Lost in the refugee bubble: Experiences and coping strategies among asylum seekers and refugees in Auckland, New Zealand during the COVID-19 pandemic

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Abstract

Context: The coronavirus disease 2019 (COVID-19) pandemic caused widespread health, social, and economic disruptions worldwide, resulting in a public health crisis that further compounded the challenges of marginalised communities. To date, we know very little about the experiences of asylum seekers and refugees during the COVID-19 pandemic and how to best support them. This study examined the experiences of asylum seekers and refugees in Aotearoa New Zealand during the COVID-19 pandemic and their coping strategies.

Methods: The study was guided by the interpretive paradigm and a qualitative descriptive methodology. Four semi-structured interviews were undertaken with former asylum seekers and refugees living in Auckland, New Zealand, to understand their perceptions, challenges, and coping strategies during the COVID-19 pandemic. Data were analysed using reflexive thematic analysis using NVivo.

Findings: The pandemic had many impacts among participants, including fear, isolation, and mental distress. Four themes were generated from a thematic analysis of data: hypocritical hospitality, dealing with separation, challenges with mitigation measures, and support and lifestyle adaptations. Participants reported having access to information and vaccinations during the COVID-19 pandemic yet reported not receiving access to other benefits, such as New Zealand's welfare support during lockdowns. They coped with the lockdowns by seeking up-to-date information from government sources on preventive measures, and received support from others and community leaders.

Conclusion: The measures to mitigate COVID-19 including early and hard lockdowns, and vaccinations were critical to ensuring a resilient nation, but asylum seekers and refugees were interested in being included in the government plan and volunteering services during the pandemic response. The findings present some insight into the perspectives of non-quota refugees in Auckland, which can be useful to inform current and future government strategies to address the needs of asylum seekers and refugees during national public health emergency.

Keywords: COVID-19; Pandemic; Asylum seekers; Refugees; Experiences; Coping strategies; Lockdown; Auckland New Zealand.

CONTENTS

List of Figures

List of Tables

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed: Date: 30 January 2023

NKESSAH ZISUH

Academic Integrity Declaration

In submitting this work, I declare that:

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Glossary of Acronyms (Abbreviations)

CoV:	Coronavirus
COVID-19:	Coronavirus Disease 2019
2019nCoV:	2019 novel Coronavirus
SARS-CoV:	Severe Acute Respiratory Syndrome Coronavirus
MERS-CoV:	Middle East Respiratory Syndrome Coronavirus
UNHCR:	United Nations Higher Commissioner for Refugees
MRRC:	Te Āhuru Mōwai o Aotearoa Māngere Refugee Resettlement Centre
ASST:	Asylum Seekers Support Trust
RASNZ:	Refugee as Survivors New Zealand
RFSC:	Refugee Family Support Category
WHO:	World Health Organization
OAU:	Organization of African Unity
EU:	European Union
UNRWA:	United Nations Relief and Work Agency
IDP:	Internally Displaced People
PTSD:	Post-Traumatic Stress Disorder
HIV:	Human Immunodeficiency Virus
AIDS:	Acquired Immunodeficiency Syndrome
OCED:	Organisation for Economic Co-operation and Development

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Ethics Approval

This study was approved by the AUT Ethics Committee on the 25th November 2021, under the Ethics Application number 21/293.

Chapter One: INTRODUCTION

1. Study Context

Aotearoa New Zealand is one of the countries that partake in the United Nations High Commissioners for Refugees (UNHCR) refugee quota resettlement programme. Since 1987, the Global Quota System (GQS) has been New Zealand's greatest contribution to refugee protection, setting the quota at 750 mandated refugees per year (UNHCR, 2002), which as of July 2020 rose to 1500 places (Immigration New Zealand, 2023a). According to Immigration New Zealand, the Refugee Quota Programme in its attempt to align with the global resettlement needs will continue to accept 1500 refugees annually from 2022/23 to 2024/25 (Immigration New Zealand, 2023b). In addition to the United Nations mandated quota refugees, New Zealand also supports non-quota refugees who consist of asylum seekers, convention refugees, refugee family support category or people from a refugee-like background.

The New Zealand Immigration Bill extends New Zealand's international obligations to protect a wider class of people, who are substantially at risk of arbitrary deprivation of life, torture, or cruel, inhuman or degrading treatment or punishment (McAdam, 2009). New Zealand has a general obligation to admit asylum seekers who arrive at the port of entry and seek the chance of acquiring legal status as refugees or protected persons (Immigration New Zealand, 2023a). However, only a third of the approximately 300 annual claims for refugee status lodged by asylum seekers in New Zealand are approved (Bloom & Udahemuka, 2014; J. Marlowe & Elliott, 2014). And asylum seekers whose refugee status claims are successful or subsequently approved are then considered as convention refugees (Human Rights Commission, 2010). The other two-third of these claims, though unsuccessful, are liable to be appealed at the Immigration Protection Tribunal, in the hope of a favourable outcome in their resettlement pathway.

COVID-19 is the disease caused by a novel coronavirus known as Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), which has already killed millions

worldwide, and resulted in psychosocial distress and socio-economic impacts like never seen before (Honigsbaum, 2009; Qiu, Rutherford, Mao, & Chu, 2017). This contagious viral infection attacks the respiratory, gastrointestinal, hepatic, and central nervous system tracts of humans (Rodriguez-Morales et al., 2020; Zhou et al., 2020). By the end of 2022, there were over 624 million confirmed cases and over 6.5 million deaths have been reported globally due to COVID-19 (World Health Organization, 2022). Despite facing Coronaviruses (CoVs) like the severe acute respiratory syndrome (SARS-CoV) and the Middle East respiratory syndrome (MERS-CoV) in the past decade, the current 2019 novel coronavirus (2019nCoV), had unprecedented global impacts in the world (Dhama et al., 2020; R. Lu et al., 2020; Rodriguez-Morales et al., 2020; Zhou et al., 2020).

On February 11, 2020, this previous unidentified 2019nCoV, which was first identified in Wuhan China in December 2019, was officially named the COVID-19 pandemic by the World Health Organisation (WHO) (Chan et al., 2020; Lu, Stratton, & Tang, 2020; Wu, Chen, & Chan, 2020). The COVID-19 pandemic created large inequalities in access to sectors in the labour market most affected by COVID-19, increased discrimination, and disproportionate representation of vulnerable populations (Jones, 2020). Also the loss of access to important cultural activities like the church or mosques showcased how the pandemic impacted marginalized communities (Meyer & Young, 2021).

The COVID-19 pandemic has raised special interest and academic discourse on community resilience and marginalised communities with pre-existing vulnerabilities. This drew my interest towards asylum seekers whose refugee claims were unsuccessful or awaiting a favourable outcome when the pandemic was declared. My focus here being to understand the impacts of the pandemic response (e.g., nationwide lockdowns) among asylum seekers and refugees living in Auckland, New Zealand, and their coping strategies. When using the terms “asylum seekers” and “refugees”, context is important because not every asylum seeker will ultimately be recognized as a refugee, though most refugees are initially asylum seekers (UNHCR, 2011). Escaping persecution from their countries of origin is just the start of the refugee journey. The challenges encountered leading up to their arrival in

the country of refugee is sometimes life-threatening, and they still must face the challenges associated with resettling in the country of refuge.

In New Zealand, a distinction is made between refugees, based on their immigration pathway. Quota refugees are the United Nations High Commissioner for Refugees (UNHCR)-mandated refugees, usually selected from established offshore refugee camps, to resettle in New Zealand (Adam, 2007). These are people with refugee status who are annually referred by the UNHCR to Immigration New Zealand. The UNHCR-mandated refugee resettlement pathway guarantees residency status upon arrival, and state housing priorities for quota refugees once they leave the Mangere Refugee Resettlement Centre (MRRC) (Adam, 2007; Dunstan, Dibley, & Shorland, 2004). Asylum seekers, on the other hand, constitute those who apply for protection upon arrival in the host country and have to wait on a decision, and are often paced under arbitrary detention, where they can experience psychosocial disturbances (Hiew, 2021; Sultan & O'Sullivan, 2001). It is unimaginable the amount of stress, torment, or what it feels like to be in limbo while waiting on the determination of their immigration status or an approval of their refuge claims. And having to experience these challenges during the COVID-19 pandemic outbreak fortifies the need to also support asylum seekers through the resettlement process.

The refugee resettlement pathway in New Zealand is not limited to just quota refugees and asylum seekers. In New Zealand, the government approved changes to the Refugee Family Support Category (RFSC) to improve the system and support the refugee family reunification (Immigration New Zealand, 2022a) New Zealand also set aside a number of places for Afghan refugees to be resettled from 2023/24 (Immigration New Zealand, 2023b). However, most studies focus entirely on quota refugees, such that even convention refugees (former asylum seekers) whose refugee claims have been approved by New Zealand still get discriminated upon (Dunstan et al., 2004). By focusing on quota refugees, the experiences of current asylum seekers are not taken into consideration, and this presents knowledge gaps about the experiences of asylum seekers, which this study aimed to address. This dissertation also considered recent refugee categories like the Afghanistan Evacuees and the Ukrainian

refugees for greater depth and relevance where necessary. Throughout this study, as there is much heterogeneity among different refugee pathways, effort will be made to specify which refugee pathway is being referred to.

Refugees face trauma, torture and suffering in their journey to safety and then can face many other challenges ranging from unemployment, underemployment, discrimination, cultural shock, stereotyping, and prejudice when they get to the country of refuge (Aimers & Walker, 2014; Chile, 2007; Mugadza, 2012). A refugee claim means different things to the claimants and to the country of refuge. For asylum seekers and refugees, a refugee claim represents the only means to escape prosecution in their country of origin. However, many countries of refuge either treat asylum seekers as a burden to their economy or opportunist and economic migrants (Dustmann, Fasani, Frattini, Minale, & Schönberg, 2017). This may account for the non-consideration of asylum seekers and other non-quota refugees in many country's policies and strategies, as seen with the New Zealand Refugee Resettlement Strategy. Refugee exclusion based on their resettlement pathway raises substantial compliance issues for New Zealand, and contravenes the agreements laid by the Refugee Convention in relation to non-discrimination, wage-earning employment, non-penalization for illegal entry, and prohibiting refoulement (Goodwin-Gill, 1988; Haines, 1994, 1999).

The concept of discrimination is the basis for this study because it emanates from the differential treatment of refugees based upon their resettlement pathway and refugee status, which inadvertently threatens the 1951 Geneva Convention relating to the Status of Refugees. According to Schuster (2003), many signatory countries to the 1951 Convention, who initially shared commitment to principles of equality and non-discrimination, have in recent years embraced practices that permit discrimination against and unequal treatment of asylum seekers. With New Zealand being among the few countries that receive more quota refugees through the UNHCR resettlement plan than asylum seekers through the asylum seeker applications, this inherently puts little focus on the rights-based approach towards asylum seekers (Stephens, 2017). And the outbreak of the novel COVID-19, the rights of asylum seekers afforded in the Refugee Convention is negated and this only further exacerbates

concerns surrounding the health and wellbeing of asylum seekers and refugees who often have pre-existing vulnerabilities, and the services available to support them.

2. Research Problem

The COVID-19 pandemic has disrupted societies and resulted in unprecedented response measures to curb disease spread. The COVID-19 pandemic elevated the risk of exposure for refugees, negatively impacted access to support service and healthcare system, mental health and socio-economic wellbeing of asylum seekers and refugee globally (Clarke et al., 2021; Jayan & Dutta, 2021; Mares, Jenkins, Lutton, & Newman, 2021; T. McGuire, Yozwiak, & Aultman, 2021; Officer et al., 2022; Wilson et al., 2021). For people of refugee background, the psychosocial impacts were immense considering their pre-existing vulnerabilities. Some studies have investigated how COVID-19 strained the remote psychosocial service provision for refugees (Refugees as Survivors New Zealand, 2020). However, little is known about how the pandemic outbreak affected asylum seekers and non-quota refugees.

Both government and non-governmental organisations put forward policies and strategies to manage the pandemic disruptions, but often overlooked the specific needs of refugee background communities. The New Zealand COVID-19 response strategy, for example, exposed many underlying issues amongst people of refugee backgrounds (Jayan & Dutta, 2021; Ferdinand C. Mukumbang, Ambe, & Adebiyi, 2020; Officer et al., 2022; Wilson et al., 2021). This dissertation aims to identify the hurdles posed by the COVID-19 pandemic among asylum seekers and non-quota refugees living in Auckland and explore their coping strategies. There is a limited pool of qualitative research that explores how asylum seekers and refugees experienced the COVID-19 pandemic and associated mitigation measures within a highly multicultural setting. This study, to the best of my knowledge, is the first to explore how the national pandemic response in New Zealand addressed the specific needs of asylum seekers and non-quota refugees in Auckland, amidst the COVID-19 pandemic. An insight into how asylum seekers and non-quota refugees coped with the COVID-19 pandemic

and associated mitigation measures (e.g., regional and nation-wide lockdowns), provides a unique understanding of the challenges of people from refugee backgrounds and how to best support them.

3. Research Question and Objectives

This dissertation seeks to answer the following research question: What are the lived experiences and coping strategies used by asylum seekers and non-quota refugees in Auckland during the COVID-19 pandemic?

In order to help address this question, the following objectives were developed as guide for the research:

a) To understand the challenges faced during the COVID-19 pandemic from the perspective of asylum seekers and non-quota refugees in Auckland.
b) To explore their knowledge about COVID-19, their perceptions of the COVID-19 response by the NZ government, sources of information and their coping strategies.
c) To highlight their recommendations for improved pandemic management that better address the needs of asylum seekers and refugees in New Zealand.

4. Dissertation Structure

This dissertation contains six chapters. Chapter one provides the overall rationale for the study by giving a background about asylum seekers and refugees and the COVID-19 pandemic, the research problem, the research question and objectives.

Chapter two reviews the current refugee resettlement dynamics in New Zealand in relation to the global refugee trends, refugee resettlement, and national agencies and policy documents related to people of refugee backgrounds, including asylum seekers and non-quota refugees. This chapter also discusses the existing literature on the global COVID-19 pandemic and vulnerabilities, capacities, and coping strategies during the pandemic that relate to asylum seekers and refugees.

Chapter three outlines the research paradigm and methodology that underpin this study. This chapter also details the methods for data collection and analysis, describing how these were used to address the research question and objectives along with ethical considerations.

Chapter four outlines the demographic characteristics of the participants and presents the results of the data collected from interviewing four asylum seekers and non-quota refugees. Four themes were derived from the data through the process of reflexive thematic analysis. Chapter five critically discusses the study findings in relation to current academic and grey literature, highlighting implications for policy and practice, and recommends areas for future research and discusses the strengths and limitations of the study.

Chapter Two: LITERATURE REVIEW

1. Structure and search strategy

This literature review explores the global and national refugee context and the impacts of the COVID-19 pandemic outbreak with a focus on refugee background communities. The literature review is separated into two sections. The first section focuses on the existing refugee dynamics, keys terms, current global trends of the refugee situation internationally, displacement patterns and the legal framework that determines the refugee pathway in New Zealand. The second section centres on the COVID-19 pandemic, drawing upon journal articles and government documents on the impacts of the pandemic and the COVID-19 pandemic response strategy. This chapter explores the inequity amongst refugees based on their resettlement pathways and the COVID-19 pandemic strategy to support resilience during the pandemic.

The databases used for searches were Google Scholar, CINAHL complete by EBSCO, Scopus and ScienceDirect. Grey literature were accessed from international, national, and local sources. Search terms used in the literature review focused on each concept individually with the use of truncations, and where relevant, in different combinations, such as refuge*, asylum seeker*, COVID-19, pandemic*, SARS-CoV-2, experience*, coping strategies, lockdown, refugees and vulnerabili*, refugee bubble, pandemic strategies, Aotearoa, Auckland, and New Zealand. The structure of the literature review started broad, looking at publications on the experiences of people in the marginalised communities and infectious diseases. The broad approach was then narrowed to focus on people of refugee backgrounds, particularly asylum seekers and non-quota refugees.

2. The Refugee Crisis

2.1. Legal Framework of Refugees

The 1951 United Nations Convention relating to Status of Refugee (herein referred to as the Geneva Convention) and its 1967 Protocol, define a refugee as anyone who:

> ‘‘owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group, or political opinion, is outside the country of his nationality or habitual residence, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country (UNHCR, 2009; United Nations General Assembly, 1951);
> or who, not having a nationality and being outside the country of his former habitual residence is unable or, owing to such fear, is unwilling to return to it’’ (United Nations General Assembly, 1951).

