



Article

Service Uptake Challenges Experienced by Pasifika Communities during COVID-19 Lockdowns in New Zealand

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Abstract: Background: New Zealand was one of the first countries to adopt an elimination strategy based on a four-tier Alert Level system that included strict lockdowns at levels three and four. The lockdowns meant shutting out external social networks and being confining to individual household 'bubbles' only. This presented challenges for minority Pasifika communities in New Zealand as their cultural values are based on social bonding, interconnectedness, community engagement and caring for each other. The aim of this research was to conduct a small-scale pilot study to test and refine the study design and identify the major challenges faced by Pasifika communities in relation to accessing health, social and mental services while in lockdown. Methods: This exploratory study was designed using an online anonymous questionnaire survey targeting people who identified as Pasifika. A total of eighty-seven respondents were included in our analyses following the questionnaire survey. Results: Five main barriers to accessing health, social and mental health services during lockdowns were identified; (1) unavailability of or limited services; (2) fear of contracting the virus; (3) perception of high costs associated with seeking medical assistance; (4) transportation difficulties; and (5) lack of time. Almost a quarter of the respondents reported losing their jobs, 80% indicated a decline in their household income and more than half experienced some form of psychosocial distress while in lockdown. Conclusions: The findings of this research highlight existing challenges faced by Pasifika communities in adequately accessing essential services. Future research can focus on the key barriers to access identified in this research to gain a deeper understanding of services and its interaction with Pasifika communities during lockdowns.

Keywords: Pasifika community; COVID-19; New Zealand; lockdown; challenges; health services



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1. Introduction

The World Health Organisation declared the COVID-19 outbreak a global public health emergency on 30 January 2020 [1]. As of February 2023, there have been approximately 672 million cases and just under seven million deaths globally due to the pandemic [2]. In this period, New Zealand has recorded over two million cases and approximately 2500 COVID-related deaths [2]. Countries across the world adopted different measures and strategies to battle the COVID-19 virus, many of which were highly restrictive [1]. These measures included self-isolation or national lockdowns and quarantines, social and physical distancing, mandatory vaccination, travel and border restrictions, use of personal protective equipment (such as masks), employing preventive hygiene behaviours (e.g., handwashing with soap or sanitizer) and the use of contact tracing apps to report close contacts. The global impact of the pandemic was not limited to its immediate health effects. It had far-reaching consequences on the world economy [1]. The measures implemented to mitigate the spread of the virus, such as travel bans, border closures and

quarantines, created significant disruptions in the supply chains and the demand for goods and services. The long and widespread break in trade and free movement around the world meant that many local, national and international businesses and government services could not deliver products and services at all or in a timely manner. The flow-on effect for some businesses was to close. Countries who were reliant on outside suppliers for primary goods and services faced unprecedented wait times, causing loss of income and jobs.

The first New Zealand case of COVID-19 was confirmed on 26 February 2020, and on 26 March 2020, the country had moved into a strict nationwide lockdown, which was defined as Alert Level four [3]. It had from the outset the end goal of elimination. This was later replaced with a minimisation strategy once community transmission rates were considered manageable. Mitigation measures implemented during the peak of the pandemic included border control and closure, self-isolation, restricted social gatherings and social distancing at Alert levels one and two [4]. The majority of the nation united in its support of the government's decision to go into lockdown for the greater good of all [5]. New Zealand was one of the first countries to adopt a stringent elimination strategy based on a four-tier Alert Level system that was reinforced by the government's 'Go Hard, Go Early' message [4]. Alert level 1 allowed businesses, schools, workplaces, churches, sports centres, public transport, etc., to be open or operate but COVID-19 Tracer QR codes had to be displayed so that everyone's movements could be traced should a case test positive and community contacts had to be notified. At this level, there were no restrictions on the number of people at social gatherings and no restrictions on movement across the county, but mask wearing on planes and public transport was mandatory for people 12 years and older unless they had a diagnosed mental health condition or disability. The assumption in alert level 1 was that the disease is contained. Alert level 2 applied where the government believed there to be a low risk of community transmission. At this level, social movement was allowed with gatherings of up to 100 people only. Physical distancing, contact tracing and mask wearing were mandatory. In Alert level 3, restrictions on movement were intensified. People were strongly advised to remain and work from home in exclusive 'bubbles' but some businesses could open for trade and contactless trading services were recommended. Mandatory mask wearing and social distancing applied. Gatherings of only 10 people were allowed and restrictions were in place on how many staff could work in person in any workplace. The 'bubbles' were made up of family or friends who were living together or were in constant close contact with each other. Alert level 4 was the most restrictive level. In this level, the area is declared to be in lockdown. This meant that all people were to remain and work from home in their bubble/s. This meant no gatherings were allowed, mask wearing was mandatory, all supplies were rationed and only essential services (such as approved food stores, hospitals, pharmacies, petrol stations, and other approved services or businesses) operated. However, the lockdown meant that the masses were required to remain in small household 'bubbles', giving up on their liberty of freedom to some extent. This has contributed to negative health, social and mental health outcomes arising from an extended period of isolation in lockdowns [6–8].

