Pacific families and frontline workers' experience of COVID-19

March 2021

NGĀ MIHI - ACKNOWLEDGEMENTS

Special thanks to all the participants who took part in this research for their participation and time, and for generously sharing their experiences. The authors would also like to acknowledge [redacted] s 9(2)(a) for their review of the report.

BACKGROUND TO THE RESEARCH

COVID-19 IN AOTEAROA

In January 2020, the World Health Organization (WHO) Director-General declared the novel coronavirus outbreak a public health emergency of international concern. At that time, there were 98 cases and no deaths in 18 countries outside China. Four countries outside China had evidence (8 cases) of human-to-human transmission (Germany, Japan, the United States of America, and Viet Nam) (WHO, 2020).

On 28 February 2020, the first case of COVID-19 was reported in Aotearoa. This followed an extraordinary roll out of events, both internationally and here in Aotearoa. The Government announced a self-isolation period of 14 days for visitors entering the country (except for those arriving from the Pacific); this was quickly followed by the introduction of a four-tiered Alert Level system to aid in the prevention of the spread of COVID-19. Aotearoa moved swiftly through the tiers arriving at the highest Alert Level 4 (nationwide lockdown) on 25 March 2020, less than one month after the first confirmed COVID-19 case.

The speed at which an entire country moved from confirming its first case of COVID-19, to an entire country effectively shutting down, was remarkable. The country moved swiftly and put measures in place to stamp out the virus, while continuing to run essential services.

From an epidemiological perspective: *"Inequitable morbidity and mortality for Māori and Pacific peoples, seen during previous influenza pandemics, continue for many communicable diseases today. COVID-19 ethnic and social disparities have been observed overseas. Aotearoa's response sought to prevent COVID-19 disparities and minimise transit of infection to lower-income Pacific countries." (Jeffries, 2020)*

The Pacific community is a vulnerable population for multiple reasons. Pacific families having underlying medical conditions, live in crowded housing, and experience difficulty accessing health care due to language barriers (Ministry of Health, 2020).

The first time Aotearoa was in lockdown at Level 4 during March to June 2020, the Pacific community had the least infections of COVID-19 of any other ethnic grouping in New Zealand. After 102 days of Aotearoa being COVID-19 free, four new cases were confirmed on 11th August 2020 in the South Auckland community. A day later, the Auckland region moved to Alert Level 3 (a regional lockdown) and the rest of Aotearoa to Alert Level 2.

THE RESPONSE FOR PACIFIC PEOPLES

As of late September 2020, the Government had allocated a total of $36.5 million to the COVID-19 Pacific Response ($17 million in April 2020 and a further $19.5 million in August 2020 to meet increased demand) to support District Health Boards (DHBs) and Pacific health and disability services; extend Pacific language public health messaging and guidance; and connect high-risk Pacific peoples with support services.

Mobile outreach services of non-clinical health support staff in Pacific communities and a Pacific case management model, which includes pathways for working with churches, have made a significant contribution to the pandemic response. This has included an enhanced Pacific capacity and capability within the national contact tracing service to find, spot-test, and provide wrap-around

assessments for Pacific close contacts who cannot be traced through standard National Close Contact Service processes.

The COVID-19 Pacific health and disability system response has been a multidisciplinary effort involving a broad range of Pacific organisations and expertise. Key programmes have included the provision of advice by technical, clinical, policy, cultural and community experts to the MoH; engagement with Pacific clinical and public health leadership; development of an All-of-Government communication strategy to ensure that timely, accurate messages reach and engage Pacific communities; mobilisation of Pacific health providers and other health, disability and social service providers to Pacific communities; and ensuring high quality research and analysis was undertaken to support planning and intervention decisions.

RESEARCH RATIONALE

The Pacific team within the Population Health and Prevention Directorate of the MoH developed the Pacific COVID-19 Response Improvement Framework to improve the Government's response to future pandemic outbreaks within the Pacific community.

The Response Improvement Framework consists of three key components, and while they are considered independent pieces of work, they also come together to inform the overall approach in the Government's response to future pandemics. The key elements are:

1. System Research and Review;
2. Independent COVID-19 Response Review; and
3. Pacific Experience of COVID-19:
    a. Pacific experience exploration; and
    b. A quantitative component on the impact on Pacific communities.

This report responds to: *Pacific experience of COVID-19: Pacific experience exploration* in relation to public health compliance measures.

RESEARCH DESIGN AND METHODS

Our aim was to explore Pacific peoples' lived experiences of the COVID-19 pandemic in Aotearoa, in order to document their knowledge, experiences, attitudes, hopes, and expectations of health and welfare services. Pacific families' experiences are particularly important to understand and draw on, in order to improve future programmes responding to infectious disease and pandemic threats and to ensure that Government responses meet Pacific families' needs.

The research explored what mattered to Pacific families during the two significant COVID-19 outbreaks in Aotearoa in 2020 (namely, the 1st outbreak on 25 March and the 2nd Auckland 11 August 2020 outbreak), and why. The research recognises the diversity of Pacific peoples living in Aotearoa and aims to explore the implications of that diversity for programme responses to COVID-19.

The overarching research question for this research is: What were the experiences of Pacific families living in South Auckland during both COVID-19 outbreaks?

Our research explored the experiences of two groups of Pacific peoples:

(i): Pacific Families

This covered a set of topics of interest in relation to public health compliance measures. These included: Demographics; knowledge (knowledge about government agency responses including communications); attitudes and behaviours/practices (in response to the pandemic); hopes and expectations of accessibility to services; and experiences in the context of managed/self-isolation, testing, and contact tracing.

(ii): Pacific Essential Workers

This sub-theme recognised that many Pacific people are employed in the health workforce and can provide a unique view of the health system and health services, as members of their communities but also in their professional roles working in mainstream and Pacific health organisations. This aspect of the research focused on a set of topics of interest in relation to public health compliance measures.

The research team acknowledged the Guidelines on Pacific Health Research developed by the Health Research Council of New Zealand (HRC)[1] and recognised that Pacific research must attend to the ethical principles of relationships, respect, cultural competency, meaningful engagement, participation, and capacity building. Our research design recognised that 'Pacific' research needs to respect subtle but significant differences between the ethnic, cultural and/or language groups included under the social construct 'Pacific'. The need to be inclusive of many perspectives (such as across ages, gender, or kinship groups) is not simply to represent variation for its own sake. Rather, it is based on the research team's experience that each group will have different experiences and views of COVID-19.

Mindful of the need to provide rapid and responsive research that is relevant, we proposed a method that was streamlined to minimise delays. Our research approach involved recruiting participants through personal and professional networks and broad stakeholder input was integrated throughout the research process (that is, via health workers, church leaders and families). A key feature of our recruitment was that we drew on well-established working relationships with diverse networks.

A phenomenological[2], qualitative approach was utilised to gain an in-depth knowledge of the issues. It was important to ensure our interview techniques aligned with Pacific values (respect) while observing cultural protocols (prayer before discussion) within a Pacific framework (talanoa). We used a semi-structured interview guide to ensure we included the main themes and topics of interest to the MoH, at the same time we encouraged families to share their experiences without the constraints of a schedule. Our interview guide was utilised as a starting point to our discussions.

Our processes of engagement reflected a commitment to the HRC Pacific Guidelines so that barriers to participation were minimised. This included attention to cultural protocols as well as provision of refreshments at the interview and assistance with transport. Each participating family received a koha[3], a gift acknowledging their participation in the research. Interviews were conducted in the

[1] https://gateway.hrc.govt.nz/funding/downloads/Pacific_health_research_guidelines.pdf

[2] As a research methodology, phenomenology is uniquely positioned to aid researchers to learn from the experiences of others. Phenomenology is a form of qualitative research that focuses on the study of an individual's lived experiences within the world. Transcendental or psychological phenomenology is focused less on the interpretations of the researcher and more on a description of the experiences of participants and includes "what" they experienced and "how" they experienced it (van Manen 1990).

[3] Koha was offered to each family unit, rather than individual family members.

English language. We offered families the option of undertaking the interview in their language by providing a translator to assist with other Pacific languages, but this was not necessary. All the family participants read the Information Sheet and were given an opportunity to ask questions before signing a consent form.

Research Participants:

- Group 1: Pacific families. Through our community, personal and professional networks, we recruited ten Pacific families[4] who lived, and had been living, in the South Auckland region (Mangere/Ōtara) during the first and second pandemic outbreaks; this was the region where quarantine facilities are located and which was the centre of the second outbreak of COVID-19 in Aotearoa. We interviewed families from the three largest Island groups – Samoa, Tonga and Cook Island – and recruited a mix of gender, ages, households, including intergenerational, extended, nuclear, single families, and with a range of immigration status.
- Group 2: Pacific essential workers. Through community provider networks, we recruited five Pacific essential workers who worked in the South Auckland region and were part of the frontline staff during the first and/or second pandemic outbreaks.

Family participants were invited to have their interview at a public venue. We exercised flexibility around interview settings to suit each family i.e., in some cases we were invited to interview families in their homes, while some families chose to be interviewed in a conference/apartment room – two researchers were present at all times where the interviews took place in the conference/apartment room.

The number of family participants at each interview varied - from one family member to six family members. With the families' consent, we audiotaped the interview, and transcribed them verbatim.

Data was analysed for thematic content, based around the interview schedule, and input into the NVivo qualitative data management programme.

[4] Up to 3 family members were invited to attend the interviews.

THEMES OF INTEREST

Pacific Families Living in South Auckland

This section sets out the findings on topics related to public health compliance measures.

Demographics

Family Code	Ethnicity	Nuclear[5] family	Children/adult children living at home	Immigration status	Household composition
F1SA	Samoan	No	Yes	NZ citizen	3 generations, 7 people. Parent, 3 adult-children, 3 grandchildren.
F2SA	Samoan	No	Yes	NZ citizen	2 generations, 5 people. Parents, Couple with 1 child.
F3SA	Samoan	No	Yes	NZ citizen	2 generations, 5 people. Mother, Couple with 2 children.
F4SA	Samoan	No	Yes	NZ citizen	2 generations, 8 people. Father, Couple, 5 siblings.
F5SA	Samoan	Yes	No	NZ citizen	2 people. Couple.
F6SA	Samoan	Yes	Yes	NZ citizen	3 people. Mother, 2 teenage children.
F7TO	Tongan	No	Yes	PR	2 generations, 5 people. Mother, Couple with 2 children.
F8TO	Tongan	No	Yes	PR	7 people. Couple with four children, and sister.
F9CI	Cook Island	No	Yes	NZ citizen	3 generations, 12 people. Parents, adult children couples, grandchildren.
F10CI	Cook Island	No	Yes	NZ citizen	6 people. Couple with 4 children.
EW1	Samoan	Yes	Yes	NZ citizen	
EW2	Tongan	No	Yes	NZ citizen	
EW3	Samoan	No	Yes	NZ citizen	
EW4	Samoan	No	Yes	NZ citizen	
EW5	Samoan	No	Yes	NZ citizen	

Pacific Families' Cohort:

Those participating included the following ethnicities (over 10 families):

- 6 x Samoan families;
- 2 x Tongan families;
- 2 x Cook Island families.

Of the 10 families, the number of individual family members who participated in the interviews:

- 22 individuals;
- 7 males, 15 females.

Pacific Essential Workers Working in South Auckland - 5 Health Professionals working in the community.

[5] Nuclear family as defined in this report: a couple, or single parent living with or without dependent children.

Composition of Families Living in the Same House

Intergenerational families included: living with elderly parent(s), adult children, or grandchildren; a couple with a baby living with in-laws; a couple with adult children not living in the same household; a single mother with college-aged children (her adult children were living elsewhere); a couple with four school-aged children and living with an adult sister; a couple with teenage children; a young couple expecting their first child.

Family participants were a mix of Aotearoa and Island-born individuals; and Aotearoa Citizens and Permanent Residents.

The family members had a range of employment statuses: paid, unpaid and voluntary employment.

Pacific Essential Workers Working in South Auckland

SECTION 1: EXPERIENCES OF PACIFIC FAMILIES DURING COVID-19 PANDEMIC

EXECUTIVE SUMMARY

The Pacific Directorate of the Ministry of Health (the MoH) commissioned this qualitative research to understand the experiences of Pacific families and Essential Workers during the 2020 COVID-19 pandemic, to help inform and prepare for any future pandemics.

In this report, we present findings from qualitative interviews with 10 Pacific families and 5 Pacific Essential Workers living in the Auckland region. The interviews were undertaken during November and December 2020 to understand the perspectives and experiences of Pacific families and Pacific Essential Workers during the pandemic. Pacific families' experiences can be drawn on to improve future infectious disease and pandemic programmes. The Pacific Essential Workers' experiences were important as they were involved at the operational level in setting up and running testing stations and they also worked closely with the Pacific community in the provision of health services during the 2020 COVID-19 outbreaks.

The report is presented in two sections: Section 1: Pacific families' experiences during COVID-19; and Section 2: Pacific Essential Workers' experiences during COVID-19.

This report is presented around the narratives of the evolving experiences of Pacific families and Pacific Essential Workers during the 2020 COVID-19 pandemic, including both lockdowns (the nationwide March 2020 lockdown and the regional Auckland August 2020 lockdown).

The report starts with Section 1, the Experiences of Pacific Families during the COVID-19 Pandemic. The subsections are presented in a chronological order starting with Families' Knowledge and Perceptions of the virus COVID-19, transitioning into the national March 2020 Lockdown; before moving into the Auckland lockdown in August 2020; and then presenting supplementary conclusions under Other Findings. This report concludes with Insights gleaned from the findings. Families' experiences with testing for COVID-19 and Communication were pertinent issues explored and are reported under the sub-section of August 2020 Lockdown – Auckland. Section 2 presents the Experiences of Pacific Essential Workers during the COVID-19 Pandemic.

The structure of the subsections within this report are as follows: (a) family experience; (b) author reflections-analysis; (c) recommendations families made.

SECTION 1: Pacific Families' Experiences During COVID-19

1.1 Knowledge and Perceptions of Covid-19 Pre-2020 Pandemic

Pacific families had minimal knowledge about COVID-19 and contextualised the virus within previous outbreaks of measles, SARS or a bad flu outbreak. Some felt confident that, as a country, the outbreak would quickly be resolved. Families moved to being on high alert as they realised the gravity and spread of the virus and as they prepared for the national March lockdown.

1.2 March Alert Level 4 Lockdown – Aotearoa

Overall, families were compliant in response to the MoH health measures. Many families had positive experiences during the first lockdown, as it presented opportunities to spend more time

with others who were part of their bubble; they increased their connections with family and friends via Zoom; and they had time to rest and reflect. The downside for some families was the uncertainty around employment; borders being closed to their families overseas; financial insecurity; and balancing the demands of schooling children while managing working from home.

Families developed familiarity with, and everyday use of, obscure and new medical and social terms e.g., coronavirus, pandemic, self-isolation, and quarantine. Families experienced heightened levels of anxiety and concern throughout both lockdowns at certain times. Common descriptions of emotions in response to the lockdown included being frightened, scared, fearful, overwhelmed, and experiencing sadness and uncertainty. Families drew heavily on their family, community, faith, religion and spirituality for support.

Other than two hospitalisations during lockdown, there was a decrease in families reporting illness and sickness during both lockdowns, in particular amongst older and younger members of the family. This finding should, however, be treated with caution as a decrease in seeking medical attention could mask the emergence of other health issues unrelated to COVID-19 symptoms.

1.3 August Alert Level 3 Lockdown - Regional Auckland

All the families who were interviewed were surprised when COVID-19 was found in the Pacific community. It brought an awareness of the vulnerability of their community to the virus. Many families did not believe the community was as strict in their adherence to the rules and regulations of level 3 during the August lockdown. That said, awareness and lessons learned from the March Alert Level 4 lockdown, seemingly a rehearsal of what was to come, meant that Pacific families felt more prepared for the August Alert Level 3 lockdown. The transition to lockdown seemed more seamless, less stressful, and there was less panic as families were more aware and cognisant of what to expect. By the August lockdown, family structures were already in place e.g., work and schooling spaces in the home; awareness of the need to maintain exercise; following health measures such as practice physical distancing and good hygiene practice; and prior knowledge of 'bubbles' which meant that forming these was easier during the second lockdown.

Families' decisions to test, or not, was made as a collective group; as were decisions on the best ways to manage daily life during the pandemic. Some families stressed that collective care and individual responsibility were key and encouraged others to get tested. COVID-19 testing became a top priority for all of the families; the urgency became evident with the emergence of multiple testing stations in the community, and the rising number of community cases.

Testing stations were associated with long queues, long waiting times and food parcels. Families tried different strategies to avoid the waiting times by visiting smaller testing stations during the least popular times of the day. Some families went in convoy, took food, drink and games, played music in the car and used other means of distraction while queuing. Delays in receiving test results were a challenge for families, particularly for some who had to take annual leave while they were self-isolating which, at times, was inconvenient or impractical, as was 'having to chase up' their results. The number of tests each family member underwent varied, with tests ranging from zero up to seven tests, with some family members having multiple tests. For some families, the expectation of the physical test was worse than the reality in terms of the perceived pain and discomfort.

Families' uncertainty about whether they were a close or casual contact created confusion about their degree of risk and whether they should have been tested; or should have isolated themselves from family. The overall uptake of the Quick Response (QR) app and codes was mixed; some of the

families used the app more regularly than others, the older family members needed help with the technical setup and use.

Communication

All the families mentioned Prime Minister Jacinda Ardern and Director General of Health Dr Ashley Bloomfield by name as trusted individuals, as well as trusted government representatives e.g., Pacific MP, Hon. Aupito William Sio. All the families revealed a high level of trust in the Government's handling and management of the pandemic.

Fake news and other information not aligned with Government messaging was taken with a grain of salt; it was not considered by the families as authentic or factual. The families felt the Government messages were clear, their updates reliable, albeit some of the communication was confusing (e.g., the message 'everyone should get tested' when the focus was on those with symptoms).

Reasons for the high level of trust expressed by the families included: the inclusive communication styles of the Prime Minister and the Director-General of Health; families' positive experiences with the wage subsidy; collective action expressed by the Government appealed to the Pacific community as it aligned with Pacific values; the Government upholding national unity with the tagline 'Unite Against COVID-19'; and families having witnessed the Government's management of previous national disasters all of which led to a greater sense of community. In addition, the leadership and service shown by Aotearoa's leaders aligned with Pacific peoples' own cultural and spiritual values of collectivism, i.e. for the greater good, and in particular regarded the collective and social cohesion the Government promoted.

The official daily 1pm update was considered a highly successful communication tool for access to, and engagement with, Pacific families. Communicating and engaging with the Pacific community took on many forms and Pacific families embraced the new pattern of communication that included social media (Instagram or Twitter) and mass media, and portals via community organisations and institutions. This mattered to families as information from the Government was easily accessible. There were concerns for those who did not have access to technology that they may not have received the same level of engagement. Families expressed the view that language was a barrier to being informed for those for whom English is a second language.

Collectivism

The Government's promotion of togetherness, strength-based messaging such as 'be kind', and thanking the community appealed to Pacific families as it was a natural alignment to Pacific values and beliefs.

Communication Between Families

The pandemic and subsequent lockdown strengthened or developed good or better communication between family bubbles. For some, family discussions were already part of their everyday functioning; for others, having conversations about the pandemic provided another level of commonality and provided a topic for discussion between families. For families who were apart, digital technology and communication played a major role during the pandemic. It enabled families to maintain meaningful social relationships with each other, and to some extent mitigated the negative emotional effects of the lockdowns.

Pacific Providers

Pacific providers played an integral role in supporting the Pacific community throughout the pandemic and two lockdowns. The response from Pacific providers during the August lockdown was phenomenal and families noticed a shift in the look of the community (e.g., more testing stations, pop-up stations); families received more communication from health and social providers; better overall social and emotional support. Pacific providers encouraged families to access services when needed and reassured families not to let cultural pride or embarrassment be a barrier.

Transferred Knowledge From the March lockdown

The experience of the March lockdown helped families to know what to expect in the August lockdown and they were better prepared. Structures were set up by families during the first lockdown, such as online church services, designated workspaces in the home, and the installation of better internet services. One family said they were pleased the March lockdown was nationwide, as it gave families the opportunity to experience a lockdown without being the epicentre of the virus.

The 'New' Norm

Families accepted that their 'new norm' is an evolving landscape. Changes in behaviours and attitudes that may have seemed unusual, such as mask-wearing, habitual handwashing and sanitiser use, were now common. There was less socialising with others, and fewer trips out of the house other than for supermarket shopping. Online communication using internet-based technologies – Zoom and Facebook – was routine. Involvement with online church services was accepted, and for many of the families, was enjoyable. Working from home and trying to work out the boundaries between work and social/private life was challenging. Physical distancing from families and friends does not need a reason; it was now considered the new norm. For 2021, families expected a vaccine against COVID-19 virus to be developed and easily accessed by the community.

The Executive Summary for Essential Workers Experience during COVID-19 is presented at the beginning of Section 2.