The Geneva Convention is the main international instrument on refugee law since World War II. The 1969 Organization of African Unity (OAU) Convention governing the specific aspects of refugee problems in Africa (referred to as the 1969 OAU Refugee Convention) criticized the Geneva Convention for not recognising refugees identified by UN agencies other than the United Nations High Commission for Refugees (UNHCR) (Mamer, 2010). A glaring example is indicated by its exclusion of the Palestinian refugees receiving protection and assistance from the United Nations Relief and Work Agency (UNRWA) and the Darfur refugees in Western Sudan supported by the UN Humanitarian Department (Organization of African Unity, 1969). Additionally, the Convention was limited in its framework mainly to the protection of European refugees (Ahmad, Rahim, & Mohamed, 2016), hence neglecting the inclusion of new realities pertaining to who has the right to seek safety or refuge. So, for State parties to the African Union Convention governing the specific aspects of refugee problems in Africa, a refugee is:

> “every person who, owing to external aggression, occupation, foreign domination or events seriously disturbing public order in either part or the whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality” (Organization of African Unity, 1969).

Once a displaced person is granted refugee status they are entitled to certain rights as agreed in the 1951 Refugee convention. The 1951 Convention and its 1967 Protocol, the law of the EU, the 1984 UN Convention against torture and other Cruel, Inhumane or Degrading

Treatment of Punishment (UNCAT), the 1950 Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR) and its Protocols are refugee laws used to alleviate oppressions that render those who seek refuge vulnerable in their journey towards normalcy (Mole & Meredith, 2010).

2.2. Global Trends and Displacement patterns

The refugee crisis depicts a world where millions of refugees seek safety from life-threatening situations, get exposed to violence, persecution, family separation, culture loss, and exile (Alemi, Stempel, Siddiq, & Kim, 2020; Castles, 2006). The refugee crisis in essence describes pressing issues of international migration like finding durable solutions to the forcefully displaced refugees and others fleeing life-threatening situations (S. F. Martin, 2016). The forceful displacement dates back to the aftermath of World War II era, where refugees were only classified under “military personnel” and “civilian refugees” (Hawkins, 1972). Nowadays, the increase in the number of refugees is perpetuated by politically unstable zones, which are particularly characterised by political repression, persecution, strife, armed conflict, violence, social disfranchisement or human rights violation.

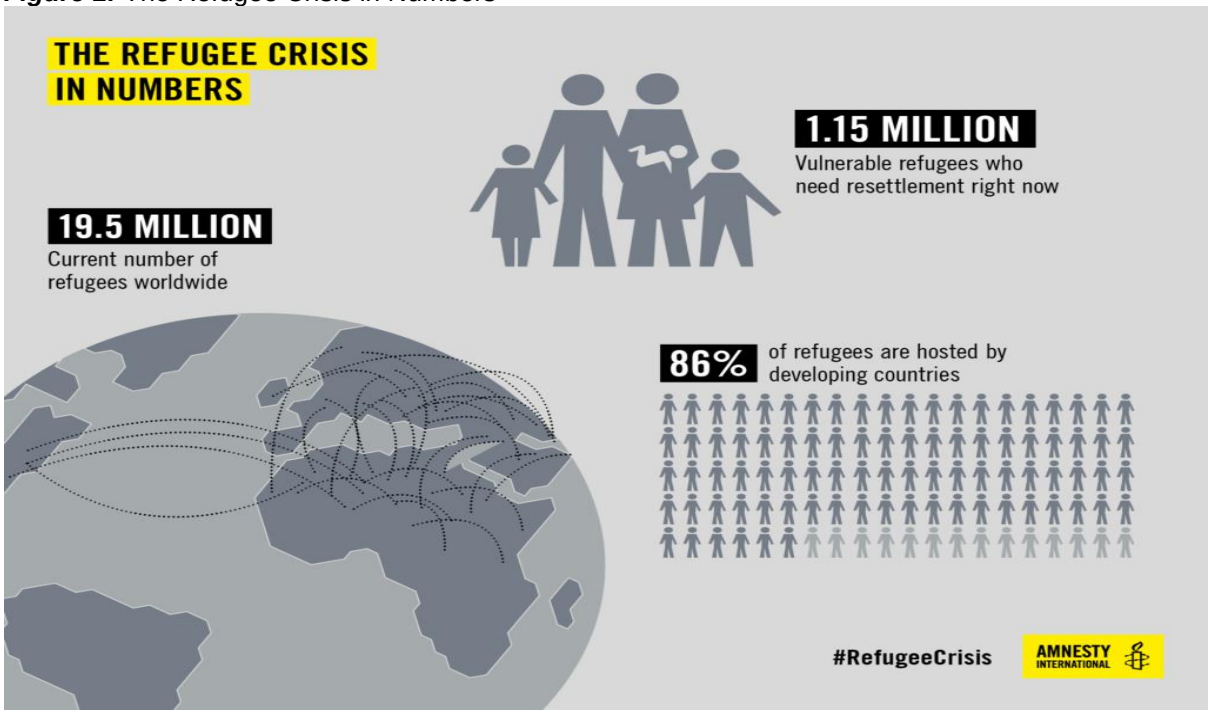
Forced migration is increasingly at the heart of global politics, with refugees and asylum seeker only discussed in terms of decisions, declarations and priorities by resettlement countries (Whittaker, 2006). In the same light, issues relating to the macro-level structures that influence state’s responses to forced migration and determine the outcome of refugees and asylum seekers globally displaced are increasingly being ignored (Betts, 2009). In the discourse of refugees and asylum seekers today, the commitment to the 1951 Geneva Convention’s principles of equality and non-discrimination has been overshadowed by proposals that permit discrimination against and unequal treatment of asylum-seekers, thus threaten the 1951 Convention itself (Schuster, 2003). The unequal treatment of asylum seekers compared with other categories of `illegal' immigrants, demonstrate how articulating these constructions of racism in political discourse can be extrapolated from many political conversations (Every & Augoustinos, 2007). Even New Zealand resettlement pathways can

contravene the agreements outlined in the Convention in relation to non-discrimination, wage-earning employment, non-penalization for illegal entry, and prohibiting refoulement (Goodwin-Gill, 1988; Haines, 1994, 1999).

According to Dustmann et al. (2017), many countries of refuge either treat asylum seekers as a burden to their economy or opportunist and economic migrants rather than protection from political persecution. By virtue of being compelled to flee their home countries due to the fear of persecution, war, strife or social disfranchisement, people are forced to abandon their homes, family and livelihood in search of safety in a host country (Hathaway, 2007). In fact, some refugees resort to unconventional methods, including using fake documents and relying on smuggling networks, to escape persecution in their countries of residence, rendering them homeless, helpless, stateless, vulnerable to exploitation, abuse or harm and marginalisation (Babacan & Babacan, 2009; Sabates-Wheeler, 2019).

In 2015, data from the United Nations (UN) Refugee Agency indicated that 59.5 million people were forcibly displaced globally, 19.5 million of which were refugees from Syria, Afghanistan, Somalia, Sudan, South Sudan, Congo, Myanmar, Central Africa, Iraq and Eritrea (Amnesty International, 2015; Khiabany, 2016) (***Figure 1***).

Figure 1: The Refugee Crisis in Numbers



Source: The Refugee Crisis (Amnesty International, 2015)

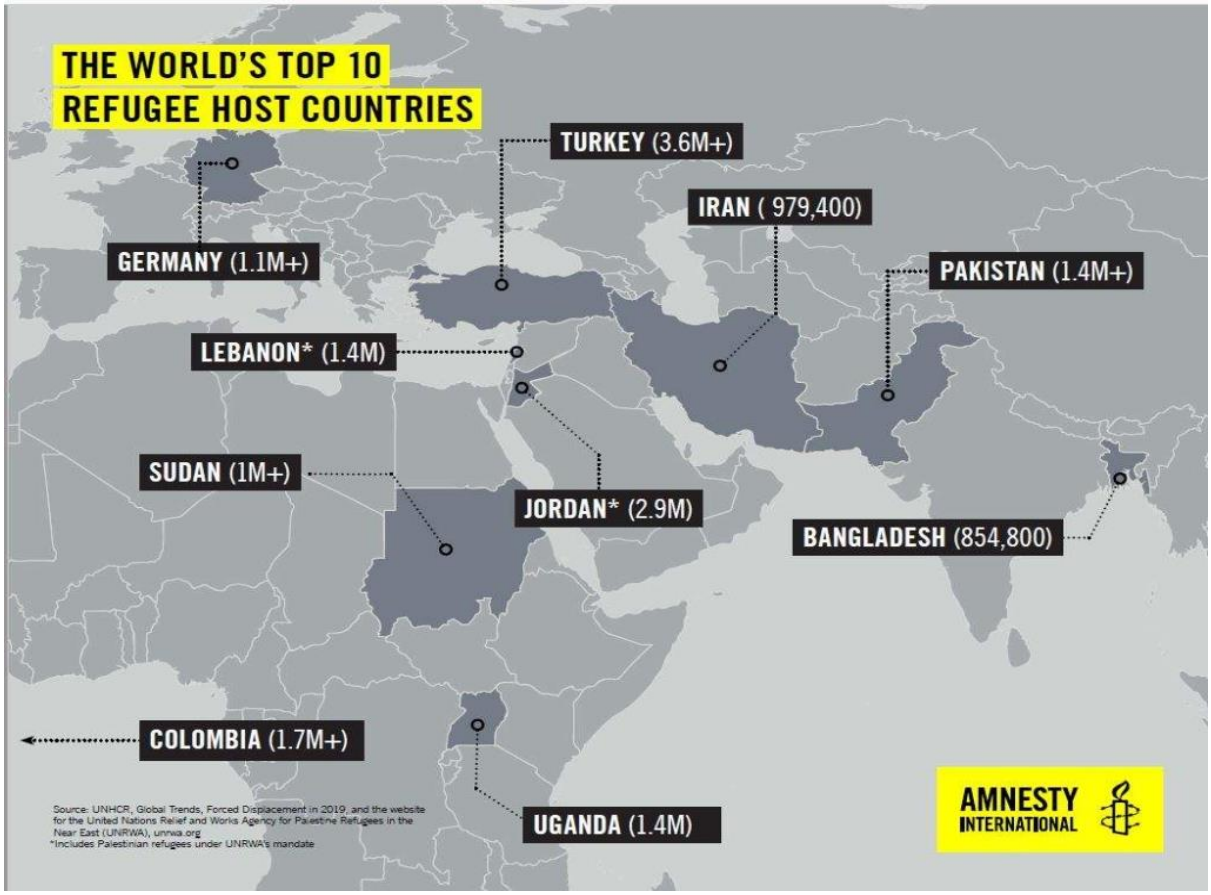
By 2019, the number of people seeking safety worldwide increased from 19.5 million in 2015 to 26 million, along with their resettlement needs rising from 1.15 million in 2015 to 1.4 million, but the host destination remained indifferent (UNHCR, 2019) (***Figure 2***). Numerical data from the UN Refugee Agency showed that around 86% of the world's refugee population are hosted by developing countries, either as internally displaced persons (IDPs) or refugees in countries neighbouring conflict zones, which has since seen a 70% rise in the past 10 years (Kasozi, 2017; Khiabany, 2016). For example, the Sub-Saharan African region is known for hosting a remarkably high numbers of refugees, to the toll of about 30% of the global refugee population (Kasozi, 2017). Historically, countries like Afghanistan, Iraq, and Burundi produced the highest number of refugees in the beginning of the third millennium (Brolan, 2002), but 4 million refugees and 8 million IDPs were the most visible mass movement reported to be emanating from Syria (S. F. Martin, 2016).

Figure 2: People Seeking Safety Worldwide in Numbers

Source: Global Trends, Forced Displacement (UNHCR, 2019)

Less than 1 per cent of the world's refugees resettle in any given year, and the burden of assisting refugees fall to some of the world's poorest countries, as most asylum seekers and refugees are hosted by developing countries (J. Phillips, 2013b). The Sahel regions of Africa, including the Syrian Arab Republic (Syria), Yemen, the Democratic Republic of Congo (DRC), Somalia, Mozambique, amongst other militarily conflicted locations due to the continuous or increasing violence has become the recent refugee hub (UNHCR, 2020). This contradicts the narrative pushed by politicians and media coverage that high-income developed countries, especially those in the Western or European Union (EU) regions, do more than enough to provide safety to refugees around the world. According to the press release from Amnesty International, top host countries for refugees ranked Turkey at 1.59 million refugees in 2014 and now more than 3.6 million, Pakistan hosted 1.51 million, Lebanon was at 1.15 million, Iran saw 982,000, Ethiopia received 659,500 and Jordan registered 654,100 refugees (Amnesty International, 2015) (***Figure 3***).

Figure 3: The World's Top 10 Refugee Host Countries



Source: Global Trends, Forced Displacement (UNHCR, 2019)

In 2017, a record high of 68·5 million individuals were forcibly displaced due to wars and persecution around the globe (Jindal, 2020); and by 2018, this number increased to 70.8 million (Proença et al., 2020). Based on United Nations (UN) reports, the new global record of roughly 80 million people forcibly displaced constituted 26.4 million refugees, 4.2 million asylum seekers, 3.6 million Venezuelans displaced abroad, and 45.7 million internally displaced people (UNHCR, 2020). Most recently, the Taliban's takeover of Afghanistan in 2021 resulted in the UNHCR supporting the evacuation programs for the Afghan evacuees, hence leading to a specially allocated 200 Afghan refugee places in New Zealand in 2022/23 (Immigration New Zealand, 2023b, 2023c). Despite the UNHCR reports portraying the highest recorded number of refugees since the end of World War II (Jozaghi & Dahya, 2020), international response continue to lack cohesiveness (S. F. Martin, 2016).

2.3. **Refugee pathways in New Zealand**

> ''Not every asylum seeker will ultimately be recognized as a refugee, but most refugees are initially asylum seekers'' (UNHCR, 2011).

The above statement holds true in New Zealand, where a distinction can be made between refugees and protected persons, based on their resettlement pathway. According to Nde (2017), the UNHCR's definition of refugee is broad including the African Union's definition, and individuals granted complementary forms of protection – "protected persons" and individuals in refugee-like situations. Hence, Section 129 of the Immigration Act 2009 allows for many protected persons or asylum seekers, who meet the criteria for recognition as refugees by the UNHCR, to be resettled in New Zealand as refugees under the Refugee Quota Programme (Immigration New Zealand, 2023b; Nde, 2017). New Zealand has therefore played a vital role in refugee protection since the end of World War II. New Zealand first officially received 838 Polish refugees in 1944 (Humpage, 2001) and subsequently more than 6000 people from Eastern and Southern Europe from 1949 to 1956 (Brooking & Rabel, 1995). This number soon resettled into the 750 annual refugee quota framework for decades using

the Global Quota System (GQS) before reaching the current 1500 places or quota in Aotearoa New Zealand in 2020 (Immigration New Zealand, 2023a).

New Zealand became a signatory party to the 1951 United Nations Convention relating to the Status of Refugees in 1960 and the 1967 Protocol in 1973, and has accepted the definition of refugees from the Geneva Convention for resettlement since World War II (Humpage, 2001). The government of New Zealand is also signatory to the 1984 Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and the 1966 International Covenant on Civil and Political Rights (Immigration New Zealand, 2023a). In New Zealand, there are three principal resettlement pathways, which includes quota refugees (or UNHCR resettlement), asylum seekers or convention refugees if their claim is successful (spontaneous refugees), and family reunification refugees (Marete, 2011). A fourth resettlement pathway is the recent Community Organisation Refugee Support (CORS) Category. In recent times, the government of New Zealand created a special residency category for Afghans arriving on temporary visas in response to the ongoing humanitarian support for Afghan evacuees (Immigration New Zealand, 2023c). In alignment with the refugee resettlement pathways, the New Zealand Refugee Resettlement Strategy was developed to support the participation and integration of refugees; however, it only currently covers quota refugees. The New Zealand Resettlement Strategy is currently being refreshed to strengthen refugee resettlement support (Immigration New Zealand, 2022b).

2.3.1 **The Quota Refugee Category (or UNHCR Resettlement Refugees)**

The UNHCR regards resettlement as the selection and transfer of refugees from a state in which they have sought protection to a third state that has agreed to admit them as refugees with permanent residence status (Resettlement Handbook, 2004). By deduction, quota refugees or UNHCR resentment refugees request protection status while still overseas, usually from refugee camps, and move to host countries with residency status after approval via the quota system. The quota system was established to address rhetoric on where the displaced individuals or refugees around the world end up, thus providing a durable solution

in the refugee determination process to support those who fled their home country and are unable to return for fear of persecution (Barrett, 2018). Quota refugees, otherwise known as resettlement refugees, are people whom the UNHCR has mandated as refugees offshore, i.e. UNHCR-mandated refugees selected from established refugee camps, a proportion of which quota places have been reserved for women at risk, disability or emergency cases (Adam, 2007).