The COVID-19 pandemic has presented unique challenges at health, political, socio-economic and community levels. Lockdowns have contributed to an increase in perceived levels of loneliness, which pose a myriad of public health risks [9]. In addition, patients with pre-existing anxiety disorders have reported heightened concern for the future and increased difficulty in managing anxiety with restrictions implemented [10]. The effects of lockdowns have not discriminated by age either, as young adults exhibited increased loneliness and reduced social support during the pandemic [11,12]. Furthermore, there is evidence to suggest that frustration emanating from adjusting to the initial period and length of lockdowns had a negative effective on domestic violence abuse and mental health [6,13]. Vulnerable and marginalised groups have been hit the hardest and research from the UK suggest that Black, Asian and minority groups, together with those experiencing socioeconomic deprivation and health disorders, reported higher thoughts of self-harm/suicide [14]. This demonstrates that lockdowns during pandemics and crises

give rise to a multitude of anticipated challenges such as economic hardships, mental health impacts, social isolation, domestic violence concerns, among others. The resulting educational and social inequalities emphasise the importance of considering the broader social and economic impacts beyond just disease containment.

Pasifika communities represent approximately 10% of the New Zealand demographic [15]. 'Pasifika' is the term used throughout this article when referring to people of Pacific Islands ethnicities. Inequalities resulting from high unemployment rates, fewer economic resources and lower-than-average income levels have led to poor health outcomes and poor access to healthcare [16]. There were concerns that Pacific community views were overlooked in the initial COVID-19 response planning [17]. Social bonds, interconnectedness and community relationships are the fundamental cultural values that underpins Pasifika people's way of helping each other in times of crisis. These were leveraged in the Pacific response to the pandemic [18]. However, lockdowns worked against this very ethos as Pasifika communities follow a collective perspective and may belong to more than one household [17,19]. Despite the challenges, Pacific health service providers united in mobilising their resources to reach Pasifika communities during the pandemic, but it is important to learn what worked and what did not and how it influenced health outcomes [20].

Given the existing inequalities, it was timely to gain a better understanding of the major barriers that hindered access to essential health, social and mental health services in Pasifika communities during the COVID-19 pandemic. Research in New Zealand suggests that people delayed seeking healthcare [21] and the loss of autonomy impacted individual wellbeing during the lockdown [19]. The aim of this research was to conduct a small-scale pilot study to test and refine the research methods, procedures and data collection techniques to inform the development of a large-scale future research study. We were also interested in establishing the key drivers that hindered service-seeking behaviour specifically among Pasifika communities in New Zealand.

2. Materials and Methods

This exploratory study was designed using an ad hoc online anonymous questionnaire survey. The questionnaire was developed with the consensus of the research team who identified four domains of interest as a focus of the survey (Table 1). The aim of the survey was to collect data to identify the major challenges faced by Pasifika communities with respect to access to essential services during COVID-19 lockdowns in New Zealand. In addition, this study would help inform methodological considerations for a future large-scale study.

2.1. Participants

The inclusion criteria were that participants needed to be of Pasifika descent. This research was open to all genders, age groups, occupations and locations of potential participants. Convenience sampling was used to recruit the participants. The survey was advertised through email contacts via established Pacific community networks. Ethical information was delivered at the beginning of the questionnaire and respondents were requested to indicate their consent to participate before continuing with the survey. The English language survey completed through a Qualtrics link took approximately 10–15 min to complete. At the end of the questionnaire, participants were included into a draw to win one of ten NZD50 vouchers (supermarket or petrol). Ethical approval to conduct this research was granted by the University of Auckland Human Participants Ethics Committee (reference #: 024697).

2.2. Measures

Participants reported demographic characteristics such as age, gender, ethnicity and place of residence. Items were included to capture responses from participants about their personal experiences during the COVID-19 pandemic in New Zealand in four domains that included (1) barriers to services; (2) employment disruptions; (3) psychosocial impacts; and

(4) lockdown preparedness (Table 1). The domains included items that were highlighted in the literature as drivers of barriers to seeking health, social and mental health services. The domains were represented by 22 multi-choice or multi-point Likert-scale items to capture quantitative responses from participants about their personal understanding and experiences they felt most, and their health needs based on their real-life experiences during the COVID-19 pandemic in New Zealand

Table 1. Summary of survey domain items.

