



# Negotiating Health Amidst COVID-19 Lockdown in Low-income Communities in Aotearoa New Zealand

Christine Elers , Pooja Jayan , Phoebe Elers & Mohan J. Dutta

To cite this article: Christine Elers , Pooja Jayan , Phoebe Elers & Mohan J. Dutta (2021) Negotiating Health Amidst COVID-19 Lockdown in Low-income Communities in Aotearoa New Zealand, Health Communication, 36:1, 109-115, DOI: [10.1080/10410236.2020.1848082](https://doi.org/10.1080/10410236.2020.1848082)

To link to this article: <https://doi.org/10.1080/10410236.2020.1848082>



Published online: 23 Nov 2020.



Submit your article to this journal [↗](#)



Article views: 213



View related articles [↗](#)



View Crossmark data [↗](#)



## Negotiating Health Amidst COVID-19 Lockdown in Low-income Communities in Aotearoa New Zealand

Christine Elers , Pooja Jayan , Phoebe Elers , and Mohan J. Dutta 

Center of Culture-centered Approach to Research and Evaluation (CARE), School of Communication, Journalism and Marketing, Massey University

### ABSTRACT

Aotearoa New Zealand's public health crisis communication approach amidst the COVID-19 pandemic effectively mobilized the nation into swift lockdown, significantly reducing community transmission. This communication approach has been applauded around the world. How did communities situated amongst the "margins of the margins" in Aotearoa New Zealand navigate through the existing structural barriers to health during the pandemic? In this study, we use a culture-centered analysis to foreground the structural context of disenfranchisement amidst the COVID-19 lockdown. Drawing on in-depth interviews with participants in a larger ethnographic project on poverty and health across three communities in Aotearoa New Zealand, we attend to the ways in which health is negotiated amidst the COVID-19 outbreak and lockdown response at the "margins of the margins." The narratives point out that health communication interventions to prevent COVID-19 in the context of Aotearoa New Zealand furthered the marginalization of communities at the margins, and community voices were largely erased from the enactment of interventions. With the extant structures failing to recognize these aspects of everyday struggles of health at the margins, the health and access challenges were further magnified during COVID-19. Our attention to communication situated in relationship to structures builds a register for health communication scholarship in the context of COVID-19 that is committed to disrupting the behaviorally based hegemonic health communication literature and transforming the unequal terrains of health experiences.

The trajectories of COVID-19 (C19) as well as the preventive policy responses to it have disproportionately impacted the global margins (Dutta et al., 2020). Across countries, regions, and communities, those at the gendered, raced, and classed margins have borne largely the effects of the pandemic (Patel et al., 2020). Aotearoa New Zealand has been globally recognized for its decisive leadership and the overarching effectiveness of its science-based C19 response, accompanied by clear communication and state-led welfare support (Cousins, 2020; Dutta et al., 2020; PProvoke Media, 2020). How then do inequities in health play out amidst this effective model of C19 response? Traditionally, Māori, Pasifika, and refugee communities have borne the greatest burdens of poor health outcomes in Aotearoa New Zealand (Mahony et al., 2017; McIntosh & Mulholland, 2011; Ministry of Health, 2014). These features of raced/citizenship-based identity intersect with poverty to produce marginalization (Bowleg, 2020).

In this essay, we draw on our ethnographic fieldwork embedded in the culture-centered approach (CCA) with Māori, Pasifika, and refugee communities across three sites in Aotearoa New Zealand to examine the interplays of culture, structure, and agency at the margins in constituting the everyday negotiations of health and wellbeing amidst the C19 outbreak (Dutta, 2020). Our emphasis here is on foregrounding the structural context of marginalization, drawing out the common threads in the diverse experiences with the Whiteness of the pandemic communication response across

raced identities at the peripheries in Aotearoa New Zealand that historically bear disproportionate burdens of health inequities (Mahony et al., 2017; McIntosh & Mulholland, 2011; Ministry of Health, 2014). The C19-related advocacy work performed by our academic-activist team emerged out of our advisory group members seeking solutions to the existing and new challenges to health introduced by C19. In this essay, we highlight the structural dimension of the culture-structure-agency framework of the CCA, challenging hegemonic message-based theorizing (Dutta, 2015).