Refugee camps have served as a temporary shelter for many people in refugee-like situations, including IDPs, environmental migrants, and economic migrants. Quota refugees go through challenging conditions in established refugee camps, which presents a deplorable environment for people already facing traumatic situations and irrefutable psychosocial distress, prior to being resettled in host countries as part of an annual quota (Haines, 1999; Pahud, 2008). Refugee camps are characterized by unsatisfactory accommodations, poor health care services, harassment and enemy attacks, lack of education, compromises to children's safety, and subject people to change their perspectives to adapt to a camp's requirements (B. E. Harrell-Bond, 1995). Nevertheless, most refugees worldwide do not live in refugee camps, with many reported to be resettled under the guidelines of the 1951 Convention or under the UNHCR mandate. By the end of 2015, the UNHCR reported that 67% of refugees around the world lived in individual, private accommodations (UNHCR, 2015).

In New Zealand, quota refugees are selected from established refugee camps, and referred to New Zealand for resettlement as UNHCR-mandated refugees, and they arrive as part of an annual quota programme (Haines, 1999). Established refugee camps can have huge implications for host countries in terms of safety and protection, with domestic violence, alcohol abuse, limited socialisation, depression, hopelessness, anxiety, and mental health concerns associated with surviving refugee camps. When Dr. Gerrit Jan van Heuven Goedhart addressed the refugee problems at Oslo on 12 December 1955, he explained that even the UNHCR mandate still excludes many people like the Palestinians, East Germans in West, Europeans in China, Indian Muslims in Pakistan, and Pakistani Hindus in India (UNHCR, 1955). Since 1987, the New Zealand government introduced the Global Quota System (GQS)

which set the quota at 750 mandated refugees per year, with less focus on specific ethnic groups (UNHCR, 2002). The global quota refugee eligibility criteria adopted by New Zealand is in accordance with the UNHCR humanitarian and safety needs for refugees in the world, which identifies the most needy cases as such as women at risk, medically disabled and protection cases (Marete, 2011). The quota selection starts from the first country of asylum, and the selected refugees go through health screening and cultural orientation by the International Organization for Migration (IOM) and New Zealand Immigration officials (Marete, 2011). So, if a person is to be resettled in New Zealand, they are interviewed by the New Zealand Immigration and Refugee Services officials to determine if they meet New Zealand eligibility requirements (Immigration New Zealand, 2023b), then assigned to the Mangere Refugee Resettlement Centre upon arrival.

Once the quota refugees are approved to resettle in New Zealand, they spend six weeks at the resettlement centre in Auckland where they receive orientation to New Zealand, free English lessons, medical screening and health services (Dunstan et al., 2004; Joudi Kadri, 2009). It is noted that the orientation programme will be changing as the quota has recently increased to up to 1,500 places annually. After the orientation programme at the Centre, receiving basic information about NZ, medical checks, English language lessons, they are then move to a Housing New Zealand property in resettlement areas (e.g., Auckland, Hamilton, Wellington, Christchurch and Napier) with the aid of NGOs, government departments and Crown entities (Miller, 2006; Verbitsky, 2006). They are eligible for all services provided to New Zealand citizens including being prioritised for state housing once they leave the Mangere Refugee Resettlement Centre (MRRC), since they are granted permanent residence on arrival (Adam, 2007; Dunstan et al., 2004). Moreover, the Refugee and Migrant Service - New Zealand's refugee resettlement agency - and Housing New Zealand Corporation (HNZC) assist with housing the quota refugees around the country in Auckland, Hamilton, Wellington and Christchurch (Adam, 2007; Joudi Kadri, 2009).

2.3.2 **Asylum Seekers (or Spontaneous refugees)**

An asylum seeker is anyone who has entered a host country to seek protection under the terms of the UN High Commissioner on Refugees 1951 Convention – 1967 Protocol, whose claim is awaiting preparation, submission, or adjudication (Kalt, Hossain, Kiss, & Zimmerman, 2013). So, unlike refugees, asylum-seekers do not have residency in their host country, and await a decision on their claim for protection under the Refugee Convention or the European Convention on Human Rights (Mole & Meredith, 2010). Moreover, not every asylum seeker will be granted refugee status by the contracting state or the UNHCR, even after lodging a claim for asylum. An asylum seekers is therefore regarded as an individual who says he/she is a refugee, but whose claim has not yet been definitely evaluated (UNHCR, 2011). Asylum seekers unanimously embark on strenuous, life-threatening journeys, including employing unconventional methods like the use of fake documents or no documentation to arrive a host country, where they can indicate their intention of seeking refuge. This largely corroborates with J. Phillips (2013a)'s representation of asylum seekers as ''individuals who are seeking international protection, but whose claims have not yet been determined''; having lost the protection of their state of origin after crossing the national borders (B. Harrell-Bond, 1996).

Asylum claims pose concerns to some host countries who remain torn between providing humanitarian response and the challenges of accommodating mass movement in relation to its national population. These host nations responsible for protecting refugees, only registered a small proportion i.e. 11 per cent of asylum seeker claims with the UNHCR in 2011 (J. Phillips, 2013b). Such circumstances place asylum seekers at a disadvantaged position in the host country as they await on a decision on their claims. According to Hainmueller, Hangartner, and Lawrence (2016), asylum seekers have their lives placed on hold, experience cultural bereavement with separation from family, and face the new reality of possibly never returning to their home countries. To Kalt et al. (2013), this implies asylum seekers also face violence and health challenges in their refuge journey. Even asylum seekers who found temporary shelter in refugee camps out of their countries of origin and aiming to be recognised

as refugees, were only addressed by the 1967 Protocols Relating to the Status of Refugee was drafted (Mamer, 2010). Summarily, there was no clear definition of an asylum seeker in the 1951 Refugee Convention, not until the 1967 Protocols was established to provide a legal understanding for people who enter a second country without meeting legal requirements for entry, seeking asylum or residence.

Asylum seekers apply for protection upon arrival in the host country, hence do not have the luxury of reuniting with family until after their refuge claims have been approved, and they become “convention” refugees. Asylum seekers only become “convention” refugees once their refugee claim is assessed against criteria contained in the United Nations’ 1951 Convention and 1967 Protocols Relating to the Status of Refugees and subsequently approved (Adam, 2007). In New Zealand, asylum seekers are considered as people who lodge a claim for refugee or protection status in New Zealand” (Immigration New Zealand, 2023a). This is accomplished by applying for refuge or asylum in New Zealand through the Refugee Status Branch, and according to Haines (1999), this is achieved using one of two ways.

1. Lodging refuge claim upon arrival at the host country, as it is generally the case with refugees who arrive in NZ without proper entry documents, or
2. Lodge a claim before your permit expires, which is commonly the case for those who came in using proper legal documents and became at risk of harm following changes in circumstance back in their home country.

Asylum seekers who arrive New Zealand without proper travel documents, usually end up detained by the border control officers to ensure they are not a threat to national security, before they are allowed to live in the community on a conditional bail (Fenton, 2004; Mamer, 2010). According to the mediatised opinion of asylum seeker support activist in Auckland, asylum seekers experience arbitrary detention in New Zealand prisons, and are stuck behind bars with some of the country’s worst criminals, for using fake documents to escape an inhumane and life-threatening fate (Maurice, 2019). This may be highly debated opinion, but the detention of asylum seekers ignores considerations for asylum seekers’ right to pursue asylum for fear of persecution and human rights violation or death (Boed, 1994), plus

conditions and services under claims of common humanity (Babacan & Babacan, 2009). This situation is no different than the policies of deterrence adopted in Australia, which includes confinement of asylum seekers in detention centres, restriction of the right to appeal and issuing them with temporary and not permanent asylum (Kisely, Stevens, Hart, & Douglas, 2002). Legal regimes for the international protection of asylum seekers and refugee rights have subsequently been drafted to address regularly abuses noticed in a context of restrictive asylum policies (Chetail, 2014).

Asylum seekers are those whose claims to refuge have yet to be determined and are therefore required to demonstrate that their fear of persecution, is well founded (Barrett, 2018; UNHCR, 2011). Simply put, if an asylum seeker can successfully demonstrate risk of persecution and harm, their refugee claim would be approved (Pinzón-Espinosa, Valdés-Florido, Riboldi, Baysak, & Vieta), and Immigration New Zealand then regards the claimants as convention refugees or successful asylum seekers (Bloom & Udahemuka, 2014; Bogen & Marlowe, 2017). However, asylum claims have restrictive measures imposed upon asylum seekers to increasing deter their arrival (Guy, 2012; Woodhouse, 2013). For example, the amendments in Section 128 of New Zealand's Immigration Act allows provision for detention of asylum seekers who arrive with illegal documents for 28 days pending security clearance and/or removal (Haines, 1999). This Immigration Act 2013 particularly endorses the detention of asylum seekers arriving in groups of over 30 people under a mass warrant, and treats them different to individual arrivals (Bloom & Udahemuka, 2014). This can be particularly difficult for asylum seekers being treated as "illegal" and detained upon arrival in a country where they deemed may offer them a haven, even after declaring their intention to lodge a refugee claim. That notwithstanding, asylum seekers can get bail on the condition that they must live in an agreed location and report periodically to the authorities (the police) while they are awaiting the outcome of their application for refugee status (Mamer, 2010).

2.3.3 **Family Reunification Support Category (or Family Sponsorship)**

The family reunification support category offers support to the family members or relations of quota refugees and successful asylum seekers in the host countries, and those that benefit from the refugee family reunification status are recognized by the UNHCR under the family reunification category (Adam, 2007; Goodwin-Gill & McAdam, 2007; Stoll & Johnson, 2007). Family sponsorship can be a very challenging in reality to deal with particularly because "family" can be culturally defined differently, rendering this a sensitive problem when dealing with people from different cultural backgrounds. The notion of family differs in the African context and in Eurocentric contexts. In the African context, and according to Stoll & Johnson (2007), the family consists not only of blood-related kin but includes the tribal network that cannot be directly traced back to specific blood relations. A case in point is the Sudanese cultural setting, where being in a "spider web" of family members is a significantly important element in the maintenance of social and physiological wellbeing of individuals in the society (Stoll & Johnson, 2007). Resettlement countries are often discouraged by hard to understand family webs of relationships because in those countries the "family" definition means the nuclear unit consisting of mother, father and mostly 2 children (Adam, 2007).

2.3.4 **Community Organisation Refugee Sponsorship (CORS) Visa Category**

The CORS was the newly introduced private resettlement programme intended to complement the Quota Refugee Programme in New Zealand (Mismash, 2021). In 2017, the NZ government agreed to pilot the CORS visa category as an alternative resettlement pathway, a new initiative that would allow for community-based organisations to sponsor up to 25 refugees in 2017/2018 (Noted, Needs, & See, 2019). The aims of this pilot were threefold. Firstly, provide an alternative form of admission for refugees; secondly, enable communities to be more actively engaged in refugee resettlement, and thirdly, support refugee sponsorship instigated by community organisations. Eligible applicants were required to be mandated as refugees under the 1951 Refugee Convention (UNHCR, 1951). Selection criteria

also included that refugee applicants were required to: demonstrate English language ability; meet minimum work experience or qualifications and be aged 18 to 45. These criteria were considered to maximise the likelihood of former refugees' successful integration and employment.

3. The Coronavirus Disease 2019 (COVID-19) outbreak

3.1 Overview of the Pathogenic disease: COVID-19 pandemic

In the past decades, pathogenic diseases like Ebola virus, Zika virus, Nipah virus, Avian H7N9, and Coronaviruses (CoVs) have caused viral disease outbreaks in different geographic locations around the world (Dhama et al., 2020). CoVs are simply zoonotic disease spill overs, associated with pathogen exposure that can infect the respiratory, gastrointestinal, hepatic and central nervous system tracts of man (Rodriguez-Morales et al., 2020; Zhou et al., 2020). In November 2002 and in September 2012, infectious outbreaks like the severe acute respiratory syndrome (SARS-CoV) and the Middle East respiratory syndrome (MERS-CoV) were responsible for severe respiratory diseases in Guangdong (southern China) and Saudi Arabia respectively (Dhama et al., 2020; R. Lu et al., 2020). Though pandemics or CoVs are not a new phenomenon (Chan-Yeung & Xu, 2003; Chan et al., 2020; Falisse, Macdonald, Molony, & Nugent, 2021; Jindal, 2020; Yang et al., 2020), the higher transmissibility of the current 2019 novel Coronavirus (2019nCoV), first identified in Wuhan China in December 2019 (Chan et al., 2020; H. Lu et al., 2020), produced unpredicted global public health burden (Carbone, Lednicky, Xiao, Venditti, & Bucci, 2021; Dhama et al., 2020; Jakovljevic, Bjedov, Jaksic, & Jakovljevic, 2020; Mallah et al., 2021). As such, the current 2019 novel Coronavirus (2019nCoV) or coronavirus disease 2019 (COVID-19) is unique and accounts for unprecedented global impacts, with far reaching effects on marginalised populations of the world.

3.2 Impacts of the COVID-19 pandemic (SARS-CoV-2)

The global pandemic of COVID-19 has disrupted social, psychological and economic rhythms worldwide, claiming millions of lives and impacting medical capacity in the process (Bandyopadhyay & Meltzer, 2020). In 2019, the severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) was determined to cause COVID-19 which caused devastating impacts globally. As of January 2023, the World Health Organisation (WHO) reports over 663 million confirmed cases of COVID-19, out of which over 6.7 million deaths have been recorded (World Health Organization, 2023). It is worth establishing that around 30% of individuals infected with SARS-CoV-2 develop COVID-19 and experience flu-like symptoms, among which approximately 25% require hospitalization, out of which a third of these patients may require treatment in the ICU (Abate, Ahmed Ali, Mantfardo, & Basu, 2020). However, the mortality rate of COVID-19 can vary depending on how COVID-19-related deaths are defined by different countries around the world. Belgium records the highest COVID-19 mortality rates with 154.9 deaths per 100,000 persons, which includes anyone who died with symptoms compatible with COVID-19, even those never tested for SARS-CoV-2 (Carbone et al., 2021). The United States, on the other hand, includes all patients who died with a positive test, whether they died because of, or with, SARS-CoV-2 (Carbone et al., 2021).

It is also worth considering that the infection rate is proportional to the transmissibility of the SARS-CoV-2 or COVID-19. COVID-19 transmits from person-to-person via respiratory droplets or aerosols (micro droplets) suspended in the air when an infected person coughs, sneezes, or talks (Mallah et al., 2021). Also, this virus spreads rapidly in enclosed environments, especially those in which temperature and humidity are regulated by means of air-conditioning (Carbone et al., 2021). Transmission is also possible through touching a contaminated surface and then touching a mucosal surface, or via any direct contact of respiratory air droplets with any mucosal linings, including mouth, nostrils, and eyes (Centers for Disease Control and Prevention, 2020; Jernigan, COVID, & Team, 2020; Mallah et al., 2021). A number of studies already revealed the SARS-CoV-2 virus causes clinical diseases

in humans, with a disease spectrum ranging from common cold, asymptomatic to severe acute respiratory distress syndrome (ARDS) like SARS and MERS, and death (Cheng, To, Tse, Hung, & Yuen, 2012; Mallah et al., 2021). Maintaining hand-hygiene, social distancing, and personal protective equipment like masks have been the most effective precautions known to minimise or prevent the spread of COVID-19 (Mallah et al., 2021).

3.3 COVID-19 Pandemic and refugee resettlement

The COVID-19 pandemic globally disrupted refugee resettlement. And the stress of living in refugee camps, makes refugees more vulnerable to disease, especially infectious and viral diseases (Ivakhnyuk, 2020). The most commonly reported health outbreaks in refugee camps prior to the COVID-19 pandemic were measles, hepatitis A or B, leishmaniosis, poliomyelitis, meningitis, scabies, typhoid, tuberculosis, cholera, and dysentery, as well as diseases spread by rats and mosquitoes (Sharara & Kanj, 2014). Literally, refugees live under precarious circumstances in refugee camps, which are densely populated, thus rendering the implementation of COVID-19 preventive measures or precautions very difficult. The overcrowded conditions in refugee camps, with limited access to basic sanitation, creates more dire consequences than in general populations, which disproportionately increases the risk of contagion (Beech & Hubbard, 2020; Grewal & Koul, 2021). The typical challenge faced in these densely populated refugee camps, is the burden of enforcing social distancing and where basic sanitation is lacking, rendering proper hand hygiene close to impossible (Centers for Disease Control and Prevention, 2020; Reynolds et al., 2021).