RECOMMENDATIONS

PACIFIC FAMILIES' EXPERIENCES:
Communication

- Continue with strategic messaging around hygiene practices, particularly at relevant times, leading up to and at the peak of an outbreak. Families will continue to reinforce this message throughout their communities.
- Keep broadcasting 1pm Updates. Families want information that is reliable, informative and consistent. The updates provided a level of stability during unsettling times.
- Use simple messages. Keep the messages brief and to the point, using language that is not too technical, and use catchy phrasing.
- Ensure that all communication outlets are well utilised by the Government for messaging e.g., Social media including Twitter, Facebook and Instagram; and Mass media ethnic-specific Samoan/Tongan Radio, National Radio, and Television. Continuing to improve the engagement between the Government and the Pacific community via these communication platforms will maintain and strengthen the trust families have developed in the Government and related agencies – and lead to greater compliance with policy measures in the future.
- Reinforce the catchphrase: 'the virus is the problem, not the people'. Education interventions that diminish social stigma and discrimination are important, utilising all communication outlets available, and messages should be in ethnic specific Pacific languages.
- Ensure access to reliable and high-speed internet connection to enable attendance at work, school, and church. Digital Communication Technologies were critical to Pacific families during the pandemic. In addition, reliable technology and internet connection enables families to continue to foster and strengthen social connectedness that leads to social cohesion with others.
- Provide clear and concise information on the meanings and differences of COVID-19 related terms and terminology. COVID-19 related terminology confused families who used terms interchangeably.

Pacific Provider and Community Support

- Continue with food parcels for families but centralise and coordinate a more structured distribution plan to minimise families being left with an abundance of food.
- Offer extra financial support for bills, food and other essential expenses (e.g., to fix a broken washing machine).

Testing/Testing Stations

- Carefully consider the locations of testing stations. Ensure they are in locations that have safe access to public toilets, shops and supermarkets; and are close to public transport.
- Provide a variety of options for opening hours at testing.
- Ensure better and faster delivery of test results. Consider analysing the swabs of family groups together, family members have a better chance of receiving the results at the same time.
- Consider special leave for employees who have to attend testing during their usual working hours; and who are waiting for their test results, so employees do not have to use up their personal annual leave (essentially they are paying to get tested).

Ethnic-Specific Languages

- Ensure the availability of language interpreters at facilities such as managed isolation and quarantine facilities; and testing stations.

Recommendations and insights from Essential Workers are presented in Section 2 of this report.

1.1 KNOWLEDGE AND PERCEPTIONS OF COVID-19

Key Points Summary:

- Families' early knowledge of the virus known as COVID-19 was minimal and it was initially perceived as nothing more than a passing virus.
- Families' initial perspectives of COVID-19 were based on previous experiences of SARS, flu and measles that can be eliminated with a vaccine.
- When Aotearoa's first COVID-19 case was confirmed, families started to get concerned.
- Families were keen to prepare for the March lockdown but did not know what that meant or what it entailed.

1.1.1 Emergence of a New Virus

In early January 2020, Pacific families in Aotearoa started to hear stories about COVID-19. Their knowledge of COVID-19 was minimal, perceived as a flu-type virus, and considered to be at arms-length, as it was not yet in the realm of the Pacific. Families could not accurately recall COVID-19 information sources, but they were definitive in how they felt once they realised the significance, gravity and spread of the virus globally. In particular, after countries such as the USA shut their borders to and from China:

> *What really got me was when America shut their borders to China towards the end of February. I was like 'oh, this sounds pretty serious if America is going to shut their doors to China, this is a serious issue'. F10CI*

Families were worried and alarmed at the speed with which the virus was taking hold of other countries and realised it was now a case of when, rather than if, COVID-19 reached Aotearoa. What was a casual news item had suddenly morphed into a daily ritual of families checking news sources for regular updates of COVID-19 and communicating with extended family living outside of Aotearoa.

1.1.2 The COVID-19 Virus in Aotearoa

On 28th February 2020, the first positive case of COVID-19 in Aotearoa was announced by the MoH, closely followed by the entire country going into lockdown. Pacific families had very limited information of the virus and the implications of transmission.

The COVID-19 pandemic came at a time soon after the 2019 measles outbreak that affected the Pacific community in Aotearoa, making families nervous. Yet, families believed the new COVID-19 virus could be managed in a similar vein as the measles outbreak.

> *I didn't think much of it, I just thought, it's like the measles, yeah, there was an outbreak, but we managed it as a country. F4SA*

Initially, families believed that vaccines would be available to combat the spread of COVID-19 as it had in the past for other viruses such as SARs and the flu; thus fostering a belief, for some families, that COVID-19 was a passing virus.

> *I thought it might be just like the SARS, it will come, and it will slowly disappear… eventually they will find a vaccine, and everything will be back to normal, just like the normal flu. F6SA*

Families who were overseas at the time of the first outbreak, were warned by family members to return home immediately as they were concerned about borders closing in Aotearoa. Returning family members were also advised by their families not to bring anything back including food items as it would potentially have held them up at customs, a risk that was not worth taking.

> *My brother rang us on Wednesday night and said we might go into lockdown. It's all over the news. There is a virus, the corona virus, it's spreading around and the borders is what is more dangerous at the time and they might close down the borders. He also said is all we want you to do is get to the airport and get out (and return to Aotearoa). F3SA*

1.1.3 Families' Heightened Levels of Anxiety and Concern

All the families experienced a range of thoughts, feelings and reactions to hearing about the virus particularly when it entered Aotearoa. They expressed feelings of being 'frightened, scared, fearful, overwhelmed, panicked, sad, and uncertain'. Most were concerned about their families, particularly those who were out of the country when the pandemic hit; about their community and about the spread of the virus. The utter uncertainty of what to do or how to behave during this time accelerated their concerns.

> *We don't know what is going to happen and whether it does hit what it would look like and it's pretty much our first time seeing a pandemic of this size. How the whole world is pretty much come to its knees, it's gripped the whole world. F10CI*

Families modified their behaviours to align with the official messaging in how to combat the spread of COVID-19. Families encouraged each other to apply good hygiene practices at all times as they understood the benefits for their own families, and for the wider community. Families had sanitisers in their homes, cars, workplaces or carry it with them.

> *I make sure we have to carry our mask. We avoid crowded places especially going to the malls and food courts, that['s] the other thing we don't want to go. And when we go and do our shopping, we have to sanitise the trolleys. I am like a freak in making sure everything is clean. Sanitise everything. Before I didn't care about the dirt but now I carry my sanitiser, I would be crazy if I didn't have my sanitisers around. F2SA*

This indicated that families received the Government recommended health procedures, understood them and acted upon them.

1.1.4 Unintentional Discrimination

Increased levels of fear and anxiety about the virus being in Aotearoa led to new attitudes, including unintentional discrimination against people perceived to be from China. There was also a barrage of information from the news, fake or fact, about the origins of, and exposure to, the virus that exacerbated any fears in relation to the spread of the virus. One family member worked in the travel industry and dealt with multiple passengers explains:

> *We were kind of scared of them to come any closer… they built glass frames in front of the counter to protect you against the passengers, so you don't get into close contact with them. I think we were scared and discriminating against them just because they were Chinese. It was sad to think about it now. F6SA*

On reflection, F6SA acknowledged the discrimination against international visitors was unwarranted, and that it was spurred on by an increased level of fear. As time progressed, she had a better understanding that her judgements were based on information from unreliable news outlets and was regretful. It is important to continue to reinforce the Government message that 'the virus is the problem, not the people'.

Families received messages from other people who had a more relaxed approach to the pandemic. This was unhelpful.

> *When you hear people saying 'oh we are in level blah, blah, you don't need the mask anymore, you don't need the QR, you don't need the contact tracing, it's not compulsory', and things like that saddens me with some people… the sickness is still out there. F3SA*

Regardless, families continued their efforts to maintain a consistent approach in the face of others' waning compliance. Families we spoke with had a firm belief that COVID-19 is here for the foreseeable future, and not to underestimate the stamina of the virus itself. Combatting the negative messages, families adopted ideals of how to keep safe by continuing to observe the health and safety measures.

> *Forget about whoever is saying what but as long as we are taking care of our own family and do what we need to do to keep safe, it's okay. Wear a mask if you need to go where it is public, where there are a lot of people wear a mask, that's what we do, we stick them on the kids. F3SA*

1.1.5 Preparation for a Government-Directed Lockdown

On 21 March 2020, Aotearoa moved to Alert Level 2; just two days later it was raised to Alert Level 3. By 25 March, Aotearoa was in nationwide lockdown at Alert Level 4. In less than a week, the country went from Alert Level 2 to Alert Level 4. In the lead up to the national lockdown, some families went out shopping for grocery items and stockpiled, others wanted to know the whereabouts of their family members at all times.

> *My wife did admit it that we did go into a panic buy and I was glad we did that. But we didn't carry on, we did that one off and that was enough. F10CI*
> *We stayed at home the whole period. The first one, because I was really scared because they said it was a deadly virus. It was a really deadly one, so I didn't want to take my baby anywhere. F2SA*

Families accepted that the virus had arrived and they wanted to be as prepared as possible, but families were unsure of exactly what 'being prepared' looked like, what it meant, and what they should do. Families actively searched for information specifically about the virus, and how to behave in order to combat the spread.

> *At first we didn't take it seriously. Once it hit (Aotearoa), we heard that people were getting infected, we were afraid, we were getting scared. F2SA*

> *For me, I really wouldn't keep up with the news but then when it was coming closer to home it was now like: what's on the news, what's happening, what's up, what's happening with this COVID, where is it spreading across, the do's and the don'ts. F10CI*

Monitoring the spread of the virus through news-tracking became a preoccupation for many of the families. This was a critical point for the Government in relation to engagement with families who were receptive to messages about health measures and compliance.

1.2 MARCH 2020 LOCKDOWN – NATIONAL

Key Points Summary:

- Families in Aotearoa worked together as a collective to prepare for an impending national lockdown.
- Families complied with official health measures and were dismayed at those who did not.
- Pacific bubbles were larger with the inclusion of extended family members.
- Spirituality, Religion and Faith and the continuation of religious practices were important to families. Technology supported church/religious organisations to maintain the connection between family and church.
- Employment: Job insecurity, loss of income and decreased work hours affected families. Families had minimal insight into the mechanisms of their claims to the wage subsidy and leave entitlements.
- Families required extra resources when setting up work and school spaces at home. Some families found it a challenge to work from home alongside the expectation to home school children.

On 23 March 2020, the MoH announced Aotearoa has moved to Alert Level 3, effective immediately.

By 25 March 2020, Aotearoa was at Alert Level 4, where the entire nation went into self-isolation. A State of National Emergency was declared.

On 27 April 2020, Aotearoa moved to Alert Level 3.

By 8 June 2020, the MoH announced that Aotearoa would move to Alert Level 1 where the country remained until 12 August 2020.

1.2.1 Families Working Together as a Collective

Each of the 10 families we interviewed for this research stressed how important it was to work together as a group, be it family, church and/or community. Families made decisions as a group to achieve a common goal e.g., who gets COVID-19 tested, who does the grocery shopping, and they worked together to find the best outcome for their family, e.g., all family members got tested to protect their elderly family members. Families consulted with other families on issues of uncertainty and families were a source of assurance against fake or real news information. It was evident from their narratives that Pacific families were functioning as a collective - in their behaviours, how they made decisions and how they worked as a group.

Families felt very unprepared for the March Alert Level 4 lockdown. Families did not have time to mull over the impending lockdown, and perhaps like most families living in Aotearoa, responded by adapting to the new situation in an ad-hoc manner. Each family consistently prioritised and protected the elderly and younger members of their family. F1SA's family bubble included 7 adult family members, across three-generations. In preparing for the lockdown, F1SA purchase large items to cope with the increase of essential items.

> *We bought a dryer and a freezer before the first lockdown; we already have two fridges. We would get 8 loaves of bread and put it [sic] in the freezer, we would normally get 4 but we were getting 8, so we didn't have to go [to the supermarket] every week… we were down to our last rubbish bag, we used our last baby wipes for mum… a brother came from Samoa and he brought heaps of sanitisers so that was our sanitisers because everything was gone from NZ supermarkets. Everything was gone before the lockdown, so we had 24-28 hours to do all that. F1SA*

Families returning to Aotearoa were uncertain of what they needed for the duration of a lockdown. The uncertainty was amplified for those travelling with children. Families relied heavily on others to provide support on their return and were in constant contact with each other between countries.

For example, when F3SA and family returned to Aotearoa just before the borders closed, they were scared. They went directly to their home as outlined by MoH regulations. Their elderly mother, who lived with F3SA, was being cared for by other family members and she remained in their bubble for the duration of the lockdown. F3SA's family dropped off essential items including food, and basic necessities for the children.

> *And everyone listened [to New Zealand Government messages], we even listened, and we weren't even in the country. We listened. We didn't even go to [holiday town], we were scared, it was here in New Zealand and we didn't even go to [holiday town] to do our shopping, that's how scared we were. F3SA*

1.2.2 Compliance With Health Measures

At the beginning of the March national lockdown, family anxiety was high because the lockdown experience was 'new'. Families understood the entire country was going through the same thing, and for some families the lockdown was intriguing, with an element of curiosity and fascination. That said, families' behaviours reflected the seriousness of the March lockdown, they scorned others whom they perceived did not follow the rules, they were compliant in the measures outlined or recommended by the MoH by observing physical distancing, hygiene practices, and mask wearing. Families self-isolated at home and did not venture out unless it was necessary, usually to the supermarket, doctors, or for exercise.

> *During the lockdown, I was surprised how strict [my husband] was being into level 4, no visitors, no nothing. I was really impressed he closed the gate and said, 'leave us, we are fine… 'this is a lockdown, you stay in your own house, if I do need you, I know you are there'. Our families will come by and he let the kids talk to them through the fence, they just waved. F7TO*

1.2.3 Family 'Bubbles'

Most families were more often than not part of larger bubbles that included extended family. Family bubbles included all in their household, or merged bubbles with others, or multi-bubbles where several bubbles would come together. The bubble extension was significant for families not only for extra support but it allowed them to continue shared care of their family members e.g., older people who live alone, children.

Once in lockdown, the families questioned themselves 'what do we do now?'. There was a settling in period and eventually families viewed the lockdown as a way of being together within their bubbles.

F3SA, her husband and two children returned to Aotearoa just before lockdown. Her elderly mother was taken from the house while F3SA and her family self-isolated for 2 weeks.

> *My two brothers, they live next door to each other. They came and packed mum away for the two weeks [while we] quarantined. They packed her away and they just had to look after her because that was their bubble, their two houses together because they share the same drive. The houses were right there so they just go between houses, that was their bubble, so mum was with them. F3SA*

The emotional strain on families during the March lockdown expressed itself through various ways: anxiety about employment, testing, and, for children in particular, boredom. For example, F7TO worked during the night and was with his young children during the day while his wife was in another country waiting for a flight back to Aotearoa. F7TO's shared bubble allowed the family to visit others, an example of an extended way of living.

> *[Children were getting bored] I explain to them we can go for a walk, but we can't be together with other people. The only thing I allowed them to do because my neighbour are my two brothers and because it is one bubble I said to them if you want to see your uncles you can pop over to see them. F7TO*

The lockdown also provided an opportunity for families to bond and further develop their relationships, as people in their bubble/s had little choice but to be together. Activities such as cooking, baking, playing board games, or watching TV and Netflix brought families together as a group.

> *… it brought some really good relationships with us, it drew the family together, I must say. I felt that that was something that will encourage families to build one another up and find comfort within each other in this area… to meet each other's need this way if they can. I felt that. I enjoyed the first lockdown. F9CI*

1.2.4 Food Security

Food security was in the minds of all the families at the start of both lockdowns. Families stocked up on groceries for their own households, and in some cases for other households, if they had the financial means. During the August lockdown the provision of food parcels to families was received with gratitude. The food was accessible and available from within their community provided by health providers and/or the church.

Large family bubbles or merged family bubbles meant food supplies had to increase to provide for the household. Some families stocked up on items; others brought slightly more groceries in their usual shop. Some families did panic buy at the start of the first lockdown but did not stockpile food. Families knew that basic food items were accessible and available from supermarkets, dairies, online shopping, foodbanks, petrol stations, family, friends, neighbours, health providers, and testing stations. Some families purchased online ready-prepared-meals such as [organisation name]. Families were worried about restrictions on food items, supermarket queues and the affordability of groceries.

Food boxes offered by community providers were a great help to families, but not all families needed them. An oversupply of food boxes delivered to families was shared with others such as neighbours and family members.

If we need more than maybe five things then we will go to [the supermarket] and stand there with our masks on and all that … if we needed a couple of things the dairy is just right next door, there was also a queue there. F3SA

When [community provider name] rang, they say: 'oh it's me'. They ask: 'what food you need?'. I say: 'I don't want any food'. And they say: 'that's why we rang you because you can't you self-isolate [and do shopping]. We already prepared, we already did our shopping I said to them is I always buy the nappies for my kids. Sometimes they give those things and I give them to the neighbours because it's too much, otherwise it gets wasted.F8TO

Other family members bought food for their extended families, particularly during the first lockdown, if they could not afford to buy or they could not leave the house.

They just called us and goes 'hey sis, your shopping is out here for your food and all that, we know you don't have money so come and grab the stuff.' We opened the door and we went and grabbed all the stuff. That was our two weeks shopping. F3SA

Some families used online shopping at the beginning of the lockdown. Families took COVID-19 transmission seriously. One family thoroughly cleaned the delivered groceries before they were taken into the house. They believed unwashed items posed a risk of exposure to the virus. The family developed a cleaning system that involved several members of the family:

Initially we got our shopping online. Whatever we got we had to wipe down, everything. The stuff that you get online, people are actually going and taking them off the shelves, so it gets touched anyway. We had a process [when the groceries arrived] where someone will take it out of the car, it gets wiped down and bring it inside. And the veges will get washed too. It was fun in the beginning but then it got tiring. F1SA

When online shopping became less accessible due to restrictions[6], families returned the supermarket. Supermarket shopping restrictions during COVID-19 lockdown meant families could no longer shop as they usually did. Buying groceries for larger families made families feel judged by other shoppers who assumed they were stockpiling food, when it was their usual supermarket shop pre-COVID-19 restrictions. Families found creative ways to deal with the short-term problem by shopping separately.

The difficulty here is that we have a big family, so when they [supermarket security] said 'one trolley', and we always have two trolleys when we go normally, that didn't fit our family. Security was quite strict. They were taking it literally that it was one person per family. I think they forgot that many of the Pacific and even Asian, Indian families, they have got huge numbers. We always needed to go with two, so we just lied and said we were from different families. Everyone goes in with a different list, so we would always meet at the counter to pay for it… it was just wearing and draining. F1SA

F7TO budgeted and bought enough food, for two adults and two small children, to last for a couple of weeks. F7TO was asked to accommodate extended family members, unexpectedly, whose parents had to self-isolate on the suspicion that they had contact with a positive case. F7TO was concerned

[6] Due to unprecedented demand on online shopping services, large supermarket chains prioritised their online services to customers whom the Government identified as most vulnerable e.g., the elderly, vulnerable, emergency services and medical personnel during the Covid-19 lockdown period.

they did not have enough food to feed an extra two teenagers. The family went out and bought extra groceries.

> *… they came through during the first week of the lockdown and immediately in my mind 'the shopping she (wife) had done was not going to be enough' … the growing boys (visitors) eat like horsemen. So immediately that wasn't going to work, and so I had to do a bulk shopping. It was [extra] necessities, flour, sugar, noodles… I went for gold, 10kg of rice, 10kg of flour. If we run out of meat, we just live on pancakes. F7TO*

With the closure of takeaway restaurants and fast food chains, families were forced to rediscover home cooking. And, with extra time at home, families developed their culinary skills and chose to prepare 'good healthy meals', a positive by-product of the lockdown. That said, families also baked a lot, and snacked a lot. Families stated there was a direct link between their snacking, and consumption of home baking to the weight gain that all the families said occurred during the March Alert Level 4 lockdown. However, by the August Level 4 lockdown, families were more cognisant of this and made a concerted effort to decrease their food intake, increase their exercise and make better food choices.

> *The first lockdown was bad, we were just cooking and eating and baking. We all put on weight. Cooking competition going, everything, we had the works. It was good fun. Family time, movie time. The second [lockdown], we didn't go back to our baking and cooking. We went back to our healthy eating and did a lot of walking. Sir Barry Curtis park, every day we were there. And that's where we would see the tag tournaments happening with more than 10 people on the field. Walking was more us with the kids F10CI*

> *We cooked, that's what we did. We cooked good healthy meals, most of the time. More than we ever have because we weren't able to get any takeaways, it was great. We had yummy, good nutritional food. F1SA*

Families felt that mealtimes were another way of slowing down and reconnecting with each other. Cooking and baking became competitive for some families of who could cook the best meal, the healthiest meal or bake the best bread. Most of the families appreciated the fact that sharing food with family happened without rush.