### C19 response in Aotearoa New Zealand

Aotearoa New Zealand has been praised globally for its effective response to C19 (Cousins, 2020; PProvoke Media, 2020). The communication from the beginning was, 'We are a team of 5 million', demonstrating unity. However, the voices from the margins point to erasure of socio-cultural-economic contexts. Observing the entrenched institutional racism that pervades Aotearoa New Zealand's healthcare system (Waitangi Tribunal, 2019) and the exclusion of Māori from pandemic decision-making, Jones (2020) described the government's C19 communication updates as "an exercise in Whiteness" (para 10). Whiteness in the organizing of healthcare in Aotearoa New Zealand positions the entrenched values of White Pākehā culture as universal, erasing the cultural values, knowledge systems, and voices of Māori, Pasifika, and refugee

communities (Huygens, 2006). The health experiences at the margins are played out on a canvass of entrenched social, economic, and political inequalities. Inequities in health outcomes precede and will survive C19; who can function in a lockdown “normally” is constituted by inequality and in turn also constitutes that inequality.

### Margins of Aotearoa New Zealand

In Aotearoa New Zealand, marginality is shaped by the interactions among ethnicity, citizenship status, social class, and geographical areas of living, evident among Māori, Pasifika peoples, and refugees negotiating poverty and living in high deprivation areas (Mahony et al., 2017; McIntosh & Mulholland, 2011; Ministry of Health, 2014).

### Māori

Māori are the Indigenous peoples of Aotearoa New Zealand. Moewaka Barnes and McCreanor (2019) highlight the serious harm that colonization continues to exact upon Māori. The most challenging barriers are embedded in the lived realities experienced by many Māori, who endure extensive oppressions and reflect debilitating outcomes for income deprivation, family welfare history, unemployment, and education (Webb, 2017). These realities are embedded in the historical and contemporary contexts of Aotearoa New Zealand and have inflicted Māori since the onset of colonization, exacerbated by neoliberalism. McLeod et al. (2020) analyzed the adverse impact of C19 on Māori sited amidst the lower socio-economic factors that intensify communicable disease transmission such as poverty, low-quality housing, homelessness, and high comorbidity rates, exacerbated by differential healthcare access derived from institutionalized racism and colonization.

### Pasifika peoples

The *Pasifika* grouping encompasses a large number of Pacific ethnic groups in New Zealand (Ministry of Health, 2014), which can erase distinctiveness and diversity, and so we use individuals' self-reported ethnicities when reporting on participant narratives. Nevertheless, as a statistical grouping, Pasifika peoples are poorly represented in poverty indicators (Webb, 2017); experiencing higher rates of housing insecurity (Amore et al., 2020), ambulatory-sensitive hospital admissions, youth mental health, mortality from cancer, and a shorter life expectancy (Ministry of Health, 2014). In the early 1970s, there was a large-scale immigration of Pasifika peoples to Aotearoa New Zealand to fill unskilled jobs. From the mid-1970s when the economy contracted, Pasifika peoples were significantly impacted by unemployment (Foliaki, 1997).

### Refugees

New Zealand Immigration outlines five key strategies for integration of refugees: self-sufficiency, participation, health and well-being, education, and housing (Mahony et al., 2017). Referring to refugees as ‘Birds in a Gilded cage’ Altinkaya and Omundsen (1999) criticized the policy issues that impact

the effectiveness of Aotearoa New Zealand's humanitarian gestures toward refugees. The economic, social, and cultural rights of refugees are inadequately implanted in Aotearoa New Zealand's legal framework, resulting in incompatible and discriminatory policies (Mahony et al., 2017). According to Immigration New Zealand (2020), during the financial years from 2015–16 to 2019–20, refugees mostly arrived from Syria, Myanmar, Colombia, Afghanistan, Palestine, Pakistan, Bhutan, Eritrea, Sri Lanka, and Iraq. The diversity of the refugee population indicates that they bring different cultures, histories, gender expectations, linguistic competencies, human and social capital. Even though refugees in New Zealand possess diverse cultures, they face a similar level of marginalization in negotiating a system that is embedded in Whiteness and neoliberalism (Kale et al., 2018).

Amidst these multiple registers of marginalization in Aotearoa New Zealand (poverty, indigeneity, race, and citizenship status), our advisory groups foregrounded the ways in which the Whiteness of the structure of pandemic communication erased their voices. Guided by the advisory groups, we ask, what are the experiences of negotiating C19 at the “margins of the margins” of Aotearoa New Zealand?