Throughout their journey, refugees and asylum seekers face challenging psychological conditions (Robertshaw, Dhesi, & Jones, 2017). Also, mental health and substance-use related disorders have been linked to refugees and asylum seekers (Jozaghi & Dahya, 2020; Langlois, Haines, Tomson, & Ghaffar, 2016). This elucidates numerous negative mental health issues, which can vary from psychological trauma related to war and other abuses (Burchill & Pevalin, 2014; Jensen, Norredam, Priebe, & Krasnik, 2013); torture (Farley, Askew, & Kay, 2014; Griffiths, Emrys, Finney Lamb, Eagar, & Smith, 2003); post migration stresses

from the asylum and resettlement process (Burchill & Pevalin, 2014; Johnson, Burgess, & Ziersch, 2008); social isolation (Furler et al., 2010; Tobin & Murphy-Lawless, 2014); and other social vulnerabilities (Riggs et al., 2012; Yelland et al., 2014). Following the sudden outbreak of the COVID-19 pandemic, the vulnerabilities of refugees and asylum seekers in terms of healthcare burdens and humanitarian needs have been exacerbated (Jozaghi & Dahya, 2020; Khalatbari-Soltani, Cumming, Delpierre, & Kelly-Irving, 2020; Mattar & Piwowarczyk, 2020; Ross, Diaz, & Starrels, 2020). The COVID-19 pandemic outbreak generated uncomfortable stressors, hardship, and disruptions for people of refugee backgrounds. And given the history of pre-existing health issues like tuberculosis, malaria, viral hepatitis and parasitic infections, common to people of refugee background, COVID-19 only exacerbated their lived experiences (Proença et al., 2020).

The fear of being isolated in quarantine and being separated from their families caused many refugees with COVID-19 symptoms to shy away from getting tested (McPherson & Paul, 2020). Another fear for refugees comes in the form of the increasing discrimination encountered, with the general public viewing these forcibly displaced groups as susceptible to COVID-19 (Alemi et al., 2020). This economic hardship might interact with past trauma exposure to prolong and exacerbate mental health conditions in refugee populations (Li, Liddell, & Nickerson, 2016). Also, the plight of other forcefully displaced groups like the internally displaced individuals, stateless individuals and asylum seekers, often scarred by pre-existing health conditions are totally neglected during the COVID-19 pandemic. In the midst of the global burden created by the pandemic, Carbone et al. (2021) ponders if the price humanity is paying for implementing strict restrictive measures for fear of contracting SARSCoV-2 infection outweighs the benefit of decreasing the rate of viral spreading.

3.4 New Zealand COVID-19 response and marginalised communities

On 28 February 2020, the first case of the SARS-CoV-2, the virus causing the COVID-19 pandemic, was confirmed in New Zealand (Summers et al., 2020). With 5.81 cases per the million people recorded in the country, the New Zealand government responded to the

threat of or the impact of COVID-19 by closing its borders to non-residents on March 19, 2020 (Bandyopadhyay & Meltzer, 2020). Aotearoa New Zealand's early public health response to the COVID-19 pandemic eventually led to a strict lockdown and the declaration of a national state of emergency on March 25, 2020 (Every-Palmer et al., 2020). Because of New Zealand's 'go hard, go early' policy, the exponential COVID-19 community transmission of the SARS-CoV-2 was eliminated, based on its nation-wide border restrictions and stringent stay-at-home national lockdown policy (Bandyopadhyay & Meltzer, 2020; Officer et al., 2022). The COVID-19 pandemic prompted the New Zealand government to respond by initiating the COVID-19 elimination strategy, based on the projections of its disease model. As early as February 2020, the New Zealand disease model had predicted that the pandemic would overwhelm its health system and disproportionately burden Māori and Pacific Peoples (Baker, Wilson, & Anglemyer, 2020). As such, New Zealand began implementing its pandemic influenza plan, which included preparing hospitals for an influx of patients, while instituting border control policies to delay the arrival of the outbreak (Baker et al., 2020; Summers et al., 2020).

The New Zealand COVID-19 pandemic response describes the national crisis response and management plan adopted in New Zealand to mitigate the disastrous effects of SARS-CoV-2 over the nation, after the WHO declared the COVID-19 pandemic (Baker et al., 2020; Bandyopadhyay & Meltzer, 2020; Bhopal, 2020; Brickhill-Atkinson & Hauck, 2021; Dhama et al., 2020; Elers, Jayan, Elers, & Dutta, 2021; Kabir, Afzal, Khan, & Ahmed, 2020; Officer et al., 2022; Refugees as Survivors New Zealand, 2020; Summers et al., 2020). When COVID-19 was declared a pandemic, nobody had prior immunity to the SARS-Cov-2, and everyone was susceptible to COVID-19 infection. Because of this, COVID-19 pandemic negatively impacted the world in terms of the burden on the economy and on the healthcare system, in addition to various psychosocial impacts (Jayan & Dutta, 2021; Officer et al., 2022; Wilson et al., 2021). But New Zealand's national COVID-19 response following the outbreak, placed the Aotearoa New Zealand's response strategy amongst the best in the world. New Zealand's proactive response resulted in much lower community transmission rates compared to most OECD countries; a relatively lower burden of COVID-19 that culminated to the initial

elimination of community transmission by May 2020 (Baker et al., 2020; D. McGuire, Cunningham, Reynolds, & Matthews-Smith, 2020; Summers et al., 2020).

The COVID-19 pandemic has exacerbated pre-pandemic inequities between marginalised populations especially asylum seekers and refugee. COVID-19 pandemic shed light on not just income inequalities but very large inequalities in access to decent work for people who were already vulnerable to economic and structural inequalities and have historically experienced marginalization and discrimination in the workforce (Kantamneni, 2020). Some recent literature indicated that elderly people are vulnerable in COVID-19, making them feel ostracized in their community (Rambaree & Nässén, 2020). Also, refugees without legal status and asylum seekers experience greater health and social inequalities compared to officially resettled refugees (Mengesha, Alloun, Weber, Smith, & Harris, 2022). In the context of Aotearoa New Zealand, the narratives point out that health communication interventions to prevent COVID-19 furthered the marginalization of communities at the margins, and community voices were largely erased from the enactment of interventions (Elers et al., 2021). According to Bromfield and McConnell (2021), New Zealand embraced the waves of public administration reforms in its unitary system of governance, where powers are centralised, as its approach towards managing the crisis challenges of COVID-19. New Zealand's approach comprised of the COVID-19 elimination strategy which was a protection framework based around a four-tier alert level system (Baker et al., 2020); which subsequently shifted to a mitigation strategy in 2021 with the introduction of the COVID-19 protection framework (Kvalsvig & Baker, 2021; Vattiato et al.), a very reliant communication strategy based on using efficient public messaging to raise awareness around the disease and a vaccination roll-out plan (Beattie & Priestley, 2021; Grieve, 2020). These measures were made legally binding by the COVID-19 Public Health Response Act 2020.

3.5 Conclusion

For asylum seekers and refugees living in New Zealand, there is limited literature or data to improve our knowhow of their lived experiences in relation to healthcare and welfare

and coping strategies during the COVID-19 pandemic. This justifies the need for this study which focuses on understanding the impacts of COVID-19 pandemic on asylum seekers and refugees from their perspective. As such, this dissertation will provide insight on the lived experiences of asylum seekers and refugees living in Auckland New Zealand during the COVID-19 outbreak, which can help inform future policies and practices.

Chapter 3: RESEARCH DESIGN

This chapter describes the research methodology and methods employed by the researcher in conducting this study, which includes the researcher's positionality, study population, data collection procedures, and data analysis. This study is guided by the interpretivist paradigm and employs a qualitative interpretive descriptive research methodology to explore the lived experiences of asylum seekers and refugees living in Auckland, New Zealand, during the COVID-19 pandemic. The chapter outlines the methods used for recruitment, and data collection and analysis. The ethical issues for this study are addressed along with considerations when conducting research with people of refugee backgrounds.

1. Research Paradigm: Interpretivism

The research paradigm that guided this qualitative research study was interpretivism. Interpretivism values the meanings people attach to the events in their lives, obtained by using intensive or in-depth interviews or focus groups, that explores the participant's perspectives and beliefs and interpreting the significance of people's self-understandings in ways they may not have been able to see (Grant & Giddings, 2002). According to Smith and Shinebourne (2012), the interpretive worldview creates more room for expressive freedom, thereby enabling us to follow the interest and concerns of participants. With this worldview, individuals perceive the world differently based on their perceptions in different contexts and captures participants' observations (Glaw, Inder, Kable, & Hazelton, 2017; Khan, 2014). In order to understand and explain human and social reality, the interpretive approach looks for culturally derived and historically situated interpretations of the social life world (Al-Ababneh, 2020).

The interpretive paradigm holds a belief in multiple realities, and argues against the reductionist approach to human experience (Grant & Giddings, 2002), thereby supporting value-laden research, where the focus is on subjective meanings and social phenomena (Al-Ababneh, 2020). Through the interpretive paradigm, the subjective nature of opinions and

findings reflects the diversity of human experiences, hence the construction of multiple realities (Thorne, Kirkham, & O'Flynn-Magee, 2004). The assumption of multiple realities accounts for the subjective and intersubjective meanings people create as they interact with the world around them, hence using open-ended questions in qualitative research can help to reveal participant's perception of certain events (Braun & Clarke, 2006; Grant & Giddings, 2002). The interpretive paradigm allows researchers to view the world through the perceptions and experiences of the participants (Phothongsunan, 2010; Thanh & Thanh, 2015). Thus, each participant's individual experience is essential to better understand the impacts of COVID-19 on asylum seekers and refugees living in Auckland, New Zealand, during the COVID-19 pandemic outbreak. According to Grant and Giddings (2002), the choice of research methodology and method can be influenced by the research questions, personal motivation, and experience.

2. Research Positionality

The positionality of the researcher is based on a deep understanding of some of the challenges that people of refugee background experience based on the researcher being a former asylum seeker in Aotearoa New Zealand. Being a former asylum seeker, the researcher learned about the inequalities that distinguish people of different refugee backgrounds, based on their resettlement pathway to New Zealand. This study was an opportunity to create a space for voices of ethnic minority groups like Afghan evacuees, family reunification refugees, community sponsorship refugees and asylum seekers. Given the challenges non-quota refugees face during their resettlement journeys, the researcher was interested in understanding the impacts of the COVID-19 pandemic on asylum seekers and non-quota refugees living in Auckland from their perspective or viewpoint. Since this researcher is of a refugee background, it facilitated the subjective positionality of the researcher. Using the maintained connections and close relationships built with organisations that support asylum seekers, the researcher was able to attain a "hard to reach" group of

people in the refugee community, which facilitated the researcher's recruitment of willing participants.

3. Methodology: Qualitative descriptive

This research is based on a qualitative descriptive research methodology. A qualitative descriptive approach aligns with the interpretivist worldview and qualitative research processes (Grimaldi & Engel, 2007). The qualitative methodology is descriptive in nature and allows for the critical analysis of data production techniques that guides the researcher in deciding what type of data is required and which data collection tools is most appropriate for the study purpose (Rehman & Alharthi, 2016). This research opted for semi-standardized open ended interviews as preferred method amidst varying degrees of structure for qualitative studies. Using a qualitative descriptive research methodology creates an effective means of exploring and understanding the meaning individuals or groups of individuals attribute to specific experiences and events or ascribe to a social or human problem (Khaldi, 2017; Lambert & Lambert, 2012). This approach naturally provides an understanding of a phenomenon from the unique perspective of those experiencing it (Vaismoradi, Turunen, & Bondas, 2013). Moreover, the qualitative descriptive is effective in producing useful findings and data tailoring to health sciences or studies related to healthcare (Kim, Sefcik, & Bradway, 2017; Neergaard, Olesen, Andersen, & Sondergaard, 2009). The qualitative descriptive is a comprehensive summarization of events experienced by individuals or a group of individuals (Lambert & Lambert, 2012) as this sets out on qualitative procedures such as data collection, data analysis, representing the material to audiences, standards of evaluation and ethics, which are indicative of an interpretive stance equated to listening to people of the researched population.

4. Study Area and Population

The focus of this study was asylum seekers and non-quota refugees living in the Auckland during the COVID-19 pandemic. The participants were eligible to participate if they

were an adult (18 years or older), proficient in English or French, and identified as being a (former or current) asylum seeker or non-quota refugee. An option for an interpreter was also provided. Auckland is the biggest city in New Zealand hosting most of the population, so was chosen as the site to conduct this study as it is one of the refugee resettlement locations in New Zealand.

5. Recruitment and Sampling

This study was advertised in community agencies and organisations in the Auckland region that offer refugee and asylum seekers support services. The advertisement posters were sent electronically for display on notice boards of the organisations, which included the

- Auckland Refugee Community Coalition (ARCC)
- Asylum Seekers Support Trust (ASST)
- New Zealand Red Cross Services (NZRCS)
- Refugees as Survivors New Zealand (RASNZ)

Participants interested in contributing in the research study could reach the researcher via the telephone number and email address included in the flyer poster (Appendix B: Flyer Information). Information about the study and invitations to participate were distributed by through the networks of these organisations, providing avenues to reach out to asylum seekers and refugees willing to participate. Purposeful sampling guided recruitment of participants that would offer a wide range of information and represent different features of the study population (Thorne, 2016). Although this is a small qualitative study, efforts were made to recruit across different socio-demographic characteristics, in an attempt to reach people of refugee background, from particularly different nationalities.

6. Data collection

Data were collected using semi-structured in-depth interviews. Using semi-structured interviews gave guidance around some areas of interest and at the same time gave room for flexibility in the questions asked (Thorne, 2016). The semi-structured format creates a relaxed

discussion forum, while allowing participants to express the attached meanings to their experience and opinions through discussion, without feeling restricted or constrained. The one-on-one interview sessions allowed for open-ended questions that give room for participants to express the meanings they have attached to their experience during COVID-19, and allowance for new questions and insights to arise during the discussion. During the interview, I asked interviewees questions about their experiences as asylum seekers and non-quota refugees in New Zealand and impacts of the COVID-19 pandemic, including the associated lockdowns and restrictions (Appendix D).

All participants provided informed written consent (Appendix C), after they read and understood information provided in the Participation Information Sheet about the study (Appendix B) and had an opportunity to ask any questions. Semi-structured interviews were conducted in-person or online with four (4) participants living in Auckland during the COVID-19 pandemic. The interviews lasted between the 45 minutes to an hour on average and were conducted between April and May 2022 after delays in recruitment due to the COVID-19 restrictions. The interviews were audio recorded with participant's permission and transcribed verbatim.

7. Data analysis

Data collected from asylum seekers and non-quota refugees was analysed according to the six steps of reflexive thematic analysis outlined by Braun and Clarke (Braun & Clarke, 2006, 2019; Braun, Clarke, Hayfield, & Terry, 2019), and facilitated by using NVivo® software. Thematic analysis, which offers theoretical flexibility and accessibility when analysing qualitative data, can entail using an inductive approach through coding and theme development (Braun & Clarke, 2006; Merton, 1975). This enables flexible and ample examination of data gathered during interview sessions to discover common themes and patterns from the thoughts from various participants (Alhojailan, 2012). There would be constant comparison of data collected, relevant literature and the patterns formed from in-depth information and data collected. By going through the transcripts generated from the

interviews and identifying meaningful elements or aspects (Vaismoradi, Jones, Turunen, & Snelgrove, 2016); thereby better portraying what it means to seek refuge in New Zealand and experiences during the COVID-19, from the perspective of asylum seekers and non-quota refugees in Auckland, New Zealand.

Braun et al. (2019) outlined six phases in their reflexive thematic analysis approach, consisting of familiarisation with the data; generation of initial codes; construction of themes; revision of themes; definition and naming of themes; and production of the report (write-up of the analysis/storytelling of themes in context).

***Phase 1**: Familiarization*

This first phase involves becoming fully immersed in the dataset from the asylum seekers and refugees living in Auckland during the COVID-19 pandemic. The researcher achieved this by reading and rereading transcript from interviewed participants to acquire an in-depth knowledge of refugee experiences and coping mechanisms, based on the data analysis or engagement with the data set. Familiarisation with data also allowed the researcher to gain deeper insight through relistening to the audio recordings multiple times, and making notes in the margins and helps the researcher to move the analysis beyond the most obvious meanings.

***Phase 2**: Generating initial codes*

Coding is the systematic and thorough creation of meaningful labels attached to specific segments of the dataset, which involves identifying these relevant data within each data item. The codes were created by analysing the relationship and similarities between meaning units, which were not directly related to the spoken data provided by the participants, but still aimed to support the development of a rich thematic description of the entire data set. The researcher sorted interview texts into codes using NVivo®, which saw some of the codes moving from descriptive to analytics codes. After coding dataset, a list of codes were produced to identify patterns and diversity of meanings, and similar data codes were merged to generate themes from analysed codes.