Domain	Item	Response Options
Barriers to services	What barriers to accessing health/social/mental services did you face during lockdown levels 3 and 4 (tick all that apply)?	<ol style="list-style-type: none"> 1. Services were unavailable or limited during lockdown, 2. Cost of services, 3. Lack of childcare (to supervise my children at home), 4. Fear of getting COVID-19 from the community, 5. Lack of transport, 6. Cost of transport, 7. Mobility difficulties (e.g., disabled), 8. Lack of time, 9. Other (please specify), 10. (No barriers)
Employment	Have you lost your job due to the lockdown?	<ol style="list-style-type: none"> 1. Yes 2. No
	Household income:	<ol style="list-style-type: none"> 1. Reduced a lot, 2. Reduced a little, 3. Didn't change, 4. Don't know—I haven't received any feedback, 5. Other ([please specify]);
Psychosocial impacts	Do you think that the pandemic has had mental health and social impacts? (<i>depression, anxiety, loneliness, suicide, family violence</i>).	<ol style="list-style-type: none"> 1. Harmful, 2. None, 3. Don't know—I haven't received any feedback
Preparedness	Were you and your whanau (family) prepared for the COVID-19 lockdowns?	<ol style="list-style-type: none"> 1. Yes 2. No

2.3. Analysis

Descriptive statistics were generated in IBM SPSS Statistics for Windows version 27.0 (IBM Corp., Armonk, NY, USA) to report the data frequencies and percentages related to the survey domains.

3. Results

3.1. Participant Characteristics

A total of eighty-seven respondents were included for analyses, of which 68% were females. A total of 17 respondents started the survey but did not complete it and as such were omitted from the final analyses. The average age was 39 years (range: 20–68) and about 70% of respondents identified as Samoan (49%) or Tongan (22%) ethnicities. Between two and nine percent of the participants identified as either Cook Island Māori, Niuean, Tokelauan, Tuvaluan, Ni Vanuatu or Fijian. Furthermore, half were from Auckland, with most respondents residing in South Auckland (74%). According to the 2018 New Zealand Census, there were 381,642 people who identify as Pasifika [15]. This was composed of an approximately equal male to female ratio and a median age of 23.4 years. The largest sub-ethnic group was Samoan (48%), followed by Tongan and Cook Island Māori at

approximately 20%. All other Pasifika ethnic groups were composed of numbers less than 8% and 64% of all Pasifika people who live in Auckland.

3.2. Access Barriers to Services

The three main barriers to accessing health services during COVID-19 lockdowns were reported to be (1) unavailability of or limited services (58%); (2) fear of contracting the virus at health facilities (54%); and (3) perception of high costs associated with seeking medical assistance (26%). It was found that 14% of respondents reported no barriers to accessing health services (Figure 1).