### Methods

Most participants were recruited through existing advisory groups, which initially sought to examine experiences of poverty and deprivation in low-income areas (see: Statistics New Zealand, 2020a; 2020b). In total, we completed 35 audio-recorded interviews between May 2020 and July 2020, lasting between 30 and 90 minutes (see Table 1). We used a semi-structured interview technique, involving open-ended questions with probes, and that due to the changing restrictions of the lockdown, we used a mixture of in-person (5/36) and remote interviews (31/36) undertaken through phone (13/36), Skype (5/36), and Zoom (13/36). Five interviews were

**Table 1.** Participant demographics.

Demographic	Palmerston North	Feilding	Glen Innes	Total
Ethnicity*				
Māori	3	7	3	13
Pacific	1	0	7	8
Pākehā/NZ European	0	1	1	2
Refugee	12	0	0	12
Non-refugee other	1	2	0	3
Gender				
Male	7	3	2	12
Female	9	6	8	23
Occupational Status*				
Employed	3	1	3	7
Unemployed	9	8	2	19
Homemaker/Looking after children	3	4	2	9
Unable to work due to disability	2	2	1	5
Student	2	1	2	5
Age				
18–25	5	1	2	8
26–35	1	3	4	8
36–45	5	3	2	10
46–55	4	1	1	6
56–65	1	1	1	3
66+	0	0	0	0

undertaken with the assistance of registered translators. The participants completed informed consent procedures and demographic forms before the interviews. Based on the CCA, which involves building theories from within communities, the method of analysis was guided by grounded theory.

## Findings

The narratives voiced by the participants attend to the structural contexts of everyday living amidst the lockdown, the interplays of communicative and structural inequality, and the mobilization of relational and community agency in negotiating the effects of the lockdown.

### Everyday living

Prior to C19 lockdown, many of the participants were already struggling to find housing or were living in crowded accommodation in shared households. The narratives of lived experiences of severe housing deprivation contained here began prior to C19 lockdown, with participants noting salient systemic structural barriers to housing that they face on a daily basis. The C19 lockdown prolonged and exacerbated these challenges. “We were homeless just before lockdown ... we were sleeping in a tent with our kids ... and baby ...” (Māori woman, age group 26–35 years). This participant’s partner explained the number of house viewings he attended before the C19 lockdown,

I was viewing three or four places a day, even before COVID, it was hard ... we were looking, we’re looking, we’re looking and denied, denied, denied denied ... and then COVID kicked in and made it even worse because we couldn’t even look at places (Irish American man, age group 36–45 years).

The last national census conducted in 2018 revealed that Pasifika peoples rate of homelessness is six times greater compared to Europeans (Amore et al., 2020). Household crowding,<sup>1</sup> one of the determinants of homelessness is prevalent amongst Pasifika peoples more than any other ethnicity in Aotearoa New Zealand.<sup>2</sup> In Glen Innes, household crowded living situations also impact the community.

... because my household, we’re overcrowded and so. um pre-COVID we applied for a place for my parents and my two younger siblings to move into. Only because they can have their own space. and we have our own. and because my dad is going through ough medical treatment at home ... (Tongan woman, age group 26–35 years).

In Palmerston North, the refugee participants are allocated housing through the support of New Zealand Red Cross. This support ceases after one year. The participants spoke about their anxiety around informing Housing New Zealand<sup>3</sup> that the household appliances such as the stove needed fixing because of the ensuing repair bill that the refugee participants would receive and struggle to pay.

At the onset of C19 lockdown, some participants faced tough decisions regarding continuing their employment as essential workers and therefore putting their families at a higher risk of contracting the virus or leaving their employment to reduce the risk to their family bubble, “people were

coming to work sick, so I chose to stay home ... some of the workers chose to walk out ... didn’t wanna put their family at risk” (Māori woman, age group 26–35 years). Another participant, concerned for her young baby and unsure about the co-parenting lockdown rules, also left her employment to keep her children safe. The anxieties related to loss of employment and the struggles to get by were voiced as some of the most salient challenges to health and wellbeing.

Not everyone who lost their employment as a result of C19 received the government’s C19 wage subsidy, “we went to my partner’s employer, he told us to go to WINZ, they put us on an emergency benefit ... it was horrible for me, I’ve never been in the system but ah I had to do it” (Cook Island Māori woman, age group 18–25 years). The Job Seeker’s benefit for a single person over 25 years of age is a maximum of 250 USD per week, after tax, with an add-on supplement for housing and winter energy payments (RNZ, 2020). Adjusting from employment income to the Job Seeker’s benefit during C19 lockdown was “not nice to be on benefits because really you get stuff all ... I do not recommend anyone to go on a benefit” (Māori woman, age group 26–35 years).

