyas observed that they had to wait days or even weeks to get an appointment with a GP.

A Rohingya participant mentioned that a key challenge faced was getting a GP's appointment. He observed that the long waiting times in the hospital created further barriers to accessing health services. He observes:

> When people are sick, they really need to see the doctor. But the doctors said, you need to make an appointment, maybe tomorrow or day after tomorrow or even after that. Maybe after 2-3 days and sometimes after two weeks. Sometimes you need to see a doctor now, but you could not do it without getting an appointment. During lockdown even you were not able to take Doctors' appointments. I should tell you a thing about my life here though that had not happened during lockdown but before that. One day my daughter has been suffering from vomiting. Finding no other way, I went to the hospital and tried to admit my daughter. But after waiting for seven hours (5pm-11:45pm) I was unable to get admitted to my daughter in the hospital. Then I came back with my daughter and talked to my community and also thinking about anti vomiting tablets. Then I found some anti-vomiting tablets and those tablets helped my daughter's vomiting stop but failed to admit my daughter in the hospital. So, I think health service problems or getting an appointment with a doctor is the main problem here.

Not only in the hospitals, but purchasing food during the COVID-19 lockdown was also met with long waiting times. Rohingya participants mentioned that they had to wait one to two hours outside shops to enter. Again, queues to pay after shopping also ensued.

> Yes, I faced various difficulties. Like I had to spend too much time purchasing foods. What we did was that I kept myself with my kids in the car and my wife used to buy food items. But a lot of time was required because she had to stay in the queue for about 1 hour and then get a chance to go inside the market.

Another description of the experience by another Rohingya participant:

> … At the time of lockdown too much time was needed for shopping. I had to put myself in a queue for about 1-2 hours to enter the market.

> After a long time waiting, when I was able to enter, sometimes, I could not find the item that I needed. Again, the price of the essential items was higher at the lockdown period.

Long waiting times to purchase groceries and at the pharmacies were also voiced as health barriers by participants. They mentioned needing to wait hours in the queue to enter shops or pharmacies and often required items that were not available or had higher price tags attached to them. Again, because the instructions on the items were written in English, they did not understand which item was *halal* (appropriate for Muslims), and they could not discuss with others as social distancing had to be followed during the COVID-19 period. Long waiting time to receive healthcare was already a challenge by the Rohingya refugees before the lockdown, which was exacerbated further during the COVID-19 pandemic.

Discussion

The narratives voiced by participants note the role of limited or disappearing structures in exacerbating the experiences of marginalization negotiated by Rohingya refugees in Aotearoa New Zealand amidst the COVID-19 lockdown. The dominant reading of the lockdown in New Zealand as model health communication response is disrupted in the narrative accounts offered by Rohingya refugees. The participants note the challenges to the everyday negotiations of health and well-being amidst the lockdown, foregrounding the disappearing migration resources that are essential to the negotiations of health. The implementation of the lockdown was experienced in the form of the sudden disappearance of the health providers, navigators, volunteers, caseworkers, and refugee organizations in the community. Participants experienced ruptures in their everyday negotiations of health, shaped by the communicative vacuum introduced by the lockdown. The communicative vacuum is shaped by the whiteness of the structures of health and migration, configured in a bureaucratic top-down model that approaches refugees as passive recipients of services. This chapter renders visible the cracks in a health communication response that is put forth as an example of good communication grounded in science and clarity. The hegemonic construction of what is clear health communication is marked by the erasure of the "margins of the margins." Amidst the neoliberal transformations in Aotearoa, refugees negotiate the financial struggles with accessing resources of

health and well-being (Elers et al., 2021), which are further exacerbated by the lockdown. The lockdown and the accompanying panic buying, constituted amidst the exponentially higher prices of certain food and other grocery items, shaped the everyday experiences of Rohingya refugees with food insecurity amidst the lockdown. The lack of cultural considerations in the selection of the food that was delivered through assistance programs often failed to meet the everyday health needs of community voices. The structural challenges with health were also experienced in the context of the everyday challenges with securing access to preventive resources such as hand sanitizers and face masks. The increased demand on these supplies, the limits on accessibility to the stores, the lack of access to caseworkers, and the costs of the supplies resulted in refugees often struggling to practice the recommended preventative behaviors.

The voices of Rohingya refugees dialoguing with us document the lack of clarity, the absence of guidelines, and the absence of the consideration of their fundamental needs when the lockdowns were implemented. This translated into increased anxiety and inability to seek healthcare, with participants often noting that with the caseworker disappearing from their everyday negotiations of health, they felt lost, not knowing where to go to and whom to speak with. Everyday negotiations of health amidst the lockdown were shaped by the inability to understand interactions, further exacerbated by the technologically mediated distance-based solutions that were put into place rapidly without the participation of community voice. The absence of refugees from the communication structures to lay claims for their health rights translated into their everyday erasure from spaces of participation and decision-making about their health and well-being (Dutta, 2021). The whiteness of the health and migration systems built on the ideology of altruism fails to take into account the fundamental human right to voice of refugee communities. The erasure of the human rights to voice is the fundamental challenge that shapes the vast gaps in health communication negotiated by refugees. This calls for health communication work with refugees as health activism that seeks to transform the structures of health organizing. In sum, the lockdown exacerbated the communicative gaps experienced by the Rohingya refugees in accessing health resources and services, depicting the limits of the health communication model adopted in Aotearoa New Zealand. This chapter contributes to the existing scholarship on the CCA by foregrounding the role of communicative vacuum in the context of the refugee experience. Without the right to have rights, refugees are erased on an ongoing

basis from the structures of health decision-making. These erasures are catalyzed exponentially amidst a crisis, marked by a health communication infrastructure that is largely absent in the lives of refugees amidst COVID-19. The experiences of erasures and communicative loss voiced by the refugees challenge the narrative of excellent health communication guided by clarity and kindness that is being deployed to depict the COVID-19 response of Aotearoa New Zealand (Dutta & Elers, 2020).

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