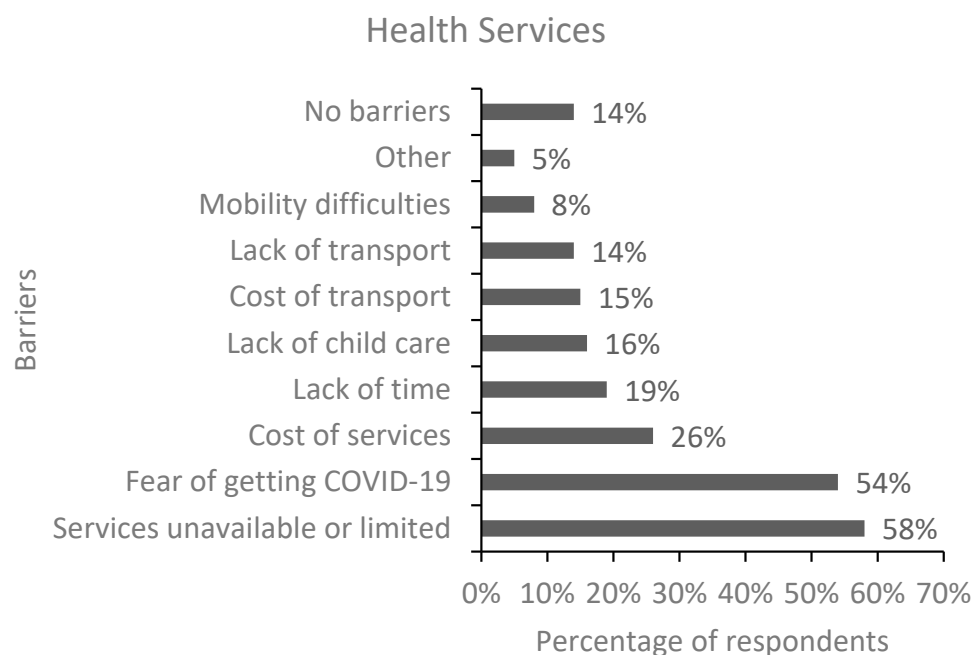


Figure 1. Barriers accessing health services during lockdown levels three and four.

The three main barriers to accessing social services during COVID-19 lockdowns were reported to be (1) unavailability of or limited services (46%); (2) fear of contracting the virus (38%); and (3) transportation difficulties and lack of time (14%). It was found that 24% of respondents reported no barriers to accessing health services (Figure 2).

The three main barriers to accessing mental health services during COVID-19 lockdowns were reported to be (1) fear of contracting the virus (30%); (2) unavailability of or limited services (27%); and (3) lack of time (18%). Interestingly, a high percentage (34%) of respondents reported no barriers to accessing mental health services (Figure 3).

3.3. Employment Issues Faced by Respondents during Lockdowns

There were 23% of participants who reported to have lost their jobs during the lockdown and 44% reported that their employment status was unaffected. Factors that would improve employment were reported to be (1) more financial help from the government, (27%); (2) taking up a job in a new field (21%); and (3) better employment-related policies (15%). In addition, approximately 80% of the respondents reported a decrease in their household income during the pandemic; decreased a lot (62%); and decreased a little (19%). With regard to challenges experienced due to employment disruptions, the participants reported (1) embarrassment seeking financial assistance (70%); (2) lack of awareness of the financial assistance available (65%); and (3) being afraid to ask for financial assistance as they did not know their rights (64%).

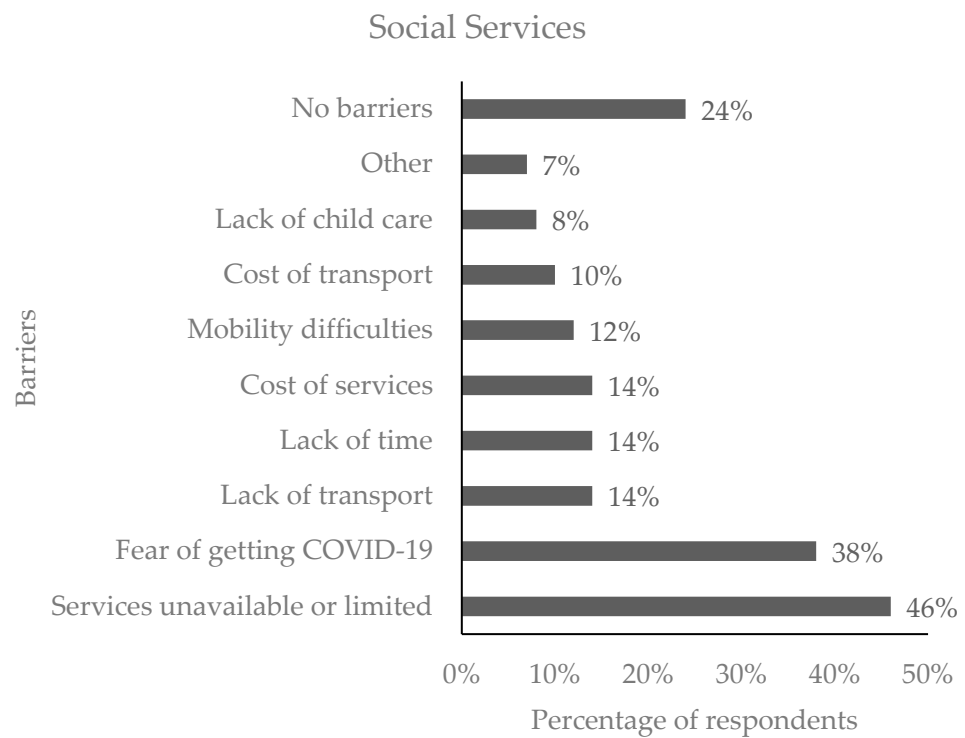


Figure 2. Barriers accessing social services during lockdown levels three and four.