Families, who were already facing socio-economic difficulties including employment challenges pre-C19, were now also navigating access to food as many staple items flew off the supermarket shelves during panic-buying “we are on a limited budget and the food that we could afford was gone so that was challenging” (Māori male, age group 46–55 years). The high cost of living in Auckland is acutely experienced by those experiencing employment challenges, “I only have enough money just to pay for rent and don’t have enough money to get like groceries and that ...” (Tongan man, age group 18–25 years). At all sites, some participants commented on the increase in electricity bills due to all family members being home. For some, they had to carefully arrange their household budget to ensure there was enough internet data for children to participate in online schooling.

### Communicative inequality

There were communicative challenges experienced by many participants, uttered through words like, “language barrier”, “cannot understand English”, “don’t know where to find the resources from” and “confusing”. Recalling his distressing experience in the supermarket during lockdown, a refugee participant stated “When I went to the supermarket, I wasn’t able to read the instructions given there, to maintain distance ... I was not sure what to do there. Not knowing the language” (Refugee man from Nepal, age group 56–64 years). In the absence of proper information in their language, refugees may not have adequate knowledge on prevention. Acknowledging her struggles with communicative platforms during the lockdown, another participant revealed, “I had to get used to the platforms that we had to use which was really confusing” (Māori woman, age group 36–45 years).

Lockdown measures forced people at the margins to abandon their everyday living patterns, including work, social lives, and to remain at home. Adherence to lockdown was, for many, challenged by access to communicative resources. A refugee participant described how a volunteer is her only hope for

navigating the healthcare structures in Aotearoa New Zealand. However, due to the sudden C19 lockdown, the means of such support were disrupted. The single mother of five children alluded “All kids get cold ... One person get cold and then everyone get cold. We didn’t do much ... Normally, volunteer take to doctor ... She didn’t come to meet during lockdown to help” (Refugee woman from Afghanistan, age group 46–55 years). A Māori participant from Feilding expressed his concerns while contacting the support services during C19. He stated,

I live alone, whereas Whānau<sup>4</sup> you know, like my children, were getting [food] packages, but we had to bloody ring up, and you know hammer away at them all the time you know. Hello we’re here, anyone out there. \* where are you? Kei hea, kei hea koe? (where are you, where are you?) (Māori man, age group 56–64 years).

For people living under conditions of precarity, adherence to lockdown conditions posed significant communicative challenges affecting their health and wellbeing. The following statement by a Tongan participant details the dissatisfaction with the communicative challenges posed by C19.

Before COVID we would just walk in ... but during the lockdown we would have to phone ... and wait. for a doctor to call you and make a phone consultation, and they would decide over the phone without checking whether she needed to be seen or not ... my mum had to be seen by two doctors, the first doctor, the doctor prescribed her. ugh I dunno if it’s the wrong medication could be. one that ... wasn’t needed for her cos it made her sicker ... so maybe if the doctor diagnosed her properly by seeing her umm she may have ... haven’t had to go through that ... (Tongan woman, age group 26–35 years).

While communicating their experiences of C19, the participants described that the C19 healthcare strategies, which centralized health interventions and priorities from outside resource-poor environments, often compromised their health and wellbeing. In an articulation that attends to the substantial communicative challenges brought by C19, a participant from Glen Innes records her struggles

not being racist but the, the white people are pretty fortunate to have you know ... umm the support and, and, and the resources. I mean they know where to go and find help from ... it’s, it’s just um, our poor Island people who have either, kinda ashamed or don’t know where to find the resources from so yeah (Tongan woman, age group 26–35 years).

Many participants were skeptical about the contact tracing measures during C19. The participants spoke about their lack of trust in the health system because of its ineptness in aiding the resource-starved people at the margins. Shared a participant from Glen Innes:

Everywhere you go you have to do it like, what is this for? Like, do they want to know where we are, or. our phone numbers or stuff like that ... it doesn’t ugh really, it doesn’t really relate to the disease right? It’s something else, yeah, they say it’s tracing but. tracing what? Right, I don’t think so. Maybe for them who’s graded the thingie, but not, I dunno, does it help people? (Tongan woman, age group 46–55 years).

While structures constrained access to communicative infrastructures, people at the margins enacted their agency by drawing on community-based resources. Many people in this

study sought assistance from a community member or family in order to stay updated and navigate C19. In this narrative, a single mother expresses how she attempted to get household supplies for the family during C19.

