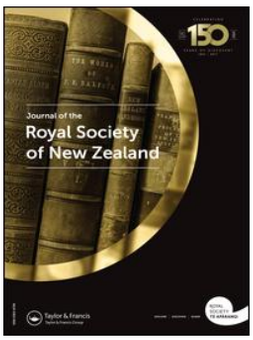

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Integrated social protection and COVID-19: rethinking Pacific community responses in Aotearoa

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ABSTRACT

COVID-19 has forced us to think critically about alternative global and local response strategies to the unprecedented devastation. Some of the most infected groups are Pacific communities and this has raised concern about the need to seriously address the issue of health and socio-economic inequality. One way of doing this is through social protection. The paper critically examines some of the conventional notions of social protection, especially those predicated on market-imperatives and assumptions and argues for new and community-relevant innovative social protection strategies to effectively mitigate the effects of COVID-19. It then discusses the integrated social protection approach (ISPA). The paper argues that while ISPA is an attempt to create an alternative, inclusive and participatory social protection strategy, the issues of equity in terms of distribution of resources and power still need to be fully addressed because of their potential to cause tension within the community. The meaningful participation and empowerment of the Pacific communities and the strategic use of their cultural norms in social protection framing and implementation are important in building up resilience and sustainability to mitigate effectively against the sudden onset of pandemics such as COVID-19.

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Introduction

Humanity has been jolted by COVID-19. The pandemic has wreaked havoc across the globe, infecting tens of millions of people, killing hundreds of thousands and paralysing economies causing significant unemployment, poverty and impacting dramatically on social well-being across countries and communities (Pawar 2020). In response to the unfolding crisis, social protection programs and policies of all types in the form of government wage subsidy, food distribution, cash transfer and a whole range of other community-focused services have been put in place by a range of players such as states, international organisations, not for profit organisations (NFPOs) and community organisations (Diwakar 2020; ILO 2020a). In Aotearoa New Zealand (AoNZ), the state has

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rolled out social protection strategies at the national level through wage subsidy schemes and other initiatives. The picture is more complex at the community-level where a triple-layer system consisting of government NFPOs and the community are part of a partnership to disburse, administer and control social protection resources relating to the COVID-19 response. We propose to call this multi-stakeholder partnership, the integrated social protection approach (ISPA).

The ISPA has long been a mainstream model for the government's contracting service delivery approach and provides an alternative model in response to the neoliberal model of full privatisation of well-being services (NZ Treasury 2003). While ISPA appears to have worked well in terms of providing a space for multi-stakeholder partnership, there are also important issues of participation and equity in terms of distribution of power and resources which need some scrutiny. This partnership appears to have worked well in the immediate response to the pandemic, especially in the context of the high health risks associated with Pacific communities. Knowledge of these risks became a cause for anxiety during the second wave of the pandemic in New Zealand, after more than 100 days of COVID-free conditions, when those of Pacific heritage were disproportionately infected. Cases around the world have highlighted the ways in which COVID-19 has exacerbated pre-existing socio-economic inequities and health vulnerabilities and the need for effective social protection responses which are tailored to meet the needs of disadvantaged and vulnerable communities (Diwakar 2020; ILO 2020b).

This paper examines the dynamics and social roles of ISPA and some of the challenges in relation to the delivery of social protection programs to Pacific communities during the COVID-19 period. This requires discussions of some related issues such as the implications of COVID-19 on Pacific communities and their existing economic challenges as well as the ways in which resilience can be built through an innovative mix of indigenous and formal social protection strategies. It also examines the ideological justifications, mechanisms and results of this state-NFPO-community partnership and some of the long-term implications of community-focused social protection strategies for health in New Zealand. The paper also critiques the market-based neoliberal approach to social protection and argues for the need for alternative human-centred discourses which are of relevance to Pacific communities. The ISPA is presented as a possible alternative model which, if refined much more thoughtfully, could have a lot of potential for future social protection policies. In terms of structure, the paper firstly provides a critical discussion of social protection, especially offering a critique of the market-based neoliberal approach and identifying some alternative human-centred discourses which are of relevance to Pacific communities. It then provides an assessment of the relationship between inequality, health and ethnicity in the context of the Pacific community in Aotearoa New Zealand (AoNZ), based on a comparative discussion of the Pacific community in the United States of America. The paper then examines the actual impact of the pandemic on the Pacific community in AoNZ, before discussing the concept of ISPA and how it is operationalised in response to COVID-19 and some of the shortcomings and challenges.