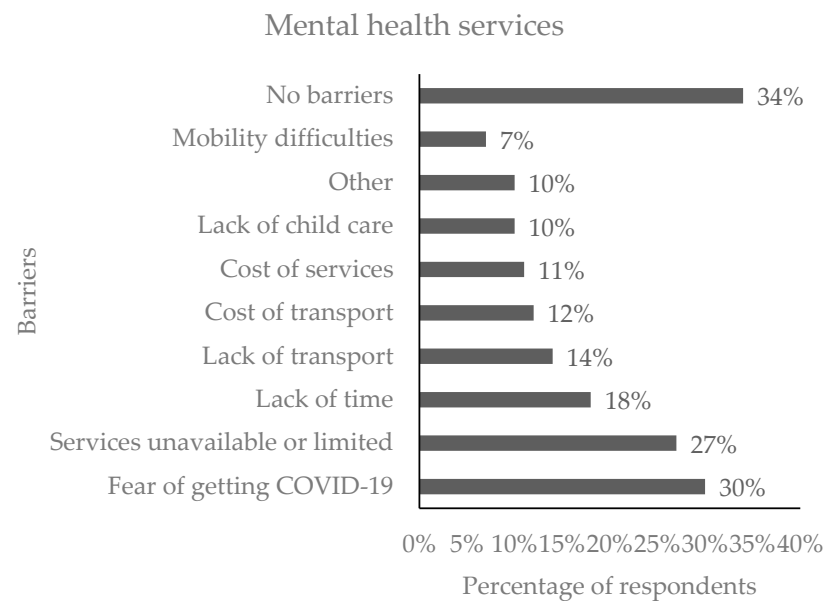


Figure 3. Barriers accessing mental health services during lockdown levels three and four.

3.4. Psychosocial Wellbeing and Preparedness

More than half the respondents (Table 2) reported experiencing psychosocial challenges during the pandemic. Most thought that there were harmful effects on anxiety (67%); loneliness (61%); depression (57%); family violence (52%); and having suicidal tendencies (43%). Nearly half (48.4%) of respondents reported that they and their family were unprepared. The most common priority that was reported to be poorly planned was having sufficient food stored (76%); adequate financial resources (62%); and medication (52%). The most common source of help for participants reported were family, relatives and friends (62.3%); the Ministry of Health (31.1%); and non-governmental organisations (26%).

Table 2. Mental health and social impacts.

Impact	Response (<i>n</i> = 87)	
	<i>n</i>	%
Depression	38	56.7
Anxiety	45	67.2
Loneliness	41	61.2
Suicide	29	43.3
Family violence	35	52.2

4. Discussion

The five main barriers to accessing health, social and mental health services during lockdowns were (1) unavailability of or limited services; (2) fear of contracting the virus; (3) perception of high costs associated with seeking medical assistance; (4) transportation difficulties; and (5) lack of time. These barriers were consistently highlighted by the respondents across each of the service delivery options. Almost a quarter of the respondents reported losing their jobs, 80% indicated a decline in their household income and more than half experienced some form of psychosocial distress while in lockdown.

Unavailable or limited services was a common challenge as the pandemic forced a reset of priorities that included the postponement of elective surgeries, chronic disease diagnostics and non-urgent medical care [22]. This is understandable given the significant surge in infections and deaths. The World Health Organisation reported disruptions to essential health services in 90% of the countries mainly due to workforce and financial challenges [23]. The services that were most frequently disrupted were routine immunization, noncommunicable disease (NCD) diagnosis and treatment, family planning and contraception, treatment for mental health disorders, antenatal care and cancer diagnosis and treatment. At New Zealand's Auckland City Hospital, surgical admissions decreased by 29% and surgeries reduced by 44% during the lockdown [24]. Access to services was further exacerbated by unclear messages and the lack of information around what was available and if people were allowed to leave their homes [19,21,25,26].

Fear of contracting the virus when presenting at healthcare facilities, perception of high costs, and transport and time constraints may have contributed to the delayed diagnosis and treatment of underlying conditions in Pasifika communities. It is unclear if the delayed treatment has discouraged the community to seek healthcare assistance post-COVID-19 lockdowns. It has been suggested that the loss of patient–clinician interaction, the discontinuity of treatment, postponed follow-ups and its influence on the uptake of health services need further investigation [22]. Interestingly, a survey of 1010 people in New Zealand found that 86% of the respondents had contact with general practice services but over half reported delaying seeking healthcare at levels three and four lockdowns [21]. The high engagement with health services in this study is contrary to our findings but it must be noted that this study comprised only 2% of participants who identified as Pasifika ethnicity. However, this research highlighted health services as being busy; services being postponed, delayed or not available; and a fear of being infected with COVID-19 as the most common reasons for delayed healthcare assistance, which support our findings.