In the lockdown, no one is allowed to look after my son and daughter. Just I keep them alone when I went to the market. In another day, I called someone from community to look after my daughter and son (Refugee woman from Afghanistan, age group 26–35 years).

In another instance, a Māori participant spoke about the support from his Whānau in navigating the communicative challenges. He narrated,

my daughter in law gave me this phone and I said to her nah I don’t want it. And she goes, No, no, \*. I want you to have it so I can call you, so I can make sure that things are right with you and I went ah okay, thank you for caring about me (Māori man, age group 56–64 years).

### **Relational and community agency**

Participants voiced feeling “scared”, “frightened”, “afraid”, “overwhelming”, “anxiety” and “struggling”. For instance, participants stated, “COVID made everything scary” (Pākehā woman, age group 26–35 years), and “I was in too much tension. We are fasting and praying C19 goes away. Lot of changes in life, it was difficult.” (Refugee woman from Afghanistan, age group 46–55 years). With the exception of a small number of participants, it was clear that the different communities represented were concerned about C19 and adhered to the lockdown rules, which created significant challenges to their negotiations of everyday health and wellbeing. For instance, two Tongan participants discussed the hardship experienced by not being able to attend funerals due to lockdown restrictions. Additionally, healthcare organizations banning patients from having support people or visitors exacerbated language barriers and anxiety concerning medical treatments. As one participant stated, “one of my births was very scary and traumatic ... I am scared to not have my partner at the birth” (Māori woman, age group 26–35 years). Furthermore, the very act of not being able to visit one another felt culturally foreign for many participants, as indicated in statements like, “In our culture, we visit people” (Refugee man from Bhutan, age group 56–64 years), “our culture is like ... they ... are close to each other” (Refugee woman from Afghanistan, age group 18–25 years), and, “like everyone’s together [in Tongan culture]” (Tongan man, age group 18–25 years). Accordingly, some participants described an emotional toll from not visiting family, such as in the following statements: “it was quite hard, like my parents literally visited my baby at the window ...” (Cook Island Māori woman, age group 26–35 years) and “I had to be away from family ... So it was pretty difficult and it ... kinda felt lonely at times because of the lockdown ... kinda took a toll on me at some points” (Tongan woman, age group 26–35 years).

Many participants described acts of care undertaken through organized groups, such as volunteer-run phone numbers for lockdown support in Palmerston North and Glen Innes, digitally screening church services in Glen Innes, and

working with local organizations in the distribution of food parcels across the sites. Just as significant were the informal acts of care described by participants, such as through community knowledge dissemination, digitally ‘checking in’ on one another, and leaving parcels for those who were more vulnerable. One participant explained: “We had to keep Mum’s house safe ... we were ringing her to make sure they were alright ... one of us would go out and do it or she’d send someone ... to get their essentials” (Māori woman, age group 26–35 years).

This care was also enacted within the home. Some older community members relied on their children to provide information, advice, and support during the C19 lockdown. For instance, two young sisters spoke at length about caring for and protecting their elderly mother, who has Alzheimer’s disease, which involved ceasing all activity outside of the home and employment to prevent contracting C19, and, in spite of the resulting financial and emotional hardship, one sister stated, “I was just worried about my mum ... nothing else” (Refugee woman from Afghanistan, age group 18–25 years). In another family, an elderly woman explained that she did not learn to read in Afghanistan and so her “children was helping to translate the English news” (Refugee woman from Afghanistan, age group 46–55 years). Finally, participants from across the sites placed immense value on spending time together with family members within the household, describing positive experiences completing shared tasks, such as cooking “Māori bread and fried bread” (Māori woman, age group 26–35 years) and “lots of naan bread” (woman from Afghanistan, age group 18–25 years), going for “walks with the family” (Māori man, age group 46–55 years), and “just like spending as much time as we can together cos like, [after lockdown] everyone’s gonna be doing their own thing” (Tongan woman, age group 26–35 years).