1.2.5 Religion, Faith and Church

Spirituality and religion play a major role in the lives of Pacific families. Most of the families were active members, or pastors, of community faith-based groups, and/or established churches. During the first lockdown, churches closed to ensure physical distancing and following the ban on large gatherings. Church leaders looked for ways to stay connected to their parishioners, while at the same time providing faith-based services to the congregation and the community.

Considering the large percentage of Pacific peoples affiliated with one or more Christian religions, access to church services was critical for families, particularly under the unusual circumstances presented by the pandemic and thereafter the March lockdown. The March date coincided with Easter, which is the most important event in the Christian calendar. For many churches, the use of available technology helped the congregations stay connected, at least for those families who had access to laptops, mobile phones, telephones and the internet.

> *Our church, obviously, we had to do online, the first time we were like 'oh man, what do you say, what do you do… church service online for our member's so they weren't missing out on Sundays. Something different for us, we were learning for the first time and when it*

came for the second lockdown, it was like we knew what to do, we improved, we weren't as anxious about it. Even Pastor, we were all adapting. We knew exactly what we had to do, it was automatic response. F10CI

F9CI described the arrival of the virus as a result of the widespread loss of religious conviction and practice. The virus was a 'pre-awakening' or a 'pre-warning' to those who were no longer affiliated with God. F9CI was not surprised about the virus as the religious teachings had already forecast that the pandemic would happen. The rationale was that the virus hit global proportions due to the void created by people failing to seek and maintain relationships with God.

I was already aware of this prior to this taking place. I am looking from the spiritual side of things and the demonic realm of how this came about. It was almost a pre-awakening or pre-warning for us and our church, if I can put it that way. This virus has hit all nations is not a surprise. It is something that has been spoken [about] prior for it to happen. It's a demonic atmosphere coming in the physical side to affect the lives of people. So that's where it is. My point of view of that, it was an awakening to all nations for the neglect of God. We have to humbly come back again and bow before God and acknowledge the distance that we have separated ourselves from God. F9CI

F9CI expressed a strong religious connection, echoing the views of most of the Pacific families we interviewed. A tension between the religious belief system held by many, and the Government response to COVID-19, could have unfolded and led to confusion about what messages families would listen and adhere to, particularly as tension between religion and science exists. This did not happen. Families including F9CI developed a solid belief and trust in the Government's response to prevent the spread of COVID-19. F9CI followed the MoH rules and regulations around COVID-19 health measures and actively and firmly encouraged her family and congregation to adhere to each of the health messages relayed by the MoH, regardless of her personal religious conviction of the origins of the virus, and any religious-based solutions such as returning to church and prayer. Families confirmed other religious communities disseminated practical health information based on the Government approach to COVID-19. This demonstrated the importance of creating, maintaining and enhancing relationships between Pacific religious communities and the Government.

Employment During Lockdown

1.2.6 Employment Changes During COVID-19

Seven of the ten families we spoke to had at least one essential worker within their family group. Some had the option to work from home, others did not as they delivered services e.g. healthcare and transportation. Family members were employed in workplaces that had the potential to further expose them to the virus (e.g., retirement home, day care centre, health centre, hospital setting, tourism, security, transport, and factory staff).

Most families were concerned about job security, or decreased hours or days of work, leading to a loss of income. Employers of Pacific peoples played a significant role in communicating changes to workplace health practices and reinforcing government messages, but employers could have done a better job in explaining the wage subsidies and leave entitlements.

Employment experiences during the lockdown were variable for families. Some employers offered flexible working times, changes to job descriptions or accessed financial support via government subsidy. The modification to current roles or undertaking different ways of working that were

offered to families included a reduction of hours or days, and/or unpaid leave for the duration of the lockdown. For example, family F6SA worked fewer hours with an increased workload, yet less income. Unable to financially support her family, F6SA sought support from WINZ and IRD who provided her with a financial subsidy to top up her salary.

> *When level4 happened, all of a sudden my hours dropped down to 20 hours a week, I asked for help from WINZ, so the help was there for people from WINZ and from IRD. Money wise with help, there help is there. I think if you don't seek and find out you wouldn't know. But the help is there. At the moment I am still doing 20 hours but sitting comfortably now with the help. It was a relief. F6SA*

Most families who remained in paid employment expressed their gratitude for keeping their jobs and communicated their empathy towards families who had not. F10CI and her husband both kept their jobs throughout both lockdowns. F10CI had decreased her hours, thus her income, to help her company deal with the effects of COVID-19, while her husband's workdays stayed the same.

> *I was lucky enough to keep my job. It was in my department, 7 in our department was let go. The effects of COVID from my job is I have gone from a five day to a four day. I am still lucky enough to still have my job. They asked if we could all pitch in to save the company some money and go from five days to four days which meant a decrease in our pay. I just had to do it. I still have my job; I am still able to pay my mortgage. F10CI*

Some families made significant lifestyle and wellbeing decisions for their family, but those decisions had direct consequences for the family. For example, F2SA's father resigned from his job in security as he thought he was at high risk of contracting COVID-19 and passing it to his infant grandchild. F2SA's father was so anxious and frightened, he thought he had no choice but to resign from his job, leaving the household on one less income. Fortunately, his wife, who was also an essential worker in an ECE centre, continued to work, as did F2SA's husband.

> *I was really scared because they said it was a deadly virus. My mum was scared because she works in a kindy and she was scared she might bring the virus with her to the baby. Especially my dad, he worked as security… so basically he left his job because he was really scared that he might bring the virus in. F2SA*

Continuing or returning to the workplace, particularly if working with the public directly, created nervousness and anxiety for some of the families, who wanted assurance that their employers created a safe environment on their return from lockdown.

> *We were kind of scared of them to come any closer. They built these glass frames in front of the counter to protect you against the [clients] so you don't get into close contact with them. Even though you are wearing gloves, we are wearing gloves, right now they [employer] tell you it's up to you if you wear your mask and gloves, but I always do wear it. F6SA*

1.2.7 Salary, Subsidies and Leave Entitlements

Families did not have a clear understanding of the COVID-19 wage subsidy, leave and pay entitlements during lockdown, self-isolation periods and while waiting for test results. Families including F3SA had reasonable background knowledge of payroll and therefore had a good understanding of salaries and the Government subsidy scheme but most families' level of

understanding was largely inconsistent, meaning families needed better information on workplace benefits.

> *They were pretty good because they also still paid us on the first two weeks of COVID lockdown, they still paid us fully, 100 percent. The following pay, we get paid fortnightly, we got the subsidy which was 80 percent. With [my husband], he was only down for the two weeks because they were still open, he is at the airport, they were working normally. He was only quarantined for the two weeks [and had to use his annuals] and then he was back at work. F3SA*

There was confusion among some families about whether they were receiving a salary or the wage subsidy as it was not specific in their payslips, nor mentioned or explained by their employers. For example, F9CI family compared two nephews, both were essential workers for different organisations. One nephew had his hours reduced and had to use his annual leave while he was self-isolated and waiting for his test results; while the other nephew was given a financial allowance for the same situation. The family were unclear why there were differences between the two organisations and noted the extreme inconsistencies. The family called for better transparency in the use of government subsidies.

> *The thing it wasn't clear what the wage subsidy covers. It's not like it's broken down in your payslip to say this is the funding provided by government and this is what we are contributing… questions there around how it is supposed to work, and was it followed through. Especially where employees were required to use their annual leave. F9CI*

F10CI was an essential worker employed by providers of food supplements. Small changes to his workplace ensured that employees were safe. His employers encouraged staff to continue the hygiene measures at home to keep their family safe. F10CI appreciated and welcomed the changes.

> *Even at work there are so many things put in place to control the hygiene that is happening at work. Even the paths that we walk, we have to walk one way and other another way. Even sitting at the table, there used to be like four of us but now it's just one person at the table. There was a lot of things put in place, even in break times has changed, so there are not a lot of people in the cafeteria. One thing that I liked was they encourage use 'when you go home go straight in the shower'. Clean. Having showers was the message. F10CI*

1.2.8 Spending Habits During Lockdown

Other than a small spike in spending to stock up on groceries, sanitisers, and toilet paper, many of the families described some or no change in their spending habits during the first lockdown. For some, they saved money. For others, there was no change to their savings. For families who were employed and received a regular income, the lack of spending meant bigger savings e.g., due to closure of retail stores, restaurants, bars, takeaways, less petrol and transport costs as a result of working from home, and the availability of food boxes.

> *Save money, saved money, saved money. Saved money, yes. There was nowhere else to go and spend money apart from online but even online was on. Saving money, it saved a lot of money for us. The only places that we spent money was at [the supermarket]. And if [the supermarket] was too packed, we go to the [supermarket name] in Otahuhu, the queue was less. F3SA*

Families welcomed other areas of unexpected savings was the ceasing of church donations, fa'alavelave[7] and changes to tithing rules i.e. families could tithe what they could afford rather than a set amount. Families didn't have anywhere to spend their money.

> *Our church during the first lockdown we cancelled all church programmes, just the Sunday service and we have annual conference and annual tithing they have that's been cancelled for the rest of the year, 'just tithe what you can'… as before they tithe 10% but they understand what families are going through.F7TO*

The provision of support to help families maintain and build their savings post-lockdown was advocated by F7TO who has a finance background. F7TO suggested offering families robust financial advice to help build financial security going into the future was necessary.

> *One thing that I haven't heard of being talked about openly or brought up is services like budgeting at a time like this for families who are struggling, maybe you have come down from two incomes to one, how are you managing that? How are you managing that moving forward… remove the subsidy it is ended, now what does it look like at home and with kids? You [government agencies, providers] want to throw money to people but we also have to educate ourselves, you educate them what to support themselves rather than keep feeding them. Educating our people how to be budget conscious. F7TO*

F7TO advocated for Government agencies and community institutions such as churches to take a more proactive approach to support families with budgeting and, perhaps, see the usefulness of saving for future emergencies such as another lockdown. F7TO was disapproving of the Government 'throwing' money to people without providing the education or support to build their financial capital, rather than 'feeding them'.

1.2.9 Working, Studying and Schooling From Home

The pandemic revealed that different ways of working away from the physical workplace can be achieved and managed for Pacific families. It also showed how much of the workforce can reasonably, and with some success and support, operate from home. Families working from home found it was convenient, appealing, novel, but also bittersweet. Obviously, incomes were vital during the lockdown, as was good access to technology and the internet. Spending time with family, and working to maintain those incomes, families were also expected to ensure schoolwork continued for their school aged children. Boredom was a common thread for children of the families we interviewed, and parents struggled to find a balance between schoolwork, leisure and their own workload commitments. One mother felt overwhelmed with the demands and expectations in balancing children's schoolwork with her own work. She felt guilty that she didn't have the skill set to help her children, especially her college-aged children, complete their homework, at the same time meet her work deadlines that included several Zoom meetings per day. She sought support from her husband as tensions rose between herself and her children.

> *… for me at home, it was honestly really stressful at home. I can't handle it. I was like [to my husband] 'you ring your boss and take 2 days off work and stay home and teach these girls'. I was still working and having Zoom meetings, trying to attend to the kids. And because I was getting the pressure from the teachers, incomplete work, not even done. I was thinking 'I don't know, I didn't do it in my day'. It was hard to try. I felt a lot of stress and pressure on me because I didn't want my daughter falling behind. It was just getting*

[7] Fa'alavelave – ceremonial and other family obligations.

really frustrating for me to try and push them to learn. I got to a stage where I was like always yelling at my kids 'you need to try'. I wasn't really nice. F10CI

Other parents received a lot of support from schools who provided the tools that enabled their children to access online teaching from home and made home schooling for parents less arduous. Children initially welcomed the chance to stay home from school but missed the social and sport aspects of going to school, and soon became bored.

I think the kids got bored, they got really bored from just staying home. School was really good, they provided them with their laptops, and they had online classes every day. I think it was just boring for them to stay home. They had sports and things that they enjoyed doing at school. School was really supportive, and I always get updated from them of what classes they were doing to date, and make sure the kids will be online. F6SA

Those who worked from home faced a variety of issues that included the set-up of the work spaces and finding the resources they needed that suited their situation and family. F1SA family did not have reliable internet connection and this made working from home less enjoyable and less productive. F1SA family worked closely with their internet provider to improve the internet service.

I always had issues with the system while working from home… we couldn't get the cable, but we have sorted it out. They had a backlog of other people calling, this is [name of phone company]. First, it was the internet, second, it was because it was the system on the laptop and I just didn't like working from home. I rather not take calls from home, and just work on something at home. F1SA

With many families working or studying from home, the demand for enhanced internet functions increased. F7TO, an IT consultant, set up technology for business employees working from home. To keep up with the demand, F7TO often worked through the night.

We got a lot busier as we were trying to get businesses going to work from home. One small [Pacific] accounting business, they have never thought of working from home and immediately when they heard the lockdown is coming… so I had to set up their laptops so they could work from home. My work became busier because I had to be with the kids. So, they [employers] were okay with me showing up [online] at 7pm or late at night. F7TO

Families need reliable internet access and relevant technology to maintain their digital connections with schools, workplace, churches and other families and friends.

1.3 AUGUST 2020 LOCKDOWN – AUCKLAND

Key Points Summary:

- Families revealed they were less worried about the August lockdown than they were during the March lockdown. Families were more cognisant of what to expect in a lockdown.
- Communication: Families developed a high level of trust in the Government's communication about COVID-19. Other trusted sources included family, friends, community providers, websites and social media. Access to reliable technology is critical to ensure families are kept informed, and socially connected to others.
- Testing: The decision to test for COVID-19, or not, was made as a family. Factors included government guidelines; protecting vulnerable family members; or whether family members were symptomatic or asymptomatic. The delay in receiving test results affected many of the families. Families found it easier to get a test if the location of testing stations were accessible and close to safe amenities.

On 11 August 2020 the MoH announced four of the five new confirmed COVID-19 cases were in the Auckland community. There was no known source.

On 12 August 2020, Auckland went into Level 3 lockdown, the rest of the Aotearoa went into level 2. The Auckland lockdown at level 3 was extended to 30th August 2020 when it stepped down to Alert level 2 but informally known as 'level 2.5' due to restrictions of smaller gathering sizes than the rest of the country.

By 21 September 2020 Aotearoa moved to Alert Level 1.

On 7 October 2020, Auckland joined the rest of Aotearoa as it moved back to Alert Level 1.

Interviews with Pacific families were undertaken after the Auckland August 2020 lockdown: between 22 October – 24 October 2020, just over two weeks after Auckland moved from Alert Level 2(2.5) to Alert Level 1 in line with the rest of Aotearoa. Families were still recovering from the regional lockdown and were honest in how they perceived each lockdown and described a stark contrast in how they behaved, how they perceived others behaving, during each lockdown. The August Alert Level 3 lockdown, they were not sticking so stringently to the rules.

Families described themselves as being more less concerned about the August lockdown than they were during the March outbreak.

1.3.1 Attitudes and Behaviours During the August Lockdown

Families observed that others in the community took more notice of the imposed restrictions during the March Alert Level 4 than during the August Alert Level 3 lockdown. This was despite the fact that confirmed cases COVID-19 were in the Pacific community. Families drew from their experiences gained from the March lockdown and applied their knowledge in the August lockdown. For example, by the August lockdown support structures were already in place including: working and schooling from home; physical distancing and hygiene practises were part of family routines. Other actions were easily applied, that is, getting into family bubbles; recommencement of online church services and online shopping. The move in to the August Alert Level 2, while easier, featured unique aspects:

the Government response was faster i.e. an increase of testing stations in the community; community providers offered a multitude of services including food distribution and social support.

During the August lockdown, families were frustrated by others not observing the level restrictions by playing sports in the park, not wearing masks, not adhering to the 2 metre rule, and acting as if things were 'normal'. Some families mentioned seeing up to 100 people in groups at parks and recreation areas, highlighting Barry Curtis Park in Ōtara as a popular meeting place. Families used road traffic and crowds on the streets as indications of whether public health measures were being adhered to. For example, during the March lockdown F10CI observed deserted streets during his daily drive to and from work; he compared this to the 'normal' traffic volumes he drove through during the August lockdown.

> *The second time we went into lockdown, people didn't take it more serious compared to the first one. I remember the first lockdown, there was no cars on the streets. I thought wow, even coming back home there was hardly any, one or two. When it came to the second lockdown it was like it was normal. We would go for walks and stay on our path, there was people playing at the parks and we were like 'hey, we are in lockdown [level] 3'. F10CI*

Some families commented on their own attitudes and behaviours between lockdowns.

> *In lockdown 2 we got the time to prepare. We didn't go overboard like the first one, but we were prepared. People are not panicking [in August Alert Level 3 lockdown]. We went to Manukau, we had masks on, and people were still walking around with nothing. Like I said, the Ministry of Health has done everything, it's the people that needs to listen. F3SA*

During the August lockdown, families were less fearful of the situation as they were more knowledgeable about what to do and what to expect. On the other hand, families were tired, they were concerned about financial implications such as loss of income, and they questioned the 'fairness' of the August lockdown when they were compliant in the March lockdown. Families were exhausted, making it challenging to adhere to public health rules such as physical distancing or wearing masks; they had been socially disconnected for a long period of time, and as F10CI comments, they had already 'sacrificed' so much.

> *I felt the second time was people didn't take it… it was a lot lighter. The first time you didn't see anybody. The second time I think they got tired, we put ourselves in lockdown 1, we abide by the rules, we sacrificed so much, and we stayed at home. Then it happened again, and it was like 'why, why did it happen again, when we did all those things to get us into level1, and it was like opening up as much as can. Why are we going back when we listened the first time? I think also, work came into play as well, money for family and stuff like that. People were like 'oh who cares about COVID, I need to go out and make some money for my family. F10CI*

> *The second lockdown there wasn't that fear, the initial fear compared to Lockdown1…we know what to do, there wasn't a lot of fear to buy a lot of stuff. F7TO*

That said, overall most families complied with the self-isolation rules and regulations. If they breached the rules it was out of necessity to fulfil a basic need. In this case, F2SAs parents needed to access the laundromat. The parents of F2SA were in the middle of their self-isolation period as F2SA's mother worked at an ECE where a family had tested positive. F2SA's parents did not have a washing machine and were desperate to have fresh, clean clothes. It is highly unlikely the family

would have known to wait 72 hours after their 14-day isolation period ended before going to a laundromat.

> *But the main thing was their washing, they wanted to do their washing, and they can't go. Because my parents, they wanted to go and do their laundry and I think they kind of sneaked out… to the laundromat. F2SA*

Communication

1.3.2 Trusted Sources of Information About COVID-19

Families regarded the Prime Minister Jacinda Ardern and the Director General of Health Dr Ashley Bloomfield among the most trusted and reliable sources of information about COVID-19. Families had a high level of trust in the Government, in their leadership and their delivery of core messages. The communication style, namely the collective and social cohesion promoted by the Government, aligned and resonated with the families' Pacific cultural values and spiritual beliefs.

Other trusted sources included a broad range of people within the family networks and community, Community Health Providers, and Church leaders namely the Pastor/Minister. Workplace, educational institutions, community providers and organisations. Mass media outlets included: Online Television news bulletins, Tagata Pasifika; Radio networks, specifically ethnic specific radio Samoa/Tonga Radio and National Radio (RNZ); News websites and community newspapers. Social media sources included Facebook, Twitter and Instagram – families were aware that while social media was informative, it could also provide misinformation (or 'fake news") - unless the social media accounts were church or official government pages. Families mentioned less reliable sources such as workplace gossip; and the 'Cook Island wireless'[8]. Families' mobile phones were mainly used to access the news websites. Families revealed the above sources of communication were trusted if the shared information aligned directly with the Government communications about COVID-19.

A variety of sources were accessed when families were preparing for, and during, the pandemic. One of the most reliable and essential sources for families was the official daily '1pm update'. The updates were trusted as it was a direct link to the Prime Minister Jacinda Ardern and the Director General of Health Dr Ashley Bloomfield. The 1pm updates had a wide reach audience within Aotearoa and also internationally. F7TO accessed the televised 1pm updates every day from another country and regularly updated her husband who was in Aotearoa.

> *It's funny I would update and message him [husband] from [country] with the 1pm update.*

> *I think what was also useful was the good communication/information that was coming out from the Ministry. Those afternoon programmes, the updates that Jacinda and Bloomfield gave was really good. F1SA*

> *I think the government announcements, the daily ones and updates from our Prime Minister and from the Director General of Health was important and I think that was the best way… there were so many different outlets of information and news, but to have that [update], to come from our Government, it did give a lot of confidence. F9CI*

[8] Family F10CI referred to the 'Cook Island Wireless' in the context of gossip. F10CI referenced it to physically being in the Cook Islands, with the community sharing information that may or may not be based on fact or truth.

If families believed that the information from different sources was coming via the Government, it was true, demonstrating a strong efficacy for government messaging.

