

**Auckland University of Technology (AUT)**

**Investigating COVID-19 health seeking and health  
information seeking during Alert Level 4, 2020: A  
qualitative descriptive study of Laotian New  
Zealanders in Auckland, New Zealand**

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## **Abstract**

Risk communication is a key element of effective epidemic and pandemic response. The COVID-19 pandemic has underlined the crucial role of risk communication to guide the public health response during this complex, global public health emergency. Recognising the limited research on risk communication in public health emergencies as this applies to migrant and ethnic minorities, this study sought to investigate Laotian New Zealanders' COVID-19 health seeking and health information seeking during Alert Level 4 or "lockdown" conditions in Auckland, New Zealand.

The study applied a qualitative descriptive approach which was underpinned by interpretivism and adopted semi-structured interviews as the data gathering method. Despite the challenges of the COVID-19 pandemic, face-to-face interviews were carried out with 10 Laotian New Zealanders residing in Auckland in 2021. Thematic analysis and a coding process using NVivo software identified three main themes related to health seeking and health information seeking: 1) the socio-economic characteristics and family profile; 2) individual capability and self-beliefs; and 3) exposure to diverse information sources.

The findings highlighted five important issues. These included the role of socio-economic factors and family profile in informing participant preferences for specific COVID-19 health information sources. They also reflected the importance of improving certainty and stability in participants' lives through work subsidies to reduce the impact of disrupted employment and income. Study results highlighted the relationship between trust in public authorities and self-efficacy in implementing public health advice, and the importance of preserving and protecting the stability of existing health services in times of public health emergency. They underlined the complex role of transboundary information sources and the need to manage this more effectively.

Study results highlight the need for continuing research with migrants and ethnic minorities to strengthen risk communication and community engagement with these vulnerable, but resourceful populations. It also calls for research to examine how online and geographic communities influence information-seeking and healthcare seeking during public health emergencies.

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## **List of Abbreviations**

AUT	Auckland University of Technology
AUTEC	Auckland University of Technology Ethics Committee
CALD	Culturally and linguistically diverse
CDC	Centers for Disease Control and Prevention
CERC	Crisis and emergency risk communication
COVID-19	Coronavirus disease 2019
ERC	Emergency risk communication
GP	General practitioner
HBM	Health Belief Model
IHR	International Health Regulations
PHEIC	Public health emergency of international concern
PIS	Participant information sheet
QD	Qualitative descriptive
RCCE	Risk communication and community engagement
SARS	Severe acute respiratory syndrome
SARS-CoV-2	Severe acute respiratory syndrome coronavirus 2
WHO	World Health Organization

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## **Attestation of Authorship**

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

Signed:

Phoutthanaphone Nedthongsavanh

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# Chapter 1 Introduction

The role of risk communication in public health emergencies is well recognised (Jha et al., 2018). Since the introduction of the International Health Regulations (IHR) in 2007 (World Health Organization [WHO], 2021a), there has been increased focus, first, on emergency risk communication and, more recently, on risk communication and community engagement (RCCE) as core elements of a pandemic response (Jha et al., 2018; WHO, 2019). The central role that risk communication plays in epidemic management has been emphasised as one of ten areas for global action in preparing for future health emergencies (WHO, 2021b). It has also been underlined as key to improving the implementation of the IHR (WHO, 2021a). To address these priorities, WHO has stressed the need for systematic research on risk communication, including the impact of the vast amount of information on health-seeking behaviour (WHO, 2021b). Addressing such gaps requires concerted empirical research that includes studies on the risk communication experiences of culturally and linguistically diverse (CALD) communities during global public health emergencies such as the coronavirus disease 2019 (COVID-19) pandemic.

## 1.1 Background

The emergence of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) in Wuhan, China, in 2019 (Zu et al., 2020), followed by its rapid escalation to pandemic levels by March 2020 (WHO, 2020a), has had wide-reaching global impacts. By 31 August 2021, more than 217 million cases and 4.5 million deaths had been attributed to COVID-19, the official name issued by WHO for the new condition (WHO, 2020b, 2021c). While COVID-19 has had wide-ranging health and related economic impacts, there is growing evidence of its unequal effects on ethnic minority groups and Indigenous peoples (Hooper et al., 2020; Laurencin & McClinton, 2020; Mathur et al., 2020). These are attributed to multiple factors, including structural inequalities that increase health risks, as well as language and cultural barriers to accessing information and healthcare, and other forms of communication inequalities (International Organization for Migration [IOM], 2020). Despite the recognition that ethnic minority groups face risk communication barriers during public health emergencies, there has been limited research in this area (Munodawafa et al., 2020; Tambo et al., 2021).

This applies even in well-resourced countries with a highly diverse population profile like Aotearoa New Zealand, and particularly in Auckland, New Zealand's most populous city, and home to 1.7 million (Stats NZ Tatauranga Aotearoa, 2020). Auckland is the most

diverse, multicultural, and cosmopolitan city in New Zealand with Asians comprising 28% of the city's population in 2018 (Auckland Council Research and Evaluation Unit, 2020).

The Laotian community in Auckland, New Zealand is one Asian minority community. With only 1,600 people mainly located in Auckland (Stats NZ Tatauranga Aotearoa, 2018), this almost invisible ethnic group faced specific risk communication challenges during New Zealand's Alert Level 4 COVID-19 'lockdown' that began in March 2020. Insights from this community's experience during the lockdown period can sharpen the focus of future epidemic responses so they are more responsive to the needs of ethnic minorities.

## **1.2 Key concepts in risk communication in public health emergencies**

### **1.2.1 Risk communication**

While the concept of risk communication is widely applied in fields beyond the health sector (Glik, 2007), it is a crucial term in managing public health emergencies. As part of the IHR (2005), risk communication represents one of the eight core capacities that countries must build and maintain to protect global health security (WHO, 2012a). Over time, however, its application in this context has broadened, shifting from an initial "top-down" compliance focus to a more horizontal, two-way interpretation (Boholm, 2019; Vaezi & Javanmard, 2020).

The original definition of risk communication in public health emergencies emphasised "the range of communication capacities required through the preparedness, response and recovery phases of a serious public health event to encourage informed decision making, positive behaviour change and the maintenance of trust" (WHO, 2014, para. 1).

More recently, and building on lessons learned from the West Africa Ebola virus disease and Zika global health emergencies, WHO substantially adjusted its interpretation of risk communication to refer to "the real-time exchange of information, advice and opinions between experts, community leaders, officials and the people who are at risk, which is an integral part of any emergency response" (WHO, 2017, p. vii). This shift reflected the growing recognition that an effective emergency response required the inclusive involvement of experts and officials actively listening to people's concerns, so that any advice given was "relevant, trusted and acceptable" (WHO, 2017, p.1).

### **1.2.2 Public health emergency of international concern and pandemics**

Although the term 'pandemic' has been widely used by both media and the general public during the COVID-19 public health emergency, it lacks a uniform, globally recognised definition.

Singer et al. (2021) noted that the International Journal of the Epidemiology Association's Dictionary of Epidemiology defines pandemic as "an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people" (Porta, 2008, as cited in Singer et al., 2021, p. 1). Other definitions have also highlighted the transboundary character of pandemics. For instance, Morens et al. (2009) suggested that pandemics can be classified depending on key features such as wide geographic extent, high attack rates, infectiousness, disease movement, novelty, and severity. Similarly, Kelly (2011) viewed a pandemic as an infectious disease that occur globally, crossing international boundaries or existing over broad areas, and usually affecting a large population. This interpretation also recognised the unpredictable character of pandemics along with their capacity to change quickly, leading to severe illness or death.

In Aotearoa New Zealand, it is described as "an epidemic of an infectious disease that spreads through human populations across a large region, for example, multiple continents or even worldwide" (The Office for Māori Crown Relations - Te Arawhiti, 2020, p. 5).

In contrast to the many qualitative descriptions of a pandemic, the concept of a 'public health emergency of international concern' (PHEIC) is clearly specified. Article 1 of the IHR defines this as "an extraordinary event which is determined, as provided in these Regulations: (i) to constitute a public health risk to other States through the international spread of disease and (ii) to potentially require a coordinated international response" (WHO, 2016a, p. 9).

Unlike a pandemic, the process for verifying and declaring a PHEIC is tightly prescribed. Its declaration also prompts governments who are signatories to the IHR to collectively activate public health measures including communication processes. This is to prevent further international spread of infection. In the context of the COVID-19 global public health emergency, the use of the term 'pandemic' by reputable health authorities like WHO was crucial for emphasising the seriousness of this global health threat. This is despite the fact that WHO no longer uses the term 'pandemic' to assign any official status to an infectious disease outbreak.

### **1.3 Health-seeking behaviour**

The wide-ranging disruptions to mobility, employment and social interaction associated with a serious public health emergency have implications for the health-seeking actions of individuals and their families. The concept of health seeking was first proposed by Chrisman (1977) as "the steps taken by an individual who perceives a need for help as he or she attempts to solve a health problem" (p. 353). More recently, Poortaghi et al.

(2015) noted that health-seeking behaviour refers to actions and behaviours that promote maximum well-being, recovery, and rehabilitation, which could be initiated with or without health concerns.

A cross-cutting theme in understanding the health-seeking process is the role that broader socio-cultural factors play in individual choices. For instance, MacKian (2003) noted that although an individual's education and knowledge may influence health seeking, these are not sufficient to promote a change in behaviour. Kulbok and Cox (2002) also underlined the complexity and importance of factors that influence a person's health-seeking behaviour, and that go beyond an individual. The importance of understanding these other factors was highlighted during the COVID-19 pandemic, when established patterns of individual health seeking were disrupted by society-wide 'lockdown' rules and other restrictions that prevented face-to-face contact.

## **1.4 Research context: COVID-19 in Aotearoa New Zealand**

### **1.4.1 Early responses: "Go hard and go early"**

In Aotearoa New Zealand, the first case of COVID-19 was reported on February 28, 2020 (Baker et al., 2020). In March 2020, the country implemented a vigorous COVID-19 elimination strategy, reflected in its "go hard and go early" slogan (Jamieson, 2020). Immediate measures adopted in March 2020 included closure of all international and entry ports to non-residents, and the introduction of mandatory managed isolation for returning citizens and permanent residents (Jefferies et al., 2020).

The strategy was also reflected on the establishment of a National Health Coordination Centre and the introduction of a COVID-19 Alert System (New Zealand Ministry of Health, 2020; Unite Against COVID-19, 2021). This sought to manage and mitigate the risk of infection, in which Level 1 was the least likely to cause infection and Level 4, the highest level of infection (Unite Against COVID-19, 2021). With rising case numbers reported in March 2020, the government activated Alert Level 4 provisions from 11:59PM, March 25, 2020, until April 27, 2020 (Elliott & Crozier, 2020). During this time all those in New Zealand were required to observe strict rules related to physical and social distancing, associating only with those in their "bubbles" (Elliott & Crozier, 2020), and staying at home or remaining local (Christey et al., 2020).

### **1.4.2 COVID-19 response implications: Positives and negatives**

Aotearoa New Zealand's vigorous response to the COVID-19 pandemic was positively acknowledged globally (Cumming, 2021). By May 10, 2020, the combined effect of strict border control, contact tracing and social and physical distancing resulted in a steep decline in COVID-19 cases and the introduction of more relaxed Alert Level 2 on May

14, 2020 (Jefferies et al., 2020). These achievements, however, were also accompanied by drawbacks in access to health services.

For instance, White (2020) reported an increase in surgery waiting time due to the cancellation of elective surgeries during Alert Level 4. In addition, parental anxiety, and concern about accessing healthcare services reportedly led to thousands of children missing their measles immunisations, particularly those from Māori and Pasifika communities as well as migrant groups. This prompted concerns about a potential measles infection resurgence in New Zealand (Bradley, 2020). Other studies reported obstacles to acute care for children. Duncanson et al. (2021) described how hospital avoidance and reduced access to primary and secondary support may have compromised healthcare for children in up to 55 instances in May and June 2020. They also noted that new-born infants were at specific risk and highlighted particular difficulties in communicating with families where English was a second language.

### **1.5 Rationale, research questions and objectives**

Effective risk communication played a crucial role in New Zealand's COVID-19 response (Bloomfield, 2021; Jamieson, 2020). However, the country's diversity of ethnic and language groups created real challenges for the authorities to provide accessible and up-to-date information (Tupou, 2021). Although Asian communities comprise 28% of Auckland's population, it was only in 2021 that detailed translations of COVID-19 public health advice were made available in some – but not all – of the different Asian languages (Tupou, 2021).

The Laotian community represents one of the less “visible” Asian ethnic groups in Auckland. They comprise Laotians who came to New Zealand as refugees in the late 1970s and 1980s due to the armed conflict after the Communist Pathet Lao government took over the country (Liev & Chhun, 2015). In recent years, while the number of Laotians entering New Zealand as refugees has fallen, others continue to settle in the country under the family reunification scheme (Liev & Chhun, 2015).

Currently, there are approximately 1,600 people in New Zealand's Laotian population, with the majority living in Auckland (Stats NZ Tatauranga Aotearoa, 2018). Even though Laotian New Zealanders seem to have integrated well into their new country, they still face obstacles that have an adverse impact on their socio-economic status. These include cross-cultural communication barriers, insufficient English skills, feelings of isolation and distress, or working in unsatisfactory employment (Liev & Chhun, 2015).

In the context of COVID-19 and the sudden application of social and physical distancing rules, access to health services by this small ethnic group became even more complex

and difficult. Given the limited research on health-seeking behaviour by this “almost invisible” Asian community, the researcher sought to investigate how Laotian New Zealanders accessed healthcare and health information during the first COVID-19 lockdown in Auckland, New Zealand.

The research question which this study sought to address was: how did Laotian New Zealanders obtain, interpret and act on COVID-19 public health advice during Alert Level 4 in 2020 in Auckland, New Zealand?

This research question was addressed by five guiding objectives:

- To identify the main sources of public health information consulted by Laotian New Zealanders during Alert Level 4.
- To explore Laotian New Zealanders’ perceptions of the most significant public health messages they could recall during Alert Level 4.
- To explore specific health-seeking behaviour of Laotian New Zealanders during Alert Level 4.
- To identify the factors that either hindered or enabled Laotian New Zealanders’ understanding of public health advice and their health-seeking actions during Alert Level 4.
- To make recommendations for Asian migrant health service delivery needs.

## **1.6 Dissertation outline**

This dissertation comprises six chapters:

**Chapter One**, the present chapter, introduces the study, including the problem context, rationale, and key concepts. It also describes the research gap, the research question, and the study’s objectives.

**Chapter Two** critically reviews relevant published literature on risk communication and its evolution in public health emergencies, health seeking and information seeking. The chapter continues by focusing on the challenges face by migrant and ethnic communities in public health emergencies and risk communication during COVID-19. It also identifies the knowledge gap in previous research.

**Chapter Three** clarifies the study’s methodology which is a qualitative descriptive approach. This chapter presents the study paradigm, research design and measures taken to ensure both academic rigour and compliance with research ethics requirements.

**Chapter Four** provides the findings and outcomes of this study after analysing data gathered from interviews with Laotian migrants living in Auckland.

**Chapter Five** discusses the implications of the study findings, as they apply to existing studies and literature. It also proposes recommendations for policy and practice and considers the study's strengths and limitations.

### **1.7 Chapter summary**

This chapter has introduced the research background and highlighted significant themes that are relevant to the research topic. It has described specific gaps in existing literature and knowledge. The chapter also introduced the research question with its objectives and presented an overview of the dissertation.

## **Chapter 2 Literature Review**

### **2.1 Introduction**

This study's focus on Laotian New Zealanders' health information seeking and healthcare seeking during the 2020 Alert Level 4 'lockdown' required a comprehensive literature review. With a specific emphasis on risk communication in public health emergencies, this chapter addresses the challenges faced by migrant and refugee groups when seeking healthcare. It begins with an overview of the evolution of global approaches to risk communication in the context of public health emergencies, and then gives background information on healthcare seeking and health information seeking. It continues by focusing on the health-seeking implications of pandemics, especially as these apply to migrants and other ethnic minorities. The chapter concludes by framing the knowledge gap this study sought to address.

The literature search was conducted between November 2020 and August 2021, during which time the researcher was able to access the Auckland University of Technology (AUT)'s library, Google Scholar, Scopus, and other sites for appropriate literature. A thorough literature search was carried out by using the terms 'migrants', 'asylum seekers', 'Laotians', 'immigrants', and 'refugees' for migrants; and 'emergency risk communication', 'health information', 'healthcare-seeking behaviours' and 'risk communication' for information seeking and healthcare-seeking behaviours; and by adding terms such as 'public health emergency', 'international health regulations', 'epidemic', and pandemics such as H1N1, influenza, Ebola, and COVID-19 to identify relevant articles that included the information and healthcare-seeking behaviours of migrants during epidemics and pandemics.

### **2.2 Evolving global approaches to risk communication in public health emergencies**

#### **2.2.1 Recognition of risk communication in pandemics**

Although risk communication has long been a key element of health promotion and public health campaigns (Glik, 2007; Lowbridge & Leask, 2011; Reynolds & Seeger, 2005), its central role in the management of public health emergencies became more prominent with the introduction of the 2005 International Health Regulations (IHR) (Bakari & Frumence, 2013; WHO, 2012a). The stimulus for amending the IHR was the 2002–2004 outbreak of Severe Acute Respiratory Syndrome (SARS) (WHO, 2012a), which highlighted the need to strengthen the role of global communications in actions to manage potential infectious diseases (Wilson et al., 2010). In parallel with this, global recognition of the urgency of improving risk communication action in public health crises

was also prompted by the 2001 anthrax attacks in the United States (US) which followed the 9/11 World Trade Center attack of 2001. These two events of global significance between 2001 and 2004 highlighted the need for strengthened risk communication in public health crises. As a result, WHO accelerated its efforts in advancing 'emergency risk communication' (ERC) focused on epidemics and disasters (WHO, 2017) while the US Centers for Disease Control and Prevention (CDC) developed its comprehensive guideline for 'crisis and emergency risk communication' (CERC) (US Department of Health and Human Services & CDC, 2014).

### **2.2.2 Criticism of top-down approaches to risk communication**

The early definitions of ERC reflected a "top-down", expert-oriented approach to crisis communication. These were reflected in WHO's 2012 characterisation of risk communication as the process by which "national and local government authorities provide information to the public in an understandable, timely, transparent and coordinated manner before, during and after a crisis", in addition to information exchange between scientists and public health and veterinary experts during preparedness efforts (WHO, 2012b, p. 4).

The disadvantages and constraints of this conventional, hierarchical approach to risk communication during outbreaks became clear during 2014–2016 with the West African Ebola Virus Disease, and 2015–2016 with the Zika outbreaks and multi-country yellow fever outbreak (WHO, 2017).

Growing awareness and criticism of these "top-down" risk communication measures resulted in WHO commissioning systematic reviews of both peer-reviewed and grey literature related to risk communication in public health emergencies. These included a systematic review of scientific and grey literature on integrating ERC into national and international public health preparedness (Jha et al., 2018). While this revealed limited empirical studies on the questions probed, especially from low- to middle-income countries, it highlighted the importance of engaging with stakeholders (Jha et al., 2018). In a complementary review on communicating uncertainty during public health emergency events, Sopory et al. (2019; 81) differentiated between "uncertainty as information" and "uncertainty as experience" (p. 81). They underlined that vulnerable groups, including those living with socio-economic pressures, already faced multiple uncertainties in their day-to-day experience and that uncertainty around a public health emergency was just one of many concerns (Sopory et al., 2019).

A third review (Toppenberg-Pejcic et al., 2019) focused on the grey literature on Ebola, Zika and yellow fever produced in 2015–2016. This review recognised that many useful insights on risk communication during public health emergencies could be sourced from

high quality field or organisational reports. A central finding from this review highlighted the importance of local communities in communicating risk. While acknowledging the rising use of social media in ERC, this review also underlined the continuing value of “traditional modes of communication” for conveying risk information (Toppenberg-Pejcic et al., 2019).