***Phase 3**: Constructing candidate themes*

The theme development phase is focused on examining codes clustered together to identify patterns and plausible mapping of key patterns formed from the codes generated in the data gathered during this study. The researcher used post it notes to establish a deep understanding of meaning full patterns from dataset, hence the identification of key themes.

***Phase 4**: Reviewing themes*

This phase relates to the review of codes defined by the thematic analysis process. For this phase the researcher transitioned from the process of theme generation to checking whether the themes align with the coded data or dataset. This involved checking whether the themes generated from participant's interviews captured the meaning in the coded dataset.

***Phase 5**: Defining and naming themes*

This stage is where the themes were defined, that is, each theme was given a brief summary that captured the essence of the story behind each theme. At this point, the researcher dissolved, discarded or merged duplications and renamed based on how the themes relate. This phase ensures clarity, precision, cohesion and quality of developing thematic analysis and provide a road map for the final write-up.

***Phase 6**: Writing up*

This phase is the sixth and final phase of the thematic analysis where the researcher weaved together a vivid and analytical narrative from the data extracts to produce the final dissertation. Quotes were selected from participants to support the final written analysis that addressed the research question and connections to existing scholarly and grey literature.

8. Trustworthiness

Trustworthiness is a complex and challenging topic in a quantitative study (Braun et al., 2019). According to Lincoln and Guba (1986), trustworthiness was used to describe the rigour and authenticity in qualitative research. Trustworthiness has four components: credibility, transferability, dependability and confirmability. A vital aspect of trustworthiness is

confirmability, to support this, the researcher engaged in reflexivity by keeping a researcher journal. Researcher reflexivity also supports credibility. Transferability was supported by using purposive sampling and providing a detailed description of the research process.

9. Ethical and cultural considerations

This research involved working with asylum seekers and non-quota refugees, who are usually vulnerable due to the traumatic experiences throughout their resettlement journey. As such, it is vital to consider the ethical and cultural safe standards when working with people with refugee backgrounds. Care must be taken with regards to the non-divulgation of refugee and asylum seeker information, directly or indirectly. As such, no questions were asked about their refugee claims and solely focused on their experiences during the COVID-19 pandemic. Ethical approval was obtained from the AUT Ethics Committee (AUTEC), as this dissertation involved interviewing a sensitive and sometimes deemed vulnerable group (reference number: 21/293).

To enable interested and prospective participants who might struggle with English language proficiency, an option for an interpreter or confident of their convenience was provided. Moreover, arrangements to translate documents to the preferred language of the interested participants was available. Also, taking into consideration possible individual reservations and considerations for personal health and safety, and current government requirements given the ongoing COVID-19 pandemic and lockdowns, interviews were offered to be done online via Zoom, if a face-to-face interview was not feasible or not the preference of the participant(s). Moreover, participants were offered to conduct the interview at a time that was most convenient for them.

Prospective participants were informed beforehand of the nature of the study, its objectives and any additional information they required regarding this research study. An information sheet was prepared for participants, explaining their rights, the research purpose and dynamics and obtaining their informed, written consent before proceeding with the interview. Based on the sensitive nature of questions asked about their experiences, which

intrudes into the private lives of participants (Cohen, Herman, Jedlinski, Willocks, & Wittekind, 2007), consent to audio record the interview and take notes was explained, and their rights to choose to respond or not to certain questions. It was also explained to participants that they have the right to withdraw from the interview. The participant information sheet also outlined options to access free counselling sessions in case participation in this study created any distress.

As a former asylum seeker, the researcher was able to draw upon his experiences and understanding throughout this research. Considering the range and diversity of participants based on their religious affiliations, sexual orientation, ethnic or cultural and moral inclination, as well as education level of people of refugee background, the researcher's positionality was taken into consideration during the interviews. This arrangement created an environment or a comfortable space that allowed for freedom of expression, respect and consideration of participant's worldview.

Chapter Four: RESEARCH FINDINGS

This chapter outlines the socio-demographic attributes of participants involved in my research and presents the findings from a thematic analysis of data collected. The data highlighted key themes which describes the struggles of a marginalised group amidst the COVID-19 pandemic and associated mitigation measures (e.g., nation-wide lockdowns), which can inform future pandemic planning efforts.

1. Socio-demographic characteristics

Four participants of refugee background participated in my research, three of whom were former asylum seekers. The socio-demographic characteristics of participants as detailed in ***Table 1***, show that most participants (n=3) were of African descent, and were all former asylum seekers. All participants were adult males (+18 years old) and resettled in Auckland at the time of being interviewed. One of the participants of Middle Eastern descent, resettled in New Zealand via the Afghan evacuee pathway after the Taliban took overrule of his home country. All participants had children, with half of the respondents married and living in New Zealand with their children. The other participants were not married but had dependent children who were living out of New Zealand at the time of data collection. Two of the participants resettled in Auckland less than two years ago, during the COVID-19 pandemic. Meanwhile the other two respondents had been living in Auckland long before the pandemic outbreak.

Table 1: Socio-demographic characteristics of participants (n = 4)

Sociodemographic characteristic	Description	Number
Sex (Gender)	Male	4
	Female	0
Country of Origin	Afghanistan	1
	Cameroon	2
	Somalia	1
Type of resident in Auckland (NZ)	Afghan evacuee	1
	Convention refugee (former asylum seeker)	3
Family status, with dependents	Married, with kids in NZ	2
	Unmarried, with kids out of NZ	2

Year of arrival (Stay in New Zealand)	2021 (1 year)	1
	2020 (2 years)	1
	2015 (7 years)	1
	2005 (17 years)	1

2. Summary of key themes

Four key themes were derived from the thematic analysis of data collected from the interviews and are described below. These themes provide insights of the lived experiences of asylum seekers and refugees in Auckland, including strategies highlighted by participants that helped in overcoming some challenges presented by the COVID-19 pandemic. Supporting quotes from participants are used to exemplify the essence of my interpretations (participant numbers were used to protect their identity).

2.1. Hypocritical hospitality

Participants expressed discontentment with the claims of care and support provided to asylum seekers during the pandemic lockdown. One of the participants in the study described being in limbo and not being properly looked after upon arrival in New Zealand during the pandemic lockdown.

> *Beside the quarantine, I think they didn't do anything like trying to look after you because you're new, you don't know anyone, which is quite not good. The New Zealand government didn't do anything to say, "Oh, since you are an asylum seeker, these are the things you can get or what you can get."* (Participant 4)

Another participant expressed hypocrisy in government policy which made them believe there was support and were left disappointed at the experience faced upon arrival which deprived refugees from some expected benefits, even amidst the COVID-19 outbreak and lockdown.

> *I think for me in particular and my family, the impact was tremendous ...It says on the StudyLink website that dependent children or person sponsored into New Zealand by a refugee ...And that for me was really devastating, because suddenly I have three mouths to feed that I was helpless with …to make matters worse, before applying for them to come, I had checked the policy and how they look. And they define refugee including someone who's got refugee status through seeking asylum or someone who comes through any of the other refugee pathways, but sponsored by a refugee protected*

> *person can get student loan or student allowance. They can get it.* (Participant 3)

This hypocrisy was supported by another participant, who alluded to that even refugees whose claims were approved did not benefit from the promised welfare support like the emergency benefits and temporary additional support.

> *"As an asylum seeker in New Zealand, it's like you're left with no choice but to get whatever they present to you. A beggar has no choice, as they always say. And I experienced that situation here in New Zealand. You have no choice."* (Participant 4)

With concerns over the omission of refugees on government sources during the pandemic, some refugee needs and challenges were overlooked by the pandemic response communications, leaving them feeling lost or stuck in a state of limbo with less control over their lives.

> *"I thought by now, they [government] would've picked it, but it's still carrying on. If you could go onto the Ministry of Health website, I can dare say that you may not even find the word, 'refugee' anywhere… people of refugee background are lost in the literature and inequalities and challenge they face are not addressed. Not catered for like the Māori and Islanders [Pacific Island community]"* (Participant 3)

Despite remaining appreciative of being welcomed into the country, some participants still felt misaligned in the system, which compounded the hardship associated with feeling ignored and neglected.

> *"Yes, it was tough. Really, really tough. And for me, that is what I would see falling through the cracks, but I don't know whether it's even a crack or it's a deliberate policy…I had three girls that were receiving absolutely no support from the government during that time, because if you looked at the policy, the way it's been written, they're actually classified as migrants. We all know in New Zealand that if you need welfare support, you go to Work and Income, but Work and Income policy, the way it's been stated, unfortunately, dependent children of people who have refugee status do not fit under that category."* (Participant 3)

In summary, these sentiments describes by participants indicated failure of the NZ government to provide the much-needed support in their refugee resettlement journey.

2.2. Dealing with separation

This theme of dealing with separation encompasses the solitude from being separated from family during the COVID-19 lockdowns. The suspension of immigration processes during extensive lockdowns amplified their fears, stress, anxiety, and time in limbo for some participants. However, for other participants, the thought of never seeing their loved ones after the suspension of the family reunification visa or the possibility of losing their loved ones to COVID-19 weighed negatively on the mental health and hopes.

> *"It doesn't help mentally wise because when you are an asylum seeker, you are undergoing a very difficult moment of your life, especially as a family person. If you have a wife back home or kids, it's very stressful. You're going through the stress of waiting for your case to be approved or you're going through the stress of how you're going to reunite with your family again."* (Participant 4)

> *"And yeah, it's been a devastation, loss of life, loss of family, loss of job, loss of family reunification or connections."* (Participant 3)

In contrast, one participant sacrificed family time to volunteer and give back to the community, to assist the elderly and physically challenged, even if this meant sacrificing family time.

> *"It is my family time, but I give it to other people…You have your own family that needs time from you, but you take that time away to help other people. That was my biggest issue, my family, I don't have time for them. Most of my time, I give it to other people to help."* (Participant 2)

Another participant also demonstrated the zeal to engage in volunteering activities as it gave them a sense of value and pride to give back to the community during the pandemic even when it increased their chances of exposure to the virus.

> *"We realized the importance of volunteer 'social support mechanisms' like looking after each other, caring for others and checking on our loved ones. These mechanisms helped become stronger, more informed and psychologically more prepared."* (Participant 1)

Contrarily, some participants also felt the government policies and strategies was not inclusive and did not help refugees who already felt isolated from family and friends due to the COVID-19 pandemic lockdown.

> *"the government should be thinking about how we work with Māori, how we work with Islanders, how we work with Asians, how we work with Middle Eastern, how we work with people from refugee backgrounds …developing strategies that once they start talking to ethnic groups, ethnic minorities that are deprived… So, the government should list these groups. Yeah, so it becomes clear rather than just list two main ones, because once the government list only those two mains, the truth is that you turn up somewhere, let's say to the GP center and say, 'I'm here for this and I'm an asylum seeker.' Often they turn and ask, 'Well, who is an asylum seeker?'."* (Participant 3)

> *"… government support mechanism …a direct line where you could put out a complaint or a suggestion and it gets answered immediately …to say some of the things you need personally, as an asylum seeker, to help you navigate through the COVID-19, especially in Auckland, because I understand the COVID-19 is now something we have to live with."* (Participant 4)

2.3. Challenges with mitigation measures

The implemented COVID-19 mitigation measures resulted in different challenges for different participants. Some participants expressed feelings of exhaustion or being worn out and fatigue particularly from the constant lockdown.

> *"I think it has been wearing people out, the lockdowns and all that. You may think, I think it's going to be okay, and then another restriction and then another restriction. There's this fatigue. People get tired of all these restrictions."* (Participant 2)

Being confined with a group of other asylum seekers or refugees during lockdowns brought up emotions such as feeling imprisoned, sentiments which inferred the housing challenges that asylum seekers and refugees face.

> *"Sometimes you need to go out and experience the energy out there, but when you are locked in the same place [hostel] with more than 10 persons, it become like a prison."* (Participant 4)

For all asylum seekers with pending claims, sentiments reflected feelings of being lost and in limbo during the waiting time for their claims to be approved as immigration processes were halted.

> *"the long-time waiting on a decision from immigration affects mental state of overthinking. If wait time is shortened, it will do great help*." (Participant 3)

Some participants also felt very disadvantaged about lacking choice regarding the implemented mitigation measures. For example, participants commented about the vaccination mandates and how they received vaccinations as a means to return to some normalcy during the pandemic and be able to work.

> *"You must take the vaccine because if you don't take the vaccine, they were saying you can't go to do groceries. You can't go anywhere. You can't go to the offices. You can't even get a job because most jobs that is the number one key role is you must present your vaccination pass. So, I think that was one of the motivators for me. So, I went for it so I can get my life going."* (Participant 4)

Moreover, the intent of staying healthy motivated some participants to accept the vaccine. But not all participants spoke well either about the vaccine or their fear of COVID-19 infection and how this underpinned their decision to get vaccinated and follow the restrictions in place.

> *"The issue I faced is one of the biggest issues, it is fear. The fear that if I get sick, I wouldn't get any medical support, or I can't afford to pay the bills if I go to the hospital. That was my biggest worry." (*Participant 4)

> *"I was tested positive 2 times and was petrified for lack of information when I first tested positive but I was both mentally and socially informed for the second infection."* (Participant 1)

> *There's no change because from 2020 that the pandemic started going really wide, I didn't get any vaccine until 2022. I got a vaccine. After about seven months I got COVID. So I'm accusing the vaccine now that the vaccine brought COVID to me because I was healthy. Without the vaccine, I didn't get COVID but when I got the vaccine, I got COVID. So what is the essence of the vaccine there?* (Participant 3).

On the bright side, participant entrusted their health and safety into the hands of the government, which indicated that the government strategies and government agencies can rely on the trust of the community to fight or cope better with the pandemic, using the COVID-19 pandemic response systems.

> *"Actually it gives us a lot of confidence that the people can trust on the government and then it makes the people responsible that they have to respect the government's decisions because at the end of the day, they think for the benefit of everybody. So, it gives us the confidence that we have to be very responsible citizen and we have to respect all these mitigation measures, no matter how intense they are."* (Participant 1)

2.4. Support and lifestyle adaptations

The essence of this theme related to aspects of resilience, which in this context referred to the level of support received and adaptions or lifestyle changes made by some participants following the COVID-19 outbreak. Participants discussed some beneficial aspects of the pandemic, mainly in terms of the role played by community leaders to strengthened ties within their community and helping refugees cope better with the challenges of the pandemic.

> *"Afghan community leaders or elders, they have been very supportive. So they provide a lot of psychological support. They make sure that they listen to us and then they contact us every now and then to make sure that we are safe, we are healthy, we have all our food and hygiene supplies" (Participant 1)*

Participants also acknowledged the role played by the church and asylum seekers service providers which inadvertently reassured participants that they are valued.

> *"It's a big support, from my community here, from the church. I belong to a church here. Sometimes they just bring food to my door and then they would just send me a text message. I'm surrounded by support. I'm quite happy with support here."* (Participant 2)

There was equally renewed hope for asylum seekers and refugees longing to embark freely with their daily activities. With the arrival of vaccines during the pandemic, as well as the additional knowledge of the virus and its protective measures, participants coped better with the challenges of the pandemic.

> *"…it gives me the confidence that I am healthy. I am ready to go out and continue my normal life, while wearing masks and using hand sanitizers if I come into contact with anything or anyone. And, I can seek the public services, like I can use public transport, I can go to restaurants, to museum, to cinemas, to wherever I plan. So, that is number one."* (Participant 1)

Participants reported changing their unhealthy habits during the pandemic and opting for immunity boosting livelihoods like opting for healthy diet, regular physical exercise or going out for walks around the neighbourhood among other healthy habits. One participant said:

> *"I think not only the friends or the relatives that I know, but even in my family, healthy lifestyle has become very, very important and healthy diet has been an integral part of healthy lifestyle."* (Participant 1)

Financial burden has been touted to be one of the challenges brought by the COVID-19 pandemic. For some participants, even the financial support could not replace or supplement other refugee needs or the support they needed to cope with the psychological challenges faced.

> *"They never reached out to say, 'Oh, how are you coping? How are you doing?' Even during the lockdown, nothing. No food boxes were supplied or even offered, which was really hard. I know I was receiving some money from the immigration, but when you are just in the same spot, you need other things, other support. Even verbal support is quite good to encourage you to keep up with the time and how things have changed. Living the life where you were out there and living another life where you are locked up, you can't go out, you can't do anything. It was really strenuous to me."* (Participant 4)

Also, participants found things as simple as socialising very helpful. New bonds and social connections were created with neighbours, and reconnecting with other refugees from similar countries of origin, religious or cultural affiliations; these were beneficial in alleviating the stress, anxiety, loneliness, and depression that accompanied the COVID-19 pandemic restrictions.