> *So, whatever the Ministry of Health gave our bosses that's what she [school management] would distribute out to us and also to our parents. All the letters and things from the Ministry of Health went out to the parents first, before the children and then us staff too. F3SA*

Television, Facebook and ethnic-specific radio stations worked especially well for the older generation and those who were not connected with community or church organisations.

> *I was still working, pretty much just stay at home, don't go anywhere. On the news, on Facebook or on TV, Radio Samoa, or on the radio in the car on the way to work or somewhere. It was everywhere with that. Communication was quite good with the media. That's where I mostly got the information from apart from people at work. We don't go to church, so we don't really see anyone. F6SA*

A wide range of communication modes were useful for families who engaged with several media platforms and services, this should be continued.

1.3.3 'Voices' on Behalf of the Pacific Community

Families want clear, concise messaging that is reliable and trustworthy. As already noted, all the families articulated a high level of trust and engagement with the PM Jacinda Ardern and Director General of Health Dr Ashley Bloomfield. Families were, however, concerned about the multiple 'voices' emerging from the Pacific community during the second outbreak, and worried that it could lead to miscommunication or misinformation. Some families believed the 1pm updates could include a leader from each Pacific ethnic group, or, at the very least, one Pacific leader trusted by the Pacific community to relay information. The key consideration was the messaging was to be consistent.

> *…because so many Samoans are on [TV or radio], like different doctors and different people, and they're saying different things and all of a sudden it was an opinion piece, and I think that is where it went wrong. It's easier to correct one person if there is a bit of a glitch there. I think that the problem is that are just so many people responding. Too many voices. F1SA*

1.3.4 Announcing a Positive Case of COVID-19 in their Community

Senior members of a South Auckland Church and their Early Childhood Centre (ECE) expected better consultation processes with government organisations before it was publicly announced a confirmed COVID-19 case was linked to their church and ECE. An official representative of the Regional Public Health (RPH) office contacted F4SA to confirm a family from their ECE had tested positive to COVID-19. RPH was to contact trace other ECE families and help F4SA through the official processes in managing the case. F4SA wanted to notify other ECE families but was advised to delay until he received the official RPH letter. It arrived very late that day. Soon after, a media statement was released without giving F4SA sufficient time to alert church management, ECE families and the congregation. This created tension between the Manager and the church minister.

> *8.30pm they sent us the media release that it's going to go out and it was releasing at 9pm, and they sent it to us. The right process [for us] is I should be sending it to our Director to pass on to our Minister, but at the short time I called the church office… [and spoke to the*

Minister] he said 'you are calling me and it's the final minutes'. I said 'yeah, I know it's not good enough, but I am not the one to shoot'. He was quite good and said 'look, all we need to do is what we need to do to move forward'.

F4SA understood the RPH urgency to release the information to the public. F4SA wanted the ECE families to receive the news from the church and ECE management who they trusted, rather than at the same time as the public.

1.3.5 Communication Terminology

The pandemic introduced new or rarely used terminology into everyday life. The families became familiar with many terms associated with the pandemic and used a variety of these words in relation to their experiences (e.g., case cluster, asymptomatic, symptomatic, contact tracing, community transmission, pandemic, physical/social distancing, QR code, MIQ). Families used them interchangeably (e.g., self-quarantine vs self-isolate) or used them for specific meaning (e.g., surveillance[9]).

Families used the terminology often but did not necessarily use it in the right context. Families would better understand messages if they were in plain, consistently used language and terminology. F1SA understood the difficulties MoH faced in having to provide the cluster information, which is relatively technical, to the public, while at the same time conveying it in the best possible way:

I don't know how simply they can make it. I guess everyone was trying to work through it, and they're trying to get the language for it as well. It was a bit confusing at the beginning.

1.3.6 New Patterns of Communication for Pacific Families

Technology played a major role in the lives of the families during both lockdowns. Many of the families had access to technology (laptops, mobile phones) and internet connections, but this will not be the case for many families in the community. Families were irritated by the technical difficulties, a lack of data, or slow internet speed. During the lockdown, with more people in the house, internet usage was high, and while families reported that they were able to work around it or fix the issues, it was frustrating.

I didn't [enjoy the lockdown] because I always had issues with the [workplace IT] system while working from home. Because working from home we always take calls from students and stuff. First it was the internet, second it was because it was the system on the laptop. F1SA

Families continued to strengthen their social connectedness with others through the digital vā space. A family Facebook Messenger page was set up by most of the families to keep in touch with each other.

Every two days we all jump on messenger, a message will come through 'okay we are all going on', so everyone comes on. We are all facetiming, even my brother in Australia, my nephews in Australia, everyone is all up and then my mum is sitting there with the laptop talking to everyone, and everyone is saying hello to everyone else. We are all talking for a

[9] Family F1SA used the term 'surveillance' in context to the continuation of COVID-19 testing to provide data on the traits of the virus, as part of the broader government elimination plan.

good half an hour together. It was the only way to keep in touch with everyone and for everyone to see her. F3SA

Religious organisations went through major changes in their response to the pandemic during both lockdowns. The disruption and ceasing of all physical church sermons were quickly and swiftly replaced with online services by most of the organisations, much to the relief of many families. The online link to church was a critical part of maintaining and strengthening the connection with families during lockdown. Internet technology enabled religious groups to facilitate church sermons, deliver church notices, send lockdown updates, and operate a church noticeboard.

Yeah. It's funny, like I said, we have a livestream that goes on every day on our church, for our church. It was implemented from our first lockdown, because we couldn't come to church, our ministers thought, okay, we will go to them through Facebook. And then Pastor started doing his pastoral sermons online. F4SA

1.3.7 Communication Between Families Across International Boundaries

Pacific families have strong social capital in the form of relationships with each other; they have wide networks of family and friends across different countries, and across multiple generations. Relationships were critical for Pacific families during the pandemic, as were the maintenance and sustainability of those kinships. Many of the families connected or reconnected relationships across international boundaries, particularly the Pacific rim, Australia and USA. The reciprocal nature of exchanging and sharing knowledge about COVID-19 between families across countries is something to be cognisant of in understanding the complexity of mixed messages. It provides an opportunity for Aotearoa to convey consistent messaging about the pandemic with the knowledge that families living in other countries will be accessing information from Aotearoa.

Because [Pacific nation] was also on lockdown they were looking at NZ how we were doing things… for them [they] started praying together, the struggles we were going through and because we were all in that lockdown together commonality we were able to be there for one another… and for the first time in years [we had contact with] some of our first cousins, aunties and uncles overseas having our parents seeing them face to face because you do not talk every day. Pre-Covid we would only talk to them couple of times a year, now our kids know everyone by face by names in the States and in [Pacific nation] and they haven't even met. F7TO

Decision-Making to Get Tested for COVID-19

1.3.8 Reasons to Get Tested

The decision to get tested, or not, for COVID-19 was taken seriously and thoughtfully by all of the families. Of the ten families who were interviewed, one family decided against testing for COVID-19. The decision to test, or not, was highly dependent on family priorities at the particular time, for example protecting vulnerable members in the household or being encouraged to get a test.

Factors that influenced decision making included: discussions with families and others such as Healthline, or GP; workplace; offers of food boxes at testing stations; being symptomatic; protecting one's self in order to protect others especially vulnerable family members; encouragement by trusted sources (e.g., family, pastor, community leaders, public health); possible close or casual contact; or as a result of government regulation requirements e.g., having returned from overseas.

Showing symptoms of the virus did not always dictate testing, as families who were symptomatic and asymptomatic got tested.

F1SA family held regular meetings to discuss the rationale to tested, one of which was based on their family situation. In their case, their 74-year-old mother/grandmother did not get a test, but the rest of the family members did in order to protect her. The family set up a rotation system to ensure each individual family member took turns to get tested.

> *It all had to do with mum. She was our main concern. I don't mind. We all have rotation; we all take turns going [to get tested]. It's a family obligation to participate. F1SA*

For a variety of reasons, families got tested mostly during the August lockdown. For example, F6SA had her first COVID-19 test during the August outbreak, not during the March outbreak as her health was good, she was feeling well, and nobody was sick at home. F6SA did not believe that there was the same level of encouragement, either by her workplace or government, to get tested during the March outbreak than there was during the August outbreak. F6SA worked in the tourism industry and got tested during the August outbreak when a pop-up testing station was set up at her workplace. F6SA was encouraged to get tested by her employer and was motivated by the accessibility and convenience of the testing station.

> *Work told us to [get tested] and everybody was going to get tested. I think it was because we were urged to get tested. If that didn't happen, people will never go to get tested. You are feeling okay and think you are fine and don't need to get tested. We were asked to get tested and we did. I have been tested four times now. No symptoms at all. The first two tests I did was with MoH, they were at the airport then. F6SA*

This aligns with the approach taken by the Government in their communication. Messaging was more effective during the second outbreak, and there was a lot more emphasis and drive targeted at the Pacific community during the August period.

Church representatives played an important role in contributing to families making the decision to test, or not. F10CI was advised of a possible COVID-19 close contact at their church, and immediately encouraged her congregation to get tested. Another pastor, F4SA, requested all the congregation to get tested, as a family who attended their church service tested positive. Families had high levels of trust in their pastors and, if asked to get tested, they did not hesitate.

> *[Our Pastor] told us all to get tested and get back to her of the results. We have got a church page on our Facebook messenger, so all the comms went through that which was good. Everyone was posting up 'all done Pastor, all clear'. So the comms was really good from our pastor [she] told everyone 'go and get tested and get back to me with your results', and everyone did that. F10CI*

Families continued to protect their vulnerable family members by writing rules for family members who wanted to visit. For example, F3SA created and implemented visitor guidelines that included rigid hygiene rules in place to protect the family matriarch, mother/grandmother. Family members who wanted to visit their grandmother had to get tested and provide proof via the Facebook messenger screenshot. Messages were communicated through a family messenger group with the tagline: 'no testing, no near grandma'. For the wider family, this was a significant motivator to get tested. F3SA, as did other families, made no excuses in their efforts to keep their 'Queen' healthy.

Everything we do is because of this old lady, you know, she is our only Queen that is with us. We try and do everything to protect her in every way. Yes, we have to follow the rules. When we are in lockdown or isolation, this is when everyone stops going to people's houses and this is where our messenger comes to life. We have a page on messenger, we call it 'staying in touch with nana'. And that was one of the rules of seeing her is they have to get tested, and they have to screenshot their results, just to make sure. You can't play around with COVID. F3SA

Some families received mixed messages that clouded their decision to get tested or not. For example, during the national March Alert Level 4 lockdown, F10CI returned from overseas and on the advice from Healthline went to their medical centre to get tested; but their GP decided against testing. F10CI eventually got tested along with her two daughters after they developed symptoms.

We rang Healthline, Healthline advised us to go to a doctor, see the doctor to get tested. We went to our doctor, they said no you don't need to get tested. Although he [husband] was symptomatic, I wasn't but I have come from overseas. So, they said no. We didn't get tested. Not on that first time, first lockdown. I went a few times… My two younger daughters were symptomatic, so they said take them to get tested. I took them, and then I got tested just to support them, I thought I might as well get tested. That is the only time I got tested because my two kids were symptomatic. F10CI

The offer of food boxes at testing stations, no questions asked, motivated some people to get tested.

That's how a lot of people decided to go out [and test] because of the boxes of food and things like that… it was a way for them to get people, come and test, test, test. F3SA

1.3.9 Reasons Not to Get tested

Of the 22 family interviewees, four[10] did not take a test for COVID-19. This was for a range of reasons that included: being asymptomatic; social stigma, embarrassment; taking time off work to get a test; or feeling that testing was unnecessary.

For example, most of F9CI family tested for COVID-19. One family member did not. The untested family member reasoned that she did not have any symptoms, she was not in close contact with anyone who had COVID-19, and she heard the testing was painful. In addition, everyone in her bubble had been tested providing a level of protection for her and her son, who as a toddler, she was told, did not have to be tested. F1SA grandmother also did not get a test; her children and grandchildren had multiple testing to protect her and her health. F7TO family did not get tested.

1.3.10 Cultural Nuance

F3SA offered an alternative reason for why Pacific families avoid getting a COVID-19 test. It was suggested that it was due to underlying cultural nuance based on the rationale that if you test for COVID-19 you must be sick. If you test positive, you are branded. This generates fears of social stigma, of embarrassment, of rejection and isolation from friends, that not only impacts the

[10] Participating family narratives may occasionally refer to 'others' in their families who may or may not have tested. The 22 tested and not tested family members referred to in this section are those who participated in the interviews only and not inclusive of other family members.

individual but has implications for the entire family. For example: F3SA provided a hypothetical scenario, that if one person tests positive for COVID-19, the entire family would be affected.

> *I think the other thing is people are too scared to go and get tested in case it comes positive… it's embarrassing… not only from work, friends, family, everyone. [My] kids will get teased, or people might not want to go near my kids anymore, or people might not want to come near me anymore. And then even though I am out of it [recovered], and don't have it, it will still stay with them… [people will say] 'hey, you had Corona, look there comes Corona down there'. Suddenly, he will be named Corona, it's the embarrassing part and the fear of them getting that result of positive. For instance, Samoan families, when you are married, you married into the whole family, it's like that. F3SA*

Perceptions of being judged, of others knowing the family's business, of others attitude towards their family, can lead to a change in behaviour, in this instance family members not getting tested:

> *Some people feel that if they go get tested, other people might think you have got the Corona. If you go and get tested, he must be sick, she must be sick, she has probably got someone in their family who has the virus. You know, it's all in people's heads. Then …people start making up things in their heads and then they start believing it, then they just don't bother. They start thinking that before, it's all in their minds and then they just don't bother going because they don't want other people to see them going to get tested. It's like when you go to the doctors and it's time for a smear test and you don't want to go because the doctors or nurses might think of something else, it's all in the mind. F3SA*

F7TO family did not get tested. The entire family including a wife, husband and their two children decided against getting tested because the family had no contact with anyone with COVID-19, they were asymptomatic, and didn't see the point in getting tested. F7TO husband was encouraged to get a test after he heard about the low testing rates. But he did not want to go the testing station alone and therefore did not get tested.

> *The second lockdown they [government messaging] said 'if you have been sick go and get tested'; 'if you've been in contact with anyone then go and get tested'; 'if you got a cough go and get tested'. Haven't you just wasted all these things a, b, c if all no, so why? For that reason, we haven't, and we are very cautious we don't take our girls out like we used to freely before or go shopping we've never taken them to supermarket. There was a point where they [government messaging] say 'there was no one coming for testing'. At that time I was willing to go test, but no one wanted to go with me to go testing, I didn't want to go alone. F7TO*

F7TO husband decided to get a test after government messages encouraged testing, an aspect of surveillance, a concept F1SA understood and implemented for their family. For example: from a public health perspective, F1SA encouraged their family to test to ensure the surveillance and monitoring aspect of testing continued to help the Government make better informed decisions about the resources.

> *The other reason we do it is also to keep the numbers up, because we know about the surveillance is important, so we want to keep those numbers up, yeah, nationally. It's so we have an idea of what the situation is nationally. So, it's just basically so that the monitoring is more accurate. People should have access. There's a lot of people…*

if you go in, there are quite a few, so that's resources, but I mean, it needs to be accessed, they need to keep the numbers up. F1SA

F1SA was aware of the role of surveillance in disease elimination, F7TO was not. Government messaging influenced F7TO to reconsider his position not to get tested. The messaging was subtle but effective.

Church leaders, ministers and pastors were highly regarded by families as being trustworthy. Many families got tested on the advice of their pastor, not only because of the high level of trust the families had of the pastors, but because the message from pastors aligned with the Government public health messages. F8TO was concerned about the influence and power church leaders have over their congregation, as decisions they make can impact negatively on the health of the family, particularly if the church leaders promote themselves as experts. F8TO was worried that offerings of alternative, traditional medicines that would cure COVID-19 would be enough for families to disregard government messages and become complacent.

Because [in] the Pacific community whether they call themselves experts or whatever, may be they're expert, they're pastor or whatever. But if that pastor says Covid is not that serious, whoever their followers are, they're just gonna take whatever that person says. If someone comes up with a [Pacific] medication that is going to cure it, and if they've already presented themselves as expert, people would alert to that person. They've already got their community people that listen to them and it makes it hard for the Government to present and it happens a lot. F8TO

It is important for the Government's public health communications to maintain a consistent and powerful message to overcome false information and strong enough to counter misinformation, or the lure of false hope for families.

Experience of Getting Tested for COVID-19

The experience of getting a COVID-19 test starts with families agreeing or accepting to get tested in the first instance. This is followed by a decision of where to get tested[11], whether it is at a Community Based Assessment Centre (CBAC), a pop-up testing station (at a workplace or church), a medical centre, or their GP.

Some families preferred to go to the same place to get tested, convenience was a factor, as was the level of busy-ness at other stations and the estimation of waiting times. Families identified two main issues at the testing stations - long queues, and waiting times. These issues created extra feelings of anxiety for families. Families looked for ways to avoid or alleviate waiting in the queues, they accessed GP and medical centres, or went early (6am) to be first in line, while others avoided getting tested altogether by opting for one family member to get tested; if they tested positive, other family members would get tested, or others tested at their workplaces.

Some families took a pragmatic approach when they planned their visit to the testing stations. F10CI decided to get tested as a family and record the event. They turned the negative aspects of getting tested (e.g., long queues) into a positive event (e.g., a family day trip out). They planned and

[11] NB: Family members have different timetables and obligations with work and study. While many family members tested together if it was convenient, other family members did not test together and may have tested at several different testing stations to align with their own commitments.

prepared for the day that mitigated any unforeseeable problems that might lead to increased levels of stress (e.g., hunger, boredom).

> *So, we all went into the van and waited for four hours… we packed our lunch, took the kids and it was like we created it like a family trip out. We were like, let's just get ourselves tested. We were like, let's get in the car, I did all our lunch, packed it, got our drinks put it in. For four hours waited in the car, the kids were occupied. We had lunch, four hours, got tested. We filmed each other getting tested, had a bit of a laugh. F10CI*

1.3.11 Self-Isolation

Families used the terms 'isolation', 'self-isolation' and 'quarantine' interchangeably and often incorrectly. To them, it invariably meant the same thing - separating themselves from others. Achieving self-isolation in alignment with the MoH guidelines was not always possible for families for various reasons. Some family members were considered casual contacts, others were unsure if they were close or casual contact as they did not know who the infected person was, and therefore how close they came into contact with them. Self-isolating at home can be challenging for Pacific families.

For individual family members to go into self-isolation, families recognised it required a certain level of planning and management in order for this to happen, especially where there were several members living in the home who were not required to isolate. Planning was needed, for example, for shopping, maintaining physical distancing, ensuring hygiene practices were adhered to (e.g., not sharing plates etc). Some families found it a challenge to comply to the Public Health Standards to self-isolate at home. F8TO tried her best to avoid contact with her children but found it impossible. Her children were young and dependent on her.

> *We've got kids it's very hard to self-isolate in a room because especially myself I have a child. I myself didn't self-isolate you know when I wake up in the morning to be honest it was hard to self-isolate if one of the [children] is sick I have to come have to attend to him to be honest I never self-isolate myself [from the children]. They [workplace] did look after us well, they rang offer shopping. F8TO*

Two adult grandchildren from family F1SA had to go into self-isolation as one returned from overseas, and one worked with young people; both were considered high risk as both were vulnerable to COVID-19. The family decided that the two granddaughters' usual roles and responsibilities in the household, for the time they were in isolation, would be distributed between family members. The family sectioned off one room, with its own entrance, where both stayed for the duration of the 14 days; they did not have any contact with their family and were required to stay in the one room. Although one became bored as she was a 'social butterfly' and liked to go out, the upside of self-isolation for them was that their cousin did all their chores.

> *We had one person assigned to us, to do our food and stuff. We always had to put away our own plates and [cousin] was the assigned person to us. She will come in and do our meals and everything else. We only came out when we needed to go to the bathroom, that was mainly it. So [cousin] did all of our chores. F1SA*

Families who were able to isolate family members successfully and safely over 14 days because they had access to resources (family support, cooked meals, internet service), the space (a separate room was set aside), and the knowledge (access to MoH guidelines).

Physical separation from family members was, at times, unbearable. Families realised the necessity of taking action to stay away from others who were vulnerable and were generally compliant. Access to technology assisted families greatly.

> *When we are in lockdown or isolation, this is when everyone stops going to people's houses and this is where our Messenger [Facebook] comes to life. F3SA*

Physical and/or social distancing terms were used interchangeably and intermittently by families. Families knew the difference between 'social' and 'physical' distancing, they mentioned both in the context of the physical 2-metre rule to keep their distance from others, rather than distancing themselves socially. F2SA provides an example.

> *We had a competition [at church], he [Pastor] telling us to make a competition… he was making families to make ads about social distancing. I was the person recording the ad and my dad was doing these ads that you have to keep 2 metre distancing, in Samoan. To make the older ones understand, that was his main thing. We had to do our way, Samoan way, to educate our own families. F2SA*

Families continued to strengthen their social networks by maintaining virtual social connections. This indicated that families kept abreast with the Government's changing terminology and definitions from social distancing to physical distancing.