### **2.2.3 Emergence of risk communication and community engagement**

Insights drawn from these studies resulted in a two-step reframing of risk communication in public health emergencies by WHO. First, risk communication was re-framed as “the real-time exchange of information, advice and opinions between experts, community leaders, officials and the people who are at risk and ... an integral part of any emergency response” (WHO, 2017, p. 1). This view of risk communication in public health emergencies was underpinned by eight principles, including creating and maintaining trust and communicating even in conditions of uncertainty (WHO, 2017).

Second, building on lessons from recent emergencies and research, the approach extended further, becoming ‘risk communication and community engagement’ (RCCE). This more evolved means of reaching communities during outbreaks was first applied as part of the 2016 Zika Strategic Response Framework and Joint Operation Plan (WHO, 2016b), with the intention of engaging and empowering key populations in affected and at-risk countries to make informed decisions to protect their health. Subsequently, the RCCE approach to risk communication during outbreaks has been applied in emergencies such as the Ebola outbreak in North Kivu (WHO, 2018) and extensively during the COVID-19 global response (WHO, 2020c). RCCE effectively draws together the focus on “real-time exchange of information, advice and opinions between experts, community leaders, officials and the people who are at risk” (WHO, 2017, p.1), with the commitment to work with diverse groups to strengthen participation and communication (The United Nations International Children's Emergency Fund [UNICEF], 2019). In the context of COVID-19, RCCE was seen as essential for promoting people-centred and community-led strategies to reduce the impact of the pandemic (Gilmore et al., 2020; WHO, 2020c).

## **2.3 Health seeking and health information seeking**

### **2.3.1 Health seeking**

The more frequent inclusion of participatory approaches to risk communication in public health emergencies highlights a growing recognition of the importance of socio-behavioural characteristics and trends in managing outbreak responses. These include individual perceptions of the risk or threat, the information sources people use, communication channels that are trusted, and perceived levels of self-efficacy (WHO,

2020c). Also, central to supporting at-risk communities during public health emergencies is understanding their usual patterns of health seeking, which are shaped by socio-cultural, economic, and other conditions.

First proposed by Chrisman (1977), the concept of health-seeking behaviour reflects a sequence of steps taken by individuals who identify a need for help as they seek to solve a health problem. The health-seeking process typically involves five steps, namely: symptom definition, illness-related shifts in role behaviour, lay consultation and referral, treatment actions, and adherence (Chrisman, 1977). In this conceptualisation, cultural factors and forces are viewed as keys in the early stages of the process, while social influences, relationships, and responsibilities shape its latter stages. Chrisman (1977) suggests that these reflect the move from a focus on symptom definition, towards illness-related shifts in-role behaviour, and which result in changes in social obligations and commitments.

Health information seeking represents a process related to health seeking. This is particularly the case given the recent rapid growth and global expansion of information, communication, and technology capabilities. Although there is still no uniformly recognised definition for health-information-seeking behaviours, Zimmerman and Shaw Jr. (2020) viewed it as “an active or purposeful behaviour undertaken by an individual with the objective of finding information about health” (p. 176).

In the context of risk communication during public health emergencies, the concepts of health-seeking and health information seeking are crucial as they focus attention on how individuals and communities navigate through both disrupted health systems and, as evident during the COVID-19 pandemic, through an ‘infodemic’ of rapidly changing and sometimes conflicting information (Islam et al., 2020).

A useful model that provides more specific insights on individual health seeking is the Health Belief Model (HBM). First conceptualised by social scientists at the US Public Health Service in the 1950s (Rosenstock, 1974), this framework has been widely used to explain health-related behaviours and to guide health programmes and initiatives (Glanz et al., 2008).

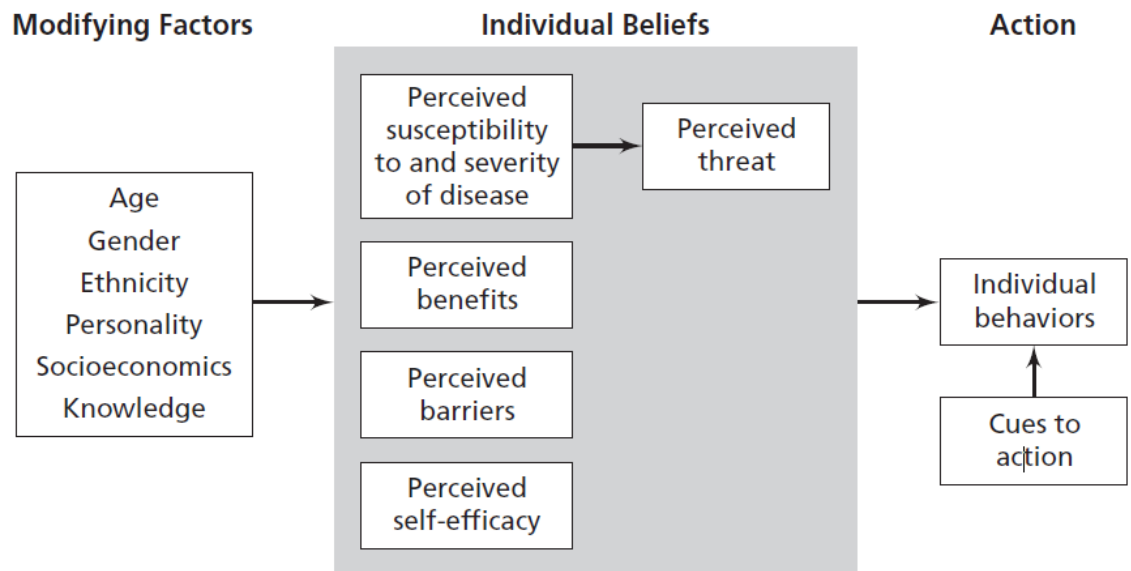
### **2.3.2 Health Belief Model**

The HBM is a conceptual framework that helps explain how an individual’s beliefs about a health condition as well as those on the benefits/drawbacks of proposed action shape his/her behaviour. Central to the model are five belief categories: an individual’s susceptibility to and severity of disease, and their influence on threat perceptions, perceived benefits (of action), perceived barriers (to action), and perceived self-efficacy (Glanz et al., 2008). Although the original HBM did not incorporate self-efficacy or

modifying factors such as age, gender and ethnicity, these key dimensions were added later (Glanz et al., 2008).

**Figure 1**

*Health Belief Model components and linkages*



*Note.* Reproduced from Glanz et al. (2008, p. 49).

Figure 1 depicts the HBM, illustrating how these factors are interlinked to explain individual behaviour in relation to health and illness. The HBM has been applied to a wide range of contexts and conditions, including research on health behaviours in the US during COVID-19 (Guidry et al., 2021). This study indicated that while the HBM is not a perfect model for addressing the COVID-19 pandemic, its constructs should still be considered as guiding principles for public health communication strategies in the areas of preventive measure campaign design and pandemic planning (Guidry et al., 2021). This is examined further in section 5.3.2.

## **2.4 Public health emergencies – Focus on migrant and ethnic minority communities**

### **2.4.1 Increased risk faced by migrant communities**

During disease outbreaks, migrant communities are viewed as more vulnerable than their host communities (McAuliffe et al., 2020). This is due to the presence of health disparities among minority communities who have migration backgrounds. There are many factors contributing to these disparities, including issues of culture, the duration of their stay, generation status, communication skills, and their personal beliefs (Charania

et al., 2019). As in many other crises or disease outbreaks, migrants are at risk of experiencing the indirect and direct impacts of infection.

In the context of public health threats, numerous factors can limit their ability to prevent infection, obtain adequate healthcare, and manage the economic, social, and psychological impacts of illness. These are wide-ranging and can include living and working conditions, lack of understanding of migrants' cultural and language diversity, xenophobia, migrants' limited knowledge, and networks, as well as their access to rights and the level of their inclusion in their host communities (IOM, 2020). A recent study examined this issue in greater depth during the COVID-19 pandemic. The study illustrated the complex interplay of factors contributing to health inequities faced amongst communities with migrant and refugee backgrounds. These factors included uncertain living and working conditions due to lockdown and economic downturn, lack of social protection and welfare assistance regarding health care utilisation, being stranded and loss of status induced further economic hardship and insecurity (Twigg et al., 2021). Thus, there is a need to adopt migrant-inclusive approaches particularly during health emergencies to address migrants' specific conditions of vulnerability (Twigg et al., 2021).

#### **2.4.2 Communication challenges and barriers**

There is also evidence that racial and ethnic minority populations face the likelihood of worse health outcomes during and after disasters and public health emergencies (Hooper et al., 2020; Laurencin & McClinton, 2020). This is in part due to limited access to accurate risk information (Abuelgasim et al., 2020).

Important obstacles to effective risk communication include cultural and language barriers, social and economic conditions, and distrust of government authorities (Abuelgasim et al., 2020). Cultural and linguistic barriers specifically represent major challenges to risk communication in times of public health emergencies. For instance, Vaughan and Tinker (2009) noted that some minority communities prefer to rely on their friends, families, or relatives instead of the public information sources for emergency preparedness advice. This may also influence their perceptions and preparedness for emergency events. In addition, language barriers can also affect the translation and interpretation of important messages. This can lead to the inaccurate or inappropriate use of information with negative implications for migrant groups, despite their increased vulnerability (Vaughan & Tinker, 2009).

In this context, trust in government authorities is a central element for strengthening the credibility of public risk messaging. "Trust refers to the assured reliance on others to act in one's interests with responsibility, capability, honesty, equity and transparency and is critical to facilitating adherence to appropriate preparedness and response actions"

(Siddiqui et al., 2011, p. 3). Trust is often influenced by various factors such as personal experience, culture, beliefs, and language proficiency. Among minorities, particularly those who are refugees, undocumented, or fleeing immigrants, trust is likely to be low if they have no clear notions of what is right and wrong. Low levels of trust in the government and other agencies or service providers may also adversely affect the preparedness of minorities in times of emergency (Coltart et al., 2017).

## **2.5 Risk communication challenges during COVID-19**

The COVID-19 pandemic has both highlighted already recognised risk communication challenges in public health emergencies and added new dimensions. The rapid growth of social-media-driven misinformation is one example. For instance, during the current COVID-19 pandemic, Islam et al. (2020) noted that as people were receiving information from multiple sources, communication efforts have been made harder. This is due to an 'infodemic' that can create confusion and misinformation among the public (Islam et al., 2020). The authors define an 'infodemic' as "an overabundance of information—some accurate and some not—that makes it hard for people to find trustworthy sources and reliable guidance when they need it" (Islam et al., 2020, p. 1). The seriousness of misinformation was underlined by the UN Secretary-General who referred to pandemic-related rumours as a "global enemy" (Islam et al., 2020). Cinelli et al. (2020) also argued that misinformation can affect the effectiveness of public health policies and pandemic countermeasures, which is why it is crucial to monitor and control these factors in order to minimise fear, anxiety or stigma during a pandemic.

In one illustrative study on the use of social media during the COVID-19 pandemic, Yassin et al. (2021) reported that social media platforms like Facebook can be used to notify the public about important information, spread awareness and promote preventive measures. This helped to minimise losses and improve the effectiveness of the response. However, the study also indicated that although social media is a tool that can help spread awareness about a virus, it can also have negative effects (Yassin et al., 2021). This research revealed that Jordanians were highly aware of the detrimental effects of social media and its role in distorting information. They were also very likely to avoid sharing questionable news with their social media acquaintances, and most of the study participants reporting that they were very cautious and followed the rules and regulations of the Ministry of Health (Yassin et al., 2021).

In other recent research on risk communication during the COVID-19 pandemic, Wang et al. (2020) investigated the effects of risk communication and behavioural responses on the attitudes and behaviours of Chinese adults. Their results indicated that most respondents said they engaged in preventive behaviours due to the messages they

received. Study results suggest that being exposed to risk communication messages was positively associated with being able to prevent illness, while believing in misinformation was negatively associated with wearing a mask in public (Wang et al., 2020). However, the study also cautioned that male respondents, minorities, and those who were older with lower socio-economic status or had lower education levels and lived in rural areas were less likely to have high exposure to risk communication messages (Wang et al., 2020).

Uneven access to risk communication for groups such as migrants and ethnic minorities is increasingly recognised as an area of concern. For instance, in a systematic review of health risk communication during the H1N1 and COVID-19 pandemics, Berg et al. (2021) noted that, despite rising use of social media, migrant and ethnic minority groups reported needing trusted spokespersons who were able to provide them with personalised information. Consistent with other studies, the review highlighted the need for greater attention to the risk communication needs of linguistic and ethnic minorities (Jha et al., 2018). In addition, Tambo et al. (2021) identified emerging gaps in prevailing global approaches to risk communication and community engagement. This specifically includes “reconceptualising” the notion of community engagement, recognising that, during COVID-19, “online communities were found to be as or even more influential than geographic communities” (Tambo et al., 2021, p. 49).

## **2.6 Laotian health seeking in COVID-19 – Addressing knowledge gaps**

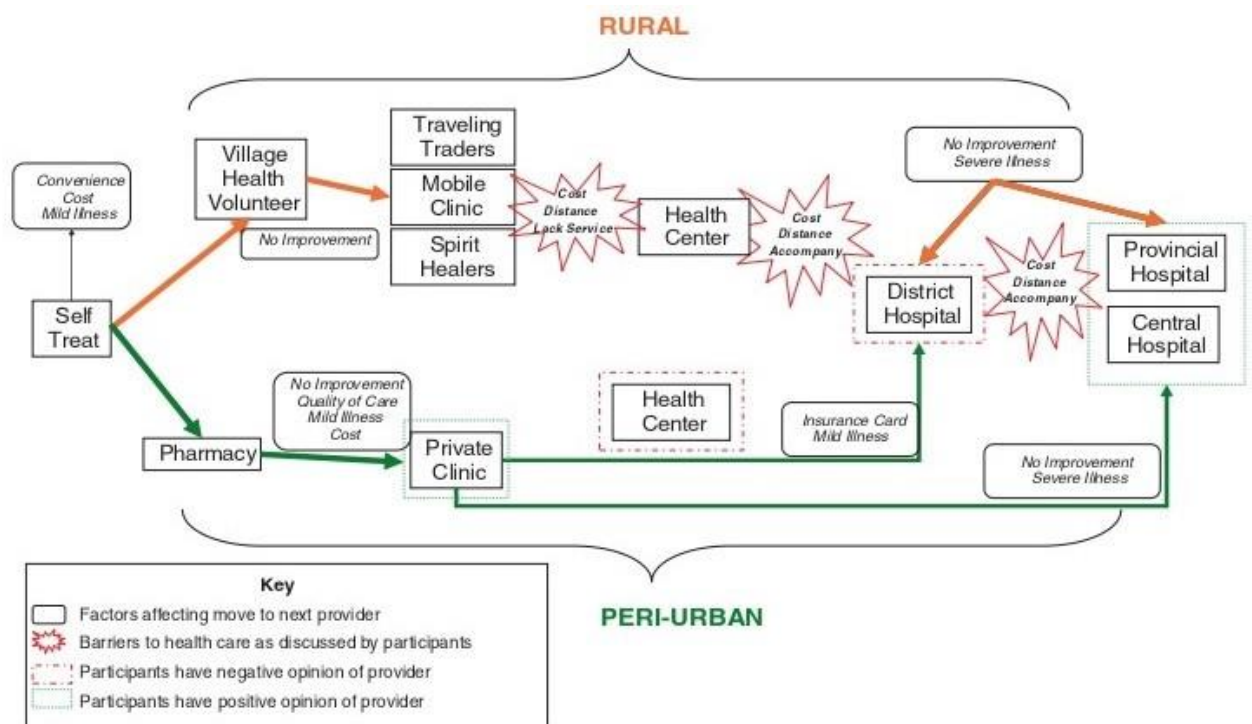
Improving risk communication in public health emergencies in culturally diverse cities like Auckland requires an understanding of the problems faced by its different ethnic groups. Although Laotian refugees first settled in New Zealand in the late 1970s and 1980s, 40 years later the Laotian community still lacks visibility in healthcare service delivery. This was evidenced during the COVID-19 pandemic where the Asian translation service translated important messages into eleven Asian languages, that still excluded Lao (Tupou, 2021). This gap is also clear globally in the limited amount of research on the health of Laotian migrants in general. While there is published literature focused on the health experience of Hmong refugees from Laos following their resettlement, the literature search yielded only a handful of articles that addressed Lao migrant health-seeking in general.

One 1989 study on healthcare-seeking behaviour in the US revealed that while some Laotian refugees were aware of western concepts of disease aetiology, this did not play a major role in shaping their understanding about disease treatment and management (Brainard & Zaharlick, 1989). The study also showed that Laotian refugees had the highest rates of hospitalisation and clinic visits across all Southeast Asian refugees, and

that they were more likely to use resettlement agency services than those from other Southeast Asian countries. This research indicated that they were less likely to rely on traditional healers or treatments, but tended to rely on Western biomedical care, even if they had minor health problems (Brainard & Zaharlick, 1989). A more recent study of health-seeking for respiratory illness in Laos reinforced this finding. It reported that sick people in peri-urban areas preferred private clinics and pharmacies as their first treatment choice (Mayxay et al., 2013). The authors mapped the health seeking process, comparing peri-urban and rural participants (see Figure 2, below).

**Figure 2**

*Process mapping of Laotian health-seeking behaviours in rural and peri-urban areas*



*Note:* Reproduced from Mayxay et al. (2013, p. 9).

Despite such studies, research on Laotian health seeking remains limited, both as this applies to migrant groups, and in relation to epidemics risk communication in public health emergencies. This study sought to address this gap by investigating how Laotian New Zealanders obtained, interpreted and acted on COVID-19 public health advice during Alert Level 4 in 2020 in Auckland, New Zealand.

## **2.7 Chapter summary**

This chapter has critically reviewed relevant published literature on risk communication and its evolution in public health emergencies, as well as health-seeking and health information-seeking. It has focused on the challenges face by migrant and ethnic communities in public health emergencies and examined risk communication during COVID-19. It has also identified the knowledge gap in previous research. This content is revisited in Chapter 5, the discussion.

## **Chapter 3 Methodology**

### **3.1 Introduction**

The risk communication knowledge domain involves numerous fields and disciplines. This particularly applies to risk communication during pandemic events for ethnic minorities like the Laotian community in Auckland. This chapter provides the research rationale for a qualitative descriptive (QD) study and the paradigm applied. It also presents the research design as well as the ethics approval process.

### **3.2 The rationale for a qualitative descriptive study**

A QD approach was applied in this study. Sandelowski (2000) stated that a QD study is a useful methodological approach that assists researchers in exploring experience-related problems as well as examining participants' perceptions, attitudes, barriers, or concerns. This type of research is also well suited for 'why', 'how' and 'what' questions for various purposes such as the identification of motives, theories, and concepts related to human behaviour, in which the main objective is to generate hypotheses and formulate theories (Neergaard et al., 2009)

The research question "How did Laotian New Zealanders obtain, interpret and act on COVID-19 public health advice during Alert Level 4 in 2020 in Auckland New Zealand?" fits well with a QD approach. It is also suitable because a QD approach enables researchers to describe a phenomenon in a way that is straightforward and helps in identifying the various feelings and understandings of individuals (Lambert & Lambert, 2012). This approach can also be used to describe events that have happened, as well as the relationships between them. Sandelowski (2000) and Neergaard et al. (2009) also argued that QD studies are more focused on uncovering participant experiences than trying to study participants in person.

There is a great depth of understanding possible in a simple QD study when the researcher and participants share a similar language. In this study, as the researcher is also from Laos, he shared the same country of origin and language as the Laotian New Zealanders he interviewed. This helped strengthen his in-depth understanding of the social and cultural context of this community and made it possible to conduct interviews in the Lao language.