As discussed above, the lack of information about services available appears to be a key factor in the uptake of services. This can be highlighted by our finding that the perceived high cost of healthcare discouraged people from accessing services. It is important to highlight that tertiary healthcare is provided free of charge to New Zealand residents and citizens through the public health system, and General Practitioner (GP) services are subsidised by the government, especially for individuals with low income. In addition, Community Services Cards were available for people on low-income to receive subsidies on health appointments and low-cost medical prescriptions [26]. The government also introduced social initiatives such as hardship assistance, food grants and wage subsidies. These initiatives would have assisted those respondents who reported job losses and

declines in household income, if only they were aware of it. Although public health services are free and general healthcare is subsidised, Pasifika families faced challenges in the uptake of health services even prior to the pandemic [27]. The findings also highlighted that Pasifika communities look to their family members for assistance and were embarrassed or afraid to seek available social and financial assistance.

A concerning finding of this research was the relatively high percentage of respondents reporting psychosocial distress during the lockdowns (Table 2). However, this is not uncommon, as existing research have associated the erosion of social interaction [6,8,14,17,19,26] and employment-related risk factors [7] with negative mental health outcomes during the lockdowns. There is evidence to suggest that people who were employed during the pandemic experienced less mental health distress, higher psychosocial wellbeing, better quality of life and lower levels of overall loneliness than those who were unemployed [28,29]. In addition, the lockdowns were particularly difficult for those who lost their loved ones during this period as there were restrictions on funeral services. Pasifika communities could not organise family gatherings to observe deep-rooted cultural traditions. These challenges imposed by lockdowns have been shown to have negative mental and social outcomes on people dealing with the loss of their family members [30]. On the other hand, 34% of the respondents in our research reported no barriers to accessing mental health services. It could be that these respondents did not need mental health services, or the service providers were effective in assisting people. Regardless, it is essential to further investigate what worked and what did not for Pasifika communities in terms of access to these essential services.

This exploratory research focusses on descriptive analyses and did not aim to draw conclusions based on inferential statistics for the association between variables. The non-probability convenience sampling technique of this research could have introduced sampling bias, leading to skewed or unrepresentative results. These limitations do not allow us to make generalisations about the subgroups within the Pasifika demographic such as age, gender and employment status and their associations with service access barriers. In addition, the survey was not appropriate for potential participants with limited English proficiency and digital literacy. However, the aim of this research was to first establish the key factors that would inform the development of future targeted in-depth research that aim to minimise or eliminate service access barriers for Pasifika communities. Future research should include representative sampling methods such as cluster and stratified sampling techniques to accurately reflect the characteristics and diversity of the Pasifika community.

Future research can be strengthened by using service accessibility theoretical frameworks to guide the study design. One such approach would be to incorporate Levesque's Conceptual Framework of Access to Health, which postulates five dimensions of access and the five abilities of the population to access healthcare [31] as interrelated supply and demand determinants. This framework is designed to provide a comprehensive perspective on access by considering various dimensions and determinants that can influence an individual's ability to obtain needed healthcare services. Access to services is represented by approachability; acceptability; availability and accommodation; affordability; and appropriateness. The ability to access services is characterised by the ability to perceive; ability to seek; ability to reach; ability to pay; and ability to engage. Our findings mainly correspond to three dimensions: availability, accessibility and affordability. The dimensions of accommodation and acceptability that examine the needs of diverse demographics and cultural and social preferences would offer deeper insights into service access. Future research can focus on the key barriers to access identified in this research underpinned by theoretical frameworks to gain a deeper understanding of services and their interaction with Pasifika communities during lockdowns.

5. Conclusions

The aim of this exploratory research was to conduct a small-scale pilot study to test and refine the study design and identify the major challenges faced by Pasifika communities in

relation to accessing health, social and mental services. We identified five key challenges that relate to the delivery of services and ability to access services. Given that our research identified key areas of focus, a larger representative and stratified sample would help gain richer information on the strengths and gaps in service provision and community engagement. This could inform policies and response strategies to promote health, social and mental health outcomes during times of crises for Pasifika communities.

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Informed Consent Statement: Written informed consent was not required. Participants involved in the study read the information sheet and proceeded to participate in the online anonymous survey.

Data Availability Statement: The data presented in this study are reported in the results.

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Conflicts of Interest: The authors declare no conflict of interest.