1.3.12 Managed Isolation Facility

One family experienced managed isolation in one of the facilities in Auckland. In mid-April 2020, F7TO[12] returned to Aotearoa from overseas with 10 members of her extended family, including her mother and sister, after attending a family funeral. The family were stranded in [country] for 3½ weeks. Arriving back in Aotearoa, F7TO described the airport as being deserted, check-out was quick, and there were no queues. Passengers were put on a bus and told where they were going halfway through the trip. They were told no contact was to be made with anyone outside of the facility. At the facility, military staff, health workers, and police officers were present to help passengers fill out forms and ensure safe distances were maintained before being assigned to their rooms.

The managed isolation facility did not provide an interpreter nor any other language support for the passengers, forcing F7TO to act as a translator for some of the passengers. The lack of Pacific language speaking staff and an absence of Pacific language appropriate material frustrated F7TO particularly as there were so many elderly passengers.

> *We came with a lot of elderly people travelling alone, don't speak English and the staff there, none of them were [country] speaking. [I spent] almost 2 hours helping those people filling in papers in English, some of them travel here and they don't know their home addresses and where they stay. One elderly man in his 80s could not speak a word of English, could not read as it wasn't translated, no material in [language] to fill out. I even had to put in my contact details in there and I put it out on Facebook 'if you have family in Pullman hotel blah, blah, blah, contact me'. F7TO*

The family spent 14 days in the managed isolation facility before returning to their house; they did not get tested during the period of time in isolation.

[12] F7TO's husband and children did not travel with her to [country]. They stayed in Aotearoa.

1.2.13 Managed Quarantine Facility

An adult, child of parents of F5SA family, here labelled AC, returned from overseas and was taken to a managed isolation facility. After five days, AC tested positive for COVID-19 and was then transferred from the managed isolation facility to a managed quarantine facility. The parents outlined several concerns about this process, including the need for better communication to AC about the testing; better communication and support for families who have family members returning home from a quarantine facility; and finding suitable accommodation for quarantine returnees to alleviate risks to other family members. AC left the quarantine facility after 12 days without being retested, given AC tested positive several days before. The lack of communication and guidance from health authorities triggered a chain of events that eventually led to a one-day shutdown of a health facility where a parent worked. The parents were considered close contacts even though they had not physically seen their AC.

> *We got a call from Auckland Public Health and they said to us 'we are really sorry to put you all three through all this'. I said, 'where are you guys we don't know what is going on here'. They said to us 'we don't know why [the facility] closed down, they went overboard in doing that'. And I said, 'well what do you expect' because people are scared of this virus they don't know what is going on'.*

F5SA was less concerned about AC testing positive for the virus than they were about processes and procedures that unfolded.

> *My only concern is they let AC out without letting us know or [saying] 'ok we will call your parents to see if it is ok for you to come out and stay with them or find somewhere to isolate'… that is the only part I was upset about and I was thinking to myself it's the system that is letting us down. Yes, we don't know what the virus is all about, but the system is not playing out right.*

1.3.14 Test Results

There were inconsistent processes in advising people of the outcome of their tests and this had impacted families significantly. Families were frustrated that test results were received at different times for different family members even though families took tests at the same time. The delay in results had financial implications for some family members as they were expected to use their annual leave entitlements while waiting for results.

Many of the families were tested together or were aware of when other family members would be tested, usually within a short timeframe of each other. Families or individual members returned home to isolate and minimised contact with others in the household, particularly others who had not yet been tested.

Families were annoyed they had to 'chase up' their test results because of the delay, particularly for those who were forced to take annual leave while they were waited for their test results. Leave entitlements was at the discretion of the employers, but this caused issues for families. For example, two family members were both essential workers, both in paid employment, both on full salary, both were waiting for test results. Yet one had to use up his annual leave. The other did not, he received an allowance.

> *He [son] didn't want to use his annual leave but it was out of our control of what we could do. F10CI*

Family members were allowed to return to their workplace upon proof of a negative test result, not only for themselves, but for all other family members in their household who had been tested.

> *[My husband] went to work but my son hadn't been cleared. Then he was sent home because he shouldn't have gone in until my son was cleared. So, [my husband] had to come back home and couldn't go to work… results [were] negative but they said no, your whole family has to be negative. F10CI*

There was a lot of concern that the longer families had to wait for their test results, the more likely it would be a positive result, the worst-case scenario. Families were advised that if the test results were negative they would receive a text notification. If the test results were positive they would receive a phone call. One young family member waited for several days for his test results before he received a phone message to call the nurse. In a panic, he called his parents, who in turn called the medical centre to get the results. In the meantime, a concerned mum instructed her son to return home immediately, fearing the worst. This caused an enormous amount of anguish. The results were negative.

> *I knew that if you get a phone call, it's not good. That stressed me out a bit because we got a call. I said 'son, go straight home, go straight into your room, I am on the way home'. I said, 'don't you go to nana and pops, stay away from them, stay in your room, wait there'. They [medical centre] called back to say 'okay, it's negative, they got the result, it's negative'. And I thought, that is all I wanted to know. F10CI*

To avoid the anguish and stress the young family member and his parents went through, a better communication approach was needed. For example: the phone message could have been more informative or indicated that a non-urgent call back was required rather than the vague message left to 'call the nurse'.

1.3.15 Contact Tracing and the COVID-19 Tracer App

Families who were exposed to a positive case were uncertain if they were a 'Close contact' or a 'Casual contact'. For example, some families attended a church service at the same time as a family who later tested positive. The positive family's identity was kept confidential by the Pastor, in consideration of the family's right to privacy but also to negate or decrease any negative stigma towards the positive family from others. As a precautionary measure, the Pastor encouraged all the congregation to get tested.

One family member did not know how close to the positive family they had been, and hence was unsure what level of exposure they had to the virus, and whether she was considered a close or casual contact. This caused great concern for families.

> *We didn't know where that person was sitting. We had to [test] because in my mind I was like, this virus, it's like little molecules around, you never know, your baby might crawl around this area and might get infected, so we had to get tested. She [nurse] was asking me 'are you a close contact, or your family?'. [I replied] 'no, it's someone from church'. F2SA*

The uncertainty led families to expect PHU representatives to contact them. Another family concerned about being exposed to COVID-19 was so frustrated, she vented her anger about the positive family.

I was angry. I was really angry. I was angry at the fact that (1) during that week [workplace] was on the news; (2) that guy knew that's where he works; It was all over the news that week, why couldn't he just stay away, why couldn't they isolate themselves, get tested when his colleague tested positive. It was like they knew that they could be positive, but just didn't do anything about it, didn't bother go testing just because you didn't have the symptoms at the time. And then decides to come to our church and then suddenly started getting the symptoms. F3SA

There is a need for better, streamlined communication between families and health agencies such as the PHU and DHBs. For example, some families from an ECE Centre were contacted by health agencies, but the ECE manager, F4SA, was unclear exactly who the agencies were, he suspected they were from contact tracing centres. F4SA did not want to criticise any health organisation or health team as they were doing a great job but he was concerned about the messages families were receiving from these calls that were confusing and incorrect and had the potential to misinform families.

You'll get information saying, oh okay, you should be getting tested on the first day, and then the 12th day, and if it's negative, then you are okay to end your 14 days self-isolation. Then you get another representative saying, you should get three tests, you get one on day 1, day 5, day 12. And then you get another one saying, you should get five tests. And its hang on, why the different information. And then I have families calling back and saying, look I don't know how it works, I am being told getting 2 tests, getting 5 tests … what's happening. And then you get other information saying: if you get tested first time around on day 1, then if you get a second test, then you restart your self-isolation… Yeah, so what, they just want you to stay home. Obviously you have to get a second test just to reassure. I saw a doctor and said: I am just going to tell this to our families, just one information. Get tested on day1, tested day12, if you are negative on day12, 14 days up, you are free. No hassle. Just think, day 1, day12, that's it. F4SA

There is a call for messaging to be clearer and consistent across the board. This will help people better understand the definitions of a 'close' or 'casual' contact, and what that means for families in terms of compliance measures.

The COVID-19 Tracer App was used by some families, who found using the App 'second-nature' and promoted the scanning app to family and friends. Families felt that since the Auckland August outbreak, they would never underestimate the virus and if everyone used the different tools (e.g., QR code) and measures, it would minimise the opportunity of spread, but it was up to everyone to play their part.

… just the fear as you don't know who you may have contact within the supermarket at the same time as someone else. QR is now second nature, [as] soon as you go into place, you lock-in for that. F7TO

F4SA set up QR coding and the contact tracing register for an ECE. F4SA spent a considerable amount of time encouraging families to use one of the contact tracing systems but ECE families were concerned about confidentiality and questioned the level of privacy of the register list. Families argued that anyone can take a photo with their cameras of everyone's details, and that could lead to families being harassed.

It was hard for me to encourage our parents to use this (QR app). Especially with what is going around in the world. They will say: we scan it and they have our details they can hack… I say, that is okay, but if we get affected [with the virus] and you haven't scanned or signed in or signed out, I am not going to tell you that we got affected because you are not on there, the option is yours.

From these experiences, it is recommended that marketing about the COVID-19 Tracer App particularly targeting older people, who found utilising the app challenging.

Testing Stations

1.3.16 Location of Testing Stations

Accessibility and location of the testing stations was important to families especially if they were located close to where they lived, at their workplaces or close to public transport. Some knew the location of testing stations if families passed by, from social media, from friends and family, word of mouth, through the COVID-19 website, Healthline, or on language radio – e.g., Samoa Radio, Tonga Radio.

The physical location of the testing stations, that is being close to shops, public toilets, and public transport mattered to families. As an example, the Mangere Town Centre testing station was located close to shops, toilets, pools, shopping centre, and supermarkets. The access to these facilities made waiting in queues for long periods of time bearable especially for those with children. If there was more than one family member, you could leave the car, stay in the queue and not lose your spot.

I told my son to go to the shop because we weren't far from the shop because he was hungry. But I let him go while I am in the queue, we know once we move out from the queue we will be way back, so we had to stay in the queue. It was really good for Mangere Town Centre, it was closer to toilets, the shops where you can eat, [supermarket] … you had the Mangere pools, you had the doctors and then you had the whole shopping centre and [supermarket]. It was close to everything. It's a positive, it's a good thing especially when you have old people in the car, or kids in the car. We can handle it, but the old people and the children cannot handle it if they are thirsty or need to go to the toilet. At least it was close to everything. F3SA

The community radio stations were effective in communicating the location of testing stations. F3SA mother who listened to, and 'loves', Radio Samoa, learnt the location of various testing stations from regular radio newsfeeds and bulletins.

Because my mum listens to Radio Samoa… they will tell us exactly… there is one in Otara, one in Mangere, wherever you are living, wherever. It was the radio station was the key people that will tell us where. And then my mum would say, 'oh there is one here, or one there. F3SA

1.4 OTHER FINDINGS

Key Points Summary:

- Pacific Providers were responsive, accessible and agile in their support to the families.
- Technology played a significant role in sustaining family social connectedness during both lockdowns. Families reported no major illness or sickness of family members. The pandemic affected family mental wellbeing, albeit over short periods of time.
- Humour used as a coping mechanism by or with Pacific families can mask real struggles.
- Post-COVID-19 families accepted a 'new norm' that has shifted the way they work and behave.

Pacific Providers' Support

Families received support from various Pacific providers, particularly the distribution and provision of food parcels, essential goods packages (e.g. nappies and bathrooms essentials) and in some cases, financial help. There were a number of distribution options for families to access the parcels that included home delivery and pick-up. All the families expressed their appreciation in receiving the parcels. Families shared the food boxes with others or passed them on to other families in need.

> *Food parcels were good. They advertised it on Facebook. I can't remember what they're [organisation name] called. They are a food place where they deliver to you… really much appreciated what they were doing at the time, these people should be home as well, but they were out there delivering. All you had to do was call them, give them your number, your address, they didn't ask questions. They advertised it and then you private messaged them with your number. Then they call you. F6SA*

> *The sister and the nephew were part of the [food parcel] distribution and there was so many left. [We] were able to give it to others. Pass along. There is this old lady we know down the road here, we took it to her. To me, it's just another way of continuing to give. They were happy, they were really happy and the kids. They're [non-Pacific] so I don't know if they would have had that access… they are peripheral in a way. Without sounding detrimental there are a lot of drugs going on here [suburb] so I don't know if they're the type who would actually go in [and ask for food parcels] for fear of whatever, you know. F1SA*

1.4.1 The Community Working Together to Find Solutions

During the August lockdown, a truckload of perishable foods consigned to a local Pacific provider could not be delivered to the designated venue as the provider was waiting for council approval. The food needed immediate unpacking and distribution to the community. F9CI's family heard through her personal network about the situation. F9CI's family immediately reached out to the health provider, offered to chill, store, and pack the food into individual packages, ready for the provider to pick-up and distribute to the community. F9CI opened up their church hall, and utilised their large family to volunteer as packers. Since the family were part of the same bubble, they were able to work together without the need for others to breach their bubbles.

> *We put our hand up and said, 'we are one bubble, we will do it'. So, my family ended up doing the hampers… and us doing that we were able to stay within the restrictions of one bubble. So, we cut the door off … no one was allowed in. We just passed through [the line] to the table going out … we continued doing that and finally we did get the [venue] and then we handed it back to them and they took over… but we just helped at the initial phase*

otherwise the food would have gone to waste, it wouldn't have gone out to the community. F9CI

F9CI family worked alongside the Pacific provider that ensured the food parcels went out to the community. The immediacy in which the problem was solved demonstrated the resourcefulness of the Pacific communities and the collaborative nature in which Pacific communities work.

1.4.2 Community Support for Families

F4SA ensured that ECE families were accessing as much community support as possible. F4SA used his initiative to apply for grant funding from various agencies: for example, MSD for financial support for families, 360Tautua for food parcels for 117 families; The Cause Collective for children's sleepwear; the Ministry of Education for a variety of resources. Other agencies reached out to F4SA to offer their support.

> *We had other agencies that we had never heard of, offering help… and there were emails saying: we are remembering you, let us know if there is any help that we need. When I reply back go, okay that that is great to know, thank you so much for the thought, but what help can you offer? Can you do this, and they say, 'oh no, we can't'… 'are you able to provide with this information', 'oh sorry, no we can't'. I just wanted to get to the point, there were so many,… but when I replied back to them what help can you offer, no response.*

Various community providers provided vital supports to families. F8TO was an essential worker who had to self-isolate at home following a confirmed COVID-19 case at her workplace. F8TO lived with her husband, four children and her sister. While families could not remember some of the names of the providers, they were grateful to receive the support.

> *When we self-isolate they look after us very well…they always calling us every morning, [Name] help us [asking us]: 'oh, A, how's the family?'. They're [community providers] doing well looking after us keeping calling us and when they call us some people ask if you need any help what you need and things like that.*

Health and Wellbeing

1.4.3 The Role of Digital Communication Technologies

A surprising aspect to emerge from the pandemic related to Pacific families' uptake and use of various communication methods, in particular Zoom, Facebook and Facetime, to stay socially connected, or to reconnect with family and friends. Staying connected or re-connecting with others soon became a way of life and a necessity for the families in order to maintain their bonds with family or reacquaint with those they hadn't communicated with for years through a digital space (vā[13]) of social media and other communication platforms ensuring their collective wellbeing is nurtured. Through the 'digital vā' families were able to keep in contact with each other through family Zoom and video calls. For F7TO family, utilising the technology was achievable as they had access to reliable technology and high quality, fast internet connection. Access to reliable technology for Pacific families was important, but some families will not have the same level of accessibility to technology.

[13] Vā – the vā is a concept that denotes a social space that exists between people, a relationship that is both socially and culturally significant to their way of life. It is about 'co-openness' as well as 'betweenness', that in the vā there is an opening of oneself to existing and pre-existing relationships.

I have friends I hadn't spoken to for over 20 years but during COVID we were video calling and catching up and all of that ... all of them are in America and all over and they are too busy to be interested in what they're doing. The first lockdown everything kind of stopped... I have time to reconnect with them and we started having kava parties over Zoom and Facebook. F7TO

1.4.4 Absence of Illness During Both Lockdowns

Other than short bouts of the 'sniffles', and one family reporting a family member had the flu, most families reported a decrease in sickness and illness of their family members during the August lockdown, particularly among the younger and older family members. Families did not access health services as much as they expected to and reasoned that isolation and lack of physical contact contributed to the families staying well.

The one thing we found this year is our mum [74 years] has not been sick, didn't have the flu, no cough and this is the most well she's ever been. She has not gone anywhere, she is limited to the people she is in contact with, she stays home, she is so well. F7TO

That said, families indicated they would have sought medical care if necessary.

1.4.5 GP Clinical Services - Response to Changing Circumstances

Family members with long term conditions maintained their regular appointments. Families noticed a slight change in the delivery of health services in response to changing circumstances; for example, during the August lockdown, F7TO and her mother had to wait in the car to be triaged before entering the clinic to see her GP. F7TO advocated for this to continue post-lockdown as the different way the GP service was working also worked well for her, as she was pregnant.

Yeah, with my appointments as well it is the same thing, got a different doctor but it's the same thing. 1) phone consult 2) phone when you arrive 3) phone and stay outside 4) and then they will let you in because there is one person inside at a time and being pregnant as well I loved that, it's something I feel most comfortable with it and you know when they're coming out wearing their PPE or in masks and I am there and safe and if I need to come out and I will, if not, thank you. And prescriptions as well are sent straight to the chemist. So, there is a contact list appointment so with health care at the moment it is a delight, it keeps the nurse on her feet but as a patient you walk away with a sense of [care and efficiency].F7TO

1.4.6 Hospital Experience During Lockdown – Cultural Competence

Most families reported minimal sickness during both lockdowns, one family had two members in hospital at separate times, for different treatments. The granddaughter was admitted into Auckland hospital for an iron deficiency and required a transfusion. Just before she presented to hospital, she had a COVID-19 test. She stayed in the hospital for six days for her iron levels to be adequately restored. The granddaughter, who lives with seven other family members, enjoyed the hospital experience as it provided her with some space to be on her own. The hospital stay was a good experience.

I got to experience it and it was nice to be away from my family too, it was nice to be in hospital, it was quiet. F1SA

The grandmother was admitted to hospital in the second lockdown, after suffering a stroke, the family experience was not great. Her son was told he could not stay with her as the hospital had COVID-19 patients. The son did not want to create a fuss or 'rock the boat' with staff or the hospital rules and left.

> *It lasted one night, yeah and then she [grandmother] wanted to come back home. F1SA*

The F1SA family relayed their concerns to hospital staff about leaving grandmother without a family member. She was elderly and cared for at home by the family 24 hours a day, seven days a week. The family were not permitted to stay but were told they could 'call the hospital at any time' to check on their grandmother. The family saw this as a consolation for not being allowed to stay.

> *…when they gave that blanket invitation [to call grandmother]], they didn't realise how many of us. She has children overseas. So, I think someone was told we only have one phone, but that's not our problem. The invitation to us was 'you can call her at any time', and I took that to mean 'we can't let you in, but you can have this', if you offer that then you need to keep your word on it. She would have got lots of calls during the day, all day… 'Any time' the way palagi works, you know, probably once in the morning and maybe once at night.*

During the four-day hospital stay, the grandmother had a fall. The family had to 'fight' for an official incident statement, but the report failed to mention the fall, and this further exacerbated their increasing frustrations. One of the issues raised by the family was how exemptions worked in terms of being with family members in the hospital, especially the elderly, when there is a lockdown, what were the rules and whether the rules were consistent across DHBs? That said, the family were mindful of the stress the health system and workers were under at the time yet couldn't help but to compare their grandmother's situation to that of others.

> *I have a friend of mine whose husband was terminal at home, and she was able to go, she said they allowed her to be with him, and I have heard of another who said they were able to be there, it might be different hospitals. I had heard that others allowed one person, so I don't know what the criteria or conditions were for that. So that would have been mixed information. F1SA*

1.4.7 Impact of the Pandemic on Family Wellbeing

The pandemic had an impact on families' mental wellbeing. Families reported feelings of anxiety and stress, but it was often in the context of short bursts of worry and mostly during the height of lockdown. Family was the main support network that families would often access. Many families used religion, gratitude, humour, and understanding as coping mechanisms.

> *I didn't like the second one because to me it was just an indication of what the future was going to be like, and I wanted to get home to Samoa as fast as I wanted to. So, it was very depressing to me. It was just depressing to think that is our reality now, it's very unpredictable. Now, we have this [in the area] we are all very grateful to be in NZ, we always talk about that gratefulness. F1SA*

Spirituality for families was strong and should not be underestimated in the way in which it contributed to their individual and collective resilience and wellbeing. Families placed an enormous amount of trust in their faith and their God. Many of the churches hosted online prayer meetings,

and live streaming services through their websites and social media. Communication and connection between the church and families was critical and was a key factor that contributed to their ability to cope. Families had confidence in their chosen religion and often credit their faith with supporting them through challenging times in relation to the pandemic[14].