### **3.3 Research paradigm**

The research paradigm in this study is underpinned by interpretivism. Creswell (2014) stated that a worldview or paradigm is a conceptual construct that explains how we see the world. It can be used to explain or rationalise certain beliefs or actions which do not

have specifically philosophical goals. In this study, the interpretive paradigm underpinned research which aimed to identify the link between individuals' attitudes and experiences during Alert Level 4 that affected their daily lives (Gelo et al., 2008). Through the interpretive paradigm, the researcher was able to obtain a deeper understanding of the various perspectives of the participants and different interpretations of health seeking during COVID-19. This approach also allowed the researcher to formulate his interpretations of the participants' opinions and meanings based on the information collected (Grant & Giddings, 2002).

With respect to this research topic, the interpretivist worldview ensured that the complexities and issues that members of Auckland's Laotian community faced were better understood and their different perceptions and opinions represented. This paradigm was also appropriate for the researcher, who is Laotian and able to identify with many of the challenges that faced the migrant Laotian community during Alert Level 4 in Auckland.

### **3.4 Research design**

#### **3.4.1 Overview**

This study utilised a QD approach to analyse the responses and expressions of participants. It is considered as the least theoretical approach of all qualitative research (Lambert & Lambert, 2012). The study was conducted in Auckland, which is home to New Zealand's largest Laotian population. Due to the complexity of the COVID-19 pandemic whose effects extended well into the research timeframe, face-to-face data collection only became possible in April 2021, during Alert Level 1 (Unite Against COVID-19, 2021).

#### **3.4.2 Sampling**

Purposive sampling is an approach used to select participants for a study (Etikan et al., 2016). This technique is able to help a researcher identify individuals who are able and willing to provide helpful and logical information (Etikan et al., 2016). As the researcher had attended traditional cultural events at the Wat Lao Buddharam temple in Auckland, this enabled him to approach the community leaders, the Wat Lao Buddharam – Association Trust Board New Zealand, and potential participants for data collection for the purpose of this research.

The study applied three main participant inclusion criteria. These were Laotian ethnic identity, immigration status as either citizens or permanent residents and a residence in Auckland for more than five years. The rationale for these criteria was, first, to ensure study participants shared the same legal right to access health services in New Zealand

(contrasting, for instance, with Laotian migrants who had work or temporary visa status). Second, the choice of a five-year period in New Zealand meant that study participants would be expected to be largely familiar with using public services including health and transport services.

The study also recruited participants who were primary healthcare decision-makers in their families, across a diverse range of families. These included nuclear families, extended families, and some primary healthcare decision-makers who lived alone. This research recruited 10 participants and sought to achieve a gender balance. This is because the primary healthcare decision-makers in Auckland's Laotian families tend to be those who have better English-speaking capability. The research also sought to identify participants who represented both "younger" families (where the primary healthcare decision-maker was under 45 years old), and "older" families (where the primary healthcare decision maker was 45 years or over).

### **3.4.3 Recruitment procedure**

The researcher first contacted Lao community leaders to arrange an initial meeting through the Lao temple in Auckland, New Zealand. This enabled the Lao community leaders to introduce the research topic and the researcher to the Lao community and invite community members to participate. The participation was entirely voluntary. The researcher then contacted potential participants to explore their interest in being part of the study. The researcher also asked participants to discuss with other appropriate members in their families who would best represent the primary healthcare decision-maker in their households.

At individual meetings with prospective participants at the temple, the researcher provided each with the participant information sheet (PIS) (attached in Appendix A). The PIS (in both Lao and English) provided detailed information about the project, including the time for consideration about participation, which was around two weeks. Potential participants could ask any questions to the researcher in person at the temple, by phone calls, or by email. To obtain both verbal and written consent (see the form in Appendix C), the researcher explained important details about how data could and would be protected. These details also included the use and disposal of participant numbers and the storage and disposal of data. After that, participants were invited to sign the written consent form before starting the interview.

The researcher was able to recruit 10 participants who were the primary healthcare decision-makers, comprising five females and five males. There were four participants representing young families and six participants representing older household profiles (see Table 1).

**Table 1***Gender and age category of participants (n=10)*

Age Category	Male	Female	Total
< 45 years old	1	3	4
≥ 45 years old	4	2	6
Total	5	5	10

#### **3.4.4 Data gathering tools and data collection**

The semi-structured interview method with closed and open-ended questions was adopted, as this approach is often selected in health research and typically used in qualitative research. The semi-structured interview method is also a process that enables researchers to create meaningful sub-questions that can help them gain deeper insights and data (Cohen & Crabtree, 2006). Two face-to-face pilot interviews took place with Laotian healthcare decision-makers in advance of the main study to understand the duration of the interview and to improve the appropriateness of the interview questions (see the list of indicative questions in Appendix F). Following this, actual face-to-face interviews took place during Alert Level 1 in Auckland in April 2021. The interviews were conducted in the languages that participants were most comfortable with (mostly in Lao) and recorded through audio recording and written notes.

The duration of individual interviews was approximately 20–35 minutes. They took place at the temple or places where participants felt comfortable, such as participants' houses, as guided by the approved Researcher Safety Protocol (Appendix G). Each participant responded to a question set involving around eight main questions and extra sub-questions. During the interview process, the researcher interacted with the participants in a friendly and informal manner, which allowed him to ask appropriate questions and to control the ordering of questions (Creswell, 2014).

After data collection, the transcripts were written in Lao, then translated into English, and after that back-translated to Lao. This was undertaken to check the correctness of the translation by collaborating with a co-translator to verify the accuracy of the translation (Chen & Boore, 2010), and in accordance the approved confidentiality agreement (see Appendix H). The respondents were also asked to approve certain steps in the research, including validating the accuracy and authenticity of their interview transcripts before

analysis took place. Even though participants were given the opportunity to review the transcription, none requested to do this.

#### **3.4.5 Data analysis**

As with the interpretive paradigm, thematic analysis is well-suited for data analysis in QD research. The thematic analysis that was applied in this research was reflexive, with the coding applying an inductive approach. The process involves analysing the data through multiple phases and can be performed in six steps, namely: familiarising oneself with the data; initial coding step; aggregating initial codes into themes; reviewing and defining possible themes; choosing names for categories and main themes; and planning a report (Braun & Clarke, 2012).

The researcher became increasingly familiar with the data while he was performing these phases, including the transcribing and back-translating. All information regarding COVID-19 public health advice on health service access and utility, such as perceptions, experiences, or opinions were re-read, initially coded, and transcribed into written form as themes and sub-themes.

To identify initial codes, computer-assisted qualitative data analysis software, NVivo 20, was applied to assist with the process of analysis. According to Zamawe (2015), NVivo is a powerful text analysis tool that can easily handle large amounts of information in a variety of formats such as transcripts and field notes. NVivo provides an automated digital process that also saves the researcher time and helps to minimise errors. The software enabled the researcher to organise and interpret the smallest units of information, called 'child codes', which were identified during the interviews and then grouped together under 'parent codes' (as shown in the researcher's codebook, Appendix K).

The next step was to manually cluster the initial codes from the NVivo coding process into themes. This step was carried out by the researcher and his supervisor. Each parent code and some child codes were grouped into possible sub-themed categories and the main themes were evaluated in an integrated mind-map (see Figure 3). The researcher and his supervisor then selected the names for the main themes, sub-themes, and categories. In this context, a combination of manual and NVivo automated coding techniques was applied to enable the creation of coding and theme-based classification.

### **3.5 Ensuring academic rigor**

Establishing trustworthiness in qualitative research requires a consideration of a wide variety of factors. Lincoln and Guba (1986) established several criteria for establishing trustworthiness, which include credibility, transferability, dependability, and

confirmability. In addition, according to Merriam (1998), the six main tools for achieving research rigor are peer debriefing, external audits, triangulation, member scrutiny, and the explanation of research bias.

In order to ensure credibility in this research, the peer review process served as a brainstorming session for the researcher and his supervisor to develop sub-themes and themes for the study (Lincoln & Guba, 1986). The format of semi-structured questions also helped in establishing credibility for the interviews since the individuals were asked to provide their responses (Shenton, 2004). During the interview, spending enough time with the participants of a study also allowed the researcher to gain valuable information, which was also beneficial for the study in making it possible to test for misinformation and build trust (Hadi & Closs, 2016).

In qualitative research, transferability refers to the degree to which qualitative study results can be transferred to other contexts (Finfgeld-Connett, 2010; Lincoln & Guba, 1986). In this study, transferability was achieved through a systematic process of gathering data from a sample of Laotian New Zealanders. The process, including sampling, inclusion criteria and interview procedure, is presented in this research report (Finfgeld-Connett, 2010).

Dependability is another important aspect of trustworthiness as it shows that the study results are consistent and repeatable (Chowdhury, 2015). In this study, all research-related items included recordings, field notes, and translated drafts were kept by the researcher to ensure consistency throughout the study. The researcher also performed member checking and collaborated with a researcher/co-translator to verify the accuracy of the participants' statements (Creswell, 2013; Lincoln & Guba, 1986).

In addition, establishing confirmability was also necessary. This was ensured by documenting processes related to the study's data collection, analysis, and interpretation (Krefting, 1991). In this study, all processes related to data collection, analysis, and interpretation, as well as all unique and interesting information, were documented and transcribed throughout the entire research process in order to ensure the confirmability of the study (Carcary, 2009; Lincoln & Guba, 1986).

### **3.6 Ethics application and amendments**

#### **3.6.1 Overview of the process**

Any study that involves people or population subjects can generate and raise complex ethical, legal, social, and political issues. According to Walton (2019), research ethics is a field that investigates ethical issues that arise when people are involved in a research project. The aims of research ethics are to protect the rights of individuals involved in

research and ensure that ethical considerations are followed when conducting research. They also consider the protection of confidential information, the management of risks, and the consent of the subjects (Berg, 2004). In this study, the researcher avoided the possibility of harm to the respondents through various approaches.

First, the participation of the participants was entirely voluntary, and they had the right to withdraw from the discussion and interview at any time before the analysis stage. After Lao community leaders introduced the research topic and the researcher to the Lao community, the potential participants were given the PIS. The PIS, provided in both Lao and English versions, indicated details about the project, such as study objectives, the time and place of the interview, the inclusion and exclusion criteria, the protection of each participant's privacy, as well as the various steps involved in the study. Also, potential interviewees were informed about the usage of participant numbers instead of names.

Those who expressed their interest were contacted and sent written consent forms by the temple. Before and after signing the consent form, the participants were also informed about the importance of the data and the potential benefits of the research. They were also invited to ask any questions directly in person. After the interviewees signed the consent forms, the researcher retained the forms.

Participants had several rights when it came to participating during the interviews. These included the right to withdraw, to not respond, and the opportunity to pause in the middle of answering. Participants' opinions, privacy, and interests were also prioritised. Moreover, despite the availability of counselling services at AUT, no participants expressed discomfort or reported feeling at risk during the interviewing process.

### **3.6.2 Compliance with ethics requirements and Treaty of Waitangi expectations**

This research was approved by the Auckland University of Technology Ethics Committee (AUTEC) on 30 March 2021 (AUT Reference number 21/13), as attached in Appendix I. As the researcher is originally from Laos, being from the same country of origin, and sharing the same language with the Laotian New Zealander community, helped to strengthen the researcher's in-depth understanding of the social and cultural context of this community. In addition, the three principles of partnership, participation, and protection of the Treaty of Waitangi (Te Tiriti o Waitangi) were also employed throughout this study (New Zealand Ministry of Health, 2014).

With regard to a *partnership*, this research was conducted in consultation with community leaders at Wat Lao Buddharam temple in Auckland. It sought to understand the uptake of COVID-19 public health advice by Laotian New Zealanders, with potential to improve their health status and pandemic control in the future. The research was also

designed to ensure that all participants were treated fairly and with due regard to their rights. All participants were also given equal access to information about the project.

In terms of **participation**, study participants were given the right to withdraw at any time during the interview stage. They could also decline to answer any question and stop the interview if they were uncomfortable with the situation.

With specific respect to **protecting** the privacy of the participants, before the participant provided written consent, they were given a chance to ask questions and raise any concerns. Also, participants' identities were protected by using numbers instead of names throughout the study. In addition, all the data and documents (both electronic records and hard copies) related to the study were kept confidential by the researcher and his supervisor. The data storage and disposal plan also complied with AUTECH's latest protocols. All participants were informed about the various steps necessary to protect their privacy and confidentiality both before and after signing the written consent form.

### **3.7 Research output**

The research project was submitted for review by academic staff members in the Auckland University of Technology. The researcher plans to publish his work in a peer-reviewed international journal.

### **3.8 Chapter summary**

The chapter focused on the QD methodology, which was underpinned by an interpretive paradigm and its associated procedures. It also covered the various steps involved in the collection and analysis of data such as the sampling approach, recruitment procedures, the analytic methods, and how the research was carried out to ensure compliance with ethics requirements.

## Chapter 4 Findings

### 4.1 Introduction

This study aimed to investigate how Laotian New Zealanders obtained, interpreted and acted on COVID-19 public health advice during Alert Level 4. Despite the challenges involved in conducting in-person interviews during the COVID-19 pandemic, the researcher was able to carry out face-to-face interviews in 2021 as well as conduct his analysis. This chapter discusses the steps taken to identify themes and sub-themes in this qualitative study. It also relates insights from the thematic analysis to the research questions.

### 4.2 Identification of main themes and sub-themes

The application of the NVivo coding process provided a rich set of responses on the uptake of COVID-19 public health advice and healthcare-seeking behaviour by those interviewed. These responses could be grouped into nine sub-themes and associated parent and child codes which were then clustered into three main themes which are listed in the researcher's codebook (see Appendix K). These themes were then organised and clustered by the researcher and his supervisor to create an integrated mind-map as illustrated in Figure 3, below.

Figure 3 presents the main themes identified through this process: socio-economic characteristics and family profile (Theme 1), individual capability and self-beliefs (Theme 2), and exposure to diverse information sources (Theme 3). The nested sub-themes are shown on both the left and right sides of the figure. The sub-themes for socio-economic characteristics and family profile are presented in the orange boxes on the left, the sub-themes for individual capability and self-beliefs are illustrated in blue boxes on the right, and the sub-themes for exposure to diverse information sources are shown in the green boxes on both right and left of the main themes.

**Figure 3**

*Mind-map of main themes and sub-themes related to the uptake of COVID-19 public health advice among Laotian New Zealanders during Alert Level 4, in 2020 in Auckland, New Zealand*

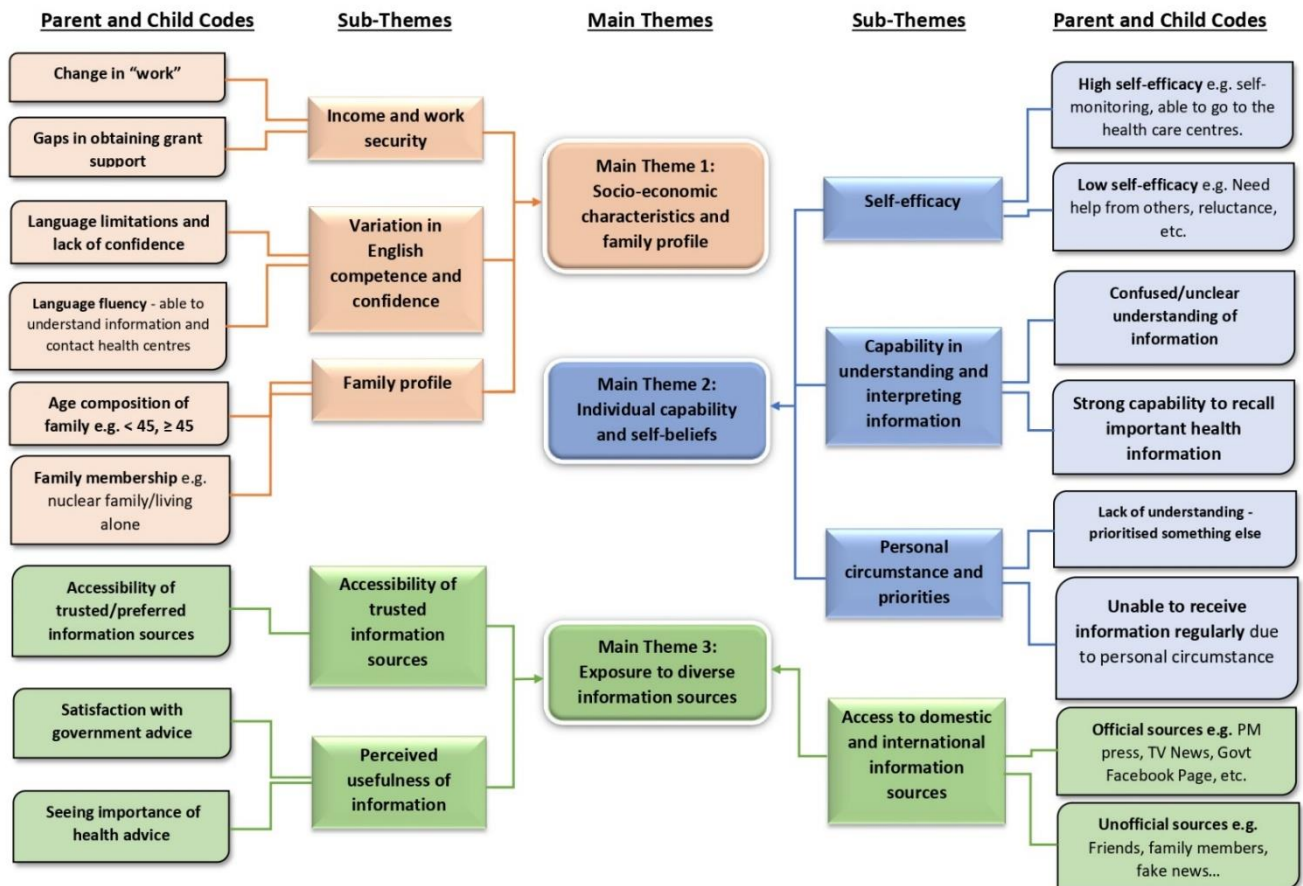


Table 2 presents a summary of the major themes and sub-themes.

**Table 2**

*Main themes and sub-themes from thematic analysis of participant interviews*

<b>Main theme 1: Socio-economic characteristics and family profile</b> <b>Participants' socio-economic characteristics and family profile that affected the receiving of health information and healthcare utilisation</b>	
<i>Sub-themes</i>	<i>Descriptions</i>
A) Income and work security	Income and work that could affect individuals' access to health information and healthcare utilisation.
B) Variation in English competence and confidence	How language competence and confidence affected access to healthcare information and utilisation.
C) Family profile	Family characteristics that could affect individuals' access to health information and healthcare utilisation.
<b>Main theme 2: Individual capability and self-beliefs</b> <b>Participants' capabilities and beliefs that impacted health-information-seeking and healthcare-seeking behaviours</b>	
A) Self-efficacy	Individuals' beliefs in their capacity to carry out their actions in relation to healthcare seeking.
B) Capability in understanding and interpreting health information	The perception of participants regarding the most significant public health messages during Alert Level 4.
C) Personal circumstances and priorities	Adverse attitudes towards adhering to rules and health information.
<b>Main Theme 3: Exposure to diverse information sources</b> <b>Effect of participant confidence and trust in information sources that affected their perceptions</b>	
A) Accessibility of trusted information sources	How participants identified specific sources of main public health information that they trusted and preferred.
B) Perceived usefulness of the information	How participants perceived and valued the public health information and advice from the government during the Alert Level 4.
C) Access to domestic and international information sources	Main health information sources consulted by participants during Alert Level 4.

### **4.3 Main Theme 1: Socio-economic characteristics and family profile**

In this research, the participants' socio-economic characteristics and family profiles played a key role in their responses to the advice they received from health authorities during Alert Level 4. These comprised income, work security, English competence and confidence, and their respective family profiles.