## Discussion

Building on earlier culture-centered studies that draw attention to the structured contexts of health behaviors (Dutta, 2015), this manuscript foregrounds the structures that constitute pandemic-related behaviors and negotiation of health. The narrative accounts dismantle the Whiteness of behavioral approaches that individualize preventive responses to the pandemic. The pandemic exacerbates structurally constituted inequalities, and policy responses to prevent the spread of C19 introduce challenges to health and wellbeing at the “margins of the margins.” In spite of the policy responses in Aotearoa New Zealand that were positioned as addressing the needs of those at the margins (Dutta et al., 2020), participants noted the ways in which they fell through the cracks of the response framework, experiencing exacerbated challenges to their health and wellbeing. These challenges were the challenges of the everyday. The findings suggest the importance of expanding the scope of what we examine as health amidst the pandemic, from looking at the direct risks of the infection to the health challenges of everyday living and livelihood that are exacerbated by the pandemic and by the responses to it. Moreover, the comparison across the contexts of Māori, Pasifika and refugee health offers a register for theorizing the structure of pandemic communication that results in cultural

marginalization. Participant narratives depict the ways in which the erasure of cultural voice in hegemonic pandemic response (lockdown) immersed in Whiteness both exaggerates existing health inequities and introduces new forms of marginalization that impact community health and wellbeing. This underscores the importance of examining solidarities across cultural contexts at the margins of neoliberal health systems embedded in the ideology of Whiteness. The comparison of the convergences across the various contexts of marginalization suggests registers for solidarity by allowing for identification across marginalized groups, offering a framework for cross-cultural mobilization of voice in health communication interventions.

The lockdown responses to the pandemic further exacerbated the challenges with securing shelter. Moreover, challenges with employment, securing access to wage subsidy, and securing access to food were often voiced by the participants as some of the key aspects that were exacerbated by the lockdown. When the lockdown commenced, it created new limitations and challenges of everyday living for communities at the margins. Old and existing forms of economic marginalization were exacerbated by new forms of economic and cultural marginalization. Some of these new forms of marginalization such as not being able to attend funerals and births communally were not previously present in Aotearoa New Zealand, and were introduced by the state’s C19 response.

These exacerbated and new forms of marginalization are anchored in the erasure of Māori, Pasifika, and refugee voices from spaces where pandemic-related policy responses and communication strategies are created. For a number of participants, the lockdown translated into not having access to the usual channels of communication that are vital to navigating resources of health and wellbeing. Refugee participants noted for instance, the ways in which the lockdown impacted their access to translators and service mediators. This in turn impacted their ability to access the fundamental resources of health and wellbeing. The disconnection from communicative infrastructures was particularly challenging for those situated at the margins, and the communal collective played a pivotal role in the localized cultures across the sites.

For a number of participants, the lockdown disconnected them from their immediate resources and spaces of support in the Whānau as well as in the community. Moreover, the practices of the C19 lockdown resulted in some collective cultural norms in the communities becoming impossible to practice and being marginalized during this time, such as how they were able to socialize and practice birthing, funeral, and religious rituals. A number of participants that were pregnant reflected the structural context of the lockdown that disconnected them from their relationships and networks of support that are vital cultural resources in negotiating health and wellbeing. This is a key contribution of this essay, pointing to the central role of communicative inequalities in constituting experiences with negotiating health at the “margins of the margins,” in spite of a pandemic response that presents itself as addressing structural factors (Dutta et al., 2020). The narratives of the participants depict the limits of the existing policy responses to C19, suggesting they don’t go far enough in addressing the fundamental needs of those at the “margins of the margins.” The gaps felt at

the “margins of the margins” are exacerbated by the lockdown, and without communicative infrastructures for voices of the margins, the policy framework fails to address the health challenges of subaltern communities. The erasure of Māori, Pasifika, and refugee communities translates into cultural gaps that are reproduced by the structures. Communities at the “margins of the margins” are pushed further into experiences of dispossession and disenfranchisement.

So far to our knowledge, this is the first culture-centered study that looks across multiple registers of marginalization, depicting the ways in which the Whiteness of pandemic communication response marginalizes Māori, Pasifika, and refugee communities. Although there are some important nuances and differences between these different registers for cultural values and community-based responses, what we have highlighted in this manuscript are the threads of marginalization that connect across these diverse cultural spaces, tied to the Whiteness of the structure of the state’s C19 response. The Whiteness of the state’s C19 response erases culture. The narratives point out that health communication interventions to prevent C19 in Aotearoa New Zealand furthered the marginalization of communities at the margins, and community voices were largely erased from the design and enactment of interventions. The voices also show that the communities at the margins are preoccupied with health-related barriers within the realm of the negotiations of everyday health that are further accentuated by the preventive policies/practices dictated top-down by the state (in this instance, lockdown). With the extant structures of pandemic communication failing to recognize the structures of social, political, and economic organizing that constitute the everyday struggles of health at the margins, the existing health and access challenges experienced by Māori, Pasifika, and refugee communities negotiating poverty were further complexified and magnified during C19. Our culture-centered reading, anchored in voices of cultural communities at the margins of Aotearoa New Zealand, suggests that an approach to prevention that has otherwise been hailed as an exemplar of effective, evidence-based, and structurally informed pandemic communication can be limited in addressing the health needs of the “margins of the margins” in the absence of communicative infrastructures for voice, further accentuating existing struggles with health and wellbeing. These erasures of voice are particularly salient in a settler colonial state where a treaty (Te Tiriti o Waitangi) explicitly calls for Māori participation and consultation in the development of public health response (Jones, 2020). Turning to solidarities with Māori struggles for voice in health communication can serve as a vital register for culturally centering pandemic communication across Māori, Pasifika, and refugee communities and in addressing health disparities. Moreover, the treaty (Te Tiriti o Waitangi) in Indigenous contexts of health organizing offers a vital decolonizing register for theorizing and developing pandemic communication.