> *We just kept praying and believing that all will be well, we stood on that and to this day, I am really thankful that I have pulled through. F10CI*

The cultural dynamics of collectivism was evident in the practices of the families in this research. For example, families had regular discussions with each other and as a family, not only in terms of the pandemic but also regarding issues such as shared care of their vulnerable family members, testing, work situations. Decisions were made as a family and collective agreement. For example: F1SA family were aware of the impending lockdowns and what the family needed in order to function well. This worked well.

> *As long as you can find your own space, when you need it… we need our own space. F1SA*

1.4.8 Humour as a Coping Mechanism

Some families felt that Pacific people use humour as a coping mechanism to mask struggles that many Pacific families face.

> *It is a Pacific Island thing, I see it a lot in Pacific Island community… it's just part of general life, even hard times, even that we don't look as if we are struggling. We never admit it's a struggle, we make a joke out of it, we see the positive out of it regardless of how bad it is even though it is serious, it is hard for people to snap out of it … it's not something that can be changed easily, that kind of mind set. F7TO*

Family F7TO was concerned if Pacific families were coping well during the lockdowns as they knew that what might be construed as resilience is actually masking a lot of struggles underneath, and that the struggles were often managed through comedy or joking about the situation. This concerned F7TO as the mindset is difficult to shift, unless it affects families directly.

> *I don't know but it's that PI kind of attitude just life in general we never take it serious until it happens to someone close to you. Some PIs we feel they play it down the severity of what this would be if you don't follow the rules and listen to what's been told. The norm is they make a joke out of it even if it is serious… until it affects you directly. If it never hits you directly a lot of people never come out of their mind set that this is the real thing that is happening. I don't think it is something that can easily be changed… [specific Pacific Island] as I grew up and be around them, it's not something you can change easily that kind of mind set. I see it a lot in the Pacific Island community… it's just part of general life even hard times… we don't look at it [as if] we're struggling. We never admit it's a struggle. We make a joke out of it; we see the positive out of it… it is hard for people to snap out of it it's a killer until it hits home. F7TO*

[14] The role of the church in a pandemic, from the perspectives of the families, was wide-ranging and included prayer meetings online, pastoral care, sources of information, advice about COVID, budgeting, a source of support.

The implications of this attitude are that Pacific families do not cope as well as they appear, and this could create a barrier or reluctance to access health or social services. While specific coping mechanisms are not within the scope of this report, it is worthy of future research and follow-up with families.

The 'New' Norm

Families mentioned some of the major shifts in their lives that resulted from the pandemic and lockdown (e.g., financial concerns, technology dependence, flexibility in working from home, loss of employment, division of families into bubbles). The pandemic created a 'new norm' that shaped their behaviours and attitudes, public health measures to contain the virus, and the changes that altered their daily routines (e.g., hygiene practices, grocery shopping, healthcare-GP visits, no international travel, less social activities). Long term separation between families living in Aotearoa and those overseas has created new ways that families communicate. Families utilised and embraced the different modes of communication to keep socially connected, and reconnected. The easiest of changes to sustain for families were the hygiene practices, wearing a mask and physical distancing.

> *Sanitisers in the kids lunchboxes now. That's one thing that we have driven, like really nailed in our kids. Clean, washing your hands, stay away, don't cough. Now it's like … if you cough once and everyone looks. For me, now, for my job. Now I just work from home and go in once a week. It's the new norm now, which I love because it saves on petrol. With reduced hours, it saves and I just need to go in once a week and I love it. I can still do my job. F10CI*

> *With me and my family, we don't want to go to the crowded areas. We don't want to go to crowded areas like malls. We don't want to take my son to the malls. We like to go outdoors, go for a walk but not crowded areas anymore, we don't want to. If we go and see the doctor, I make sure we have to carry our mask. We avoid crowded places especially going to the malls and food courts, that's the other thing we don't want to go. And when we go and do our shopping, we have to sanitise the trolleys. I am like a freak in making sure everything is clean. Sanitise everything. F2SA*

Looking ahead, families expected a vaccine for COVID-19 to be available in the future and anticipated the uptake of the vaccination for themselves and their children. The vaccine offered a solution to the eradication, or at best management, of the virus; and hope for families to resume some sort of resemblance of life pre-COVID-19, including social connectedness to others. Until then, families continued to follow the public health measures to keep them safe.

> *My general feeling about the whole Covid thing is there is no back to normal kind of there is Covid, there is normal. Now is different in my mind the reality is going to be different, until we find some sort of vaccine to fix it. Unless there is some vaccine I am not interested in sending my kids to birthday parties. F7TO*

1.5 INSIGHTS AND CONSIDERATIONS

Government messages worked for Pacific peoples in relation to COVID-19 because the collectivism the Government sought is a natural alignment to Pacific values.

Families expected a COVID-19 vaccine would be found and they understood, through their experience of the measles containment, that the success of a vaccine programme is determined by the uptake of the vaccine. Families' enthusiasm and interest for a COVID-19 vaccine is an opportunity for government to utilise as a base towards supporting any future vaccination campaigns.

In addition, there is a need to prioritise the COVID-19 vaccine for Pacific essential workers, their families and the Pacific community, given many families are essential workers, who have the potential to be transmitters of COVID-19. Family essential workers often lived in multi-generational households with older and younger family members, who used many techniques to avoid contact with family members on their return home from work. For example: family members used another entrance at their home, removed their clothes and showered thoroughly before they saw their family members. An alternative was to take a change of clothing to work, and shower before they left the workplace. Families performed these tasks each time they returned from their workplace; for some it was over many months to protect their families from potential infection. It is unsustainable.

DHBs have a responsibility to provide clear visitor guidelines and restrictions for families with members in hospital during COVID-19, and for these to be consistent across all regions. Health care providers' understanding the role of family is essential when engaging with Pacific families in health care situations. Families, as do the patients, find it difficult to leave family members alone in hospital, especially when families are the full-time carers, and or patient communication is an issue e.g., language.

Communication from health providers must ensure families are aware that health services are available and accessible during a lockdown, for treatment other than COVID-19 related issues. During both lockdowns, families reported low rates of illness, apart from minor colds and sniffles. While this was good, the low rates of reported illness should be treated with caution as families may not have sought health care during a lockdown for fear of catching the virus, being unaware that medical centres were open, or not wanting to 'burden' what they perceived to be an already overburdened health system, or thinking of others who were more in need or deserving of the health services than themselves.

Future COVID-19 response strategies should include a better and broader use of Pacific languages to communicate messages to the community. This is critical for all aspects of a response strategy, from communications, to health workers at the testing stations, to interpreters at managed isolation and to staff at DHBs. Accessibility to ethnic-specific language interpreters is key to ensure families, whose English is a second language, have a good understanding of what is happening to them. Receiving accurate communication will enable families to make informed decisions or adhere to the public health measures. Material written in ethnic-specific language should also be accessible. Families who are in Managed Isolation or Quarantine Facilities can be frightened and this can lead to significant feelings of anxiety; being able to talk with those in charge in their own language would help Pacific families enormously.

The benefit of the March lockdown was transferred knowledge. Families were more prepared and knew what to expect. Families had structures set up from the first lockdown, such as working from work and study stations; internet connections. Families knew more about the virus and how to minimise the spread, they were compliant with the public health measures.

Pacific communities need to better understand the rationale for surveillance testing and the contribution it makes to control the spread of COVID-19 in the community. Government messaging about testing for the virus, and surveillance, had an impact on F7TO who reconsidered his position of not having a test after hearing of the low rates of testing. It is important for the Government to continue engagement with Pacific communities on the role of surveillance to ensure there is an understanding of the difference between the Government testing for the virus, and the Government testing to learn more about the virus, and what the community can do to support the Government's elimination strategy.

SECTION 2: EXPERIENCES OF PACIFIC ESSENTIAL WORKERS DURING COVID-19

EXECUTIVE SUMMARY

The findings reported here are part of a larger study: *Pacific families' and Pacific essential workers' experiences during COVID-19,* funded by the Ministry of Health. This study draws on individual, face-to-face interviews to obtain Pacific essential workers' experiences with the clinical process of setting up the Community Based Assessment Centres (CBACs) or Community Testing Centres (CTCs) where people get assessed and tested for COVID-19, and with working with Pacific people, from triaging, to testing, and/or to providing social support.

As an exploratory study, the research design is explained in detail in section one adhering to the Health Research Council (HRC, 2014) guidelines of conducting research with Pacific people. Recruitment was through the research team personal and professional contacts with the Pacific community. Data collection was carried out through: In-depth interviews drawing on the *Talanoa* method (Vaioleti, 2006) with five essential workers sharing their stories about their experiences.

We present our findings to reflect the main themes about the essential workers experiences with the clinical process of setting up Community Testing Centres (CTCs) and the burden of COVID-19 on Pacific families and themselves. The findings can be summarised as below.

Essential Workers Experiences with the Community Testing Centres (CTCs)

The CTCs required a coordinated community workforce approach involving Pacific and mainstream providers, Non-Government Organisations (NGOs), volunteers, traffic controllers, security officers, administration people, nurses, doctors and support services. Although the CTCs were seen to be working well, some improvements were needed to enhance family experiences for future pandemics. It is recommended that:

- There be improved working with the long queues of people waiting to be tested – it was felt that traffic controllers and security officers should check on families waiting in queues to ensure that older people and children are prioritised and seen first.
- Clinical leaders should 'walk the line' and triage families according to needs.
- Bottles of water should be offered to families while cars or people are waiting for their tests.
- There should be shorter waiting times for result 'and improve the processes for' after 'waiting times'.

Communication

The Jacinda/Ashley 1pm update resonated with many Pacific families. It was recommended that:

- There should be follow up messaging on Facebook, Pacific/Samoan radio etc, in all languages and with the same messages.
- Simple and clear key messages and information should come from trusted sources and the same message should be sent across all the community. It is important to recognise that consistency is necessary but so also is mana – e.g. messages from the MoH come with mana.
- There be one Pacific 'hub' for all information, the same information guided by the MoH, in Samoan, Tongan, English and other languages. This would act as a key channel of communication that everyone knows and hears.
- There be one hub, with a database of Pacific translators, to translate epidemiology into Pacific language and understanding.
- There are enough Pacific, trained staff (nurses, admin, doctors, social workers); these must include a range of language speakers (e.g. no interpreters were available in MIQ).

- Messaging include Pacific nuances – to provide educational messages of change behaviours and beliefs through breaking barriers of stigma and shame *It is the virus not the people.*
- The media work with the Pacific community to lead on stigma reduction as it concerns Pacific people.

The Burden of COVID-19 on Pacific Families

The Pacific essential workers carried the 'burden' of hearing many sad stories from many families who bore the burden of COVID-19 on their wellbeing. Inequalities in housing, income and the health system all contributed to social determinants facing Pacific families. The biggest health 'burden' impacting on Pacific families was mental health. It is recommended that:

- Support for Pacific families be provided through existing models of care.

The Burden of COVID-19 on the Essential Workers

The Pacific essential workers carried the 'burden' of 'bringing the virus home' to their families. These essential workers sacrificed their own safety and their families' wellbeing because of their obligation to 'serve' (tautua) their community, this being underpinned by Pacific cultural values of caring and 'alofa' (love). The 'burden' of COVID-19 affecting many Pacific families had added more pressure on the essential workers workload and they felt the 'burden' of not having the capacity to help Pacific families over and above their tautua or service to the community. It is recommended that:

- Essential workers be encouraged and supported to seek Employee Assistance Programme (EAP) support and other counselling services.

INTRODUCTION

The findings reported here are part of a larger study, *Pacific families' and Pacific essential workers' experiences during COVID-19,* funded by the Ministry of Health. This study draws on individual face-to-face interviews to obtain Pacific essential workers experiences with the clinical process of setting up the Community Based Assessment Centres (CBACs) or Community Testing Centres (CTCs) where people get assessed and tested for COVID-19, and with working with Pacific people, from triaging, to testing, and/or to providing social support.

During both lockdowns, particularly, the Auckland August lockdown, evidence in the media, including television news, Pacific radio, and other avenues, had shown a rapid mobilising of the Pacific workforce from multiple disciplines. Pacific health providers in Auckland worked hard in a co-ordinated and integrated way to do whatever they could to support the Pacific community, because the Pacific community were a vulnerable population. The Pacific workforce is small, and this limited capacity meant that meeting the high demands of providing clinical and wraparound support would be a significant challenge. In addition, health professionals as essential frontline workers in CTCs, medical clinics, doing home visits or working in different capacities were at much greater risk of exposure to COVID-19.

THE RESEARCH QUESTION

The research reported here is part of a larger study, *Pacific families' and Pacific essential workers' experiences during COVID-19,* funded by the Ministry of Health.

The overall research questions were:

1) What were Essential Workers' experiences with the clinical process of setting up the CBACs or CTCs concerning receiving information about cases and who to test?
2) What were the essential workers' experiences working and dealing with Pacific people from triaging, to testing, and/or to providing social support?

THE PACIFIC COVID-19 RESPONSE FRAMEWORK

The Ministry of Health Pacific health team developed the Pacific COVID-19 Response Improvement Framework (the Framework, MoH, 2019). The Framework provides a contextual structure for reviewing and evaluating the outcomes and experiences of key COVID-19 policies and programmes, enabling assessment from several perspectives.
The Framework consists of three key components:

1. System research and reviews,
2. Independent COVID-19 response review, and
3. Pacific experience of COVID-19, including:
    a. An exploration of Pacific experiences, and
    b. A quantitative component exploring the impact of COVID-19 on Pacific communities.

In October 2020, the Ministry of Health commissioned two Independent Pacific Researchers to undertake qualitative research specifically relating to the delivery of component 3 (a) an exploration of Pacific experiences (the Research).

In this Section, we report the findings from the Research, exploring the perspectives of five Pacific health professionals as frontline essential workers serving the Pacific community during the national and Auckland August lockdowns about their experiences with the clinical process of setting up the CTCs, and with working with Pacific people, from triaging, to testing, and/or to providing social support; the impact of COVID-19 on Pacific families; and the impact of COVID-19 on themselves.

USE OF TERMS and CONTEXT

In this study, the term CBAC and CTC are used interchangeably to refer to Community Based Assessment Centre (CBAC) and Community Testing Centre (CTC). During the first lockdown, the term CBAC was used and then it changed to CTC. From here on, we are using the term CTC.
The term essential worker/s is used due to the small number of Pacific health professionals being interviewed, and there is a possibility their roles and place of work could be identifiable. The essential workers were all qualified clinicians working in three different Primary Health Care Services (PHCSs) located in different locations in South Auckland. We are using the acronyms PHCS1 (Primary Health Care Service1), PHCS2 (Primary Health Care Service2), and PHCS3 (Primary Health Care Service3) to refer to the three PHCSs where the essential workers work.

Three essential workers participated in the study work at a PHCS1 and all were frontline workers providing services at the CTCs and the medical practice clinic during both lockdowns. One essential worker worked at PHCS2 during both lockdowns and had left before the interview. The other essential worker works at a mainstream PHCS3 in a medical clinic.

PHCS1 has a primary health care medical practice clinic and provides social services as well as health services and was one of the health service providers delivering CTCs in both lockdowns. PHCS1 is located near a public carpark and relevant facilities (e.g. lavatories and shops) which was convenient as a location for a CTC.

PHCS2 also provided CTCs in both lockdowns. They had set up CTCs in different locations with each having access to a public carpark and a medical practice clinic.

PHCS3 is a mainstream medical practice clinic that did not deliver a CTC but provided COVID-19 testing in the clinic.

The CTCs were set up as satellite clinics and their locations for testing stations at public carparks was considered important, so that people could drive in and not having to get out of their cars to get tested.

The term triaging is defined in the medical field as the assessment of patients on arrival to decide how urgent their illness or injury is and how soon treatment is required. Triaging aims to ensure that those patients assessed as having the most urgent need are treated more quickly than those patients with a less urgent need[15]. Triaging in the context of CTC is similar, and in this case, the focus was on who should get tested first.

METHODS

Ethics approval was not required for this research because it was considered a low risk study. Ethical processes did, however, govern the research as described in detail in section one, for example, maintaining confidentiality during the study. The essential workers were recruited through the researcher's community networks. We did not use coding such as essential worker 1-5 (EW1-5) as a reference point to emphasise the importance of a quote or storyline relevant to each essential worker in order to safeguard the participants' identities.

The research adhered to the principles of the Health Research Council (HRC, 2014) guidelines of conducting culturally appropriate research with Pacific peoples. The essential workers were interviewed in English face-to-face and all participants consented to have their stories recorded. These were transcribed verbatim and the transcripts were analysed thematically, with the data stored and coded in software NVIVO12.

Key themes identified from the analysis concerned the 1) Essential workers' experiences of setting up CTCs and the process of triaging, 2) Essential workers' experiences of the impact of the pandemic on Pacific families and themselves, and 3) Communication of public health messages. These themes will each be discussed in the sections that follow.

FINDINGS

This quote sets the scene:

> *I can speak from my experience. You know, you don't have to speak from what anyone else is doing … you speak from your experience and no one can take that from you, no one can say you're wrong because that's your lived experience.*

None of the essential workers was prepared for the pandemic. Some had heard of it in December 2019 and others found out about COVID-19 in January 2020. The essential workers did not take much notice of the pandemic overseas as they felt that it would not reach Aotearoa: *… there might have been a little bit of denial that Covid-19 would make it to New Zealand.*

[15] (https://www.health.govt.nz/our-work/hospitals-and-specialist-care/emergency-departments/emergency-department).

The essential workers had no idea what a significant issue the virus was about to become. However, when COVID-19 reached Aotearoa New Zealand, the essential workers expressed their concerns about the vulnerability of the Pacific community to the virus, because they already have significant inequities in health status. They also expressed fears of what the impact on their community might be, based on their experiences and knowledge of what had happened with the measles outbreak in Samoa. Three of the essential workers had helped in Samoa during the measles outbreak and this experience was still fresh in their minds. They were anxious and asking themselves, 'what if the virus gets to Aotearoa/New Zealand and the Pacific countries'? Not only were the essential workers concerned about the impact of COVID-19 on the Pacific community in Aotearoa/NZ, they were also fearful in case the virus reached the Pacific Islands.

During the first national lockdown, all the essential workers expressed relief when the Pacific community was not really affected by COVID-19. However, during the Auckland August lockdown, the essential workers felt the burden of the devastating impact of COVID-19 in South Auckland and its effects on the Pacific community. Their main concern was their knowledge of how Pacific peoples' socio-economic conditions, such as overcrowding and living in multigenerational homes, might enable the spread of the virus, deeply affecting Pacific families. As one essential worker suggested, such conditions would be *a haven for cross infection*.

The essential workers also expressed their anxiety of how Aotearoa New Zealand would find the workforce for the CTCs, because they knew most essential workers look after their elderly parents and have young children. All the essential workers identified the greater stigma attached to the Pacific community during the Auckland August lockdown compared to the national lockdown.

2.1 ESSENTIAL WORKERS' EXPERIENCES OF SETTING UP CTCs AND THE PROCESS OF TRIAGING

2.1.1 Decision Making on the Locations of the CTCs

Key Points Summary:

- Families commented that the accessibility and suitability of CTCs' locations affected their decision making about testing, desiring them to be close to facilities such as toilets, shops, medical practice clinics, and carparks.
- It is recommended that health service providers establish CTCs in convenient locations
- near toilets, shops, medical practice clinics, and carparks.

Some essential workers attended meetings to prepare for the setting up CTCs in South Auckland. They reported that a key criterion was to identify general practices that had a satellite clinic so the patients that normally attended those clinics would still see their GPs in the main clinic and still receive primary care services, and the satellite clinic would convert into a CTC in a public carpark or other appropriate place. The team making the decisions included representatives from the District Health Board (DHB) Primary Health Organisations (PHOs) and Primary Health Care Services (PHCSs) who formed a regional leadership group. For South Auckland, PHCS1 and PHCS2 would host the CTCs at the locations of their PHCSs.

PHCS1 was an ideal place to set up a CTC because the majority of Pacific peoples reside in this area, and its location near a public carpark was favourable. PHCS1 delivers health and social services, and staff also do home visits (an existing service), which is a model of practice working well from a holistic perspective.

PHCS2 was also ideal for the delivery of a CTC and they also ran a mobile service to visit people in their homes during both lockdowns.
The location of the two CTCs at PHCS1 and 2 worked well during the first lockdown. However, during the Auckland August lockdown, the two PHCSs was told by the regional leadership team to swap locations. PHCS1 CTC moved to where PHCS2 CTC had been and vice versa. The essential workers who spoke with us felt that this change in location of the CTCs created some tension between the two PHCSs. They felt that the change involved unnecessary travel from one site to the other and moving equipment to and fro was a big task and time consuming. Most importantly, the essential workers reported that the community were used to the essential workers working in the two CTC stations and they did not appreciate the change of staff. Some families had to travel to the locations where the essential workers they knew worked even though it cost them time and petrol. The essential workers stated that there was a lesson learned from this experience for PHCSs to work together and communicate effectively in future pandemics.