The 10 participants reflected a wide range of households ranging from two people who lived alone to multigenerational households with up to nine members. During Alert Level 4, none of those interviewed reported working from home, with six receiving some form of government grant assistance (including superannuation payments), and three being in essential worker employment. While only two participants spoke fluent English, all those interviewed had at least basic skills in spoken English.

#### **4.3.1 Income and work security**

Income and work security were repeatedly identified as sources of concern by participants. Most of the participants stated that they were able to receive wage subsidies from the government even though they had to stay home, or their family members were working from home. Some of them were able to manage their expenses and did not experience financial problems. In relation to health seeking, the government's wage subsidy support was essential for preserving participants' financial access to health services. This included doctor's consultation or paying for pharmacy products. In these circumstances, their access to important health services was not affected during the pandemic.

*I did not have these kinds of problems because I am always aware of my incomes and expenses, so you should concern and have your own responsibility. (Participant 5)*

*We didn't experience these problems, as my children also received their wage subsidy and worked from home. For other people that I know, I think they didn't have these problems because, in New Zealand, unemployed people also receive government subsidies as well as older people. (Participant 6)*

Some participants also expressed concerns about changes in their work during the course of the lockdown, but this did not link this to difficulties in accessing public health information or their ability to access health services. Although most participants did not report problems with their income and jobs, some individuals were still worried about applying for a wage subsidy. For instance, participant 7 reported that some Laotian families who were having difficulties applying for wage subsidies called him to seek help, especially those who were self-employed and unable to understand or get information by themselves.

*I mostly was worried about my work. For example, I had my plan to finish some work, but government announced the Lockdown, so I had to stop it until the Alert*

*level was lifted. However, my clients mostly understood the situations, it didn't affect that much, and I always received health information as normal. (Participant 8)*

*There were some Laotian who were self-employed, and they had some problems and financial hardship during the lockdown. Some of them didn't know how to apply wage subsidy from the government, so they called me, and I then suggested them someone who was able to help them. (Participant 7)*

#### **4.3.2 Variation in English language competence and confidence**

The focus of this sub-theme was an exploration of how participants' language competence and confidence affected their access to healthcare information and its use during Alert Level 4. As English is the second language for most Laotian families, language competence and confidence were expected to affect participants' information-seeking and healthcare-seeking behaviour due to their limited capacity to understand and interpret the health information provided.

As receivers of information, eight participants reported that they did not fully grasp English and could only understand parts of the information they received. The other two participants explained that even though they could understand most of health information, they were worried about some of their family members and the older generation of the community with limited English competence.

*Most of the health information here was mostly in English, I would understand some if it was not a difficult word. (Participant 9)*

*I watched the news in English, and I mostly understood English as well as other people in my family. I think the older people probably had some problems in receiving health information due to the language barriers and I just informed them some news or important health information. (Participant 8)*

When asked about their language competency in accessing healthcare services, most participants replied that they were able to contact Healthline or healthcare providers by themselves during the lockdown, as most of them had registered with a general practitioner (GP) at a clinic for normal and routine appointments. In addition, even though there were some language barriers in communication, participants did not report major issues in communication. This was due to their capability in speaking basic English for health consultations. Some participants also explained that they were able to ask their family members or interpreters from information centres to help them when contacting their clinic or Healthline operators.

On the other hand, as active health care seekers in Auckland, many participants felt sufficiently confident in their English communication capability.

*I first called to the operators [probably Healthline] for an appointment. They asked me about COVID symptoms and told me to stay in the car. I called them by myself*

*in English, even I didn't fully understand everything [she then added]. (Participant 4)*

*If I had to go to see the doctors or had some health problems, I would call 111. If I want to meet doctors, I would tell them an ambulance. They then would ask my name and address and they would come to my house directly... If I didn't understand some information, they would ask me about languages that I prefer to speak, and they would find an interpreter for me. (Participant 5)*

#### **4.3.3 Family profile**

This sub-theme reflects the participants' family characteristics that affected individuals' engagement with health information and their healthcare utilisation, including the family's age composition and membership. As described in Chapter 3, the primary healthcare decision-makers interviewed were divided into two main groups: those aged under 45 years, and those aged 45 years and over.

Information gathered from participants in these younger and older age groupings indicated differences in health-information-seeking behaviour. For instance, the younger primary healthcare decision-makers (participants 8 and 10) reported being flexible on the variety of media sites and sources they used to receive health information. As indicated below, they had greater English fluency and reported engaging easily with social media platforms. This enabled them to be updated simultaneously with advertisements and livestreams on Facebook Live from the government (Craig, 2021).

*I didn't have any problems because I was always able to access to the internet and watch Facebook Live on my phone. The government always kept us update before they did the press. (Participant 8)*

*I would say that I updated news almost every day and hour during the lockdown especially during the initial stage of Level 4, I was always excited to watched news and updated the number of infections... I think I can access to health information advertisement from NZ Government everywhere. (Participant 10)*

However, older families, reported mainly receiving news from TV. They also explained that they needed younger family members to interpret significant information due to their limited English competency. Participants who lived alone (participants 3 and 5) were likely to rely on themselves when it came to information and healthcare seeking, even though they also faced some language barriers when compared to other participants who lived with partners and/or children.

*I live alone... I am always careful about what I am doing, didn't take any risks. But if I wanted to get a test, I definitely know how to go to the clinic by myself. (Participant 5)*

*As the news was in English, I would say that I could understand some, but not 100%. If I needed more understanding, I would call and ask my children. (Participant 7)*

## 4.4 Main Theme 2: Individual capability and self-beliefs

This theme emerged as a key determinant of the participants' health-seeking behaviour. It incorporates dimensions of understanding, interpretation and personal beliefs that affected health-information-seeking and healthcare-seeking choices. The theme comprises three important sub-themes identified during the interviews: self-efficacy, capability in understanding and interpreting information, and personal circumstances and priorities. This theme also reflected the perceptions of Laotian New Zealanders about the main public health messages that they could recall during Alert Level 4 and how they acted on this advice.

### 4.4.1 Self-efficacy

Self-efficacy is recognised as a key element in health seeking and refers to individuals' beliefs in their capacity to carry out their actions in relation to healthcare seeking (Bandura, 1977). In this study, many of participants described actions that indicated high levels of self-efficacy. For instance, the participants below described how they observed health symptoms or self-monitored, self-medicated or contacted healthcare providers when they experienced health problems.

*We often observed our symptoms, but we didn't get a test. We really had confidence as we always followed the rules and protected ourselves. (Participant 6)*

*I called to my family doctor and went to the clinic. I had done one COVID-19 test and the result was negative. Other people in my family didn't have any symptoms. There are some of my friends who were worried about COVID-19 infection and reluctant to get a test, but they just observed their symptoms, and everything was fine... I sometimes took some medications for the initial treatment by myself at home before seeing the doctors. (Participant 1)*

Other participants explained that they could contact their doctors and adjust routine appointments regarding chronic health problems during Alert Level 4. They were able to go to their health centres or clinics by themselves when they had health problems. They were also able to understand healthcare service constraints and were able to suggest important health information to others.

*We went to the clinic after setting an appointment. The healthcare providers told us to stay outside in the car, they then gave me the prescription while I was sitting in the car. I think it was quite slow, but I didn't have any problems with that. (Participant 7)*

*I went to see my GP as usual because I have diabetes and need prolonged treatment [medication], but in my family, we didn't have any other health problems. When I went to the clinic, I always listened and followed the rules. I met the doctor once a month for each appointment and practised social distancing and wore a mask [he added later]. I just went to the clinic by myself as it was very near my house. (Participant 6)*

However, thematic analysis also indicated some participants who had low self-efficacy. This was because they were unable or did not have the confidence to act on health information and advice. Those with lower levels of self-efficacy also replied that they needed help from others to get more understanding of health information and access to healthcare services. For instance, participants with very limited English language competence sought support from other family members.

*I just understood some parts of information and my daughter interpreted it for me. If I didn't understand anything, I would ask my daughter to translate the news for me for instance case number, or where the outbreak has occurred. (Participant 2)*

*For my wife, as she cannot drive and speak English well, she has to wait for me, and I would take her to see doctors. I always do it for her. (Participant 7)*

Participant interviews also revealed barriers to efficacy. These were reflected in a reluctance to use healthcare services due to expectations that this would be difficult and complicated, as indicated below.

*I think it is quite complicated to call to the health centre and they would transfer my line to others, sometimes, more than two steps and transferring, it would be great if we can talk to doctors directly. Sometimes, if just had mild symptoms, I decided not to call as I was afraid that it would be a long wait for sure. (Participant 10)*

#### **4.4.2 Capability in understanding and interpreting health information**

This second important sub-theme captures how participants understood and recalled Alert Level 4 rules and complied with them. Thematic analysis indicated that participants demonstrated a strong ability to recall important health information and rules to keep themselves safe. These included staying at home and in their own 'bubbles', practising two-metre social distancing while going outside, assigning only one person to do grocery shopping, scanning QR codes when going to public places and workplaces, and, if sick, contacting Healthline. This level of recall is illustrated by the statement below.

*Protecting ourselves from the virus. They advised us to stay at home especially older people. During that Level 4, even though I heard that the abbot of this Lao temple was sick, as I normally came to visit him, but I had to stay at home. We should not go outside and don't let others come inside the house. My children only came to drop off supply and grocery at the house and left it at the front door while they were living in another place. (Participant 7)*

*Practised two-metres social distancing, the most important message was to help each other when facing problems. Other messages were also "do not break the rules given" such as do not go outside or gathering. I remembered this from the news on TV. (Participant 5)*

Despite evidence of detailed recall of Alert Level rules, a small number of participants who were older could not remember these rules. They also wrongly mixed up the rules due to other unofficial sources, or their personal beliefs and choices. These

misunderstandings of health information, incorrect interpretations, and differing cultural and personal beliefs contributed to some inappropriate actions by participants.

One message often recalled was that people should wear a mask while going outside during Alert Level 4, although during that time, there were no rules regarding mandatory mask wearing. Such beliefs reflected the influence of unofficial sources related to mask wearing to protect themselves from virus. This was reinforced by messaging at the front of some grocery stores that stated customers must wear a mask before entering the shops. Participants also reported concerns about being fined or caught by the police if they did not wear masks or went outside, as in Australia (Glitsos, 2021). This was illustrated in the following comment.

*Don't go outside. If going outside, you have to wear a mask, if you did not wear it you would be fined \$1,000 by the police. I received this information because I watched the news. I also saw the police around my community to check if people were outside. (Participant 2)*

#### **4.4.3 Personal circumstances and priorities**

The third sub-theme relates to how the participants' personal circumstances and individual priorities limited their compliance with rules and health information. A small number of participants reported that they did not follow the rules provided, even though they could accurately recall them. This was attributed to not fully appreciating the reasons behind the rules, or because the participants prioritised duties that were not officially considered to be 'essential' during Alert Level 4. This is illustrated by the following sentences

*I normally live alone but I went to stay with my cousin during lockdown Level 4. Even though people in the house told me to stay at home, but I had to go outside as there were some people calling me to help them such as cleaning the house and cutting the lawn. Sometimes, I also went out to do massage job if people called to do so (as I normally do it), even it was in lockdown Level 4 [he insisted]. (Participant 3)*

*Some of Laotian that I know of did not follow the rule strictly. E.g., if they wanted to come to my house, they just came, even though the government told us to stay at home, but they came to knock on my door as they usually did it. I think those people acknowledged the rule, but they just didn't really care about it. (Participant 6)*

Participant responses also highlighted a wide range of personal reasons for uneven engagement with the health information provided. For instance, in the comment below, participant 10 said that, for emotional reasons, such as being overstressed and receiving sad news, she decided to stop following the news for a while.

*Sometimes, I think I received too much information such as in the 1st and 2nd week, I updated news every hour, in the 3rd week I felt over stress and I sometimes turned off my phone and stopped receiving health information for a while. Apart from this, during that lockdown, my father who lived in Laos passed*

*away, even so, I could not go back to his funeral, so it was hard for me to get through as well. (Participant 10)*

### **4.5 Main Theme 3: Exposure to diverse information sources**

This final theme reflects participant perceptions on the trustworthiness of different information sources related to healthcare seeking in Alert Level 4, and their confidence in that information. The theme includes the accessibility of trusted information sources, perceived usefulness of information, and access to domestic and international information sources. Participants described their official and unofficial sources of health information and explained their preferred sources, as well as the usefulness of the information provided.

#### **4.5.1 Accessibility of trusted information sources**

Thematic analysis revealed that the two most preferred public health information sources during the lockdown were Facebook and television. Five participants replied that the Facebook platform was their favourite and preferred information source. They highlighted the Facebook Live function because it was “fast and up to date” on the daily announcements from the New Zealand Government.

*My preferred source was Facebook. I received and watched the official government announcement from Facebook. I mostly watched the summary announcement and main information from the prime minister, as the whole session was quite lengthy. (Participant 10)*

In addition, four participants also explained that television was their preferred source. The older participants liked to watch the news and official announcements with their families at home. The same participant added:

*I would say that I updated news almost every day and hour during the lockdown especially during the initial stage of Level 4, I was always excited to watched news and updated number of infections. (Participant 10)*

#### **4.5.2 Perceived usefulness of information**

Participants expressed their opinions on how they perceived and valued the usefulness of health information during the strict lockdown. Most participants reported that they were satisfied with the public health advice from the New Zealand Government during Alert Level 4 as they received very clear information that they trusted. This gave them the confidence to follow the rules.

Participant 4 mentioned that the “New Zealand government are very good in taking care of their people, I really praise them”. Some participants also replied that the government really did an excellent job in terms of providing information, and they knew how to protect themselves and follow the rules.

*I think NZ Government quite pays attention to their people, especially to people's life. When compared New Zealand to a certain country, I would say that NZ Government can help their people almost 100%. (Participant 5)*

*I had uncertain feelings, and after I received news from government, I felt more confident and safer to live. The government told us how to continue a daily life under this circumstance and I think most New Zealanders also followed the rules. I think I can access health information advertisements from NZ Government everywhere... I think NZ Government try to reach their people in every way; for example, in the restaurant that where I worked, NZ Government or council made information accessible by public, meaning that both employer and employees were aware of government policy. (Participant 10)*

Most participants also expressed the view that the health information from the government was significant during the COVID-19 pandemic as it made them aware of the virus. They also learned how to prevent the spread of the virus, how to monitor their symptoms or go to see the doctors.

*It is very important as we can't see this virus, but we can just prevent it. We had to strictly follow and listen to the government as they had daily announcements. They will explain and guide us for each stage of Alert Levels, so we just follow them. I think people in NZ and Laos, quite listen to government and follow the rules, so the COVID situation was quite a under control. However, in some other countries, their people didn't listen to Govt and were too silly, so the situation was getting worse. (Participant 6)*

Some participants responded that not all information from the government was important as some advice was not related or specific for them. This need for more focused information is shown by participant 5's observation below.

*It was important 50/50 and it depended on us because some information was not specific for me, and it was general. If I wanted some specific information for me, I would call and ask them specifically. It would be important if that information was related about me, and it was things that I was interested in. (Participant 5)*

#### **4.5.3 Access to domestic and international information sources**

This sub-theme reflects how participants accessed their main domestic and international sources of health information. For health information in New Zealand, most of those interviewed explained that they usually received official information from TV and the government's official Facebook pages such as the news and the prime minister's media conference. In addition, a limited number of participants answered that they sometimes received health information from their GPs and family doctors.

*I received health information from news on TV and sometimes from the clinic. I watched English news from the prime minister. (Participant 2)*

*I mostly watched TV, Facebook, and YouTube. NZ Government always announce us earlier before their press conference and after the finished conference, the announcers would also tell us details of the next press conference. The main points of their announcement were mostly about COVID-19, the negative impacts of this virus, and ways how to prevent it. The press conference was announced in English, mostly from the NZ PM, and the ones who*

*was representative and response for NZ COVID team, cannot remember his name. (Participant 6)*

For domestic, unofficial sources of health information, participants mostly received news from their family members and sometimes from friends and co-workers. As most of the participants had a limited capacity to understand English, the translated version of information provided by their family members, especially the younger generation, influenced their understanding and interpretation of messages. Participant 10 also reported that as some of her co-workers were “not good in English”, when they shared information, this information was different or inaccurate.

*I sometimes received the lockdown information from my workplace and exchange information with my co-workers who a majority of them are Pasifika. My children sometimes received the news faster than me and they informed me and my husband. (Participant 1)*

*Some chefs who worked with me, didn't understand English well, so they would always confirm the news with their friends. I think sometimes it was not reliable as it was not first-hand information. I knew that when they shared information that they received to me. Moreover, there are the older people who came to live with their children in NZ and stranded, I am just afraid that how much will they understand health information if they receive it from their children. (Participant 10)*

On international sources of information, participants referred to international TV channels especially Thai and Lao TV channels. Due to the similarity between Lao and Thai languages, some of the participants preferred to get updated news from Thai channels which were varied and popular. Participant 7 said, “*Mostly I watched general news about Laos from Lao TV channels, Thai and also Australian channels*”.

On informal sources, participants mostly received news and information from the overseas relatives they normally contacted. They also reported receiving unofficial news from Facebook that was shared by their friends on this platform.

*I received overseas news from Facebook, news that my friends shared. I liked to get updated because some of my families are still living in Laos. (Participant 8)*

#### **4.6 Findings in relation to research questions**

This study aimed to investigate the COVID-19 health seeking and health information seeking among Laotian New Zealanders during Alert Level 4.

The first research focus was the main sources of public health information consulted by Laotian New Zealanders. On the official sources of health information, participants preferred to receive news and official media briefings from domestic television, and government or official New Zealand television Facebook pages. This was because they described these as being fast and up to date. On international official sources, they mostly watched the news from international television channels, especially Thai and Lao

television due to similarities in culture and language. Unofficial sources of health information, news and information included family members, sometimes friends, co-workers, or overseas relatives. A limiting factor was fluency in English, especially for older participants.

The second question examined participant perceptions of the most significant public health messages during Alert Level 4. Some participants showed a strong ability to recall and remember key messages like staying in at home, practising two-metre physical distancing, or trying to send one person per household to do the shopping. This reflected confidence in the government's public health advice and willingness to strictly observe the rules.

However, other participants expressed their unclear understanding of information due to wrongly understood or "mixed up" rules, as well as the choice not to follow the rules because of personal beliefs and circumstances.

On the question of health-seeking behaviour during the Alert Level 4 in 2020, research findings illustrated how participants' perceptions of self-efficacy influenced their beliefs and capacities to carry out recommended actions and behaviours. Most of those interviewed showed high levels of self-efficacy, with healthcare actions including observing and self-monitoring symptoms as well as self-medication. Participants were also able to contact healthcare providers and go to health centres when needed. On the other hand, a small number of participants showed low self-efficacy as they were unable or did not have the confidence to act on health information and advice because they needed help from others or were reluctant to access health information or healthcare services during Alert Level 4.

With respect to the fourth research focus on the factors that hindered or enabled understanding of public health advice, findings indicated that participants' socio-economic attributes, such as English competence and confidence, family profile, and income and work security, played crucial roles. As English is a second language for the majority of Laotian New Zealanders, language competence and confidence affected participant understanding and their interpretation of health information.

Family profile also influenced Laotian New Zealanders' information access. While the older participants, with limited English competence, required help from the young generation, younger participants with greater English language fluency could actively engage with social media and access health information easily and regularly.

An unexpected finding was the contribution that work security and stable income played in preserving health-seeking practices. For several participants, access to wage

subsidies not only reduced livelihood anxiety, but also ensured available resources to pay for medical consultations or pharmacy products. In this context, findings highlighted difficulties in “wage subsidy” seeking, as several participants described a lack of clarity in accessing subsidy support.

Figure 4 relates the sub-themes identified to the four main question areas. Cell-shading indicates that a sub-theme played a role in one or more of the four research question areas. The figure highlights the important contribution of participants’ socio-economic attributes in shaping health-seeking behaviours. It also indicates the influence of multiple information sources (both domestic and international) in health seeking and health information seeking, reflecting the wide range of sources available to participants.