> *"The best support I have, I got brilliant neighbours. I'm so blessed. I got very good neighbours here. They come and knock at the door and we talk through the window, check on me and the family, whether we're okay. Things like that, they make you feel calm, you are not in this by yourself, you get people around you." (Participant 2)*

> *"… rely on refugees who come from the same country, but they're not like relatives. So they would meet, they would have all those cultural gatherings or meetups."* (Participant 1).

3. Conclusion

This research findings identified four key themes regarding the lived experiences and coping mechanisms adopted by asylum seekers and non-quota refugees during the COVID-19 pandemic. Participants commented about many underlying factors that influenced their experiences, the frustrations as well as issues they would recommend improving for a better integration and resettlement experience post-COVID-19. Participants recommended support for all and not just a select category of refugees and maintain interactions that increase engagement with people of refugee background or refugee support service organisations and communities. Participants suggested having some form of refugee identification to support access to government services. Support needs to be culturally-tailored and address psychological, sociological, and financial needs. Another recommendation for is consultation with community leadership. This involves translation of learnings from the COVID-19 into multiple and different languages and integrating this information into cultural program that are tailored to the needs of asylum seekers as refugees represent much diversity. However, assisting the less established non-quota refugee communities to become better integrated is worth the consideration of the New Zealand government. The discussions that follows this chapter will address these issues in more depth and critically discuss the results from this study to relevant literature.

Chapter Five: DISCUSSION AND CONCLUSION

This chapter discusses the results of my findings, focusing on the implications of the research in relation to existing academic and grey literature. This chapter starts with a brief overview of the findings obtained by this study and proceeds to critically discuss the results considering the impact of the COVID-19 pandemic on marginalised communities, focusing on people of refugee backgrounds.

1. Overview of Findings

The aim of my study was to provide insights on the lived experiences of asylum seekers and non-quota refugees living in Auckland, New Zealand, during the COVID-19 pandemic, with a focus on their perceptions of the government's response. There's a limited pool of qualitative research on how asylum seekers and refugees experienced the COVID-19 pandemic. This study, to the best of the researcher's knowledge, is the first to explore how the national pandemic response in New Zealand addressed the specific needs of asylum seekers and refugees amidst the COVID-19 pandemic.

A reflexive thematic analysis of the data collected from face-to face and online (zoom) interviews with participants identified four themes – hypocritical hospitality, dealing with separation, challenges with mitigation measures, support and lifestyle adaptation. Hypocritical hospitality described the dearth in the support services provided to people from refugee backgrounds in New Zealand that calls to the disparity between expectations and experiences of asylum seekers and non-quota refugees in Auckland during COVID-19 pandemic. Dealing with separation focused on all forms of isolation or restrictions, while living away from their loved ones and family because of COVID-19 community restrictions or through suspension of immigration processes. The challenges with mitigation measures described subjective psychological and social challenges faced by asylum seekers and refugees during the pandemic and associated mitigation measures (e.g., lockdowns). Support and lifestyle

adaptations discussed the strategies adopted following the disruptions brought by the COVID-19 pandemic as a means of coping.

The themes generated from this study were reviewed within the context of the New Zealand Refugee Resettlement Strategy (NZRRS) and the New Zealand COVID-19 Response. Other relevant literature, which synthesised the impact of the COVID-19 pandemic on asylum seekers and refugees, were also considered by this study. Cognisance of the reality that COVID-19 impacted study participants differently based on their sociodemographic characteristics, experiences and needs, all findings were contextualised to arrive at three main discussion points: (i) the exclusion of asylum seekers and non-quota refugees in policies and strategies; (ii) the COVID-19 pandemic response; and (iii) post-COVID-19 resilience and new normal.

2. Exclusion of asylum seekers and non-quota refugees in policies and strategies

The most prominent finding observed from my study was the exclusion of asylum seekers and non-quota refugees from national policies and strategies during the pandemic, best captured by the theme of hypocritical hospitality. Increasing the annual Refugee Quota and providing Critical Purpose Visas in response to the Afghanistan crisis were significant policy successes, but for asylum seekers and non-quota refugees living in New Zealand, policies focused on preventing their arrival rather than ensuring their safety and connection to the community (Ferns et al., 2022). This means those seeking asylum in New Zealand and even those who subsequently have their claims accepted are still ignored by policies or excluded from the New Zealand Refugee Resettlement Strategy (NZRRS). The NZRRS is a government-led initiative developed to give refugees a strong sense of belonging to Aotearoa New Zealand through housing, health and well-being, self-sufficiency, participation, and education (Immigration New Zealand, 2012). This section will critically review the impact of COVID-19 on the housing situation, participation, healthcare needs and self-sufficiency for asylum seekers and refugees in Auckland during the pandemic.

2.1 Housing situation during the pandemic

Housing is a basic human necessity for all members of a society and of paramount importance in the asylum seeker and refugee resettlement and integration process (D. Phillips, 2006). There is a dearth of knowledge on the housing situation of asylum seekers and refugees living in New Zealand, and this presents an area for future research on the human needs' perspective embedded in the post-COVID-19 pandemic era for those in the marginalised community. According to Adam (2007), having a home has enduring psychosocial impacts on refugees, because they often lost possession of their properties during flight, and gaining access to an affordable house reinstates some sense of safety. In this light, the housing strategy was designed to ensure refugees live in a decent, safe, secure, healthy and affordable homes without needing government help (Mahony, Marlowe, Humpage, & Baird, 2017; J. Marlowe, Bartley, & Hibtit, 2014; D. Phillips, 2006).

This study presents a contrary reality to the housing expectations, with the asylum seekers and refugees in Auckland observed to be living in hostels, which are crowded environments and not the most ideal living conditions during the COVID-19 outbreak. These hostels are not state funded initiatives; they rely on philanthropic grants or charitable donations, which may present shortcomings in terms of service adaptability to ethnic and cultural considerations, past trauma history, living conditions in housing and hygiene standards. A review of refugee health during the COVID-19 pandemic by Lupieri (2021) revealed that the healthcare needs of refugees living in overcrowded conditions, like in camps and detention centres, were largely neglected (Lupieri, 2021). Living in such proximity with a multitude of others, does not only increase the risks of contracting COVID-19, and the probability of transmission, but equally might be challenging to maintain certain hygienic standards (Kabir et al., 2020; Mikszewski, Stabile, Buonanno, & Morawska, 2022). This stems from the realisation that infectious diseases disproportionately affects crowded refugee camps and refugees may also have co-morbidities that place them at higher risk during the COVID-19 outbreak (Roshni Chakraborty & Jacqueline Bhabha, 2021).

It is worth nothing that it can be hard to secure a suitable and affordable house in New Zealand. This is made worse for asylum seekers and refugees, who are not even considered for state housing because they do not have permanent residency status (Adam, 2007). This places asylum seekers and refugees in a vulnerable position based on their immigration status, besides other interrelated psychosocial, economic, and health-related challenges faced during the COVID-19 pandemic. Moreover, the stress of securing housing has negative impacts on both the health and mental wellbeing of asylum seekers and refugees (Adam, 2007), which was exacerbated by the COVID-19 outbreak.

2.2 Participation

Participation offers an avenue for local integration of refugees into the city community where they can boost of a strong sense of belonging to the community (J. Marlowe & Elliott, 2014). One would therefore be justified to assume that not engaging refugees may impart sentiments of neglect and isolation which undermines the zeal to community integration and participation. In New Zealand, participation simply meant giving refugees the chance to actively participate in social life thus building a strong sense of belonging (Mahony et al., 2017). However, asylum seekers and former asylum seekers or non-quota refugees are not considered by the NZRRS which suggests some form of discrimination and differential treatment in terms of support services provided to refugees in New Zealand. According to my study participants, they did not feel that they have the avenue to participate when they barely have a recognisable status in New Zealand while their refugee claims are still pending or suspended because of the lockdown.

There exist an observable disparity in treatment and support between quota refugees and asylum seekers or even the convention refugees in New Zealand (Cockburn-Wootten, McIntosh, & Phipps, 2014), despite no distinctions made between the two within the 1951 Refugee Convention by the United Nations High Commissioner for Refugees (Bloom & Udahemuka, 2014). Article 31 of the Refugee Convention stipulates that despite being unlawfully in the country of refuge, “one does not become a refugee because of recognition,

but is recognized because he is a refugee" (Moussalli, 1992; Office of the United Nations High Commissioner for Refugees, 1979); and so asylum seekers should not be deprived of this right. In this regard, participants from my study conveyed disappointment that the refugee resettlement strategy failed to consider their needs and rights, making them feel out of place in the refugee community and wider society. Despite being treated unfairly, participants in this study displayed courage and above all odds opted to volunteer during the pandemic, as a means of participating; they wanted to give back to their community and their country of resettlement.

2.3 Health needs during COVID-19

"Without mental health there can be no true physical health" once said Doctor Broke Chisholm, first director of the WHO. The health and wellbeing goal aims to ensure refugees and their families enjoy healthy, safe and independent lives, and education was designed to improve their English language skills, as a means help them participate in education and daily life (J. Marlowe et al., 2014). The findings presented in this research indicated that asylum seekers and refugees sought to engage in healthy activities like regular exercise and eat healthy food. Health and wellbeing were the focus areas within the COVID-19 Public Health Response Act 2020, which implemented risk-informed national COVID-19 suppression measures which initially led to the elimination of the SARS CoV-2 in New Zealand (Baker et al., 2020; Jefferies et al., 2020). The participants in this research overwhelmingly supported the government's response to the burden of the outbreak of the SARS-CoV-2 virus. To help manage challenges during the COVID-19 pandemic and associated lockdowns, the provision of welfare support like the emergency benefits and temporary additional support to asylum seekers was the New Zealand Government's duty of care (Immigration New Zealand, 2023a). Findings from all participants in my study indicated that there was accessibility to healthcare services if in need. The endeavours from refugee-related service providers to provide clinical and community services to families of refugee background in Auckland attest to the various initiatives to help refugee families during the pandemic (RASNZ, 2020). Current literature by

Refugees as Survivors New Zealand (RASNZ) noted that the organisation opted for a community response plan that provided remote psychosocial services, like communication and inclusive messaging, tele-mental health services, remote social work and community support, to former refugees and asylum seeker communities in Auckland (Refugees as Survivors New Zealand, 2020).

Despite the successes achieved by New Zealand in initially eliminating and subsequently minimising COVID-19 transmission in the community, the psychosocial impacts were less than desirable. This aligns with sentiments suggested by other literature. According to Giannopoulou and Tsobanoglou (2020), the psychological impact of long-lasting strict lockdown measures and the risks linked to isolation was a collateral threat to physical health. Mass fear of COVID-19 or hysteria, economic burden and financial losses are some of the universal psychosocial impacts caused by COVID-19 (Dubey et al., 2020). Moreover, many of the current interventions such as social distancing, contact tracing and isolation, and good hygiene would be challenging to implement for people in crowded houses, like with the housing situation of asylum seekers and refugees identified in this study. These projections of the psychosocial impacts of COVID-19 burden, epidemic speed, and healthcare needs were found to have more dire consequences in refugee camps than in general populations following the modelling study done in Bangladesh (Truelove et al., 2020). This makes our findings on the experiences of asylum seekers and non-quota refugees living in Auckland in the COVID-19 settings a critical consideration for preparedness planning towards improved national health systems applicable to future pandemics.

Some participants displayed a lack of knowledge about the availability of welfare support like the emergency benefits and temporary additional support, but even those who were aware of the benefits reported their inaccessibility during the COVID-19 lockdowns. This could be argued to sow some disbelief in government initiatives or a generate sentiments of feeling lost in the refugee bubble during the pandemic and could also be attributed to poor communication from the government or both. Regardless of the reason why, the report on not accessing emergency benefits and temporary support services during the COVID-19

pandemic and their exclusion from the refugee resettlement strategy compounds the assumptions that they are excluded from everything while their claims are still being processed. According to O'Donovan and Sheikh (2014), welfare reforms in New Zealand do not adequately consider the needs, challenges and potential of refugees to obtain work quickly. Refugees therefore rely on welfare support like the emergency benefits and temporary additional support from the New Zealand government until they can get a remunerated job (Immigration New Zealand, 2023a). But, with the limited or minimal financial support as perceived by asylum seekers and refugees interviewed for my study, acquiring necessities like food provisions for their health and wellbeing during lockdown was very challenging, and was compounded by a lack of employment opportunities. In his “Unspoken inequality” publication, Ferdinand C. Mukumbang et al. (2020) directly attributed unemployment due to the pandemic to the loss of livelihood, and decline in remittances for asylum seekers and refugees to the effects of COVID-19 on the economy. From the perspective of my study participants, the COVID-19 pandemic generated other burden and vulnerabilities like inability to enjoy a healthy, safe and independent life with family. Other issues like having difficulties accessing non-COVID-19-related healthcare like prescription medicine and general practitioners, due to priority placed on people with confirmed COVID-19 cases (Kavanagh et al., 2022) and financial hardships contributed to increasing the vulnerabilities of marginalised communities, including asylum seekers and refugees. Asylum seekers and refugees are already fighting for their basic needs to be met and the COVID-19 pandemic only made experiences worse from the healthcare, welfare, economic and psychosocial viewpoints (Bhopal, 2020; Kondilis et al., 2021; F. C. Mukumbang, 2020; Ferdinand C. Mukumbang et al., 2020).

2.4 Self-sufficiency amongst asylum seekers and refugees

The self-sufficiency indicator refers to employment, which offers purpose or satisfaction and a regular source of income. Though employment is one of the major components of a successful refugee resettlement, many people from refugee backgrounds

struggled to secure meaningful employment (O'Donovan & Sheikh, 2014). This placed a significant economic constraint on refugees, because they had to abandon everything in their original country of dwelling for their safety and face the daunting challenges of starting life in anew in the country of refuge. According to Dr. Buheji, self -sufficiency plays an important psychological role during COVID-19 lockdown as it ensures safety and acceptance of lockdowns via using self-sufficiency to eliminate poverty, build independent communities and networking opportunities post-COVID-19 (Buheji et al., 2020). Moreover, there is insufficient evidence to determine which programmes are best suited to foster economic self-sufficiency and wellbeing of resettled refugees (Ott & Montgomery, 2015). Exploring new and inventive ways of promoting the economic and social inclusion of refugees, lauded entrepreneurship as a promising route to self-sufficiency (Embiricos, 2020). In light of helping refugees achieve self-sufficiency, the NZRRS suggests the government would help all working age refugees acquire paid work or receive support from a family member in paid work (J. Marlowe et al., 2014).

Most asylum seekers do not have jobs nor the right to work while they wait on the outcome of these lengthy asylum processes (Fleay, Hartley, & Kenny, 2013; Hainmueller et al., 2016). And based on the labour vulnerabilities of refugees, even the refugees who managed to acquire jobs were not able to work following the COVID-19 pandemic outbreak. This placed asylum seekers and refugees, no matter the refugee categorization - vulnerable, employed, freelance and self-employed refugees - at an economic disadvantage when dealing with specific challenges generated during the COVID-19 pandemic outbreak (Martuscelli, 2021). It is also worth noting however that the likelihood of long-term support for asylum seekers and refugees in the country of refuge is small, and most asylum seekers and refugees do not find the dependence on such support to be an attractive option (Loizos, 2018). Even those who get their refugee claims approved and then get residency status may not guarantee equitable employment (Colic-Peisker & Tilbury, 2007; Ekren, 2018). Even those who get their refugee claims approved and at a later stage acquire residency status, may still find it hard

securing a befitting employment due other factors all related to their history as asylum seekers or refugees (Ott & Montgomery, 2015).

Summarily, all study participants expressed sentiments of inequity, neglect, or discrimination, with regards to some of the inter-related strategies of the NZRRS like housing, participation, health and well-being, and self-sufficiency during the COVID-19 pandemic. Though this study was not able to delve into the underlying reasons behind the exclusion of asylum seekers and non-quota refugees from the NZRRS, it highlighted how the inequity and exclusion exacerbated the experience for asylum seekers in Auckland during the COVID-19 lockdowns. It is worth noting that there are ongoing considerations aimed at refreshing the New Zealand Migrant Settlement Integration Strategy (NZMSIS) and the New Zealand Refugee Resettlement Strategy (NZRRS), to ensure they continue to effectively support successful settlement in the future (Immigration New Zealand, 2022b). Nonetheless, the concerns around the lack of inclusive policies and services, as highlighted by this study resonate with the deep-rooted anxieties and concerns among asylum seekers and non-quota refugees, which were further amplified by the COVID-19 pandemic outbreak.