## Notes

1. The measurement utilized to determine household crowding is the *Canadian National Occupancy Standard*.
2. A study conducted in 2007 amongst 1,224 Pasifika mothers designed to test the index and perception of household crowding.

The study highlighted the deployment and perpetuation of the racist narrative that Pasifika families choose to live in high levels of crowded household living situations due to customary practises. Instead, these living situations were created out of economic urgency (Schulter et al., 2007).

3. Aotearoa New Zealand government provider of social housing, also currently known as Kāinga Ora.
4. Whānau is the Māori word for family. Participants have used Whānau to encompass their extended family when sharing their experiences during C19 lockdown.

## Disclosure of potential conflict of interest

We have no known conflict of interest or financial benefit to disclose.

## ORCID

Christine Elers  <http://orcid.org/0000-0002-9726-4760>  
 Pooja Jayan  <http://orcid.org/0000-0002-5805-4138>  
 Phoebe Elers  <http://orcid.org/0000-0001-7769-6024>  
 Mohan J. Dutta  <http://orcid.org/0000-0002-2228-8100>

## References

- Altinkaya, J., & Omundsen, H. (1999). “Birds in a gilded cage”: Resettlement prospects for adult refugees in New Zealand. *Social Policy Journal of New Zealand*, 13, 31–42. <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/journals-and-magazines/social-policy-journal/spj13/birds-in-a-gilded-cage-resettlement-prospects-for-adult-refugees.html>
- Amore, K., Viggers, H., & Howden-Chapman, P. (2020). *Severe housing deprivation in Aotearoa New Zealand, 2018* (He Kāinga Ora/Housing & Health Research Programme). University of Otago.
- Beaglehole, A. (2013). *Refuge New Zealand: A nation’s response to refugees and asylum seekers*. Otago University Press.
- Bowleg, L. (2020). We’re not all in this together: On COVID-19, intersectionality, and structural inequality. *American Journal of Public Health*, 110(7), 917. <https://doi.org/10.2105/AJPH.2020.305766>
- Cousins, S. (2020). New Zealand eliminates COVID-19. *The Lancet*, 395 (10235), 1474. [https://doi.org/10.1016/S0140-6736\(20\)31097-7](https://doi.org/10.1016/S0140-6736(20)31097-7)
- Dutta, M. J. (2015). *Neoliberal health organizing: Communication, meaning and politics*. Left Coast Press.
- Dutta, M. J. (2020). *Communication, culture, and social change: Meaning, co-option and resistance*. Palgrave Macmillan.
- Dutta, M. J., Elers, C., & Jayan, P. (2020). Culture-centered processes of community organizing in COVID-19 response: Notes from Kerala and Aotearoa New Zealand. *Frontiers in Communication*, 5(62). <https://doi.org/10.3389/fcomm.2020.00062>
- Foliaki, S. (1997). Migration and mental health: The Tongan experience. *International Journal of Mental Health*, 26(3), 36–54. <https://doi.org/10.1080/00207411.1997.11449408>
- Huygens, I. (2006). Discourses for decolonization: Affirming Maori authority in New Zealand workplaces. *Journal of Community & Applied Social Psychology*, 16(5), 363–378. <https://doi.org/10.1002/casp.881>
- Immigration New Zealand. (2020). *Refugee and protection unit statistics pack*. <https://www.immigration.govt.nz/documents/statistics/statistics-refugee-and-protection.pdf>
- Jones, R. (2020, May 13). *Covid-19 and Māori health: ‘The daily 1pm briefings have been an exercise in Whiteness’*. Spinoff. <https://thespinoff.co.nz/atea/13-05-2020/covid-19-and-maori-health-the-daily-1pm-briefings-have-been-an-exercise-in-whiteness/>
- Kale, A., Kindon, S., & Stupples, P. (2018). ‘I am a New Zealand citizen now—This is my home’: Refugee citizenship and belonging in a post-colonizing country. *Journal of Refugee Studies*, 33(3), 577–598. <https://doi.org/10.1093/jrs/fey060>
- Mahony, C., Marlowe, J., Humpage, L., & Baird, N. (2017). Aspirational yet precarious: Compliance of New Zealand refugee settlement policy