**Figure 4**

*Summary table relating main themes and sub-themes to research focus areas*

Research focus areas	Income and work security	Variation in English Language	Family/Household Profile	Self-efficacy	Capability in understanding	Personal circumstances	Accessibility of trusted info sources	Information Usefulness	Access to domestic and international information
Main sources of public health information									
Perceptions of most significant public health messages									
Health-seeking behaviour									
Barriers and enablers									
Main themes	Socio-economic characteristics and associated sub-themes			Individual capability and associated sub-themes			Diverse information sources and associated sub-themes		

## 4.7 Chapter summary

Study findings revealed three main themes and nine sub-themes that were crucial in the participant COVID-19 health seeking and health information seeking. Results highlighted the importance of participants’ socio-economic characteristics and family profiles in their preferred sources of health-information actions and health-seeking behaviour. They also indicated the barriers to accessing public health advice as well as factors that improved understanding and access to health services.

## **Chapter 5 Discussion and Conclusion**

### **5.1 Introduction**

This chapter discusses the research findings about how Laotian New Zealanders accessed, interpreted and acted on COVID-19 public health advice during Alert Level 4.

It begins by highlighting the role of socio-economic factors that shaped participants' access to public health advice and health seeking. It continues by examining self-efficacy, trust and compliance with public health advice during lockdown and also suggests implications for risk communication and community engagement. The chapter concludes by proposing directions for future research and improved policy and practice.

### **5.2 Role of socio-economic factors in accessing public health advice**

The study's findings highlighted the important influence of the participants' socio-economic characteristics and family profile, both for health seeking and for accessing public health advice. This was reflected in participants identifying work security and income as their major concerns. The government's provision of wage subsidies ensured the security of livelihoods, enabling participants to pay for doctors' consultations or pharmacy products. Government measures such as the wage subsidy during Alert Level 4 brought stability and continuity to households, reducing their "uncertainty as experience" during lockdown. This was despite the uncertain and rapidly changing public health information they were receiving on COVID-19.

Sopory et al. (2019) distinguished between the "uncertainty as information" received during public health emergencies and the "uncertainty as experience" lived, noting the importance of managing both. This is viewed as especially important for vulnerable groups who must manage multiple forms of livelihood and other uncertainties. In the context of this study, participants' access to wage subsidies was significant for reducing this key aspect of uncertainty during lockdown and ensuring financial access to health services.

The participants' family profiles, including age and household composition, played a key role in their preferences for specific information sources. Older participants reported more limited English language capability and preferred to use more conventional information sources like the news on television. However, younger participants had higher levels of English competence and were able to access a wide range of social media and other sources. This finding is consistent with observations by Toppenberg-Pejcic et al. (2019) that underlined the continuing importance of conventional news sources. They noted that people who received information on disease outbreaks from

more conventional sources were also more likely to be better informed than those whose sources were social media, friends, or family (Abramson & Piltch-Loeb, 2016, as cited in Toppenberg-Pejcic et al., 2019).

### **5.3 Self-efficacy, trust, and compliance with public health advice**

#### **5.3.1 Self-efficacy and the “paradox of trust” (Wong & Jensen, 2020)**

Results illustrated some variation in participants’ interpretations of public health rules, with most signalling high levels of knowledge, self-efficacy, and compliance with official public health advice. This included being able to recall important Alert Level 4 messages such as staying at home, practising two-metre physical distancing, or trying to send one person per household to do the shopping, as well as accessing clinics, Healthline or other services. Such responses are expected when there is confidence and trust in government that results in individuals understanding and observing official instructions (Coltart et al., 2017).

However, interview findings also showed “the paradox of trust” discussed by Wong and Jensen (2020) in relation to compliance with COVID-19 health messaging in Singapore. They noted that high trust in public authorities may also reduce pressure for individuals to adopt recommended health measures. This was due to individual confidence that the government would take all necessary steps to protect public health and safety (Wong & Jensen, 2020). In this Auckland-based study, Laotian participants repeatedly underlined their trust and confidence in the government’s approach. On one hand, this enhanced participant compliance with public health advice; on the other, for some participants, it may have reduced their sense of urgency about the need to personally adjust behaviour to follow public health advice. For example, a small number of participants reported that they did not follow the rules provided and prioritised duties that were officially viewed as ‘non-essential’ during Alert Level 4. This suggested that they perceived COVID-19 to be a lesser concern than other issues they faced and one that was being well managed by government authorities.

#### **5.3.2 Relevance of the health belief model (HBM)**

Interview findings on self-efficacy highlighted the continuing relevance of the HBM. Consistent with the application of the HBM, findings revealed some participants whose limited English language competence reduced their perceived self-efficacy in accessing information and health services. These participants reported that they depended on family members to assist them in navigating the health system.

The finding is in line with the observations by Vaughan and Tinker (2009) who noted that members of minority communities prefer to rely on their relatives or friends for

emergency preparedness advice instead of relying on the public sources, with limited English competence being one of the main barriers.

Other results indicated how personal circumstances perceived to be more serious than COVID-19 led to some participants to consciously disregard public health messages about physical distancing or staying at home. This is consistent with findings by Charania et al. (2019), who cited personal beliefs as a potential factor that might contribute to health disparities among migrant communities.

While these observations illustrate the continuing relevance of the HBM (Glanz et al., 2008), they also indicate its shortcomings. For instance, the influential role of socio-economic conditions identified in this research is only briefly addressed as “modifying factors” in the original model. This study also highlights the important contribution of varied information sources used by participants that would not have existed when the model was developed or even in the Glanz et al. (2008) conceptualisation (see Figure 1 in section 2.3.2).

#### **5.4 Insights on health seeking and health information seeking**

Study findings provided insights on participant health seeking and information seeking. They highlighted the importance of preserving and protecting the stability of existing health services in times of public health emergency. Most participants had long-standing relationships with clinics and doctors, which they were able to continue during lockdown. This meant that they were not required to seek new services during Alert Level 4. These patterns of health seeking through local doctors and clinics were also consistent with health-seeking behaviours reported from Laos by Mayxay et al. in 2013.

If this stability of primary health services had been disrupted by a surge in infection (as occurred in other countries), participants’ reported experience of health seeking may have changed substantially.

These results on health seeking in part reflect the fact that most of those interviewed had lived in Auckland for than 20 years and had well-established connections with their primary healthcare providers. Other literature on newly arrived migrants or refugees has underlined the barriers they face in accessing health services. Charania et al. (2019) noted that there are number of factors that contributed to migrants’ health disparities. These included issues of culture, the duration of their stay, generation status, communication skills, and their personal beliefs. Other constraints identified were living and working conditions, migrants’ limited knowledge, and limited networks, as well as their access to rights and level of inclusion in their host communities (IOM, 2020).

## **5.5 Risk communication in public health emergencies**

### **5.5.1 Challenges for risk communication and community engagement**

Study results highlighted gaps in global approaches, especially on risk communication and community engagement. Despite WHO's global policy focus on two-way information exchange and community engagement, in the study, participants did not report any engagement with the health authorities. They did not refer to accessible information in Lao language and were required to draw on Thai language sources for information. This experience is not consistent with the objectives of RCCE, which in principle has an essential role for promoting people-centred and community-led strategies in reducing the impact of pandemics (Gilmore et al., 2020). The accounts of Laotian participants underline the challenges faced by "invisible" ethnic minority groups that may be overlooked by public authorities (IOM, 2020). They also highlight Laotian cultural and historic communication patterns that are characterised by compliance, politeness, and respect for authority (Dinh & Groleau, 2008). Risk communication involving such communities requires that authorities apply a wider range of outreach and engagement efforts to identify less visible and invisible groups that may be overlooked in mainstream communication. For instance, Toppenberg-Pejcic et al. (2019) stressed that effective emergency communication involves building a local network and communicating with local authorities and communities.

### **5.5.2 Approaches to health information seeking: Local, national, and international**

This research profiled the importance of understanding how people seek health information, in addition to the role of centrally developed generic risk communication strategies. Results from this study show that health information seeking varies depending on age, English competence/confidence, household profile and established patterns of information gathering (for instance, via television or social media).

Most participants explained that they usually received official information from TV and the government's official Facebook pages, and some received health information from their GPs and family doctors. However, in terms of the unofficial sources of health information that they used, participants mostly received news from their family members and sometimes from friends and co-workers as the unofficial translated and interpreted version of information. These results resonate with observations by Vaughan and Tinker (2009), who noted that minority communities prefer to rely on their friends, families, or relatives instead of public information sources for emergency preparedness advice; they also noted that this may also influence migrant perceptions and preparedness for emergency events.

This study's findings highlight the importance of transboundary information sources. Participants reported drawing on information from Laos, Thailand, Australia and elsewhere. While this clearly widened their scope of information sources, it also increased the chance of confused messages given the blurring of information presented from across the world. One example was participants' recollection of \$1,000 police fines for not following rules. While this measure was instituted in Australia (Glitsos, 2021), it was not in the case in Auckland or anywhere in New Zealand. These findings underline the emerging challenges of simultaneously managing an epidemic and an infodemic, where the public is exposed to multiple and often conflicting sources of information (Islam et al., 2020).

### **5.6 Barriers and enablers of information and health service access**

Research findings on the barriers and enablers of Laotian New Zealanders' understanding of advice on accessing and utilising healthcare services indicated that most participants referred to language competence and confidence as the main barriers to their understanding and interpretation of health information. These results match those of Abuelgasim et al. (2020) who noted that cultural and language barriers, social and economic conditions, and distrust of government authorities are important obstacles to effective risk communication. It is also in line with results obtained by Vaughan and Tinker (2009), who found that language barriers can affect the translation and interpretation of important messages, leading to inaccurate or inappropriate use of information with negative implications for migrant groups, despite their increased vulnerability.

Regarding the enablers of access to public health information, the findings highlighted the role played by trust, stability in health services and income, and the continuity and certainty of connections with primary healthcare providers. Participants underlined their trust in official messaging and government media briefings during Alert Level 4 as they received very clear information. The government's response, which included maintaining the stability of primary health services, along with the provision of a wage subsidy, also reinforced trust in official public health advice.

A related enabler was the long-standing relationship that participants had with local clinics and doctors which they could continue during Alert Level 4. This, along with translation support from younger family members, avoided any disruption in health seeking in New Zealand's first lockdown.

## **5.7 Recommendations for policy and practice**

Recommendations for strengthening risk communication with Laotian New Zealanders during public health emergencies are based on the study's results and relevant literature. The recommendations stress the need for more effort in identifying and reaching less visible migrant communities, improved access to translated messaging, and focused strategies to better manage multiple information sources - especially from overseas.

First, as discussed in section 5.5.1, health authorities at all levels overlooked the small Laotian ethnic minority in messaging and translation support. Planning for future health emergencies could be strengthened if health or local authorities applied a wider range of outreach methods to identify less vocal and less visible minority groups such as the Laotian community in Auckland. For instance, despite the size of the Laotian community in Auckland, New Zealand, community leaders and the Wat Lao Buddharam – Association Trust Board New Zealand are central players in the Laotian community and could take a stronger leadership role during public health and other emergencies. These community leaders could help strengthen access by Laotian families to key information. The association could also play a vital role and serve as a bridge between public officials and the Lao-speaking community to better streamline communication in both directions and strengthen support for Lao community members.

Second, having the capacity to rapidly provide more translated versions of public health messages in a variety of languages during emergencies would strengthen the understanding of and adherence to the rules among migrant communities. In this study, participants referred to English language competence and confidence as the main barrier in their understanding and interpretation of health information. Also, according to Tupou (2021), during the COVID-19 pandemic in New Zealand, it was only in 2021 that detailed translations of COVID-19 public health advice were made available in some but not all the Asian languages. Acting upon this recommendation would not only improve the accessibility of public health information by adding more specific languages, but it would also ensure that crucial information reaches a wide range of people in all age groups. Information should be presented on various mainstream platforms and social media to promote effective preventive measures among migrant communities (Yassin et al., 2021).

The third significant issue is minimising and avoiding the confusion of health messages. Based on this study's findings, the use of transboundary information sources and social media increased the scope for confusion in the messages and the blurring of information among participants. In the future, it will be crucial to monitor and manage these factors to minimise misunderstandings and inappropriate behaviours (Cinelli et al., 2020). This would not only help to reduce conflicting sources of information or confused messaging,

but also would enhance the observation of rules and health information during disease outbreaks.

## **5.8 Conclusion**

### **5.8.1 Revisiting the findings and their interpretation**

Previous studies have indicated that, during disease outbreaks, migrant communities are viewed as more vulnerable than their host communities due to complex socio-economic determinants as well as the presence of health disparities. In the context of COVID-19 and the sudden application of lockdown restrictions, social and physical distancing rules, access to health services by small ethnic groups including the Laotian community in Auckland had potential to become even more difficult.

This research has contributed to the advancement of knowledge on how Laotian New Zealanders' COVID-19 health seeking and health information seeking during Alert Level 4. The study was carried out in 2021 by employing a QD approach which was underpinned by interpretivism and adopted semi-structured interviews as the data gathering method. Despite the challenges involved in conducting in-person interviews during the COVID-19 pandemic, the researcher was able to carry out face-to-face interviews as well as analysis within the research timeframe.

The findings highlighted how factors such as the family profile, including age and household composition, played a key role in participant preferences for specific information sources. While older participants reported more limited English language capability and preferred to use more conventional information sources like the news on television, younger participants had higher levels of English competence and were therefore able to access a wide range of social media and other sources.

Results also illustrated the importance of providing certainty and stability in participants' lives. As participants identified work security and income as a major concern, government measures such as the wage subsidy during Alert Level 4 brought stability and continuity to households, reducing their "uncertainty as experience" during lockdown.

Study findings provided insights on participant health seeking and information seeking, which highlighted the importance of preserving and protecting the stability of existing health services in times of public health emergency. As most of the participants had well-established connections and long-standing relationships with their primary healthcare providers, they were able to continue healthcare seeking during lockdown. Participants also repeatedly underlined their trust and confidence in stability and in the government's messaging and approach, which enhanced their observance of the public health advice.

The research also revealed a small number of participants who did not personally adjust their behaviour to follow the public health advice. This suggests that these participants perceived the public health threat to be lesser concern than other issues they faced and one that was well-managed by government authorities.

This study's findings have also highlighted the importance of transboundary information sources and the need to manage these more effectively. While participants reported drawing on information from overseas, clearly widening the scope of their information sources, this also increased confusion in the messages received due to the blurring of information presented across the world. This highlights the need to better monitor and manage multiple sources of information to minimise misunderstanding and inappropriate responses during disease outbreaks.

### **5.8.2 Study strengths and limitations**

Research on Laotian health seeking remains limited, both as this applies to migrant groups, and in relation to risk communication in public health emergencies. This study represents a new contribution to the understanding of COVID-19 health seeking and health information seeking for this low-profile migrant group during Alert Level 4 in Auckland. It also provides valuable insights to researchers and CALD communities in New Zealand who are looking for ways to improve information-seeking and health-seeking behaviour during global public health emergencies such as the COVID-19 pandemic. As both participants and the researcher spoke the same language, Lao, it was possible to examine ways in which Lao migrants navigated Alert Level 4.

Purposive sampling was applied in this study to enable allow the researcher to collect data on a specific population to answer the research questions. However, this sampling method could also be viewed as a weakness. The sample studied might not be representative of Auckland's Lao population or community as the participants were self-selected. In addition, as Alert Level 4 was implemented in Auckland in March 2020, there were multiple adjustments in restrictions and Alert Levels between this date and the timing of the interviews. This may have limited the accuracy of participants' recollections, as it was difficult for participants to remember what they had done a year earlier. It was possible that participants forgot or were confused about the information they received from the public health authorities due to the passage of time since the lockdown.

### **5.8.3 Areas for future research**

The study findings highlight gaps in global approaches to risk communication and community engagement. Despite WHO's global policy focus on two-way "information exchange" and community engagement, participants in the study did not report any engagement with health authorities. Also, they did not refer to accessible information in

the Lao language and were required to draw on other language sources for information. The lack of risk communication research involving ethnic minorities is already recognised and represents a significant research priority (Berg et al., 2021; Sopory et al., 2019; Tambo et al., 2021; Toppenberg-Pejcic et al., 2019).

In addition, there is increasing use of social media in risk communication in public health emergencies. Consistent with observations elsewhere (Toppenberg-Pejcic et al., 2019; Tambo et al., 2021), this study found that online communities played an important role in providing public health information. This highlights the value of further studies to better understand the effect of online as well as geographic communities on information seeking and healthcare seeking during public health emergencies, especially in the case of migrants and ethnic minorities.

### **5.9 Chapter summary**

The chapter has discussed the research findings in relation to relevant published literature. It has also made recommendations for policy and practice, including strategies to improve engagement with less visible ethnic minority groups. The chapter has described the study's strengths and limitations and concluded by calling for further studies to strengthen RCCE, as well as better understanding of the effects of online and geographic communities in health information-seeking.

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## Appendix A: Participant Information Sheet



### Appendix A: Participant Information Sheet

#### Date Information Sheet Produced:

19 January 2021

#### Project Title

Investigating the uptake of COVID-19 public health advice and health service utilisation among Laotian New Zealanders during Alert Level 4, 2020 in Auckland, New Zealand

#### An Invitation

Sabaidee!

I am Phouththanaphone Nedthongsavanh, a Master of Public Health student at the Auckland University of Technology, New Zealand. I would like to invite you to participate in research that investigate the uptake of COVID-19 public health advice on health service access and use among Laotian households during Alert Level 4 in Auckland, New Zealand.

This research is neither associated with any non-governmental organisations nor the New Zealand Ministry of Health. Although I am a scholarship awardee by the New Zealand Scholarship Programme of Ministry of Foreign Affairs and Trade (MFAT), MFAT will not intervene in any part of this research. Participation in this research is completely voluntary and confidential. Whether or not you choose to participate in this research will neither advantage nor disadvantage you. You are under no obligation to participate the interview and you can withdraw your participation at any time during the interview.

This information page will help you decide if you would like to participate in this study. It explains more details about this research, why we are doing this research, who are eligible to participate in this research, how your privacy is protected, and what happens after the research is completed. Please feel free to discuss your decision with your family or friends.

#### What is the purpose of this research?

Due to the Coronavirus disease 2019 (COVID-19), increased illness as well as “lockdown” and travel restrictions have disrupted usual health service delivery. These effects have been particularly marked in migrant and ethnic minority populations due to pre-existing inequalities and inequities related to socio-economic determinants of health. Laotian New Zealanders represent one Asian ethnic minority who faced barriers to health information and service access during Alert Level 4 conditions due to their lower socio-economic status and limited English communication.

Given that the recent COVID-19 outbreak is expected to continue in 2021, this demonstrates growing concerns for the health care education of Laotian families and their access to services. This also highlights the need for a stronger understanding of how Laotian community received and interpreted COVID-19 public health advice during the lockdown periods and the barriers or enablers they faced in advice related to health service access and utilisation over this time. Therefore, this study will seek to understand how Laotian households obtained, interpreted and engaged with COVID-19 public health advice to access and utilise health services during Alert Level 4 in New Zealand. This research is conducted as a part of the Master of Public Health degree at Auckland University of Technology. Research results will provide beneficial

information to enhance health policies for Asian migrant health service delivery in New Zealand and may also be used for academic publications and presentations.

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

You receive this participant information sheet because you approached me and expressed interest in being part of the research. You will be eligible to participate in this research, if you are

- adult Auckland-Laotian population who are New Zealand citizens and permanent residents and have lived in Auckland for more than five years.
- being a primary health care decision maker in the family
- being young families with the primary health care decision maker under 45 years or older families with the primary health care decision maker 45 years and over
- you should stay in the same house with your family during Alert Level 4 lockdown from 25 March 2020 to 27 April 2020.

However, the adult decision health care makers who were staying outside Auckland or not living with their families during Alert level 4 will be excluded.