Some studies have indicated that in New Zealand, all durable solutions for refugees are tailored towards refugees who arrive under the refugee quota programme (Altinkaya & Omundsen, 1999; Elliott & Yusuf, 2014; Joudi Kadri, 2009; Stephens, 2017). These quota refugees were welcomed by refugee-focused service providers who ensured advocacy and frontline services needed to ease refugees' experiences of trauma and marginalisation was achieved using reception, translation services and multicultural centres (McIntosh & Cockburn-Wootten, 2019). In addition, the NZRRS offered quota refugees the right to undertake the same responsibilities and exercise the same rights as other New Zealanders (Immigration New Zealand, 2012). By all indication, the NZRRS, which was a government-led national approach developed in July 2013, only supported quota refugees in their resettlement journey towards self-sufficient and full participation in the New Zealand way of life (Bloom & Udahemuka, 2014). Such lack consideration for asylum seekers and non-quota refugees by the NZRRS amidst the COVID-19 outbreak, explains why this study described the asylum

seekers and non-quota refugees living in Auckland during the COVID-19 pandemic as “lost in the refugee bubble”.

The exclusion of asylum seekers and non-quota refugees in policies and strategies did not only disregard of their needs and rights to protection during the pandemic, but also amplified the sentiment of inequity among refugees. This finding is in accord with the ideas of (Sales, 2002), who suggested that the existing social support systems for asylum seekers portray them as undeserving, and serve to isolate them from society and promote intense social exclusion. Drawing on the politics of public health as illustrated in the article, “in sickness and in health” Ross et al. (2020) explained that policies were tailored for the privileged individuals with capital value that benefit the state's interests and maintains its power, which puts the most vulnerable groups like refugees, asylum seekers, stateless, and immigrants at high risk. According to Barnes and Makinda (2021), some states used the outbreak of COVID-19 as a cover for taking strict and hostile measures against refugees and asylum seekers, which included detentions and other refugee deterrence actions. Typically, asylum seekers and refugees are left impoverished because they were forced to abandon everything to seek refuge and having to face detention upon arrival in the country of refuge makes the process more daunting for most asylum seekers. Barnes and Makinda (2021) reckoned these pushbacks and policies allowing for the detention of asylum seekers and refugees significantly increases their vulnerability while they continued to be exposed to torture, drownings at sea, trafficking and sexual violence.

Based on these findings on the exclusion of asylum seekers or non-quota refugees, it is apparent that the exclusion of asylum seekers or refugees is not peculiar to New Zealand, but more of a global phenomenon. When the COVID-19 pandemic began, for example, many states in South Asia turned inwards to protect their own citizens, leaving refugees excluded from humanitarian services and healthcare services (R. Chakraborty & J. Bhabha, 2021). G. Martin (2015) argued that the fear of ‘invasion’ has the hallmarks of a classic moral panic and relate to campaigns to deter asylum seekers, also referred to as “boat people”, from arriving in Australia. Literature on the “cultural of indifference” and “moral panic” in relation to asylum

discourse depicts how the law changes in New Zealand also allowed for the detention of asylum seekers (Bogen & Marlowe, 2017). This raises valid concerns around the social inequity amongst refugees in New Zealand with respect to its refugee resettlement strategy during the pandemic. It could be argued that the arrival of COVID-19 helped to unmask some of the pre-existing invisible policies that put a vulnerable population more at risk. As a result, many inequalities in policies, discriminatory practices and the inadequate protection of asylum-seekers and refugees were exposed (Barnes & Makinda, 2021); and the hypocrisy over the exclusion of asylum seekers and refugees in the politics of public health was highlighted (Daher-Nashif, 2022).

Prior studies emphasized that social capital, refugee-focused service provision, identity, civic participation and social media are some pertinent variables that affect refugee resettlement in New Zealand (Elliott & Yusuf, 2014; Jay Marlowe, 2020; J. Marlowe et al., 2014). In recent times, some of the humanitarian responses led to some beneficial policies for some people of refugee background in Aotearoa New Zealand. An increase in the annual Refugee Quota after three decades was beneficial for refugees who came to Aotearoa New Zealand through the Quota programme (Ferns et al., 2022). The removal of discriminatory restrictions on African and Middle Eastern refugees, the provision of Critical Purpose Visas to Afghanistan evacuees and enabling access to Refugee Family Support Category (RFSC) are some of the other policy successes in Aotearoa (Ferns et al., 2022). However, despite a refugee being a refugee, the unfair treatment and exclusion of people seeking asylum and Convention refugees from the good resettlement strategy, suggests inequity in treatment among people of refugee backgrounds within New Zealand. This supported by the evidence that refugees who generally tend to be a neglected population during health emergencies (Martuscelli, 2021), with asylum seekers and non-quota refugees proven to experience the worse outcomes amongst the forcible displaced population (Hainmueller et al., 2016) during the COVID-19 pandemic outbreak. There is therefore a need to fully consider the needs of asylum seekers and refugees in New Zealand as well as from all signatory member countries

to the Geneva Convention, using policies and strategies that discourages any form of stigma, sentiments of neglect and discrimination and/or low sense of belonging. This includes considering the resettlement needs based on the age, gender, migration history and language competencies of asylum seekers and refugees.

3. New Zealand's COVID-19 Pandemic Response

The New Zealand COVID-19 pandemic response represents the national crisis response and management plan adopted in Aotearoa New Zealand to mitigate the disastrous effects of SARS-CoV-2 over the nation, after the WHO declared the COVID-19 pandemic (Baker et al., 2020; Bandyopadhyay & Meltzer, 2020; Bhopal, 2020; Brickhill-Atkinson & Hauck, 2021; Dhama et al., 2020; Elers et al., 2021; Kabir et al., 2020; Officer et al., 2022; Refugees as Survivors New Zealand, 2020; Summers et al., 2020). On 28 February 2020, the first case of the SARS-CoV-2, the virus causing COVID-19, was confirmed in a woman in her 60s arriving New Zealand from Iran via Bali (Summers et al., 2020). This prompted the New Zealand government to respond by initiating the COVID-19 elimination strategy, based on the projections of its disease model. As early as February 2020, the New Zealand disease model had predicted that the pandemic would overwhelm its health system and disproportionately burden Māori and Pacific Peoples (Baker et al., 2020). This prompted New Zealand to begin implementing its pandemic influenza plan, which included preparing hospitals for an influx of patients, while instituting border control policies to delay the arrival of the outbreak (Baker et al., 2020; Summers et al., 2020). Because of New Zealand's 'go hard, go early' policy to prevent COVID-19 transmission, a national state of emergency was declared, which led to a nation-wide border restrictions and stringent stay-at-home national lockdown policy (Bandyopadhyay & Meltzer, 2020; Officer et al., 2022).

When COVID-19 was declared a pandemic, nobody had prior immunity to the novel SARS-Cov-2, and everyone was susceptible to COVID-19 infection. Because of this, COVID-19 pandemic negatively impacted the world in terms of the burden on the economy and on the healthcare system, in addition to various psychosocial impacts (Jayan & Dutta, 2021; Officer

et al., 2022; Wilson et al., 2021). But New Zealand's national COVID-19 response following the outbreak, placed the Aotearoa New Zealand's response strategy amongst the best in the world. New Zealand's proactive response resulted in much lower community transmission rates compared to most OECD countries; a relatively lower burden of COVID-19 that culminated to the initial elimination of community transmission by May 2020 (Baker et al., 2020; D. McGuire et al., 2020; Summers et al., 2020). According to Bromfield and McConnell (2021), New Zealand embraced the waves of public administration reforms in its unitary system of governance, where powers are centralised, as its approach towards managing the crisis challenges of COVID-19. New Zealand's approach comprised of the COVID-19 elimination strategy which was a protection framework based around a four-tier alert level system (Baker et al., 2020); which subsequently shifted to a mitigation strategy in 2021 with the introduction of the COVID-19 protection framework (Kvalsvig & Baker, 2021; Vattiato et al.), a very reliant communication strategy based on using efficient public messaging to raise awareness around the disease and a vaccination roll-out plan (Beattie & Priestley, 2021; Grieve, 2020). These measures were made legally binding by the COVID-19 Public Health Response Act 2020.

3.1 The COVID-19 protection framework

The New Zealand COVID-19 protection framework provided a pathway for business and events to re-open to vaccinated people, based on the effectiveness of public and social health measures in reducing transmission, hospitalisations and deaths as a result of COVID-19 (Cumming, 2022; Kvalsvig & Baker, 2021; Vattiato et al.). When faced with the pandemic, the New Zealand government was widely applauded for the effectiveness of its COVID-19 protection framework which was very beneficial to the public health system. Once the pandemic hit New Zealand and national border wide restrictions were in place, it was also no longer possible for refugees to sponsor family members for residence via the refugee family reunification visas scheme (J. Marlowe & Elliott, 2014). It is important to note that reuniting with family members is an immediate priority. Richardson, Stack & Moskos (2004) reporting

on the Longitudinal Study of Immigrants in Australia (LSIA), found that the Sudanese humanitarian entrants were more likely to apply to sponsor a relative to migrate to Australia, before they thought about what to do for themselves.

From the perspective of my study participants, the COVID-19 protection framework facilitated the monitoring and minimising the transmission of the level of threats from the SARS-CoV-2 infection and exposure rate to the virus in Auckland. Participants also indicated that the suspension of immigration process due to New Zealand's nation-wide border restrictions amplified the fears, anxiety and uncertainty among asylum seekers with pending refugee claims or those with rejected claims undergoing an appeal. Some participants were left with no other choice than using social media to connect with their families and children abroad, following the implementation of a controlled COVID-19 protection framework and the fears and uncertainty of when they could see their family again became a common stressor for non-quota refugees. These results corroborate the ideas of Brickhill-Atkinson and Hauck (2021), who suggested that the suspension of resettlement and related services was a refugee experience directly linked to COVID-19 pandemic lockdown. Kluge, Jakab, Bartovic, D'Anna, and Severoni (2020) attributed the suspension of the refugee resettlement by the International Organisation for Migration (IOM) and the United Nations High Commissioner for refugees (UNHRC) on March 10, 2020, to the efforts to curb the spread of COVID-19 using worldwide travel restrictions. So, the COVID-19 protection framework offered asylum seekers with some hope at reuniting with family in the foreseeable future.

3.2 The crisis communication approach in New Zealand

The communication of public health measures is the major contributing factor to the success of Aotearoa New Zealand's COVID-19 elimination strategy (Beattie & Priestley, 2021). On 27 April 2020, New Zealand Prime Minister Jacinda Ardern announced that they had won the battle against community transmission of COVID-19 (D. McGuire et al., 2020). In a chaotic time characterised by fear, panic, misinformation and disinformation about COVID-19 (Soar et al., 2020), effective crisis communication was detrimental in the fight against the

COV-SARS-2 virus. In Aotearoa, the use of clear consistent messages in an empathetic manner during the Prime Minister Jacinda Ardern's daily press briefings with the Director-General of Health, Ashley Bloomfield, directly inspired New Zealanders to unite against COVID-19 following lockdowns (Beattie & Priestley, 2021; D. McGuire et al., 2020). The COVID-19 protection framework (traffic lights) catered to the public messaging and could be seen as crucial crisis communication approach adopted by New Zealand to fight the COVID-19 via raising awareness on COVID-19 preventive measures. On 21 March, the Prime Minister Ardern outlined a four-level alert system designed to slow the spread of the virus, which includes asking people to work from home if possible, cancel non-essential travel, and stay home if unwell or over 70 under Alert Level 2 (Beattie & Priestley, 2021). According to Chevalier (2022), COVID-19 screening at border crossing also helped a great deal to prevent community transmission rates of the COVID-19 pandemic. More importantly, the institutional stance in the early stages of the Prime Minister Ardern's crisis leadership reassured the public in relation to the government's decisiveness and evidence-based approach (D. McGuire et al., 2020).

The participants in this study attested to having access to trusted government sources of information as well as the COVID-19 hotline created to help them clarify any doubts and issues surrounding COVID-19, which helped them cope better during the pandemic. This viewpoint is supported by existing literature which portrayed the government of New Zealand's use of different mediums like parliamentary statements, daily briefings, Facebook Live broadcasts and podcasts, to engage in narrative and dialogue with the New Zealand public (D. McGuire et al., 2020). In essence, Prime Minister Ardern's communication style was very good at establishing a relationship with her audience in a way that created empathic connection between the addresser and the addressee thus inspired high compliance with the severe measures imposed by the government (Musolff, Breeze, Kondo, & Vilar-Lluch, 2022). Using varied social media platforms during crisis communication proved to be beneficial for building public relationship in New Zealand (Flew, Bruns, Burgess, Crawford, & Shaw, 2014; Proverbs, Lan, Albishri, & Kiousis, 2021). Despite the conflicting information or conspiracy

theories flooding the internet and social media platforms, some participants attributed having the necessary wealth of information on preventive measures that boosted refugee resilience during the COVID-19 pandemic. According to Abdi, Murphy, and Seale (2020)'s findings on the health literacy demand of online immunisation information, many refugee-specific resources on immunisation was not available. However, participants in this research referred to the government websites as their go-to source for updates on the COVID-19 outbreak along with the advice and recommendations suggested by the New Zealand government. The public statements made through the lens of crisis leadership and crisis communication, and the use of different mediums like parliamentary statements, daily briefings, Facebook Live broadcasts and podcasts were the key mechanisms used for engaging in the COVID-19 narrative and dialogue with the public (D. McGuire et al., 2020). Moving between different alert levels as a containment of community transmission using contact tracing, social distancing during the national state of emergency offered hope for the future, which was amplified by the introduction of the vaccines and boosters to build immunization (Abdi et al., 2020; Beattie & Priestley, 2021).

3.3 The vaccine roll-out as the new normal

The vaccination roll-out was the immunisation programme used by the New Zealand Government to protect against COVID-19. According to Prickett, Habibi, and Carr (2021), the success of the New Zealand's elimination strategy in curbing the impact of COVID-19 on population health and reopening New Zealand's international borders was contingent on high and equitable uptake of the COVID-19 vaccine. The national COVID-19 vaccination programme adopted for New Zealand aimed to vaccinate enough people (90% was the target) to achieve a population immunity threshold without the need for other interventions (Bromfield & McConnell, 2021). Despite reaching high national coverage rates, there are inequities in uptake by ethnicity and by region, and there is no reporting of vaccine uptake by migration background, so this is unknown. It was noted that the effect of New Zealand's vaccine rollout on the potential spread and health impacts of COVID-19 also considered other social

determinants like health coverage, communication and information, which supports the COVID-19 Public Health Response Act 2020.

The global database of COVID-19 vaccinations indicated that an effective rollout of vaccinations against SARS-CoV-2 offered the most promising prospect of bringing the pandemic to an end (Mathieu et al., 2021). However, a sizeable minority of people, mainly the young, female, and less educated, were unsure about getting the vaccine, primarily due to perceptions of unknown future side effects (Prickett et al., 2021) given this was still new and many theories were formulated to discourage the use of the vaccine. Based on the finding of this study, one participant had a negative response to the vaccination rollout and believed that they became susceptible to the virus only after taking the vaccine, and not before. However, contrary to some literature and one of my participant's viewpoint, all the other participants of my study were very receptive to being vaccinated and a intended to get the COVID-19 vaccine once available. They trusted the vaccine to help curb the risk of community transmission. They were relatively open to the vaccine and booster, and they believed it was readily available for everyone in the community. Getting the vaccine and booster quickly became the new normal following the COVID-19 outbreak. This was to cope with the government measures like lockdowns of private and public institutions, quarantines, social distancing, and restrictions have been used to contain the infection and such measures impacted severe effects on food availability and utilization (Khalifa et al., 2021; Merchant & Lurie, 2020; Usher, Bhullar, Durkin, Gyamfi, & Jackson, 2020).

4. Study Strengths and limitations

There are many strengths of this study, including creating a space for asylum seekers and non-quota refugees to share their experiences during the COVID-19 pandemic and their coping strategies. This study used one-on-one interview sessions to capture rich personal narratives from asylum seekers and non-quota refugees themselves. This is important for New Zealand, especially considering the limited literature on asylum seekers and non-quota refugees. Despite the strengths of this study, some limitations were noted. The restrictions

and fear of lockdown measures created recruitment challenges which in turn impacted the sample size for this study. It can be argued that COVID-19 also impacted the number of participants who participated in my study. Moreover, participants were restricted by the lockdown measures and this meant many asylum seekers and refugees needed to be tech savvy or familiar with using Zoom services on their smartphones to participate in the study. This small qualitative study is not be a full representation of asylum seekers and refugee population living in Auckland during the COVID-19 pandemic, and the results are not generalizable but may be transferrable to other similar settings.