References

1. Sohrabi, C.; Alsafi, Z.; O'Neill, N.; Khan, M.; Kerwan, A.; Al-Jabir, A.; Iosifidis, C.; Agha, R. World Health Organization declares global emergency: A review of the 2019 novel coronavirus (COVID-19). *Int. J. Surg.* **2020**, *76*, 71–76. [CrossRef] [PubMed]
2. Coronavirus Resource Center Johns Hopkins University. COVID-19 Dashboard. 2023. Available online: <https://coronavirus.jhu.edu/> (accessed on 9 February 2023).
3. Baker, M.G.; Wilson, N.; Anglemeyer, A. Successful Elimination of COVID-19 Transmission in New Zealand. *N. Engl. J. Med.* **2020**, *383*, e56. [CrossRef] [PubMed]
4. Jamieson, T. “Go Hard, Go Early”: Preliminary Lessons From New Zealand’s Response to COVID-19. *Am. Rev. Public Adm.* **2020**, *50*, 598–605. [CrossRef]
5. Coughlan, T. Coronavirus: The Government’s COVID-19 lockdown measures have overwhelming public support, according to a poll. In *Stuff*; Wellington, New Zealand, 2020. Available online: <https://www.stuff.co.nz/national/121231591/coronavirus-the-governments-covid19-lockdown-measures-have-overwhelming-public-support-according-to-a-poll> (accessed on 9 February 2023).
6. Sibley, C.G.; Greaves, L.M.; Satherley, N.; Wilson, M.S.; Overall, N.C.; Lee, C.H.J.; Milojev, P.; Bulbulia, J.; Osborne, D.; Milfont, T.L.; et al. Effects of the COVID-19 pandemic and nationwide lockdown on trust, attitudes toward government, and well-being. *Am. Psychol.* **2020**, *75*, 618–630. [CrossRef] [PubMed]
7. Wickens, C.M.; Hamilton, H.A.; Elton-Marshall, T.; Nigatu, Y.T.; Jankowicz, D.; Wells, S. Household- and employment-related risk factors for depressive symptoms during the COVID-19 pandemic. *Can. J. Public Health* **2021**, *112*, 391–399. [CrossRef] [PubMed]
8. Cheng, Z.; Mendolia, S.; Paloyo, A.R.; Savage, D.A.; Tani, M. Working parents, financial insecurity, and childcare: Mental health in the time of COVID-19 in the UK. *Rev. Econ. Househ.* **2021**, *19*, 123–144. [CrossRef] [PubMed]
9. Bu, F.; Steptoe, A.; Fancourt, D. Loneliness during a strict lockdown: Trajectories and predictors during the COVID-19 pandemic in 38,217 United Kingdom adults. *Soc. Sci. Med.* **2020**, *265*, 113521. [CrossRef]
10. Hennigan, K.; McGovern, M.; Plunkett, R.; Costello, S.; McDonald, C.; Hallahan, B. A longitudinal evaluation of the impact of the COVID-19 pandemic on patients with pre-existing anxiety disorders. *Ir. J. Psychol. Med.* **2021**, *38*, 258–265. [CrossRef]
11. Lee, C.M.; Cadigan, J.M.; Rhew, I.C. Increases in Loneliness Among Young Adults During the COVID-19 Pandemic and Association With Increases in Mental Health Problems. *J. Adolesc. Health* **2020**, *67*, 714–717. [CrossRef]
12. Lisitsa, E.; Benjamin, K.S.; Chun, S.K.; Skalisky, J.; Hammond, L.E.; Mezulis, A.H. Loneliness among young adults during COVID-19 pandemic: The mediational roles of social media use and social support seeking. *J. Soc. Clin. Psychol.* **2020**, *39*, 708–726. [CrossRef]
13. Henke, A.; Hsu, L. COVID-19 and Domestic Violence: Economics or Isolation? *J. Fam. Econ. Issues* **2022**, *43*, 296–309. [CrossRef] [PubMed]
14. Iob, E.; Steptoe, A.; Fancourt, D. Abuse, self-harm and suicidal ideation in the UK during the COVID-19 pandemic. *Br. J. Psychiatry* **2020**, *217*, 543–546. [CrossRef] [PubMed]