#### **How do I agree to participate in this research?**

If you would like to take part in the study, please contact me, and you have to sign the consent form before the interview begins. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

#### **What will happen in this research?**

The data collection process will be face-to-face interviews conducted in Lao and recorded through audio recording and written notes. You will firstly be asked about your eligibility to participate in this research. This information is collected to confirm your eligibility although you are already informed at the beginning of this information page. Then, you will be asked about your main sources of public health information and perception of the most significant public health messages on accessing and utilising health care services during Alert Level 4 that you can recall. The questions will also include barriers and enablers that you experienced as well as your specific health-seeking behaviour during the Alert Level 4 of COVID-19 pandemic in Auckland. The whole interview process is expected to take approximately one hour including around 30 – 45 minutes for actual interview and around 15 minutes for review of transcripts (if you wish to do so). The interview will take place at the Wat Lao buddharam temple or a place where you feel comfortable.

#### **What are the discomforts and risks?**

It is not expected that you will experience any risk in this research. However, during such COVID-19 pandemics, it is obvious that some participants may have had some uncomfortable experiences, and some may also feel easier to cope with such experiences. If you do feel uncomfortable to answer any questions, you already have had the right to refuse to answer any questions or pause answering or stop participation at any time during the interviewing process.

#### **What are the benefits?**

This research will benefit you to share their experiences, opinions and perceptions in relation to how you obtained, interpreted and engaged with COVID-19 public health advice to access and utilise health services during Alert Level 4 in New Zealand. The research will also assist me in obtaining a Master of Public Health degree from Auckland University of Technology (AUT). The wider community will also benefit from this research by having better information and evidence to enhance existing health policies and regulations as well as address problems related to Asian migrant health service delivery needs in New Zealand – particularly during epidemics and other public health emergencies. The findings from this research will be used for various outputs such as a dissertation, research reports, journal articles and better health policies and programmes for migrant community in the future.

**How will my privacy be protected?**

Before obtaining written consent, you will be encouraged to ask any questions and raise any concerns so that I can address these. Every effort will be made to protect the privacy of you and other participants, for instance, using participant number or pseudonyms instead of your names throughout the research process. However, please be aware that as the Laotian community in Auckland is quite small, there may still be a slight possibility that somebody might be able to identify you from this study. Moreover, all the data and research related documents (both electronic records and hard copies) will be confidential and only be accessed by me. Data storage and disposal plan will comply with AUTECH's protocols and data management matrix.

**What are the costs of participating in this research?**

There will be no costs involved in this research. You will be asked to give the time approximately one hour (including around 30 – 45 minutes for actual interview and around 15 minutes for review of transcripts if you wish to do so) for the whole interview process. After finishing the interview, you will receive a \$20.00 NZD shopping voucher or gift voucher card, as a token of appreciation.

**What opportunity do I have to consider this invitation?**

You will have the time frame of two weeks to consider the invitation after receiving this Participant Information Sheet and Consent Form.

**Will I receive feedback on the results of this research?**

After completion of the study, a summary of the research findings will be delivered to you at individual or group meeting at Lao temple, via email, video calls or paper-based documents if you wish.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Dr. Ailsa Holloway, Faculty of Health and Environmental Sciences, Auckland University of Technology (AUT), New Zealand, [ailsa.holloway@aut.ac.nz](mailto:ailsa.holloway@aut.ac.nz), (+649) 921 9999 Ext 6796.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTECH, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz), (+649) 921 9999 Ext 6038.

**Whom do I contact for further information about this research?**

Please feel free to contact the research team as follows:

**Researcher Contact Details:** Phoutthanaphone Nedthongsavanh, Master of Public Health Student, Auckland University of Technology, New Zealand, Phoutthanaphone@hotmail.com, (+64) 27 551 8395.

**Project Supervisor Contact Details:** Dr. Ailsa Holloway, Faculty of Health and Environmental Sciences, Auckland University of Technology (AUT), New Zealand, [ailsa.holloway@aut.ac.nz](mailto:ailsa.holloway@aut.ac.nz), (+649) 921 9999 Ext 6796.

**Approved by the Auckland University of Technology Ethics Committee on type the date final ethics approval was granted, AUTEK Reference number type the reference number.**

## Appendix B: Translation of Participant Information Sheet



### Appendix B: Translation of Participant Information Sheet

#### ພາກສະໜວກ B: ໃບແນະນຳຂໍ້ມູນລາຍລະອຽດສຳລັບຜູ້ເຂົ້າຮ່ວມການສຶກສາ

ວັນທີທີ່ຂຽນໃບແນະນຳຂໍ້ມູນລາຍລະອຽດສຳລັບຜູ້ເຂົ້າຮ່ວມການສຶກສາ:

19 ມັງກອນ 2021

#### ຊື່ບົດຄົ້ນຄວ້າ

ສຶກສາ ຄວາມເຂົ້າໃຈກ່ຽວກັບຄຳແນະນຳທາງດ້ານສຸຂະສຶກສາຂອງພະຍາດໂຄວິດ-19 ໃນການເຂົ້າເຖິງສະຖານທີ່ບໍລິການທາງດ້ານສຸຂະພາບ ໃນຊ່ວງການປິດເມືອງ ລະດັບ 4 ຂອງຊຸມຊົນຄົນລາວຢູ່ເມືອງ ໂອກແລນ, ປະເທດນີວຊີແລນ

#### ລາຍລະອຽດໃນການເຊີນຊວນເຂົ້າຮ່ວມການສຶກສາ

ສະບາຍດີ!

ຂ້າພະເຈົ້າຊື່ ທ. ພຸດທະນາພອນ ເນດທອງສະຫວັນ, ເປັນນັກສຶກສາປະລິນຍາໂທ ສາຂາສາທາລະນະສຸກສາດຢູ່ມະຫາວິທະຍາໄລ Auckland University of Technology, ປະເທດນີວຊີແລນ. ຂ້າພະເຈົ້າຂໍອະນຸຍາດເຊີນຊວນທ່ານເຂົ້າຮ່ວມການເຮັດບົດຄົ້ນຄວ້າໃນຫົວຂໍ້: ສຶກສາຄວາມເຂົ້າໃຈກ່ຽວກັບຄຳແນະນຳທາງດ້ານສຸຂະສຶກສາຂອງພະຍາດໂຄວິດ-19 ໃນການເຂົ້າເຖິງສະຖານທີ່ບໍລິການທາງດ້ານສຸຂະພາບ ໃນຊ່ວງການປິດເມືອງ ລະດັບ 4 ຂອງຊຸມຊົນຄົນລາວຢູ່ເມືອງ ໂອກແລນ, ປະເທດນີວຊີແລນ. ບົດຄົ້ນຄວ້ານີ້ບໍ່ໄດ້ມີສ່ວນກ່ຽວຂ້ອງໃດໆກັບກະຊວງສາທາລະນະສຸກປະເທດນີວຊີແລນ ແລະ ອົງການຕ່າງໆທີ່ບໍ່ຂຶ້ນກັບລັດຖະບານ. ເຖິງແມ່ນວ່າ ຂ້າພະເຈົ້າແມ່ນໄດ້ຮັບທຶນການສຶກສາຈາກກະຊວງການຕ່າງປະເທດ ແລະ ການຄ້າປະເທດນີວຊີແລນ, ແຕ່ກະຊວງດັ່ງກ່າວກໍ່ບໍ່ໄດ້ມີສ່ວນກ່ຽວຂ້ອງກັບການເຮັດບົດຄົ້ນຄວ້ານີ້. ການສຶກສານີ້ແມ່ນເກີດຂຶ້ນຕາມຄວາມສະໝັກໃຈຂອງຜູ້ເຂົ້າຮ່ວມ ແລະ ຂໍ້ມູນທຸກຢ່າງຂອງຜູ້ເຂົ້າຮ່ວມຈະຖືກເກັບເປັນຄວາມລັບ. ທ່ານຈະບໍ່ໄດ້ຮັບ ຫຼື ເສຍຜົນປະໂຫຍດຫຍັງ ຖ້າຫາກວ່າທ່ານເລືອກທີ່ຈະເຂົ້າຮ່ວມ ຫຼື ບໍ່ເຂົ້າຮ່ວມການສຶກສາໃນຄັ້ງນີ້. ທ່ານຈະບໍ່ໄດ້ຖືກບັງຄັບໃຫ້ເຂົ້າຮ່ວມການສຶກສາ ແລະ ທ່ານສາມາດຖອນໂຕຈາກການສຶກສາໄດ້ຕະຫຼອດເວລາໃນຊ່ວງຂອງການສຳພາດ. ໃບແນະນຳ ຂໍ້ມູນລາຍລະອຽດສຳລັບຜູ້ເຂົ້າຮ່ວມການສຶກສານີ້ ຈະສາມາດຊ່ວຍທ່ານຕັດສິນໃຈວ່າທ່ານຈະຢາກເຂົ້າຮ່ວມການສຶກສາຄັ້ງນີ້ຫຼືບໍ່. ເອກະສານນີ້ຈະອະທິບາຍລາຍລະອຽດຕ່າງໆກ່ຽວກັບການເຮັດບົດຄົ້ນຄວ້າ, ຍ້ອນຫຍັງພວກເຮົາຈຶ່ງເຮັດບົດຄົ້ນຄວ້ານີ້, ແມ່ນໃຜແປທີ່ຈະມີຜົນໄຂເໝາະສົມທີ່ຈະເຂົ້າຮ່ວມບົດຄົ້ນຄວ້າ, ຂໍ້ມູນສ່ວນໂຕຂອງທ່ານຈະຖືກປິດລັບແນວໃດ ແລະ ຈະເກີດຫຍັງຂຶ້ນຫຼັງຈາກບົດຄົ້ນຄວ້າສຳເລັດແລ້ວ. ທ່ານສາມາດປຶກສາຫາລືໃນການເຂົ້າຮ່ວມບົດຄົ້ນຄວ້ານີ້ກັບຄົນຄອບຄົວ ແລະ ໝູ່ຄູ່ໄດ້ຕາມສະດວກ.

#### ຈຸດປະສົງຂອງບົດຄົ້ນຄວ້າແມ່ນຫຍັງ?

ເນື່ອງຈາກວ່າພະຍາດໂຄວິດ-19 ໄດ້ເຮັດໃຫ້ມີການເພີ່ມຂຶ້ນຂອງການເຈັບປ່ວຍຂອງຄົນທົ່ວໂລກ, ນອກນັ້ນການປິດເມືອງ lockdown ແລະ ຈຳກັດການເດີນທາງຕ່າງໆ ກໍ່ໄດ້ຜົນກະທົບຕໍ່ການໃຫ້ການບໍລິການໃນດ້ານຕ່າງໆ ລວມທັງການໃຫ້ບໍລິການທາງດ້ານສຸຂະພາບ. ເຊິ່ງຜົນກະທົບດັ່ງກ່າວຍັງໄດ້ສົ່ງຜົນໂດຍກົງຕໍ່ກຸ່ມຄົນຜູ້ອົບພະຍົບ ແລະ ຊຸມຊົນຄົນກຸ່ມນ້ອຍ ເນື່ອງຈາກວ່າກຸ່ມຄົນເຫຼົ່ານີ້ແມ່ນຍັງປະສົບກັບບັນຫາຄວາມບໍ່ເທົ່າທຽມກັນທາງດ້ານສຸຂະພາບ ບໍ່ວ່າຈະ

ມາຈາກປັດໃຈທາງດ້ານເສດຖະກິດ ແລະ ສັງຄົມ. ຊຸມຊົນຄົນລາວຢູ່ປະເທດນິວຊີແລນ ກໍ່ອາດເປັນຕົວແທນຊຸມຊົນຄົນ ກຸ່ມນ້ອຍຊາວອາຊີ ທີ່ໄດ້ປະສົບກັບບັນຫາການເຂົ້າເຖິງຂໍ້ມູນ ແລະ ການບໍລິການທາງດ້ານສຸຂະພາບ ໃນຊ່ວງການປິດ ເມືອງລະດັບ 4 ເນື່ອງຈາກວ່າພວກເຂົາເຫຼົ່ານີ້ ຍັງມີພື້ນຖານເສດຖະກິດ - ສັງຄົມທີ່ບໍ່ໄດ້ສູງຫຼາຍ, ລວມທັງຍັງມີຂໍ້ ຈຳກັດໃນດ້ານການສື່ສານພາສາອັງກິດ.

ເນື່ອງຈາກວ່າການລະບາດຂອງພະຍາດໂຄວິດ-19 ຍັງມີການສືບຕໍ່ແຜ່ລະບາດໃນປີ 2021, ເຮັດໃຫ້ຍັງມີຄວາມກັງວົນ ກ່ຽວກັບການເຂົ້າເຖິງຂໍ້ມູນ ແລະ ການໃຫ້ບໍລິການທາງດ້ານສຸຂະພາບຂອງຊຸມຊົນຄົນລາວຢູ່ປະເທດນີ້. ນອກຈາກ ນັ້ນແລ້ວ, ການເຂົ້າໃຈບັນຫາດັ່ງກ່າວຢ່າງທ່ອງແທ້ ແລະ ຊັດເຈນ ກໍ່ຍັງເປັນສິ່ງສຳຄັນແລະຈຳເປັນ ທີ່ຈະຊ່ວຍແກ້ໄຂ ບັນຫາດັ່ງກ່າວນຳອີກ. ດັ່ງນັ້ນ, ການສຶກສາຄັ້ງນີ້, ຈຶ່ງພະຍາຍາມທີ່ຈະທຳຄວາມເຂົ້າໃຈ ກ່ຽວກັບບັນຫາດ້ານການຮັບຮູ້ ກ່ຽວກັບຄຳແນະນຳທາງດ້ານສຸຂະພາບຂອງພະຍາດໂຄວິດ-19 ໃນການເຂົ້າເຖິງສະຖານທີ່ບໍລິການທາງດ້ານສຸຂະພາບ ໃນຊ່ວງການປິດເມືອງ ລະດັບ 4 ຂອງຊຸມຊົນຄົນລາວຢູ່ເມືອງ ໂອກແລນ, ປະເທດນິວຊີແລນ. ບົດຄົ້ນຄວ້ານີ້ກໍ່ຍັງເປັນ ສ່ວນໜຶ່ງຂອງການເຮັດບົດຄົ້ນຄວ້າຈົບຊັ້ນລະດັບປະລິນຍາໂທ, ສາຂາສາທາລະນະສຸກສາດ ຂອງມະຫາວິທະຍາໄລ Auckland University of Technology. ຜົນໄດ້ຮັບຈາກການຄົ້ນຄວ້າໃນຄັ້ງນີ້ຈະເປັນຂໍ້ມູນທີ່ເປັນປະໂຫຍດໃນ ການພັດທະນາພະຍາຍາມການຮັກສາສຸຂະພາບຂອງຊຸມຊົນຄົນອາຊີໃນປະເທດນິວຊີແລນ, ລວມທັງອາດນຳໃຊ້ໃນ ການຕີຝົມເປັນຂໍ້ມູນອ້າງອີງ ແລະ ເປັນບົດສະເໜີໃນກອງປະຊຸມວິຊາການຕ່າງໆ.

#### **ຂ້ອຍຈະເປັນຜູ້ເຂົ້າຮ່ວມການສຶກສາຄັ້ງນີ້ໄດ້ແນວໃດ ແລະ ຍ້ອນຫຍັງຂ້ອຍຈຶ່ງຖືກເຊັນໃຫ້ເຂົ້າຮ່ວມ?**

ເຈົ້າໄດ້ຮັບໃບແນະນຳຂໍ້ມູນລາຍລະອຽດສຳລັບຜູ້ເຂົ້າຮ່ວມການສຶກສາສະບັບນີ້ ຍ້ອນວ່າເຈົ້າໄດ້ສະແດງຄວາມສົນໃຈ ແລະ ເຫັນດີທີ່ຈະເຂົ້າຮ່ວມການສຳພາດຄັ້ງນີ້ດ້ວຍໂຕຂອງເຈົ້າເອງ.

ເງື່ອນໄຂທີ່ເຈົ້າຈະສາມາດເຂົ້າຮ່ວມການສຶກສາໃນຄັ້ງນີ້ແມ່ນ:

- ເປັນຄົນລາວໃນໄວຜູ້ໃຫຍ່ ທີ່ອາໄສຢູ່ໃນເມືອງໂອກແລນຫຼາຍກວ່າ 5 ປີ ແລະ ຕ້ອງເປັນຜູ້ທີ່ອາໄສຢູ່ທີ່ ຖາວອນ ຫຼື ຖືສັນຊາດນິວຊີແລນ
- ເປັນຜູ້ຕັດສິນໃຈຫຼັກໃນການການປິ່ນປົວ-ເບິ່ງແຍງສຸຂະພາບຂອງສະມາຊິກໃນຄອບຄົວ
- ຖ້າຢູ່ໃນຄອບຄົວໄວໜຸ່ມ, ຜູ້ເປັນຄົນຕັດສິນໃຈຫຼັກໃນການການປິ່ນປົວ-ເບິ່ງແຍງສຸຂະພາບຂອງສະມາຊິກ ໃນຄອບຄົວ ຕ້ອງມີອາຍຸຕໍ່າກວ່າ 45 ປີ ຫຼື  
ຖ້າຢູ່ໃນຄອບຄົວຜູ້ສູງອາຍຸ, ຜູ້ເປັນຄົນຕັດສິນໃຈຫຼັກໃນການການປິ່ນປົວ-ເບິ່ງແຍງສຸຂະພາບຂອງສະມາຊິກ ໃນຄອບຄົວ ຕ້ອງອາຍຸຫຼາຍກວ່າ 45 ປີ ຫຼື ແກ່ກວ່າ
- ຕ້ອງອາໄສຢູ່ເຮືອນຫຼັງດຽວກັນກັບຄອບຄົວຂອງເຈົ້າໃນຊ່ວງ Lockdown ລະດັບ 4 ຕັ້ງແຕ່ວັນທີ 25 ມີນາ 2020 ຫາ 27 ເມສາ 2020

ແຕ່ວ່າ ຖ້າຜູ້ເປັນຄົນຕັດສິນໃຈຫຼັກໃນການການປິ່ນປົວ-ເບິ່ງແຍງສຸຂະພາບຂອງສະມາຊິກໃນຄອບຄົວ ແມ່ນບໍ່ໄດ້ອາໄສ ຢູ່ໃນເມືອງໂອກແລນ ຫຼື ບໍ່ໄດ້ອາໄສຢູ່ນຳຄອບຄົວໃນຊ່ວງ Lockdown ລະດັບ 4 ຈະບໍ່ມາສາມາດເຂົ້າຮ່ວມການສຶກ ສາໃນຄັ້ງນີ້ໄດ້.

#### **ຂ້ອຍຈະຕອບຕົກລົງທີ່ຈະເຂົ້າຮ່ວມການສຶກສາໃນຄັ້ງນີ້ໄດ້ແນວໃດ?**

ຖ້າເຈົ້າຕ້ອງການທີ່ຈະເຂົ້າຮ່ວມການສຶກສາ, ກະລຸນາຕິດຕໍ່ຂ້າພະເຈົ້າໂດຍກົງ ແລະ ເຈົ້າຕ້ອງເຊັນໃບຍືນຍອມເຂົ້າຮ່ວມ ການສຶກສາ ກ່ອນທີ່ຈະເລີ່ມເຂົ້າຮ່ວມການສຳພາດ. ການເຂົ້າຮ່ວມການສຶກສາ ແມ່ນຈະເປັນການເຂົ້າຮ່ວມໂດຍສະໝັກ ໃຈ (ເຈົ້າສາມາດເລືອກໄດ້) ແລະ ການເລືອກທີ່ຈະເຂົ້າຮ່ວມ ຫຼື ບໍ່ເຂົ້າຮ່ວມ ແມ່ນບໍ່ໄດ້ເຮັດໃຫ້ເຈົ້າມີຂໍ້ໄດ້ປຽບ ຫຼື

ເສຍປຽບໃດໆທັງນັ້ນ. ເຈົ້າຍັງສາມາດຖອນໂຕຈາກການເຂົ້າຮ່ວມການສຶກສາໄດ້ທຸກເວລາ. ຖ້າເຈົ້າເລືອກທີ່ຈະຖອນ ໂຕອອກຈາກການສຶກສາໃນຊ່ວງສຳພາດ, ເຈົ້າຈະສາມາດເລືອກໄດ້ວ່າ ຈະຖອນຂໍ້ມູນທີ່ໃຫ້ໄປກ່ອນຫນ້ານັ້ນບໍ່ ຫຼື ຈະ ຍັງອະນຸຍາດໃຫ້ນຳເອົາໄປໃຊ້ໄດ້. ແຕ່ຖ້າຫາກວ່າ, ຖອນໂຕໃນຊ່ວງຜົນໄດ້ຂອງການສຶກສາໄດ້ຖືກຂຽນອອກມາເປັນ ທີ່ຮຽບຮ້ອຍແລ້ວ, ຂໍ້ມູນຂອງທ່ານຈະບໍ່ສາມາດຄັດຈ້ອນອອກໄດ້.