5. Conclusion

The COVID-19 pandemic response resulted in unprecedented mitigation measures that amplified the inequities faced by marginalised communities, including those of refugee backgrounds. During the pandemic, asylum seekers faced adversity like social isolation, reduction in welfare, and housing support, as a result of the COVID-19 pandemic, which significantly worsened mental health vulnerabilities (Mares et al., 2021). For those recently resettled refugees, the likelihood to experience poverty, live in crowded housing, being employed in less protected, service-sector jobs, experiencing language and health care access barriers, places them at higher risk for exposure to COVID-19 (Clarke et al., 2021). As a whole, COVID-19 did not only raise public health concerns, but also caused several psychological distresses, including anxiety, fear, depression, stigmatization, avoidance behaviours, irritability, insomnia, and posttraumatic stress disorder (PTSD) (Im & George, 2022; Shahyad & Mohammadi, 2020). A combination of COVID-19 elimination strategy, COVID-19 pandemic framework coupled with good communication, and comprehensive vaccination roll-out under the COVID-19 Public Health Response Act 2020 helped New Zealanders cope better with the COVID-19 pandemic outbreak.

Study findings indicated discriminatory policies not particularly tailored towards the needs of asylum seekers and non-quota refugees living in Auckland during the COVID-19 outbreak and subsequent lockdowns. The COVID-19 pandemic led to stringent restrictions

and border restrictions, and the suspension of refugee resettlement applications and refugee claims for asylum seekers and non-quota refugees living in Auckland during the pandemic. Key findings like hypocritical hospitality, the burden involved with dealing with separation, the challenges with the mitigation measures and the support and lifestyle adaptations were constructed from interviews with four asylum seekers and non-quota refugees. These challenges during COVID-19 only worsened the level of stress, anxiety and depression experienced and the lack of befitting employment, plus the absence of government support or access to welfare services for asylum seekers and refugees living in Auckland. Participants in this study suggested the way forward for improving resettlement was to better support community leadership, cultural heritage and family, recognition via special access and benefits, as well as education and vocational training for asylum seekers and non-quota refugees. Based on these findings it is imperative to improve support services for all refugees during the current and future outbreaks to help mitigate the negative impacts on both physical and mental health of refugees.

APPENDICES

Appendix A:

Ethics Approval letter for amendment to Ethics Application 21/293

Auckland University of Technology Ethics Committee (AUTEC)
Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

3 February 2022
Nadia Charania
Faculty of Health and Environmental Sciences

Dear Nadia

Re: Ethics Application: **21/293 Lost in the refugee bubble: Experiences and coping strategies of asylum-seekers and refugees in Auckland, New Zealand amidst the corona virus disease (COVID-19) pandemic.**

Thank you for your responses to the conditions for the amendment to your ethics application.
The amendment to the eligibility criteria and the data collection protocol (focus groups) has been approved.
It is noted that individual interviews with participants will be the preferred option either in-person or virtually.

Standard Conditions of Approval.

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

Please quote the application number and title on all future correspondence related to this project. For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: zisuhnkessah@gmail.com

Appendix B:

Flyer Advertisement

Project title:

Lost in the refugee bubble: Experiences and coping strategies of asylum seekers and refugees in Auckland, New Zealand amidst the coronavirus disease (COVID-19) pandemic.

Project Supervisor: Dr Nadia Charania
Researcher: Nkessah Zisuh

ARE YOU:

18 years of age or over?

Been living in New Zealand during the COVID-19 pandemic and its associated lockdowns (since early 2020)?

AND EITHER:

Have refugee status (via quota, convention, family reunification, or Community Organisation Refugee Support pathway); or

Have lodged a refugee claim (applied for asylum) with the Refugee Status branch (RSB); or

Have lodged an appeal with the tribunal following a decline of your refuge claim been by RSB

If you answered yes to the above questions, please consider participating in a research study focused on the **experiences of people of refugee backgrounds and their coping strategies in New Zealand amidst the coronavirus disease (COVID-19) pandemic and its associated lockdown restrictions**. The research is being conducted by a former asylum seeker and student at Auckland University of Technology. Please note that some information will be used to fulfil the requirements to obtain a post-graduate qualification (Masters of Disaster Risk Management and Development).

If you choose to take part in the research, a **semi-structured interview or focus group** will be conducted that will last about **1 hour**. It will be held at a convenient time and location with your approval if lockdown restrictions permit, or through an online platform (like zoom call, WhatsApp, Skype, etc.), and a voucher ($30 koha) will be offered in recognition of your time. Participation in the research is completely voluntary and any information you share will be kept confidential by the researcher.

I hope you will please consider participating and contributing your valuable knowledge to this research study. If you would like more information or are interested in being part of the study, please contact: Nkessah Zisuh, zisuhnkessah@gmail.com, (p) 021 0255 6994.

Approved by the Auckland University of Technology Ethics Committee on [25th November, 2021]
AUTEC Reference number [21/293]

Appendix C:

Consent Form for Interview

Project title:

Lost in the refugee bubble: Experiences and coping strategies of asylum seekers and refugees in Auckland, New Zealand amidst the coronavirus disease (COVID-19) pandemic.

Project Supervisor: Dr Nadia Charania
Project Researcher: Nkessah Zisuh

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 14 September 2021.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped or recorded (e.g. zoom recording, skype recorded, etc.), and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I have the right to refuse to answer any questions and may stop participating or withdraw from the study at any time during the interview without being disadvantaged in any way.
- ○ I understand that information I supply during the interview will be held in confidence and personally identifiable information will not appear in any report or publication of the research.
- ○ I understand that research findings may be used for publications and presentations.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes ○ No ○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

……
……
……
……
Date:

Approved by the Auckland University of Technology Ethics Committee on [25th November, 2021]
AUTEC Reference number [21/293]

Note: The Participant should retain a copy of this form

Appendix D:

Participant Information Sheet

Date Information Sheet Produced:

12 July 2021

Project Title

Lost in the refugee bubble: Experiences and coping strategies of asylum seekers and refugees in Auckland, New Zealand amidst the coronavirus disease (COVID-19) pandemic.

An Invitation

Kia Ora/ Greetings/ Bonjour,

My name is Nkessah Zisuh and I am student at the Auckland University of Technology (AUT). I am inviting you to participate in my research project aimed at understanding the experiences of asylum seekers living in Auckland, New Zealand during the COVID-19 pandemic. This research is about understanding the experiences and coping strategies of those whose refugee claims have yet to be determined, during and following the associated lockdowns and restrictions introduced by the COVID-19 pandemic. Your participation in this study is completely voluntary and you may stop participating at any time prior to the analysis of data, for any reason, if you so decide. Your decision to stop participating, or to refuse to answer particular questions, will not affect your relationship with the researcher or AUT. In the event you withdraw from the study and you participated in an interview, it may be possible to destroy all records. However, removal of your data may not be possible once data analysis has commenced. It is worth noting that there are no issues related to conflicts of interest that are anticipated to arise and none of the information you provide for this study will negatively affect or jeopardise your refugee claims in any way or manner.

What is the purpose of this research?

The purpose of this study is to explore the journey of asylum seekers living in New Zealand, through their experiences of the COVID-19 pandemic and their coping mechanisms amidst the associated lockdowns and restrictions.

The goal will be to ensure no one gets left behind in the face of such an unprecedented pandemic, especially in terms of improving the immigration policies, pandemic planning, mental health and wellbeing support for asylum seekers, hence boosting resilience for the refugee community. The findings of this research may be used for academic publications, research reports, journal articles and presentations to advocate for the protection and rights of asylum seekers, in addition to developing recommendations to improve national response strategies, sustainability and disaster resilience.

How was I identified and why am I being invited to participate in this research?

You have been invited to participate in this study directly by the researcher or through your asylum seekers support network or equivalent community organisation. You have been invited to participate in this study because you are 18 years old or older, and have lodged a refugee claim and await a decision, or you have lodged an appeal for review of your claim at by the tribunal, following its decline by the refugee status branch (RSB) of New Zealand and you lived in New Zealand during the COVID-19 pandemic.

To participate and be included in this study, you must sign a Consent Form please. Anyone who chooses not to sign the consent form will not be included in this research.

How do I agree to participate in this research?

Potential participants would need to indicate their interest in participating in this research by signing a Consent Form, provided by the principal researcher. Participation in this research is voluntary (it is your choice) and whether or not prospective participants choose to participate will neither advantage nor disadvantage their refugee claims.

Participants also have the right and choice to withdraw from the study at any time. If they choose to withdraw from the study, then they will be offered the choice between having any data that is identifiable as belonging to them removed or allowing it to continue to be used. However, once the findings have been produced, removal of the said data may not be possible.

What will happen in this research?

This research involves a semi-structured interview and/or photo-elicitation interview that will be held at an agreed venue (either in person or online) at a time that is most convenient for you. Please note that an interpreter will be made available should you wish to conduct the interview in a language other than English and French.

Prior to the interview, I may ask you to take photographs that highlight your experiences before, during and following the COVID-19 pandemic and associated restrictions that we can talk about during the interview. To take the photographs, you can use the camera on your phone or tablet if available, otherwise a camera will be supplied.

During this interview, I will ask you a range of questions related to the COVID-19 pandemic and your perception(s) of its influence on you, experiences during the resulting lockdowns, and how you navigated through or coped with the lockdown restrictions. I would like to get your overall thoughts about the government's response and support provided for the refugee community and asylum seekers in particular, your perceptions of the Auckland pandemic planning or related policies and practices, and strategies to improve legal rights, needs and wellbeing of asylum seekers. Please note that you are advised to not mention any identifiable information regarding your claim during the interview to ensure your privacy and confidentiality is not jeopardised. With your permission, the interview will be audio-recorded and notes will be taken.

What are the discomforts and risks?

It is not anticipated that you will experience any notable risks or discomfort from your participation in this study.

How will these discomforts and risks be alleviated?

However, if you experience any discomfort from participating in this study, AUT Health Counselling and Wellbeing is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research, and are not for other general counselling needs. To access these services, you will need to:

- Drop into our centres at WB219 or phone 921 9992 for the City Campus, AS101 or 921 9998 for the North Shore campus. Appointments for South Campus can be made by calling 921 9992. You can also email counselling@aut.nz.ac
- Let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on http://www.aut.ac.nz/being-astudent/current-postgraduates/your-health-and-wellbeing/counselling

If you are unable to access AUT counselling services, you can contact the national free Health line service on 0800 611 116.

What are the benefits?

This research will assist the principal researcher and former asylum seeker, Nkessah Zisuh, in gaining valuable experience in migration and refugee related fieldwork, and also help him in obtaining a post-graduate (Master's degree) qualification to launch his career pathway in Disaster Risk Management and Development.

Also, it is anticipated that your comments will provide important insights to help guide policy and practice to improve the asylum seeking journey in New Zealand and potentially other developed Western countries that accept asylum seekers. The research findings will be shared nationally and internationally by producing journal articles and conference papers and presentations.

A Koha will be offered in recognition of your time and contributions.

How will my privacy be protected?

If you agree to participate in an interview, all of the information you supply during the interview will be held in confidence and your name or any personally identifiable information will not appear in any report or publication of the research.

All data collected will be safely stored using password protection and only members of the research team will have access to this information. Where someone is employed to assist with transcribing the interviews and/or act as an interpreter, they will be required to sign a confidentiality agreement to protect your information. All research materials will be stored in a locked cabinet in a restricted access office at AUT and archived for six years following completion of the study. After the six-year retention period, all related information will be permanently deleted Page 3 of 3 from research computers, and any hard copies will be shredded and destroyed. Confidentiality will be provided to the fullest extent possible.

What are the costs of participating in this research?

There is no cost for your participation in this research. Your time commitment for this research is expected to be between 1 - 2 hours would be helpful to the successful accomplishment of this project

What opportunity do I have to consider this invitation?

We kindly ask you to please consider our invitation to participate in this study and provide a response within four weeks to the principal researcher, Nkessah Zisuh, zisuhnkessah@gmail.com

Will I receive feedback on the results of this research?

Once the research is completed, a summary report of the findings shall be emailed to all participants who indicated in the Consent forms that they would want a copy of our findings.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the principal researcher, Nkessah Zisuh, zisuhnkessah@gmail.com

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, ethics@aut.ac.nz, (+649) 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Nkessah Zisuh, zisuhnkessah@gmail.com

Project Supervisor Contact Details:

Dr Nadia Charania, nadia.charania@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on [25th November, 2021]
AUTEC Reference number [21/293]

Appendix E:

Indicative Questionnaire for semi-structured interviews

For use by research members only
Study Participant Number(s):_____
Date:_____

Introduction

Thank you for agreeing to participate in this interview or focus group. I'd like to have a conversation with you to understand your experiences as a refugee or asylum seeker during and following the COVID-19 pandemic in New Zealand and how we can improve the way we provide care for people with refugee backgrounds. So, there are no right or wrong answers to any of my questions as I'm just interested in your own experiences, how you coped, where you reached out for support and any ideas you have about improvements.

Participation in this study is voluntary and your decision to participate, or not participate, will not affect the relationship with the researcher, AUT or any community organisation. This conversation should take approximately one hour. With your permission, I would like to audio record the interview or focus group because I don't want to miss any of your comments. All your responses will be kept confidential. This means that you will not be identified in any research outputs (responses will be de-identified). You may decline answering any questions or stop the interview at any time and for any reason. Are there any questions about what I have just explained?

May I turn on the digital audio recorder?

Project title:

Lost in the refugee bubble: Experiences and coping strategies of asylum seekers and refugees in Auckland, New Zealand amidst the coronavirus disease (COVID-19) pandemic

Questionnaire:

1. Can you start by telling me a bit about yourself?
    a. Where were you born?
    b. Do you have family or children?
    c. Where did you migrate from? And when did you arrive in New Zealand?
    d. What do you like to do? Any hobbies?

2. Can you please tell me your thoughts about the novel coronavirus disease 2019 (COVID-19) pandemic?
    a. Did you feel prepared for the pandemic? If yes, how did you prepare?

3. What were the biggest issues you faced as an asylum seeker or as a refugee during the COVID-19 pandemic in Auckland?

a. What did you think about the government's response to the pandemic? Probe for their thoughts on if the response and recommendations were comprehensive, inclusive or discriminatory.
b. What did you think of the pandemic mitigation measures/responses (e.g., lockdowns, wearing masks, social distancing, etc.)?
c. Were there any recommended pandemic mitigation measures (e.g., lockdowns, wearing mask, social distancing, etc.) that were feasible or not for you to implement? Why?
d. Did anything help or hinder you following the recommended COVID-19 planning mitigation measures?
e. Did you do anything else beyond the recommended mitigation measures to protect yourself and/or your family during the pandemic response?

4. Where/whom did you turn to for information about the COVID-19 pandemic?
    a. What did you think about the (risk) communication during the COVID-19 pandemic and associated lockdowns/restrictions?
    b. What could have been done better? What are some effective ways to communicate with refugees and/or asylum seekers? Prompt for messaging format, delivery and content.

5. What are some of the things that helped you cope well with the COVID-19 pandemic and its associated lockdowns and restrictions? Why?
    a. Can you please tell me about the social support/networks you have in place?

6. Are/were you aware of any support services available for refugees and/or asylum seekers during the COVID-19 pandemic and its associated lockdowns/restrictions?
    a. Was the available support service tailored or adapted to your needs as a refugee or asylum seeker?
    b. What did you think about the support available for those entering New Zealand on different refugee pathways? Was there any differential treatment? If yes, what were they?
    c. What do you think could be done differently to help refugees and/or asylum seekers cope better during a national public health emergency or crisis like the COVID-19 pandemic?

7. In general, are there any strategies that would improve pandemic preparedness and response for refugees and/or asylum seekers?
    a. What can the government and organisations do differently to better meet the needs of refugees and/or asylum seekers during a crisis or pandemic?

8. What do you think about the COVID-19 vaccine and the roll-out in Aotearoa New Zealand?
    a. Prompt for comments about safety and efficacy of the COVID-19 vaccine
    b. How likely are you to receive the COVID-19 vaccine?
        i. What factors may influence your decision to get vaccinated?
        ii. Please explain/elaborate.
    c. If you've received the vaccine, what influenced your decision? Please explain/elaborate.
        i. What was your experience like accessing the vaccination and the actual appointment? Prompt for information provided, ease of getting to vaccine location, etc.

d. If you've decided not to receive the vaccine or are still deciding, what factors are you considering? Please explain/elaborate.

9. Did any changes come about by the COVID-19 pandemic?
    a. Prompt for any changes, resolutions or long-term plans for preparing/protecting yourself for future pandemics/infectious disease outbreaks and/or protect your health and wellbeing?
    b. If yes/no, why and what changed? What would motivate or enable you to prepare for a pandemic/infectious disease outbreak?

10. Do you have any additional comments?

Thank you for your time, valuable comments and information shared today!

Approved by the Auckland University of Technology Ethics Committee on [25th November, 2021]
AUTEC Reference number [21/293]

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