2.1.2 Setting Up CTCs: *Readiness*

Key Points Summary:

- A competent nursing workforce with good swabbing techniques was required to speed up waiting times at the queues.
- Most people attending the CTCs did not know their National Health Index identifiers (NHIs) and this delayed the process.
- It is recommended that the nurses get regular training to maintain their swabbing techniques.

- It is recommended that public health messaging in Pacific languages be promoted on Pacific radios to educate people about their NHIs.

During the national lockdown and with little time to prepare, essential workers used their personal and professional networks to find the workforce and resources needed two days before starting the CTCs. Their employers asked them to organise the CTCs at different locations with little training or experience of a new approach to working with Pacific communities. The essential workers noted that there was no rule book or instructions on how to set up a CTC and were trying to do their best to figure out what was required. What was needed, in particular, was a seamless process for people to move from administration to triaging but also to maintain 'infection control principles' to keep everyone safe. The CTCs required a coordinated community workforce approach involving Pacific and mainstream providers, NGOs, volunteers and paid workers as traffic controllers, security officers, administration people, nurses, doctors and support services.

The preparation involved finding the workforce to work on the 'floor' in the make-shift tents, gathering all key equipment such as hazardous bins and PPE, and working out a triaging process for how people were to be processed through the day. The essential workers felt that selecting the right nursing workforce and administration staff was a priority, with a need to emphasise nursing knowledge; a willingness to be trained in the correct swabbing techniques, adherence to the safety precautions of handwashing, sanitising and wearing PPE correctly; and most importantly, safety measures to keep themselves and their families safe. This training was also provided to the administration staff and to everyone working on the floor, beginning with the traffic control officers as the first point of contact, administration staff, and then health professionals who were conducting clinical assessment and testing.

Most of the frontline workers were nurses. The administration staff, most of whom were volunteers, were considered an important part of the workforce, as they needed to get people's demographic details correctly, their National Health Index identifiers (NHIs: the majority of people did not know their NHIs), chase people up for their correct phone numbers, and ensure that the whole documentation process was accurate. The essential workers felt that trusting and valuing the entire workforce was of the utmost importance, as was acknowledging peoples' contribution to helping out in the CTCs.

One essential worker reported that the DHB had offered to provide nurses for the testing stations to support the essential workers at the CTCs weeks later but it *came so late* because the essential workers had already found staff and started the CTCs as stated:

> *…because it came out so late, we already had our teams and our networks. So, didn't really need to use it … when you're on the front line you need things to happen quickly, you need it now … when you're in leadership and governance some things do take time but frontline, you need to respond now, you need decisions now, you can't really wait for some things, and we just kind of did it ourselves anyway …*

2.1.3 Triaging

Key Points Summary:

- During the first lockdown, the first trial of triaging did not work at PHCS1.
- Some people were not serious about the pandemic as some of them were being observed walking around the tents to have a look.
- Some people came in their cars while others walked in.

- Families emphasised the importance of having a PHCS that provides health and social services support, so that they could refer families to support services when attending CTCs.
- It is recommended that PHCSs that provide health and social services support be used for future pandemics, so that they could refer families to support services when attending CTCs.

Triaging was mainly done by the nurses. During the first lockdown, the essential workers reported that the anxious community started to attend both PHCS1 and PHCS2 CTCs while the teams were still trying to set up the equipment and were yet to have a trial run to trial the triaging process. The essential workers from both PHCSs also noted that some people were walking around the CTCs just to have a look and were not serious about testing. This was an indication that some people were not getting the public health messaging to 'stay home' if they had not had the symptoms of COVID-19. This was an opportunity for both PHCS1 and PHCS2 teams to talk to members of the public about safety measures of hand washing and using sanitisers, staying home in their own bubbles, ringing their GPs or Healthline for instructions if they are sick, and maintaining 2 meters physical distancing. The essential workers reported that most people complied by leaving the CTCs.

At PHCS2 CTC, triaging worked very well and the essential workers put it down as having a competent team who were willing to learn and commit to working long hours and having an effective plan that everyone followed.

The essential workers at PHCS1 experienced some issues at the beginning of the national lockdown. The essential workers at PHCS1 initially applied a CTC approach that was working in an affluent area to their CTC location and found that it was not working. They found that in the affluent area, people drove into the CTCs, and at PHCS1 CTC location, some people drove in and others walked in.

During the first lockdown at PHCS1 CTC, the essential workers had to change the way they served the needs of this community by having two teams. One team was assigned to test those who came in their cars and the other team was to test people who did not have cars. This approach worked well:

> *…we tried to install something from another area which is a different community to [PHCS1 CTC] and we found more people were walking in. In that area, we had a high number of people came in their cars whereas in PHCS1 CTC we found a lot of people walk in.*

In the first two weeks of the first lockdown at PHCS1 CTC, the triaging process did not work as the nursing staff were doing both the administration and the clinical assessments, which lead to staff exhaustion and long queues of people waiting to be seen. As one essential worker said,

> *…it was taking a toll on the staff being exhausted. People were waiting, sometimes we have long queues, they were staying on one spot...The first time we had nurses do the triage and turn people away to get the health history and the second part would be the Admin staff finding out their NHIs and it was back to front. It was turning away people that didn't need to be screened.*

The essential workers changed their triaging approach as described and it worked in this way:

1. A family or person arrives. The administration person registers them to obtain their demographic details, NHIs (and most people do not know their hospital number) and the administration staff had to look them up in the MedTech system. Getting peoples' correct

phone number was important so that they could receive their test results as the results are sent through text messages. The administration people text them during the registration process to confirm the correct phone number.

2. Then the family or person go to the nurse that assessed them. The nurse asked them about their symptoms and give them information sheets about self-isolating and staying home until they are well. The nurses asked: are they essential workers, have they travelled overseas in the last two weeks, do they have close contact with anyone, how many people at their bubble, and were they referred by their Dr, Healthline or self-referral? Explaining the swabbing technique is important to ensure people understand what to expect from the test and to alleviate any anxiety.
3. The family or person then get tested and advised to check their phones for results.
4. A doctor was always available on the floor to do further assessment in case someone was worried about their symptoms or was suspected of having COVID-19 symptoms

At PHCS1 CTC in particular, the triaging process was extended to support people who had told the essential workers that they had lost their jobs and were finding it hard to manage their financial situation. At PHCS1, they have a wellbeing hub, and they give out food parcels and provide mental health and social support services for families. Families attending this CTC were referred to this service as one essential worker explained:

> *… we have a wellbeing hub for support, they give out food parcels and they have a mental health programme so we offer that to people and some people who come talk about how they lost their jobs and so we refer them to the wellbeing hub …*

And another:

> *…we give them a piece of paper which has got the wellbeing hub number, email or if they want to see them straight away we get someone of our team to get them through, and from then on we do the swabbing, and the triage nurse checks if they received the text message. Sometimes we can pick up the wrong number and they say 'oh we didn't get the text message' and we say 'oh sorry'. Accidently we may put in the wrong number and so we really want to make sure people get the results.*

There have always been challenges when working with Pacific people in terms of their correct demographic details and this created more work for the administration staff. Two essential workers stated:

> *…the Admin [staff] had to call the patients … it could be difficult as their phones started to have low batteries or they left their phones at home … when they want the results … or they didn't have a phone. Older people have landlines or they can't remember their mobile number … sometimes it's the language as well, they didn't understand the English. Many of our people didn't have health numbers, they didn't have NHIs...*

> *…At times I relieve staff at the Admin and I find they [people] don't know what an NHI is or we say hospital number and they say what's that. Most of the times we look them up.*

2.1.4 Triaging At The Medical Practice Clinics At PHCS1 And PHCS3

Key Points Summary:

- Essential workers working at the medical practice clinics were not allowed to also help out at the CTCs and vice versa to prevent cross infection.
- Colour coding was used to identify the safe and unsafe areas in the clinic to prevent cross infection.
- The process in the medical practice clinics was more effective in the Auckland August lockdown.
- It is recommended that current practices working well be used in future pandemics.

The essential workers had to change the way they worked with patients in the medical practice clinics at PHCS1 and PHCS3 to prevent cross infection. They had to be very inventive. They used colour coding to separate the clinic consultation rooms into green and red zones. The green zone was a safe zone for people with no symptoms of COVID-19 and wanting to see the doctors or nurses for other health issues. That included someone coming in for a blood pressure check, for all children coming in for their vaccinations, and for the elderly wanting their flu shots. The red zone was for people suspected of having COVID-19 symptoms, and they were sent to a tent or an isolation room or told to stay in their cars. The essential workers had to gown up to protect themselves before assessing everyone, treated everybody as if they had COVID-19. The waiting time was also a challenge as some people were complaining about the delays in getting seen by a doctor or nurse. One essential worker expressed how stressful it was for her during both lockdowns:

> *…To be honest it was really stressful because we didn't know if we were making the right decision, 'do we send people to the red zone or to the green zone', and if they had waited for an hour, the nurses inside the clinic will get all these calls from people waiting and complaining 'why are we waiting here', it was really stressful.*

During the first lockdown, although the essential workers panicked to some degree and were stressed out, the zoning plan worked, and when the second wave hit Auckland they were prepared, *we knew exactly what to do and where to direct people and encouraged them to wear their masks and use the sanitisers.*

An essential worker who works mainly in the medical practice clinic at PHCS1 reported that in any year from March to May, the clinic was always busy with people coming in for their flu vaccinations and other health conditions such as colds, runny nose, and sniffles. But this year there was *hardly anyone coming to the clinic with those symptoms or complaints in the first lockdown.*

What worked well at both medical practice clinics at PHCS1 and PHCS3 was the approach of having people waiting in the cars and the nurses or doctors triaging them there. If people needed to be seen by a GP, the administration staff texted them to come into the clinic; this saved people from having to wait in the clinic and enabled the maintenance of physical distancing.

The essential workers working in the medical practice clinics were not allowed to work at the CTCs to prevent potential cross infection and vice versa for those working at the CTCs. An essential worker working at the medical practice clinic observed that in some medical practice clinics, triaging was done mainly by the doctors, while at the worker's medical practice clinic, triaging was done by both doctors and nurses, and administration staff.

2.1.5 Getting Tested At The CTCs

Key Points Summary:

- Most people wanted to get tested because of the fear of the virus and to protect their families; some were getting tested as their employers told them to do so before they returned to work.
- There were also people who did not want to be tested because of the *fear of finding out the result and the stigma attached to it*.
- It is recommended to support and encourage people to get tested.

Most people wanted to get tested because of the fear of the virus and to ensure the safety of their families. People who went through the queue or were waiting in their cars were all tested at PHCS1 and PHCS2 CTCs, no-one was turned away.

The essential workers reported that when people were asked by their employers or a GP or a family member to go for testing, *some people panicked* and most people went to the community testing stations. The criteria for testing and the messages provided to the public were not clear. Some got the message, *if you have symptoms, come.* During the national lockdown, people were being turned away if they did not have any symptoms, only because there were not enough testing swabs at the time. Many people were still working at supermarkets and saying, *oh we heard and thought we come and get tested.* The essential workers felt that it was most important to make people feel *ok* to come to the testing stations and to tell them it wasn't a waste of time and that staff were appreciative that they had come for a test.

> *We had heaps of people come from everywhere, heaps come from West Auckland, people come from Pukekohe, drive through, we had some from Otara and Mangere*

The essential workers found that some people were surprised that children and babies were also tested because they thought it was for adults only. *They would only come if the children were referred by the doctors for a test.* Some essential workers also felt that there were Pacific people who did not want to be tested because of the *fear of finding out the result and the stigma attached to it*. There were other reasons such as, for those who had lost jobs and were just getting their jobs back, they were told by their employers to get tested before they returned to work.

The nurses had training from senior nurses from the hospital to ensure they were using the proper swabbing techniques and adhered to infection control measures. The essential workers working at both CTCs could not recall if they had picked up a positive case during the first lockdown. They had to make sure that people attending the CTCs and Medical Practice Clinics at PHCS1 and PHCS3 were tested. One essential worker explained:

> *…our community we were just swabbing them if they came through … during the first lockdown we were just making sure there were no cases in the community.*

However, during the second lockdown, they started to pick up positive cases in the community. One positive case was picked up at one of the PHCS1 CTC and this case was a referral from the Auckland Regional Health Authority (ARHA) as part of the surveillance of overseas arrivals. Essential workers working in this particular CTC were anxious to find out who did the swabbing for the positive test due to fear, in case one of them could be infected.

The essential workers spoke about reminding staff taking their first swabs to treat people with respect as people will come with emotions, and they would be scared and may express anger, and to

remember to treat people as they would like to be treated when they [the essential workers] had their first swabs. As one essential worker put it:

> *… tell them it will feel uncomfortable and if you just hold still, breathe through your mouth and afterwards they would say 'oh that wasn't bad.*

Following the swabbing, a courier picked up the swabs and the results were provided through Medtech.

2.1.6 Getting Tested At The Medical Practice Clinics

Key Points Summary:

- Some people refused a test because of the potential impact of a positive test result on their jobs.
- It is recommended that employers support and encourage people to get tested.

People were also tested at the medical practice clinics at PHCS1 and PHCS3. During the national lockdown, an essential worker reported that the limited capacity for testing in Auckland lead to difficulties, because they were getting so inundated with requests for tests. This was improved in the Auckland August lockdown.

An essential worker told the story about someone who refused a test because of the fear of losing his job and the stigma attached to it.

> *'I can't get tested … I just started my job and I might lose it and we need the money'. So, they wouldn't go and get tested because of the fact that if they tested positive, there is a stigma attached to it as they have to go into isolation at (name of hotel), and everybody will know that they were in there and it's going to get out in the community and it's shameful, and the employer will not pay them*

2.1.7 Waiting for Results

Key Points Summary:

- There were concerns over the long waiting times some people experienced in receiving their test results.
- It is recommended there be shorter waiting times for results and improvements in the processes for after 'waiting times.'

The long wait for people to get their results happened with people who had their tests done at both PHCSs CTCs and the medical practice clinics.

The waiting time to get results varied depending on where the specimens were sent to; limited laboratory capacity in Auckland meant that sometimes the tests were sent to Canterbury. The long waiting times created anxiety for people who have not heard back about their test results for weeks.

> *Sometimes it took about 3-5 days to process the results*

When essential workers had extra time, they would go through each person's records from the previous day to make sure they had received the results, just in case the vial was dropped somewhere when it was being delivered to the lab.

Even some health professionals who were also essential workers experienced long waiting times before receiving their results; they found the experience awful. One example was a colleague and family member of one essential worker stating.

> *…my medical colleague had a test and she waited for almost 2-3 weeks … she called up to find out where it was and it was going to Christchurch, she was still at home and couldn't return to work until she gets the test result.*

The same essential worker said that she and her brother had a test on the same day because they were both sick and he was in isolation for two weeks. The brother called the GP practice to follow up his test result as he had not received his results for more than two weeks. The GP practice told him that the laboratory lost his swab. He was anxious and scared. The essential worker said:

> *I did a test for him and took it back in and made sure it went, we checked and got the result that night, it was negative, it was just the anger, the anxiety, it was the fear. He asked, 'how come you got your test and I didn't, and we did it the same day', and he was calling the practice and they felt so bad because they checked it off and they signed it off, and they counted how many swabs they did that day, and that was the right number of swabs, the problem was when it got to the lab, they don't know what happened, they said they lost it.*

The long wait for test results concerned some essential workers, especially for people who did not have enough leave or were losing their incomes while waiting for their results. The essential workers at the medical practice clinics reported that people were telling them about their managers being mean to people and some were being bullied and were asked to provide proof of a negative test before they returned to work. For some people, even if they were sick, they did not want to get a test because they had to take time off and they didn't have any sick leave or annual leave and won't have money to support the family.

The waiting time was frustrating and created anxiety for some people. An essential worker expressed how she felt:

> *Depending on where the testing was done, they say you can test up to 7-10,000 tests safely a day but if it gets sent to Christchurch or Wellington, anything can happen, it can get lost, it can take time to get back. That was the issue as well, the timing of how long it took to get a test and even being informed. Some people said they didn't get a result so they would call the GP and then the GP would say 'you would have to go back to where you got tested as we don't have it on our system.*

2.1.8 Checking Results

Key Points Summary:

- The workforce was inundated with the numbers for processing and checking of the results; this improved once the Medtech system was operating.
- It is recommended that the Medtech system was operating effectively.

In both CTCs and medical practice clinics, a GP and a nurse were assigned to look up the results. During the initial setup, the workforce was inundated with the numbers for processing and checking of the results; this improved once the Medtech system was operating.

GPs can access the results in the system*:*

> *we can access it anywhere in NZ, if it wouldn't come and we couldn't check we would tell them they had to go back to where they got tested. Even that process of being able to ring to get the result if you haven't got it within five days or seven days*

2.1.9 Contact Tracing

Key Points Summary:

- Public Health Services should use Pacific community networks such as churches and Pacific service providers to do the contact tracing.
- It is recommended that Pacific community networks do the contact tracing as they know their community.

Pacific people know how to work and locate Pacific people through community and social networks. Contact tracing was, however, a big issue in the second lockdown. One essential worker felt that the Public Health Services (PHSs) should have used Pacific people to do contact tracing for its own people. He gave an example of how the PHSs called one of their Pacific managers to do contact tracing for a positive case because they could not find the family. The manager used one of her contacts through one of the agencies to get the number to get this family. He called the family and told them the result and then got them into managed isolation. The essential worker reported:

> *That was one example like how our network probably works better than the normal contact tracing. We could probably find people faster. So, and so knows so and so, and messaged so and so, and get the number for so and so, and I will get you the number. I think they have to be mindful, I think when you are dealing with different ethnic groups, not just Pacific, you have to use the networks in place because they would probably get to that person, or they would find out, you know what they're like or you will find the person that you can't find because you haven't got the contact … It's using your ethnic communities.*

The same essential worker emphasised that the church could be another avenue for contact tracing as most people go to church. Using the faife'au (church minister) as a resource as the minister would have the contact of this person or family. Using social media to send a message out and somebody would bound to know this person or family. As said, *I think to do better you have got to take into account who you are dealing with of your communities. That was one thing in terms of the contact tracing that I think could have been done a little bit better with our Pacific people.*

2.1.10 Mobile service and testing stations

Key Points Summary:

- Mobile services and mobile testing stations were effective mechanisms to serve big families in the community.
- It is recommended that mobile testing stations continue as these were effective mechanisms to service big families.

While one health service provider with an existing mobile health service continued to deliver health services to their patients, particularly the elderly and people with chronic health conditions, one other health service provider established a mobile testing station during both lockdowns. Taking the mobile testing stations service to peoples' homes, particularly for the vulnerable and large families, was a model that worked well for Pacific families. Not only was it accessible to the community who may not be able to go to the nearest testing station, it is also cost effective. An essential worker stated:

> *I mean we had one family we went out to … it was a family of nine. For them to come out to test, that's like two trips. So we went, tested everyone, you know parents were so grateful because logistically, it was quite challenging for them, and they didn't have to go out.*

In addition to the home visits, this provider extended their mobile testing station to the managed quarantine facilities to test the guests.

2.1.11 Pop-Up Testing Stations

Key Points Summary:

- Pop-up testing stations were also an effective mechanism to serve the Pacific community, e.g. churches.
- It is recommended that pop-up testing stations park at churches and other community places.

Most CTCs in Auckland were closed down just after the second lockdown and some Pacific health professionals were concerned that they were closed down too early. Some Pacific providers took the initiative to set up their own pop-up testing station for their own patients, *the nurses did it outside, we just had a tent and we were doing about 20-30 plus of our own patients. We felt that we just needed to provide that for them because a lot of them got scared.* Not only were these service providers serving their own patients, they also took the pop-up testing stations to some public places and churches. Some church ministers requested the service to ensure their congregation was safe, *can you come into our churches, can you come into our communities and do the testing … the church leaders were really concerned that people weren't going to get tested because they were so scared.*

2.1.12 Referrals For People To Get Tested At Mobile Testing Stations or CTCs

Key Points Summary:

- Most people got tested voluntarily.
- Referrals for testing were from multiple sources.
- It is recommended that public and community health services refer people to get tested at mobile testing stations or CTCs.

The majority of people were getting tested voluntarily as they were listening to the public health messaging by the Prime Minister and Director General of Health and Pacific/Samoan radios. The essential workers noted that there were referrals from multiple sources.

Most referrals to the mobile testing station team came through from primary care teams, and through the hospital for those people who had COVID-19 symptoms and couldn't make it to a GP or to a testing centre, or because they were vulnerable and it was not safe for them to attend. There

was a strong view that the mobile testing stations should be further tested as a primary care approach to deliver response services for families in the future because *mobile vans had equipment, had medications and obviously medicines could have been dispensed, tests could have been done…* It was suggested that the idea could be developed further to include other health and social services and NGOs, who have a database of vulnerable families who need the mobile service so these families are not left out. However, one essential worker felt that *we didn't have time to test the idea.*

2.1.13 Pacific Peoples' Behaviour At CTCs

Key Points Summary:

- Most people were on their best behaviour complying with public health messaging.
- A few people did not stay in their bubbles.
- It is recommended that people are reminded to stay in their bubbles in future pandemics.