### **ການສຳພາດໃນບົດຄົ້ນຄວ້າຄັ້ງນີ້ຈະເປັນແນວໃດ?**

ການເກັບກຳຂໍ້ມູນແມ່ນຈະເປັນການສຳພາດຜູ້ດຽວແບບສ່ວນໂຕ, ສຳພາດເປັນພາສາລາວ ແລະ ຈະມີການບັນທຶກສຽງ ພ້ອມທັງຈົດບັນທຶກ. ທຳອິດເຈົ້າຈະຖືກຖາມກ່ຽວກັບຄຸນສົມບັດ ແລະ ເງື່ອນໄຂຕ່າງໆທີ່ເຈົ້າຈະສາມາດເຂົ້າຮ່ວມການ ສຶກສານີ້. ຄຸນສົມບັດດັ່ງກ່າວຖືກຖາມຄືນອີກຄັ້ງ ເພື່ອຈະຢືນຢັນວ່າ ເຈົ້າແມ່ນຢູ່ໃນເງື່ອນໄຂທີ່ຈະສາມາດເຂົ້າຮ່ວມໃນ ການສຶກສາໄດ້ແທ້ຫຼືບໍ່ ເຖິງແມ່ນເຈົ້າອາດຈະຖືກຖາມຄຳຖາມດັ່ງກ່າວ ແລະ ຕອບໄປແລ້ວໃນກ່ອນຫນ້ານີ້. ຈາກນັ້ນເຈົ້າ ຈະຖືກຖາມກ່ຽວກັບ ແຫຼ່ງທີ່ມາຫຼັກໃນການຮັບຮູ້ຂໍ້ມູນຂ່າວສານດ້ານສຸຂະພາບຂອງເຈົ້າ ແລະ ຂໍ້ຄວາມສຳຄັນໃນດ້ານ ສຸຂະພາບ ທີ່ກ່ຽວຂ້ອງເຖິງການເຂົ້າເຖິງສະຖານທີ່ບໍລິການ ທີ່ເຈົ້າສາມາດຈື່ຈຳໄດ້ ໃນຊ່ວງປິດເມືອງລະດັບ 4. ຄຳ ຖາມອື່ນໆທີ່ຈະຖືກຖາມແມ່ນກ່ຽວກັບ ບັນຫາ ແລະ ຄວາມຫຍຸ້ງຍາກຕ່າງໆທີ່ເຈົ້າໄດ້ປະສົບ, ແລະ ວິທີການແກ້ໄຂແລະ ການປົນປົວດ້ານສຸຂະພາບຂອງເຈົ້າ ໃນຊ່ວງປິດເມືອງ lockdown ລະດັບ 4 ຂອງການແຜ່ລະບາດຂອງພະຍາດໂຄວິດ 19 ຢູ່ເມືອງໂອກແລນ. ການສຳພາດຈະໃຊ້ເວລາປະມານ 1 ຊົ່ວໂມງ (ປະມານ 30 - 45 ສຳລັບການສຳພາດ ແລະ ປະມານ 15 ນາທີສຳລັບອ່ານລາຍລະອຽດຕ່າງໆ ຖ້າເຈົ້າຕ້ອງການທີ່ຈະອ່ານ). ສະຖານທີ່ທີ່ຈະໃຊ້ສຳລັບການສຳພາດ ແມ່ນ ວັດລາວ ມຸທທາຣາມ (ໂອຕາຣູຣູ) ຫຼື ສະຖານທີ່ອື່ນໆທີ່ເຈົ້າມີຄວາມສະດວກ.

### **ແມ່ນຫຍັງຄືຄວາມສ່ຽງ ແລະ ຄວາມກັງວົນທີ່ຈະເກີດຂຶ້ນໃນການສຳພາດ?**

ຂ້າພະເຈົ້າຄາດຫວັງວ່າ ເຈົ້າແມ່ນຈະບໍ່ປະສົບກັບຄວາມສ່ຽງ ແລະ ຄວາມກັງວົນໃດໆທີ່ອາດຈະເກີດຂຶ້ນໃນການສຳພາດ ໃນຄັ້ງນີ້. ແຕ່ເຖິງຢ່າງໃດກໍຕາມ, ຂ້າພະເຈົ້າເຂົ້າໃຈວ່າ ໃນຊ່ວງທີ່ມີການລະບາດຂອງພະຍາດໂຄວິດ19ນີ້, ຜູ້ເຂົ້າຮ່ວມ ການສຶກສາບາງຄົນ ອາດຈະຮູ້ສຶກບໍ່ສະບາຍໃຈປານໃດທີ່ຈະຕອບບາງຄຳຖາມ. ແລະ ນອກນັ້ນກໍອາດມີບາງຄົນທີ່ ສາມາດຮັບມື ແລະ ປັບໂຕກັບຄວາມຮູ້ສຶກບໍ່ສະບາຍໃຈນັ້ນໄດ້ດີ. ດັ່ງນັ້ນ, ຖ້າຫາກເຈົ້າບໍ່ສະດວກ ຫຼື ບໍ່ສະບາຍໃຈທີ່ຈະ ຕອບຄຳຖາມບາງຄຳຖາມ, ເຈົ້າມີສິດທີ່ຈະປະຕິເສດການຕອບຄຳຖາມ, ຢຸດການໃຫ້ຄຳຕອບ ຫຼື ອາດຈະຢຸດການເຂົ້າ ຮ່ວມການສຳພາດໄດ້ໃນທຸກໆເວລາ.

### **ຜົນປະໂຫຍດຂອງການເຮັດບົດຄົ້ນຄວ້ານີ້ແມ່ນຫຍັງ?**

ບົດຄົ້ນຄວ້າໃນຄັ້ງນີ້ຈະເປັນປະໂຫຍດໃຫ້ເຈົ້າໄດ້ແບ່ງປັນປະສົບການ, ຄວາມຄິດເຫັນ ແລະ ຄວາມຮັບຮູ້ຂໍ້ມູນຕ່າງໆ ທີ່ ເຈົ້າໄດ້ຮັບ, ໄດ້ເຂົ້າໃຈ ແລະ ໄດ້ເຂົ້າເຖິງ ສຸຂະສຶກສາຂອງພະຍາດໂຄວິດ-19 ທີ່ກ່ຽວຂ້ອງກັບການເຂົ້າເຖິງການ ບໍລິການທາງດ້ານສຸຂະພາບ ໃນຊ່ວງປິດເມືອງລະດັບ 4 ຢູ່ນິວຊີແລນ. ການສຶກສານີ້ຍັງຈະຊ່ວຍໃຫ້ຂ້າພະເຈົ້າສຳເລັດ ການສຶກສາລະດັບປະລິນຍາໂທສາຂາສາທາລະນະສຸກສາດ ຈາກ ມະຫາວິທະຍາໄລ Auckland University of Technology (AUT). ຊຸມຊົນຕ່າງໆກໍຈະໄດ້ຮັບຜົນປະໂຫຍດ ດ້ວຍການນຳໃຊ້ຜົນໄດ້ຮັບຈາກການຄົ້ນຄວ້າ ເພື່ອ ເປັນຫຼັກຖານ ແລະ ຂໍ້ມູນສຳຄັນ ທີ່ຈະຊ່ວຍໃນການພັດທະນາ ມາດຕະການການຮັກສາສຸຂະພາບທີ່ມີຢູ່ແລ້ວໃຫ້ດີຂຶ້ນ, ພ້ອມກັນນັ້ນ ຍັງອາດຊ່ວຍແກ້ໄຂບັນຫາທີ່ກ່ຽວຂ້ອງກັບການບໍລິການທາງດ້ານສຸຂະພາບ ຂອງຊຸມຊົນຜູ້ອົບພະຍົບຄົນ ອາຊີ ໃນຊ່ວງທີ່ເກີດການລະບາດຂອງພະຍາດຕ່າງໆຢູ່ນິວຊີແລນ. ນອກຈາກນັ້ນແລ້ວ, ຜົນໄດ້ຮັບຂອງການສຶກສາ ຍັງ ຈະຖືກນຳໃຊ້ເປັນຂໍ້ມູນອ້າງອີງຂອງການເຮັດບົດຄົ້ນຄວ້າ, ບົດລາຍງານ, ວາລະສານຕີຟິມ ແລະ ຍັງເປັນຂໍ້ມູນ ໃນການ ປັບປຸງໂຄງການດ້ານສຸຂະພາບຕ່າງໆ ສຳລັບຊຸມຊົນຊາວອົບພະຍົບໃນອະນາຄົດ.

### **ຂໍ້ມູນສ່ວນໂຕຂອງຂ້ອຍຈະຖືກປິດລັບແນວໃດ?**

ກ່ອນທີ່ເຈົ້າຈະຊັນຍິນຍອມເຂົ້າຮ່ວມການສຶກສາ, ເຈົ້າຈະໄດ້ຖືກອະນຸຍາດໃຫ້ຖາມຄໍາຖາມ ແລະ ຂໍສິ່ງໄສຕ່າງໆ ທີ່ຂ້າພະເຈົ້າສາມາດໃຫ້ຄໍາຕອບໄດ້. ຂ້າພະເຈົ້າຈະນໍາໃຊ້ຄວາມພະຍາຍາມເພື່ອປິດລັບຂໍ້ມູນສ່ວນໂຕຂອງເຈົ້າ ແລະ ເຂົ້າຮ່ວມການສຶກສາຜູ້ອື່ນໆ. ຕົວຢ່າງ: ຈະນໍາໃຊ້ໂຕເລກ ແລະ ນາມສົມມຸດແທນຊື່ແທ້ຂອງເຈົ້າ ໃນຕະຫຼອດຊ່ວງຂອງການເຮັດບົດຄົ້ນຄວ້າ. ແຕ່ເຖິງຢ່າງໃດກໍຕາມ, ເຈົ້າອາດຈະຄຳນຶງວ່າ ເນື່ອງຈາກຊຸມຊົນຄົນລາວຢູ່ເມືອງໂອກແລນ ແມ່ນເປັນຊຸມຊົນຂະໜາດນ້ອຍ, ອາດມີຄວາມເປັນໄປໄດ້ວ່າ, ຄົນໃນຊຸມຊົນບາງຄົນ, ອາດຈະຈື່ຈໍາຂໍ້ມູນບາງສ່ວນທີ່ເຈົ້າໃຫ້ສໍາພາດຄັ້ງນີ້ໄດ້. ນອກນັ້ນ, ທຸກໆເອກະສານທີ່ກ່ຽວຂ້ອງກັບຂໍ້ມູນ ແລະ ບົດຄົ້ນຄວ້າ (ທັງແບບ Electronic ແລະ ແບບເປັນແຜ່ນເຈ້ຍ) ຈະຖືກເກັບເປັນຄວາມລັບ ແລະ ມີແຕ່ຂ້າພະເຈົ້າທີ່ສາມາດເຂົ້າເຖິງໄດ້. ຂໍ້ມູນທີ່ຖືກເກັບໄວ້ ແລະ ແຜນການທຳລາຍຂໍ້ມູນດັ່ງກ່າວຈະປະຕິບັດຕາມຫຼັກການຂອງ AUTC ໂດຍອີງຕາມ AUTC's data management matrix.

### **ການເຂົ້າການສຶກສາໃນຄັ້ງນີ້ຈະມີຄ່າໃຊ້ຈ່າຍເທົ່າໃດ?**

ເຈົ້າຈະບໍ່ໄດ້ເສຍຄ່າໃຊ້ຈ່າຍໃດໆທີ່ກ່ຽວຂ້ອງກັບການເຮັດບົດຄົ້ນຄວ້າໃນຄັ້ງນີ້. ເຈົ້າແມ່ນຈະໄດ້ຖືກອະນຸຍາດໃຫ້ເສຍສະຫຼະເວລາປະມານ 1 ຊົ່ວໂມງໃນການສໍາພາດ (ປະມານ 30 - 45 ສໍາລັບການສໍາພາດ ແລະ ປະມານ 15 ນາທີສໍາລັບການອ່ານລາຍລະອຽດຕ່າງໆ ຖ້າເຈົ້າຕ້ອງການທີ່ຈະອ່ານ). ຫຼັງຈາກສໍາເລັດການສໍາພາດແລ້ວ, ເຈົ້າຈະໄດ້ຮັບ ບັດແທນເງິນສົດມູນຄ່າ \$20 NZD ເປັນການຕອບແທນ ແລະ ຂອບໃຈ.

### **ຂ້ອຍມີໂອກາດຕັດສິນໃຈດົນປານໃດໃນການຝຶກລະບົບການຖືກເຊີນເຂົ້າຮ່ວມໃນການສຶກສາຄັ້ງນີ້?**

ເຈົ້າຈະມີເວລາໃນການຝຶກລະບົບການຖືກເຊີນປະມານ 2 ອາທິດ ຫຼັງຈາກທີ່ໄດ້ຮັບໃບແນະນຳຂໍ້ມູນລາຍລະອຽດສໍາລັບຜູ້ເຂົ້າຮ່ວມການສຶກສາ ແລະ ໃບຍິນຍອມເຂົ້າຮ່ວມການສຶກສາ.

### **ຂ້ອຍຈະໄດ້ຮັບຂໍ້ມູນກ່ຽວກັບຜົນໄດ້ຮັບໃນການສຶກສາຄັ້ງນີ້ຫຼືບໍ່?**

ຫຼັງຈາກສໍາເລັດການສຶກສາແລ້ວ, ບົດສະຫຼຸບຂອງຜົນການຄົ້ນຄວ້າຈະເຜີຍແຜ່ໃຫ້ເຈົ້າ ດ້ວຍການພິມປະແບບສ່ວນໂຕ ຫຼື ແບບເປັນກຸ່ມຢູ່ວັດລາວ, ແຈ້ງບອກທາງອີເມວ, video calls ຫຼື ແບບເອກະສານຕາມທີ່ເຈົ້າຕ້ອງການ.

### **ຂ້ອຍຈະເຮັດແນວໃດຖ້າຂ້ອຍມີຄວາມກັງວົນ ຫຼືສິ່ງໄສກ່ຽວກັບການສຶກສາໃນຄັ້ງນີ້?**

ຖ້າຫາກວ່າເຈົ້າມີຂໍ້ກັງວົນຫຼື ສິ່ງໄສຕ່າງໆກ່ຽວກັບຮູບແບບຂອງການສຶກສາໃນຄັ້ງນີ້ ຄວນຕິດຕໍ່ຫາ Project Supervisor, Dr Ailsa Holloway, Faculty of Health and Environmental Sciences, Auckland University of Technology (AUT), New Zealand, [ailsa.holloway@aut.ac.nz](mailto:ailsa.holloway@aut.ac.nz), (+649) 921 9999 Ext 6796.

ຖ້າຫາກມີຂໍສິ່ງໄສກ່ຽວກັບການເຮັດບົດຄົ້ນຄວ້າຄວນຕິດຕໍ່ຫາ the Executive Secretary of AUTC, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz), (+649) 921 9999 Ext 6038.

### **ຜູ້ໃດທີ່ຂ້ອຍຄວນຕິດຕໍ່ຫາ ສໍາລັບການສອບຖາມຂໍ້ມູນເພີ່ມຕື່ມກ່ຽວກັບການສຶກສາໃນຄັ້ງນີ້?**

ເຈົ້າສາມາດຕິດຕໍ່ຫາທີມງານດັ່ງລຸ່ມນີ້ໄດ້ຕາມຄວາມສະດວກ:

**ຂໍ້ມູນຕິດຕໍ່ຂອງຜູ້ເຮັດການຄົ້ນຄວ້າ:**

ພຸດທະນາພອນ ເນດທອງສະຫວັນ, ນັກສຶກສາປະລິນຍາໂທ ສາຂາສາທາລະນະສຸກສາດ, Auckland University of Technology, New Zealand, Phoutthanaphone@hotmail.com, (+64) 27 551 8395.

**ຂໍ້ມູນຕິດຕໍ່ຂອງ Project Supervisor:**

Dr. Ailsa Holloway, Faculty of Health and Environmental Sciences, Auckland University of Technology (AUT), New Zealand, [ailsa.holloway@aut.ac.nz](mailto:ailsa.holloway@aut.ac.nz), (+649) 921 9999 Ext 6796.

**Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEK Reference number *type the reference number*.**

## Appendix C: Consent Form



## Appendix C: Consent Form

For use when interviews are involved.

**Project title:** Investigating the uptake of COVID-19 public health advice and health service utilisation among Laotian New Zealanders during Alert Level 4, 2020 in Auckland, New Zealand

**Project Supervisor:** Dr Ailsa Holloway

**Researcher:** Phoutthanaphone Nedthongsavanh

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ☐ I understand that as the Laotian community in Auckland is quite small, there may still be a slight possibility that somebody might be able to identify me from this study.
- ☐ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a summary of the research findings (please tick one): Yes ☐ No ☐

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....  
.....