15. Statistics New Zealand. Census Population and Dwelling Counts 2019. 2019. Available online: <https://www.stats.govt.nz/information-releases/2018-census-population-and-dwelling-counts> (accessed on 10 February 2023).
16. Southwick, M.; Kenealy, T.; Ryan, D. *Primary Care for Pacific People: A Pacific and Health Systems Approach: Report to the Health Research Council and the Ministry of Health*; Pacific Perspectives: Wellington, New Zealand, 2012.
17. Ioane, J.; Percival, T.; Laban, W.; Lambie, I. All-of-community by all-of-government: Reaching Pacific people in Aotearoa New Zealand during the COVID-19 pandemic. *N. Z. Med. J.* **2021**, *134*, 96–103. [[PubMed](#)]
18. Hill, P.; Vaisola-Sefo, L.; Ryan, D.; Percival, T. Why We Should Adopt a Village Model COVID-19 Response: University of Otago. Ideasroom 2021. Available online: <https://www.newsroom.co.nz/ideasroom/why-we-should-adopt-a-village-model-COVID-19-response> (accessed on 10 February 2023).
19. Officer, T.N.; Imlach, F.; McKinlay, E.; Kennedy, J.; Pledger, M.; Russell, L.; Churchward, M.; Cumming, J.; McBride-Henry, K. COVID-19 Pandemic Lockdown and Wellbeing: Experiences from Aotearoa New Zealand in 2020. *Int. J. Environ. Res. Public Health* **2022**, *19*, 2269. [[CrossRef](#)] [[PubMed](#)]
20. Perrott, A. The Rise and Rise of Pacific Healthcare—New Zealand Doctor: Rata Aotearoa. 2021. Available online: <https://www.nzdoctor.co.nz/article/rise-and-rise-pacific-healthcare> (accessed on 10 February 2023).
21. Imlach, F.; McKinlay, E.; Kennedy, J.; Pledger, M.; Middleton, L.; Cumming, J.; McBride-Henry, K. Seeking Healthcare During Lockdown: Challenges, Opportunities and Lessons for the Future. *Int. J. Health Policy Manag.* **2022**, *11*, 1316–1324. [[CrossRef](#)] [[PubMed](#)]
22. Sabetkish, N.; Rahmani, A. The overall impact of COVID-19 on healthcare during the pandemic: A multidisciplinary point of view. *Health Sci. Rep.* **2021**, *4*, e386. [[CrossRef](#)]
23. World Health Organization. *Second Round of the National Pulse Survey on Continuity of Essential Health Services during the COVID-19 Pandemic*; January–March 2021: Interim Report, 22 April 2021; World Health Organization: Geneva, Switzerland, 2021.
24. McGuinness, M.J.; Hsee, L. Impact of the COVID-19 national lockdown on emergency general surgery: Auckland City Hospital's experience. *ANZ J. Surg.* **2020**, *90*, 2254–2258. [[CrossRef](#)]
25. Blake, D.; Thompson, J.; Chamberlain, K.; McGuigan, K. Accessing primary healthcare during COVID-19: Health messaging during lockdown. *Kōtuitui N. Z. J. Soc. Sci. Online* **2022**, *17*, 101–115. [[CrossRef](#)]
26. Choi, K.; Giridharan, N.; Cartmell, A.; Lum, D.; Signal, L.; Puloka, V.; Crossin, R.; Gray, L.; Davies, C.; Baker, M.; et al. Life during lockdown: A qualitative study of low-income New Zealanders' experience during the COVID-19 pandemic. *N. Z. Med. J.* **2021**, *134*, 52–67.
27. Fa'alii-Fidow, J. COVID-19 underscores long held strengths and challenges in Pacific health. *Pac. Health Dialog* **2020**, *21*, 351–353. [[CrossRef](#)]
28. Griffiths, D.; Sheehan, L.; van Vreden, C.; Petrie, D.; Whiteford, P.; Sim, M.R.; Collie, A. Changes in work and health of Australians during the COVID-19 pandemic: A longitudinal cohort study. *BMC Public Health* **2022**, *22*, 487. [[CrossRef](#)]
29. Ruffolo, M.; Price, D.; Schoultz, M.; Leung, J.; Bonsaksen, T.; Thygesen, H.; Geirdal, A.Ø. Employment Uncertainty and Mental Health During the COVID-19 Pandemic Initial Social Distancing Implementation: A Cross-national Study. *Glob. Soc. Welf.* **2021**, *8*, 141–150. [[CrossRef](#)]
30. Oxholm, T.; Rivera, C.; Schirman, K.; Hoverd, W.J. New Zealand Religious Community Responses to COVID-19 While Under Level 4 Lockdown. *J. Relig. Health* **2021**, *60*, 16–33. [[CrossRef](#)]
31. Levesque, J.-F.; Harris, M.F.; Russell, G. Patient-centred access to health care: Conceptualising access at the interface of health systems and populations. *Int. J. Equity Health* **2013**, *12*, 18. [[CrossRef](#)]

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