- with international human rights obligations. *International Journal of Migration and Border Studies*, 3(1), 5–23. <https://doi.org/10.1504/IJMBS.2017.081176>
- McIntosh, T., & Mulholland, M. (2011). *Maori and social issues*. Huia Publishers.
- McLeod, M., Gurney, J., Harris, R., Cormack, D., & King, P. (2020). Covid-19: We must not forget about Indigenous health and equity. *Australian and New Zealand Journal of Public Health*, 44(4), 253–256. <https://doi.org/10.1111/1753-6405.13015>
- Ministry of Health. (2014). *Tagata Pasifika in New Zealand*. <https://www.health.govt.nz/our-work/populations/pacific-health/tagata-pasifika-new-zealand>
- Moewaka Barnes, H., & McCreanor, T. (2019). Colonisation, hauora and whenua in Aotearoa. *Journal of the Royal Society of New Zealand*, 49(1), 19–33. <https://doi.org/10.1080/03036758.2019.1668439>
- Patel, J. A., Nielsen, F. B. H., Badiani, A. A., Assi, S., Unadkat, V. A., Patel, B., Ravindrane, R., & Wardle, H. (2020). Poverty, inequality and COVID-19: The forgotten vulnerable. *Public Health*, 183, 110. <https://doi.org/10.1016/j.puhe.2020.05.006>
- Poata-Smith, E. S. (2013). Emergent identities: The changing contours of Indigenous identities in Aotearoa/New Zealand. In M. Nakata, M. Harris, & B. Carlson (Eds.), *The politics of identity: Emerging indigeneity* (pp. 24–59). University of Technology Sydney E-Press.
- PRovoke Media. (2020, June 4). *COVID-19 Comms: US government worst, New Zealand & Germany best say PR pros*. PRovoke | PR News & Public 640 Relations Events. <https://www.provokemedia.com/latest/article/covid-19-comms-us-government-worst-new-zealand-germany-best-say-pr-pros>
- RNZ. (2020, May 26). *Welfare advocates not happy with COVID-19 unemployment benefit*. <https://www.rnz.co.nz/news/national/417531/welfare-advocates-not-happy-with-covid-19-unemployment-benefit>
- Schulter, P., Carter, S., & Kokaua, J. (2007). Indices and perception of overcrowding in Pacific households domicile within Auckland, New Zealand: Findings from the Pacific Islands Families Study. *New Zealand Medical Journal*, 120(1248), 63–74. [https://assets-global.website-files.com/5e332a62c703f653182faf47/5e332a62c703f6659d2fc6fb\\_Vol-120-No-1248-26-January-2007.pdf](https://assets-global.website-files.com/5e332a62c703f653182faf47/5e332a62c703f6659d2fc6fb_Vol-120-No-1248-26-January-2007.pdf)
- Statistics New Zealand. (2014). *New Zealand definition of homelessness: Update*. [http://archive.stats.govt.nz/browse\\_for\\_stats/people\\_and\\_communities/housing/homelessness-definition.aspx#gsc.tab=0](http://archive.stats.govt.nz/browse_for_stats/people_and_communities/housing/homelessness-definition.aspx#gsc.tab=0)
- Statistics New Zealand. (2020a). *Glen Innes West*. <https://www.stats.govt.nz/tools/2018-census-place-summaries/glen-innes-west#qualifications>
- Statistics New Zealand. (2020b). *Highbury*. <https://www.stats.govt.nz/tools/2018-census-place-summaries/highbury-east>
- Waitangi Tribunal. (2019). *Hauora: Report on stage one of the health services and outcomes kaupapa inquiry* (Legislation direct).
- Webb, C. (2017). *Working paper 2017/03 key graphs on poverty in New Zealand: A compilation*. McGuinness Institute.