Date:

**Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEK Reference number type the AUTEK reference number**

*Note: The Participant should retain a copy of this form.*

## Appendix D: Consent Form (Lao Version)



### Appendix D: Consent Form (Lao Version)

#### ພາກພະໜວກ D: ໃບຍິນຍອມເຂົ້າຮ່ວມການສຶກສາ

ສໍາລັບນໍາໃຊ້ເມື່ອມີການກ່ຽວຂ້ອງກັບການສໍາພາດ

**ຊື່ບົດຄົ້ນຄວ້າ:** ສຶກສາຄວາມເຂົ້າໃຈກ່ຽວກັບຄໍາແນະນໍາທາງດ້ານສຸຂະສຶກສາຂອງພະຍາດໂຄວິດ-19 ໃນການເຂົ້າເຖິງສະຖານທີ່ບໍລິການທາງດ້ານສຸຂະພາບ ໃນຊ່ວງການປິດເມືອງ ລະດັບ 4 ຂອງຊຸມຊົນຄົນລາວຢູ່ເມືອງ ໂອກແລນ, ປະເທດນິວຊີແລນ

**ອາຈານທີ່ປຶກສາ:** Dr Ailsa Holloway

**ຜູ້ເຮັດບົດຄົ້ນຄວ້າ:** ພຸດທະນາພອນ ເນດທອງສະຫວັນ

- ຂ້າພະເຈົ້າໄດ້ອ່ານ ແລະ ເຂົ້າໃຈຂໍ້ມູນຕ່າງໆກ່ຽວກັບການເຮັດບົດຄົ້ນຄວ້າໃນຄັ້ງນີ້ ຈາກໃບແນະນໍາຂໍ້ມູນລາຍລະອຽດສໍາລັບຜູ້ເຂົ້າຮ່ວມການສຶກສາ ວັນທີ .... / .... / .....
- ຂ້າພະເຈົ້າໄດ້ມີໂອກາດຖາມຄໍາຖາມ ແລະ ໄດ້ຮັບການຕອບຄໍາຖາມແລ້ວ.
- ຂ້າພະເຈົ້າເຂົ້າໃຈວ່າ ການເຂົ້າຮ່ວມການສຶກສາໃນຄັ້ງນີ້ແມ່ນຍ້ອນຄວາມສະຫມັກໃຈ (ເລືອກເອງ) ແລະ ຂ້ອຍກໍ່ສາມາດທີ່ຈະຖອນໂຕອອກຈາກການສຶກສາ ໄດ້ທຸກໆເວລາ ໂດຍບໍ່ໄດ້ເສຍປະໂຫຍດໃນທາງອື່ນໆ.
- ຂ້າພະເຈົ້າເຂົ້າໃຈວ່າ ເນື່ອງຈາກຊຸມຊົນຄົນລາວຢູ່ເມືອງໂອກແລນ ແມ່ນເປັນຊຸມຊົນຂະໜາດນ້ອຍ, ອາດມີຄວາມເປັນໄປໄດ້ວ່າ, ຄົນບາງຄົນໃນຊຸມຊົນ ອາດຈະຈື່ຈໍາຂໍ້ມູນບາງສ່ວນທີ່ຂ້າພະເຈົ້າເຂົ້າໃຫ້ສໍາພາດໃນການສຶກສາຄັ້ງນີ້ໄດ້.
- ຂ້າພະເຈົ້າເຂົ້າໃຈວ່າ ຖ້າຂ້າພະເຈົ້າເລືອກທີ່ຈະຖອນໂຕອອກຈາກການສຶກສາ ຂ້າພະເຈົ້າຈະສາມາດເລືອກໄດ້ວ່າ ຈະສາມາດຂໍຖອນຂໍ້ມູນທີ່ໃຫ້ໄປກ່ອນໜ້ານີ້ ຫຼື ຈະສາມາດອະນຸຍາດໃຫ້ນໍາເອົາໄປໃຊ້ໄດ້. ແຕ່ຖ້າຫາກວ່າ, ມີການຖອນໂຕໃນຊ່ວງຜົນໄດ້ຂອງການສຶກສາໄດ້ຖືກຂຽນອອກມາເປັນທີ່ຮຽບຮ້ອຍແລ້ວ, ຂໍ້ມູນຂອງຂ້າພະເຈົ້າຈະບໍ່ສາມາດຄັດຈ້ອນອອກໄດ້.
- ຂ້າພະເຈົ້າຕົກລົງທີ່ຈະເຂົ້າຮ່ວມການສຶກສາໃນຄັ້ງນີ້
- ຂ້າພະເຈົ້າຫວັງທີ່ຈະໄດ້ຮັບບົດສະຫຼຸບຂອງຜົນໄດ້ຮັບຈາກການສຶກສາ (ເລືອກຫນຶ່ງອັນ): ແມ່ນ ☐ ບໍ່ແມ່ນ ☐

ລາຍເຊັນຂອງຜູ້ເຂົ້າຮ່ວມການສຶກສາ:

.....

ຊື່ຜູ້ເຂົ້າຮ່ວມການສຶກສາ:

.....

ຂໍ້ມູນຕິດຕໍ່ຂອງຜູ້ເຂົ້າຮ່ວມການສຶກສາ (ຖ້າເໝາະສົມ):

.....

.....

ວັນທີ:

**Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEK Reference number type the AUTEK reference number**

ໝາຍເຫດ: ຜູ້ເຂົ້າຮ່ວມການສຶກສາຄວນຮັກສາສໍາເນົາໃບຍິນຍອມເຂົ້າຮ່ວມການສຶກສານີ້ໄວ້ຫນຶ່ງສະບັບ

## Appendix E: The Interview Protocol



## Appendix E: The Interview Protocol

The data collection process will be face-to-face interviews conducted in Lao and recorded through audio recording and written notes. The semi-structured interview approach will be also adopted to guide the researcher to create meaningful sub-questions and gain in-depth insights and data. The whole interview process is expected to take approximately one hour including around 30-45 minutes for the actual interview and around 15 minutes for review of transcripts (if the participants wish to so). The interview will take place at the Wat Lao buddharam temple or places where participants feel comfortable.

The participation will be entirely voluntary, and participants will have a right to withdraw from the interview at any time during the data collection process. All participants will be given a Participant Information Sheet (PIS), explaining the study and a written consent form to review and sign.

In order to protect the privacy of participants, for the interview recording the researcher is choosing only audio-recording and participant number or pseudonyms will also be used instead of their names throughout the research process. The participants will be informed prior to commencing the interviews that all the information they provide including their answers will be kept in total confidentiality. Moreover, all research related documents both electronic records and hard copies will be confidential and only be accessed by the researcher. Data storage and disposal plan will comply with AUTEK's protocols.

After data collection, the transcripts will be written in Lao, translated into English and then back translated to Lao to check the accuracy of the translation by collaborating with an independent reviewer/interpreter to verify the accuracy of the translation. Participants will also be asked to approve certain steps such as validating the accuracy of their interview transcripts prior to data analysis. This research will apply the thematic analysis method and the analysis process will begin by familiarisation with the data and looking for issues of potential interest. The application of both manual and NVivo software will be applied to assist with the process of data analysis such as coding and themes construction processes.

## Appendix F: Indicative Interview Questions for the Participants



### Appendix F: Indicative Interview Questions for the Participants

- Who is the primary health care decision maker in your family?
- How many years have you lived in NZ?
- How many people in your family?
- What is your main job? What and where did you do during the Lockdown?

#### **1. Where did you receive main health information or public health advice during Alert Level 4?**

- From whom did you normally get information? Or how did you get such information? (which one do you prefer?)
- Did you also follow-up or get updated news from overseas or your home country?

#### **2. Can you please tell me what the key messages of COVID-19 information are during lockdown Level 4?**

- Any other messages?
- What should you do and don't?

#### **3. Why is the public health information important to you? or it is not so important?**

- What do you think about main health information or public health advice from NZ government? Is it good or helpful?

#### **4. What were your main problems or difficulties in getting health information during Alert level 4?**

- Did you know why those problems happened?

#### **5. Do you think that your economic status or income could affect your health information receiving? why or why not?**

- Example a type of job, job status, sickness?

#### **6. During the Alert level 4 if someone in your family was sick, what did you do?**

- who did you consult with?
- How did you go to the clinics or receive health care service?  
(if not, let's imagine... or tell me about people that you know...)

#### **7. What did you do when you and your family members want to get the COVID-19 tests or are not sure about COVID-19 symptoms?**

- (if not, let's imagine... or tell me about people that you know...)

#### **8. If you as the primary health care decision maker was not available during that period, how did your family members do or access health information and services?**

- (if not, let's imagine... or tell me about people that you know...)

#### **Extra**

- Do you have anything else related to health information during lockdown level 4 that you want to share?

## Appendix G: Researcher Safety Protocol



### Appendix G: Researcher Safety Protocol Auckland University of Technology Ethics Committee (AUTC)

#### Project title and brief description:

Investigating the uptake of COVID-19 public health advice and health service utilisation among Laotian New Zealanders during Alert Level 4, 2020 in Auckland, New Zealand. The study will identify the main sources of public health information and perception of the most significant public health messages on accessing and utilising health care services during Alert Level 4 that Laotian households can recall. Apart from this, the study will try to explore barriers and enablers that Laotian households experienced as well as their specific health-seeking behaviour during the Alert Level 4 of COVID-19 pandemic in Auckland.

#### Applicant

Phouththanaphone Nedthongsavanh

#### Primary Researcher

Dr Ailsa Holloway

#### Where is the research being undertaken?

The interview might also take place in some Lao participants' houses or private places in Otahuhu or nearby Lao temple. Those places will surely access to the public transports such as bus or train. Moreover, the Taxi or Uber is to be also available in those areas. The researcher has saved the contact details of Lao community leaders in case some emergency situations happened.

#### Who will be collecting the data and interacting with participants?

There is only a researcher who is going to do the interview with participants.

#### How familiar is the researcher with the social or cultural context of the research?

The researcher is originally from Laos. Being from the same country of origin and having the same language with the New Zealand - Laotian community can help strengthen his in-depth understanding of the social and cultural context of this community. The researcher sometimes also attends traditional cultural events at Wat Lao buddharam temple and has known some New Zealand – Laotians in Auckland and community leaders. Furthermore, initial consultation with community leaders has also occurred to ensure that the interviewing process used are appropriate for the potential participants.

#### How safe are the activities in which the researcher is taking part?

The interview will not involve sports or activities that may be hazardous in nature.

#### What level of access to support is available?

Based on the initial consultation with community leaders and monks at the temple, they can provide some assistance such as advice or transport in case some emergency situations

happened. Moreover, the researcher will also inform Lao community leaders, his supervisor and friends before doing the interview in private places.

**What emergency plans are in place? Who can help?**

The researcher has contacted and consulted with Lao community leaders and monks at the temple for the initial advice on doing data collection with New Zealand - Laotian community. The researcher's itinerary and research schedule for the interview will also be informed to Lao community leaders, his supervisor and his close friends for some assistance such as advice or transport in case some emergency situations happened. For instance, the researcher will send a text to his close friend (who are staying near Manurewa) before going to and after coming out the interviewing place. If after 1 hour or finishing the interview, his close friend has not received a text from the researcher, his close friend will try to contact the researcher. If the researcher is still not contactable within 15 minutes after the end of the interview, his close friend will call emergency services or the police immediately. Apart from this, the researcher will also ensure that his mobile phone will be ready to contact anyone for some helps all the time.

Don't forget to update your safety protocol regularly:

**Date for next review**

N/A

## Appendix H: Confidentiality Agreement for a Translator



### Appendix H: Confidentiality Agreement for a Translator.

*Project title:* Investigating the uptake of COVID-19 public health advice and health service utilisation among Laotian New Zealanders during Alert Level 4, 2020 in Auckland, New Zealand

*Project Supervisor:* Dr Ailsa Holloway

*Researcher:* Phoutthanaphone Nedthongsavanh

- ☒ I understand that the interviews meetings or material I will be asked to translate is confidential.
- ☒ I understand that the content of the interviews meetings or material can only be discussed with the researchers.
- ☒ I will not keep any copies of the translations nor allow third parties access to them.

Translator's signature:

Translator's name: Xinnouvat Phichit

Translator's Contact Details (if appropriate):

+64 21 1623096

joey.phichit@gmail.com

.....  
.....  
.....

Date: 13 January 2021

Project Supervisor's Contact Details (if appropriate):

... Dr Ailsa Holloway

... Faculty of Health and Environmental Sciences

... Auckland University of Technology (AUT)

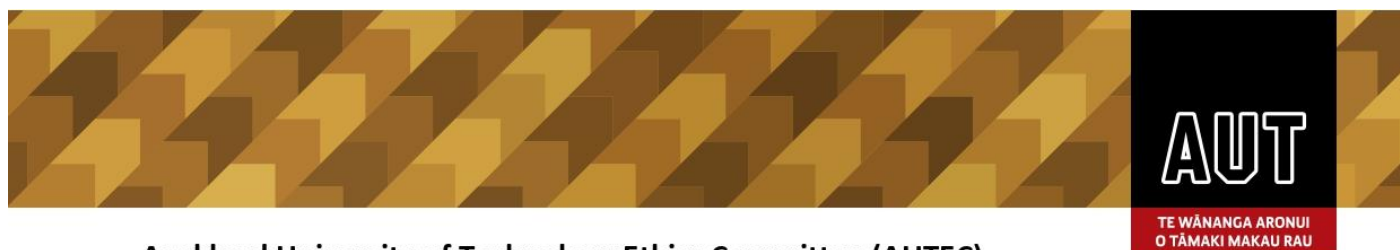
... Email: ailsa.holloway@aut.ac.nz

... Phone: (09) 9219999 Ext 6796

**Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTEK Reference number *type the AUTEK reference number***

*Note: The Translator should retain a copy of this form*

## Appendix I: Ethics Approval from AUTECH



### Auckland University of Technology Ethics Committee (AUTECH)

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

30 March 2021

Ailsa Holloway  
Faculty of Health and Environmental Sciences

Dear Ailsa

Re Ethics Application: **21/13 A qualitative descriptive study: Investigating the uptake of COVID-19 public health advice on health service access and use among Laotian households during Alert Level 4 in Auckland, New Zealand**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH).

Your ethics application has been approved for three years until 30 March 2024.

#### Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTECH in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTECH prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTECH Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTECH Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTECH grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz). The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

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

The AUTECH Secretariat  
**Auckland University of Technology Ethics Committee**

Cc: Phoutthanaphone@hotmail.com

## Appendix J: PGR1 Research Approval Confirmation



AUT

28 January 2021

Phouththanaphone Nedthongsavanh  
Empire Apartment  
Unit 1017  
21 Whitaker Place  
Grafton  
Auckland 1010

Dear Phouththanaphone

Thank you for submitting your PGR1 Research Proposal for the Master of Public Health.

Your proposal has been reviewed and approved by the Faculty of Health and Environmental Sciences, which will be noted at the Postgraduate Research Committee February 2021 meeting.

Your research details are:

Programme:	Master of Public Health
Paper enrolment:	HEAL901 Dissertation
Student ID:	18002557
Working title:	Investigating the uptake of COVID-19 public health advice on health service access and use among Laotian households during Alert Level 4 in Auckland, New Zealand
Primary supervisor:	Dr Ailsa Holloway
Start date:	1 February 2021
Expected completion date:	30 July 2021

For more information about the programme of study, please refer to the *Postgraduate Handbook*.

The AUT website for forms and handbooks is:

<https://sdw.aut.ac.nz/postgraduate-research/pg-forms-policies-and-processes>

Yours sincerely



**Professor Susan Crowther**

Acting Associate Dean Postgraduate Research · Hoa Mautaki Taura Rangahau  
Faculty of Health and Environmental Sciences · Te Ara Hauora A Pūtaiao  
Auckland University of Technology · Te Wānanga Aronui o Tāmaki Makau Rau  
09 921 9666 extension 7912

Cc Primary supervisor Dr Ailsa Holloway

## Appendix K: Researcher's Codebook

### Codes

1 = Main themes, Bold

1.A/B/C = Sub-themes, Bold

1.A/B/C.1 = Parent Codes

1.A/B/C.1.1 = Child Codes

Name	Description	Files	References
<b>Main theme 1: Socio-economic characteristics and family profile</b>	<b>Participant's Socio-economic characteristics and family that affected health information receiving and health care utilisation</b>	0	0
<b>1.A - Income and job security</b>	Income and job that may affect individuals' health information receiving and health care utilisation	0	0
1.A.1 - Changing Jobs	Worried about Jobs and business due to the changing in jobs during lockdown	2	3
1.A.2 - Knowledge gaps in obtaining grant support	Need help from the others regarding wage subsidy	1	1
1.A.3 - Getting subsidy and normal pay	receive normal pay, wage or government subsidy, able to manage their own expense or work as normal during lockdown	9	9
<b>1.B - Variation in English competence and confidence</b>	How language competence and confidence affected the access of health care information and utilisation	0	0
1.B.1 - Limited capacity and lacking confidence	Limited capacity and lacking confidence in English that may affect individuals' information and health care seeking behaviours	0	0

Name	Description	Files	References
1.B.1.1 - Language barriers in accessing health information	Unable to understand or partially understand the health information from the main sources	10	13
1.B.1.2 - Language barriers in accessing to health care service	Unable to contact the health centres when having some health problems or enquiries	4	4
1.B.2- Fluency and confidence	Fluency and confidence in English language that support individuals' information and health care seeking behaviours	0	0
1.B.2.1 - Able to understand information in English	No problems in accessing health information in English/understand majority of English information	3	4
1.B.2.2 - Able to contact health service	Individuals can contact health centre, operators and public health service by themselves	10	20
<b>1.C - Family profile</b>	Family characteristic may affect individuals' health information receiving and health care utilisation	0	0
1.C.1 - Age composition of family	Aged groups may affect individuals' information and health care seeking behaviours	0	0
1.C.1.1 - Aged 45 years old and over		6	6
1.C.1.2 - Aged under 45 years old		4	4
1.C.2 - Family membership	Types of family may affect individuals' information and health care seeking behaviours	0	0

Name	Description	Files	References
1.C.2.1 - Live alone		2	2
1.C.2.2 - Live with partner and/or/without children		8	8
<b>Main theme 2: Individual capability and self-beliefs</b>	<b>Participants' capability and beliefs that impact on health information and health care seeking behaviours</b>	0	0
<b>2.A - Self-efficacy</b>	Individuals' beliefs in their capacity to execute their actions in relation to health care seeking behaviours	0	0
2.A.1 - High self-efficacy	Ability to act on health information and advice	0	0
2.A.1.1 - Self-monitoring	Able to know and observe their own symptoms (mild or serious) during lockdown	9	12
2.A.1.2 - Able to continue routine appointments	Able to contact and adjust routine appointments regarding chronic health problems during lockdown	4	4
2.A.1.3 - Taking medicine at home	Able to do their own initial treatment that they used to when having some mild health problems	4	4
2.A.1.4 - Able to go to the health care centres	Individuals who were able to go to the health centres or clinic by themselves when having health problems or routine appointments	7	14
2.A.1.5 - Able to understand health care service constraints	experiencing the slower service but also understand situations	2	2
2.A.1.6 - Able to suggest important health information to others		7	8
2.A.1.7 - Able to be resilient in getting health information	No major problems always received health information during the Lockdown. Be able to be resilient	8	11
2.A.2 - Low self-efficacy	No confidence to act on health information and advice	0	0
2.A.2.1 - Need help from others in accessing health information	Need helps from the others and health information was being translated for them	6	6
2.A.2.2 - Need health from young generation or others	Need helps from others in order to contact and access to health care service	4	6
2.A.2.3 - Reluctancy	Not sure about their own symptoms and preferred to observe or assume to see some difficult experience regarding health care service accessibility	2	5
2.A.2.4 - No benefit on making voices	Feeling that their voices were always unheard or no positive impacts	1	1
<b>2.B - Capability in understanding and interpreting health information</b>		0	0
2.B.1 - Confused/unclear understanding of information	Unable to remember the rules or wrongly mixed up the rules from others, sometimes did it by personal beliefs and choices	10	15
2.B.2 - Strong capability to recall and remember information	Remember the main some rules and able to comply it	10	17

Name	Description	Files	References
<b>2.C - Personal circumstance and priorities</b>	adverse attitude to compliance with rules and health information	0	0
2.C.1 - Unable to comply the rules given	Sometimes participants acknowledged the rules during Alert level 4, but was not able to comply for some reasons, lack of understanding or sometimes they prioritised non-essential jobs	2	3
2.C.2 - Personal reasons to stop or unable to receive health information	Unable to receive health information regularly due to personal choices or circumstance	2	5
<b>Main Theme 3: Exposure to diverse information sources</b>	<b>The trustworthiness and confidence information sources that affect perception of participants</b>	0	0
<b>3.A - Accessibility of trusted information sources</b>		0	0
3.A.1 - Preferred some information sources	Having confidence in specific sources of information	9	9
<b>3.B - Perceived usefulness of information</b>	How participants perceive and value the usefulness of health information/ Information is valued and important	0	0
3.B.1 - Satisfied with Govt Advice		10	14
3.B.2 - Seeing importance of health advice		9	12

Name	Description	Files	References
3.B.3 - thinking some information is not specific to them and it is too general	Some messages were not specific or related to them or their situation	1	1
<b>3.C - Access to domestic and international information sources</b>	Health information sources of participants during lockdown level 4	0	0
3.C.1 – Official sources		0	0
3.C.1.1 – Domestic official sources	PM press, TV News, Govt Facebook Page	9	16
3.C.1.2 – Oversea official sources	PM press, TV News, Govt Facebook Page	6	7
3.C.2. - Unofficial/informal sources		0	0
3.C.2.1 - Domestic unofficial sources	Friends, Co-workers, relatives, family members, rumours or fake news from Facebook and social media	10	20
3.C.2.2 – Oversea unofficial sources	Friends, Co-workers, relatives, family members, rumours or fake news from Facebook and social media	6	6