Most people were compliant with the CTC or clinic process and only a few people were non-compliant. As reported in PHCS1, on some days, a group of four or five people come through the CTCs. When the essential workers asked if they were from the same bubble, the group would laugh and said 'No'. They lived in different bubbles and they do not drive. The assigned driver picked up each one at a time and drove to the CTCs. This was an opportunity for the essential workers to educate them with the importance of staying in their own bubbles and maintaining physical distancing. Some essential workers reported that there were a few people who had caused some problems in the CTCs and the medical clinics because they were tired of waiting or being asked to wear their masks and maintain the two meter social distancing in the clinics. This mainly occurred with the younger people and having the security officers on site helped to diffuse the behaviours. Despite this, the essential workers felt that the majority of families were supportive and complied with the testing techniques of swabbing.

2.1.14 Medical Practice Clinics: Transitioning from face-to-face to virtual consultations

Key Points Summary:

- Medical practice clinics had adapted their portal systems to meet the needs of the community.
  It is recommended that medical practice clinics encourage people to use the portal system to book appointments and order prescriptions.

The pandemic changed the way medical practice clinics operated. The essential workers reported that they initially panicked with the sudden national lockdown as they were unsure how to deal with patient consultations. PHCS3 medical practice clinic already had their portal system that people use to email or book appointments while PHCS1 medical practice clinic did not have an online system as they were still using telephones. As explained:

> *The transition was so sudden, so unexpected, somehow we managed … it was really difficult to get our heads around doing virtual consultations and not being able to see people … For all of us, it was a real shock to the system*

The pandemic changed the way clinical consultations were done. It was a new way of working for many clinicians. Some practices did not have any plans:

We had no plan, we didn't know how to do anything. All we had was the phone, no Ipads or nothing like that in place, it was just the phone. We were using the phones and see how we go. The first day was quite messy, sometimes the phones didn't work, people didn't have the right numbers, people still walked in and said 'can we see somebody', and we had to figure out if they were sick or not and if we could assess them on the phone if we get their correct phone number.

The essential workers noted that most older patients still liked to have a face-to-face consultation and had asked their adult children to make their appointments. The practices treated the appointment times as a normal consultation for 15 minutes. *We had the 15 minute slots, and do the phone calls in that time and we still booked in people and we still had to do that.* At other times, the essential workers would assess sick people in their cars and make decisions about whether to send them to the hospital emergency department or not. One essential worker noted that consultations done by Pacific general practices had prevented many hospital admissions for Pacific people …*to be honest, I think we managed to keep a lot of people out of hospital.*

The essential workers were aware that some Pacific people, particularly the elderly, were not IT-literate and found modern telecommunications challenging. Staff noticed that some people would walk into the clinic because they had no phone or they had a phone but didn't have credit in it. It was assumed that everyone had a cell phone, everyone had access to a landline, and everyone had access to technology or Facebook, when the reality is, some people did not have these tools. One essential worker put it this way:

I think we are much better now. I think people are used to it now, 7 or 8 months down the line. But, initially it was really frustrating, it was difficult and it highlighted how important it is to have access to correct contact details, addresses, all those things are so important to have access to healthcare, and that they are getting the message, 'if you are sick call Healthline or call your GP, if your condition is really bad go to the hospital, those messages need to get out there.

2.2 ESSENTIAL WORKERS' EXPERIENCES WORKING AND DEALING WITH PACIFIC FAMILIES

2.2.1 Impact Of The Pandemic On Pacific Families

Key Points Summary:

- The essential workers were affected emotionally, physically, spiritually, and socially because of the impact of COVID-19 on the Pacific community, particularly, during the Auckland August lockdown.
- It is recommended that essential workers be encouraged and supported to seek Employee Assistance Programme (EAP) support and other counselling services.

Pacific essential workers were devastated to hear a lot of sad stories from many families who were being displaced to live with other family members as they could not afford to pay for accommodation. One essential worker summarised what she was told:

…we had families who would move in together, you got families with about 20+ people, and 2 or 3 families living together because they had lost their jobs from the first lockdown, or their hours were cut, or they were made redundant so they had no choice but to move into a three bedroom place with 20 other people, and some people lived in the garages and sleepouts. 'It's a haven for infections'. I think what you saw in the news or the media, it only portrayed what was happening on the surface. When you are face-to-face with families who have nowhere to live, they have no food, they have lost their jobs, it really hit you hard. I think having COVID has highlighted a lot of social determinant issues for Pacific families. It's a real challenge, you have to have a heart and a passion for our people.

The essential workers faced many challenges in both lockdowns trying to support families using a holistic approach. Not only were they dealing with health problems, they were also dealing with many social and mental health issues. The following stories were told by the essential workers:

Story 1. In a family of nine people, one person caught the virus and the whole family had to go into quarantine. *I was trying to manage their anxiety, loss of income, they had no food, and providing food packages and water. There were so many different things that came out. So many different situations that you didn't even hear about it in the media. The impact was huge.*

Story 2. This essential worker had so many mums crying and upset on the phone or in front of him. He had seen young girls who had been suicidal in his presence because of the stuff that had happened, including relationship issues with work, trying to send money back to the Islands, and they were under a lot of pressure and moved out of their homes. *I have had so many of those situations. It's really tough, it kind of takes its toll. It's trying to manage how do you look after these people as best you can and get the help.*

Story 3. The essential workers were aware of a lot of people lived in emergency housing and motels. Many had moved out and waiting for permanent housing. As one essential worker said:

We have never written so many letters to WINZ and Housing NZ and to landlords, basically advocating. Probably the chunk of our job is writing support letters for them. I think in terms of what we set up at [Service provider), is like a hub and it came about because of the COVID. We have got a team of support workers, we have got MSD navigators, we have WINZ navigators, we have a social worker, and we have got the team that support and still do a lot of home deliveries like food parcels and support parcels for families. It came about because there was so much need and people were desperate. Families didn't know where they were going to live as they couldn't afford anything.

2.2.2 Impact of The Pandemic On The Essential Workers

Key Points Summary:

- The essential workers felt the burden of isolating from their families to keep family members safe.
- The essential workers considered the safety of their families and community over and above of their own needs.
- It is recommended that essential workers be encouraged and supported to seek Employee Assistance Programme (EAP) support and other counselling services.

Finding the Pacific workforce to work with the Pacific community in the second lockdown was challenging as many people have pre-existing conditions, making them highly vulnerable should they

catch COVID-19. There was also reluctance from people because of the fear of the virus and for the safety of their families. Two essential workers shared their views:

> *They want to protect their families. I think it was not for themselves, they knew their families were at risk and they tried to protect them as they are either young mums or older grandparents living with them. I think most of them was for the older people, especially what was happening in the world, people were dying, that was huge factor.*
>
> *The first time, it was really stressful and some of the nurses said 'I have young kids at home and I don't want to go there because I don't want to give it to them when I go home.*

The emotional separation, mental and physical fatigue, and not having the physical contact with loved ones took a toll on staff wellbeing as explained:

> *…my family never saw me, I'd be up, out of the house when it was dark, so everyone's asleep … doing long days, 12 hours plus days, for a long time.*
>
> *Keeping* safe *…many of us were scared*

One essential worker expressed how she felt: *It was a bit hard as I live with my sister who is a solo mum with a kid who is one year old and she wants a hug. Sometimes she just sat at my front door and cry and I couldn't kiss her, we just waved through the window and that's how we coped. My sister cooked my meals and left my food at the door and I get it … It has been a big learning, it has been hard, I've grown from the experience and I am also traumatised.*

Another essential worker who is married and have three children told her own story how hard it was for her to live separately from her family over two months:

> *The first lockdown I was a bit scared as I live with my husband's nana who is 89 years old. I lived in the caravan parked at the back of the house. I did it for the safety of the children and nana: I get changed at work and then I went to my mum's house and had a shower, cleaned the bathroom and then I went straight to my van. It was a hard time and I'm tearing thinking about it, for several weeks, about two months, I did that. It was hard but the kids understood … was the best for my family especially when a lot of people were becoming positive. It was scary and I didn't want anyone at home catching it if I was catching it … I had to go to the laundromat to do my washing and I had always been careful. I always wear masks and sanitising thinking about the public just in case I tested positive and I didn't want to spread it to the public. I tried my best not to have a lot of contact with other people, even my mum and my family.*

The frontline workers were tested weekly and then fortnightly and none of the five essential workers interviewed caught the virus. Infection control was emphasised every morning before the CTC opened. PPE was made of plastic and sometimes people got really hot wearing them as they are like insulators. People were sweating and they needed to change often and to make sure they were hydrated, drinking plenty of water. *Some people felt fainted and staff had to rotate standing on the 'floor' during the first lockdown in summer.*

Staff took extra measures and precautions when they went home. Some people lived in caravans while others had to stay in separate rooms away from their families. Some were lucky to have separate entrances and separate showers so they were not in contact with family members. As one essential worker noted:

We go straight to the garage, straight to the shower, straight to the room, stay in the room all the time, trying to maintain the 2 metres distance which was hard for some of us as we live in the same house and we don't have separate kitchen.

I was very particular about coming home … one of the things we kind of taught everyone you must have your process when you go home because you don't want to take COVID inside your house … it had more to do with traffic control staff … They didn't realise they had to actually not wear their clothes and shoes inside their houses, so that was a good learning
… we live in high risk families and big families … when we go home I don't want to take that home to my family … we wear scrubs, cover up masks, shields and at the end of the day we will leave it to get washed … That is how bad it was, working in the frontline but the fear that we can take the virus home. I would feel so bad if I took something home and my family would get sick.

2.3 ESSENTIAL WORKERS' VIEWS AROUND COMMUNICATION

2.3.1 Use simple language for health messaging

Key Points Summary:
- Having simple and clear public health messaging is important.
- It is recommended that public health messaging use simple language so that people understand what is happening and what they are being asked to do.

A coordinated communication approach is critical for getting the correct messages to the Pacific community. The Pacific essential workers considered the 1pm media update by the Prime Minister and the Director General of Health a highly trusted source of COVID-19 information by the Pacific community. Seeing and hearing the message from the same leaders gave reassurance to the community that there was 'hope' that the government cares. This line of communication was powerful and effective and people believe it.

2.3.2 Communication in Pacific Languages

Key Points Summary:
- Pacific essential workers used trusted Pacific media in different languages.
- It is recommended that agencies use trusted Pacific media to promote clear and simple public health messages.

Key messages are really important but understanding how they would be interpreted is even more important. The Pacific community is diverse with different cultural experiences and different languages, so they will have different interpretation of messages particularly when it is delivered in English. The essential workers believed that communication in Pacific language is critical to meet the needs of intergenerational families who speak English as well as a Pacific language at home.

Coordination of correct information particularly at the community level should be delivered by trusted people with the knowledge and expertise to translate and interpret information in Pacific languages. These people could be church ministers whom Pacific people respect and hold in high regard, or people like MPs who are known by the community. There was a concern from one essential worker regarding the misinterpretation of information shared in the community. *I was in some forums where there were non-clinical people representing health saying messages that were different and confusing for the community.*

One perspective about communication was that the public health messages were not clear, 'if you are sick, stay home'. One essential worker said that *was not the message we want to say because there are other reasons why you would be sick, and you need to go and get help for that.* Because the messages were not clear, people who were sick with other underlying health conditions did not seek treatment, and *that's why we were seeing a lot of late presentations because people were literally staying home. And then amputation rates increased, people's CVD became unstable, more MI's and strokes because Pacific people interpret the messages in their own way. And I know people were literally staying home until they were dying, and even not calling an Ambulance as well. And some people didn't realise that their GPs were still opened. I think if we're going to say those big messages 'keep it simple.'*

All the essential workers suggested that establishing a Pacific group to work on translating key messages into different Pacific languages would ensure accuracy of translating reliable medical information.

> *… with translation we just need a group that can be called on really quickly to translate because there was such a long delay. People were more worried about the messages in English and getting that right that really delayed anything being translated. I think for us to be prepared now, we need to know who are the key people in the community that people listen to … then everyone knows that the messages are going to be the correct ones.*

Essential workers also commended the use of Pacific radio stations, such as Samoa radio, which was considered an effective medium for health promotion messages across the Samoan community.

> *The majority of them understood and knew the reasons why they came to the testing and the importance of getting tested. That was one of the important reasons reaching out on the radio in different languages.*
>
> *Mum still listens to Samoa Radio station every morning. A lot of our elderly they listen to the language and that's where they get their information, they love the radio. The young ones are tech-savvy, but a lot of the older ones, you can't assume that they can be accessing some of the stuff with their phones.*

2.4 DISCUSSION, REFLECTIONS, AND RECOMMENDATIONS

The Burden of COVID-19 on Pacific Families

The Pacific essential workers carried the 'burden' of hearing many sad stories from many families who were being displaced to live with other family members as they could not afford to pay for accommodation, people living in overcrowded conditions, people who had lost their jobs or being made redundant, and the list goes on. They said that what was shown in the media was only what was happening on the surface, and people had to hear the stories face-to-face to feel the impact of COVID-19 on Pacific families: *having COVID-19 has highlighted a lot of social determinant issues for Pacific families. It's a real challenge, you have to have a heart and a passion for our people.*

The essential workers reported that the biggest 'burden' that had really affected Pacific families was in relation to mental health. They saw people starting to have mental health issues in the first wave and it became worse as the national lockdown went on and was even worse during the Auckland August lockdown. They observed people who came to the CTCs and medical practice clinics with high level of anxiety, stressed, depressed, and some people were telling them that they started to drink again, and there was also violence in the home. All these social issues had an impact on the kids being stuck at home. An essential worker explained:

> *… you really see it on their faces. I haven't done as much mental health before in my whole career that I have had in the last 6 or 7 months. It's just been incredible, it's just heart breaking to hear their stories, and to hear what they're going through and you don't have the solutions, you can't help them, all you can do is be an ear and help them get through or give them tools to cope what they're going through. You can't solve the problem because it is just so much bigger than what everybody says.*

The Burden of COVID-19 on the Essential Workers

The essential workers carried the 'burden' of 'bringing the virus home' to their families. The essential workers were all placed in a vulnerable position to set up CTCs with no prior experience of such work. The most challenging situation they faced was getting the Pacific workforce to work during the pandemic because some people were hesitant when asked because of the fear of infecting their elderly parents and young children. The essential workers sacrificed their own safety and their families' wellbeing because of their obligation to 'serve' (tautua) their community, this being underpinned by Pacific cultural values of caring and 'alofa' (love). The CTCs required a skilled workforce in preparation for future response. This required an integrated approach of Pacific for Pacific, Pacific health service providers and other organisations working together and sharing resources. All of the essential workers were stressed out, traumatised and exhausted from the pandemic experience, particularly, when they were living separately from their families and had no physical contact with them.

The essential workers also carried the 'burden' of dealing with mental health and social determinant issues for Pacific families such as housing, people losing their jobs or being made redundant, people being displaced to live with extended families as they could not afford to pay for accommodation, paying bills or buying food during the pandemic. In addition, they felt the 'burden' of racism towards the Pacific community during the Auckland August lockdown. Overcrowding was the biggest 'burden' because of the spread of infection. The 'burden' of COVID-19 affecting many Pacific families had added more pressure on the essential workers workload and they felt the 'burden' of not having the capacity to help Pacific families over and above their tautua or service to the community.

Recommendations:

- It is recommended that EAP support should be available, accessible and free for all essential workers during and post pandemic in the future.
- It is recommended that greater centralisation of resources and a database of the workforce and community organisations be established e.g. having a database of the Pacific workforce with different skill sets e.g. Administration people, Social Workers, Counsellors, Nurses, Doctors, Traffic controllers, Security officers, support workers, counsellors, NGOs and community organisations and so forth so that when the plan is activated, everyone is prepared. This plan should include training the workforce, hubs to provide food parcels (some families were overwhelmed with food parcels).
- It is recommended that training be provided for essential workers similar to training for a Civil Defence National Emergency Response so that people are well prepared e.g. CPR, swabbing, emergency procedures, and so forth.
- It is recommended that a coordinated response plan to be activated at community levels be developed and rolled out.

The Burden of Social Determinants Affecting the Pacific Community

Housing is a major issue for Pacific families in relation to social determinants of health; as one health professional described inadequate housing from her experience as a *haven for infections.* The essential workers working in the clinics identified that many Pacific families experience financial difficulties during the pandemic. There was an additional burden on families who could not afford to pay their rent or mortgage and moved in to live with their extended families in overcrowded conditions. The essential workers also identified Social support such as the availability and accessibility of mental health support as critical for Pacific peoples' wellbeing.

Recommendations:

- It is noted that there is already one model of practice that is successfully providing services in different areas e.g. there is a medical practice, with nursing services, navigators, social support, social workers, mental health support, maternity care support, and the location is ideal for CTCs. This practice model appeared to be 'working well' from a holistic approach and should be used as a framework to enhance a response plan for the Pacific Community in the future.

The Burden Felt by the Essential Workers Working at the CTCs and Medical Practice Clinics

All the essential workers were ill-prepared for COVID-19. They did not have the training to set up CTCs and to change the way the medical practice clinics operate. During the Auckland August lockdown, they were confident with the process as they learned from their experience in the first lockdown. The locations of the CTCs were convenient for the community, the mobile services, mobile community testing stations, and pop-up testing stations were effective to reach the community. The PHCSs and medical practice clinics did the best they could. However, from the researchers' perspective, one PHCS stood out as it provides a holistic health service to serve the needs of the Pacific community, and this PHCS needs to be considered as a hub for future pandemic preparation and planning.

Recommendations:

Although the CTCs were working well, some improvements were needed to enhance family experiences for future pandemics:

- It is recommended to work to reduce the long queues of people waiting to be tested - it is suggested that traffic controllers and security officers check on families waiting in queues to ensure that the older people and children are prioritised and seen first. And also those who do not need testing are triaged out.
- It is suggested that the clinical leader 'walk the line' and triage families according to needs.
- It is suggested that bottles of water can be offered while cars or people are waiting for their tests.
- It is recommended that waiting times for results need to be reduced and processes improved and clarified for people.

The Burden of Communication Breakdown

Public health messaging should be simple, clear, and promoted in Pacific languages on Pacific radio, and translated by qualified translators. Asking questions in English could be problematic and culturally insensitive from a Pacific perspective. As part of triaging, staff needed to ask families about their circumstances during the assessment process to give them an insight of the kind of support to offer families. One of the questions in one of the forms developed by the Regional Public Health Service was considered inappropriate. It asked:

> ***…do you live in vulnerable communities?***' *We did not ask our families that question, we reworded the question as our families would be offended if we asked that question … our Pacific workers didn't feel comfortable, we didn't have to say it out loud. We asked 'how many people live with you and your family?'; 'are you and your family doing ok during the lockdown?'; 'do you need any support?' and from there our families would say 'oh what kind of support?' and that is when we offer food parcels ... Sometimes the kind of support was to talk to some elderly people like I remember a Papa had come through and his wife was in a rest home and he was a feeling a bit down as he hasn't seen her and had come for a swab. He had a little cry and after that and said thank you.*

The essential workers had suggested the following:

- Simple and clear key messages and information should come from trusted sources and the same message should be sent across all the levels. Consistency is necessary but so also is mana – e.g. MoH
- Families wanted one 'hub' – one Pacific hub for all information, the same information guided by MoH, in Samoan, Tongan, English and other languages. One channel of communication that everyone knows and hears.
- It was suggested that the Jacinda/Ashley 1pm update was powerful and that this could be followed up on Facebook, Pacific/Samoan radio etc, in all languages and with the same messages.
- Essential workers wanted more Pacific trained staff (nurses, admin, doctors, social workers); these must include range of language speakers. (e.g. no interpreters were available in MIQ)
- Essential workers wanted educational messages of change behaviours and beliefs through breaking barriers of stigma and shame, *It is the virus not the people.*
- Essential workers wanted to work with the media to lead on stigma reduction as it concerns Pacific people.

The Burden of Technology for Families Unable to Afford it

Not everyone has access to internet or the costs of internet is a barrier for most Pacific families, particularly, the older generation. The essential workers were concerned that the older generation

who are not IT literate or those without technology/wifi/devices could have implications of e-consult if there is another pandemic.

Recommendations:

- It is recommended that there should be multiple communication channel for different communities e.g. radio might be for older people, Facebook for younger people.

REFERENCES

Pacific COVID-19 Response Improvement Framework (the Framework, MoH, 2019).

Vaioleti, T.M. (2006). Talanoa research methodology: a developing position on Pacific Research. *Waikato Journal of Education (12), 22-34.*

Health Research Council. (2014). *Pacific Health Research Council Guideline*s. Auckland: Health Research Council of New Zealand.