Rethinking social protection: a conceptual discussion

Social protection has been subjected to critical discussions over the years, partly because of neoliberal reforms leading to the privatisation, commodification and financialisation

of public goods, especially in the area of well-being. In the context of COVID-19, the failure of market-based health social protection systems must come under even more scrutiny. The tension between social protection as a public right and social protection as a private commodity has shaped the way well-being policies have been framed and articulated (Lazonick and O'sullivan 2000; Fine 2017). In the neoliberal context, market demands generally take precedence over community needs and this often creates inequality of access to health and social insurance, evidenced by the privatisation of health programs, which benefit pharmaceutical and insurance corporations (Viana and Silva 2018).

Figures provided by an International Labour Organisation (ILO) report (ILO 2020b) leave no doubt that fiscal austerity policies, broadly inspired by neoliberal prescriptions and implemented in virtually all regions of the world, have had a negative impact on social protection programs, especially those directed at children. The report shows that between 31% and 66.7% of the workers globally do not have unemployment protection schemes With respect to health, despite an extension of universal coverage, major deficits remain, particularly in rural areas and among the world's poor population (WHO 2017). It is estimated that to meet the Sustainable Development Goals (SDG) and universal health coverage, an additional 18 million health professionals are needed by 2030 (WHO 2019). It is also important to note that major regional disparities exist even within developed countries (Doorslaer and Koolman 2004). Meeting the health needs arising from epidemiological shifts (the increasing burden of chronic diseases that require long-term care) remains a challenge for many public health systems, and social protection is targeted at those who are able to pay, who are generally workers employed in the formal sector. The consequences for the well-being of individuals are numerous, with an increase in the prevalence of various diseases and mental disorders (Natasha et al. 2020).

Previous crises such as the 2008 global economic crisis and now the COVID-19 pandemic have demonstrated the fragility of marketised well-being (Mirowski 2013). In both cases, significant privatised social protection measures became dysfunctional and corporations had to seek public finances through direct state intervention. This has forced people to look within their own communities for alternative and more resilient forms of social protection, often based on indigenous solidarity economies (Ratuva 2014).

Social protection is generally defined as strategies that address the disadvantaged situations of vulnerable groups through direct assistance or development of opportunities and capacity in the areas of poverty, health, education, employment and other aspects of well-being (Walsham et al. 2019). According to Devereux and Sabates-Wheeler (2004) social protection needs to be seen as an encompassing process of prevention, protection, income-generation and transformation. But there is no generic way of framing and applying these concepts given the many multilateral, bilateral and private institutions with diverse and often competing ideological, economic and political interests engaged in social protection programs (Waring et al. 2013). What's more, multilateral agencies that use social protection as part of their broader developmental agenda, such as the World Bank (WB) and Asian Development Bank (ADB), have a more economistic approach to social protection where they attempt to create a synergy between austerity and growth on one hand and poverty alleviation on the other (World Bank 2012). Social protection and other measures to get people out of poverty are seen as dependent on growth,

their approach is largely influenced by neoliberal assumptions about managing risks to the labour market to ensure that productivity is maintained (Asian Development Bank 2011). Poverty reduction is seen not necessarily through humanitarian lenses but in relation to how the labour market can be protected and made more efficient through minimising people's exposure to risks (Holmes and Jones 2009).

The ADB's Social Protection Index (SPI), which is designed to 'gauge the extent of coverage of social protection programs and the depth of their impact' (McKinley 2013, p. 2), uses variables such as social insurance, social assistance and labour market programs, which are by and large based on formal market-based systems. These are then translated into four quantifiable variables using a simple ratio formula to determine the SPI. The variables are Social Protection Expenditure (SPEXP), Social Protection Coverage (SPCOV), Social Protection Distribution (SPDIST) and Social Protection Impact (SPIMP) (McKinley 2013).

The problem with the ADB system is that it does not take community-based and indigenous social protection systems into consideration, although it does consider the issues of systemic inequality and unequal access based on class, ethnicity and gender. Over the years, the ADB had fine-tuned its social protection strategies in a systematic way as a result of engagement with policy-makers and researchers from a region of the world where poverty and dislocation of millions have prevail. Some of these considerations have been embedded in the SPI formula and while these may have policy value for the ADB, they still do not fully reflect the intertwined and multi-dimensional complexities of culture, politics, economics and health. In a similar way, while the World Bank has developed a very comprehensive policy on 'resilience, equity and opportunity' as part of its social protection strategy, economic growth is still seen as the main driver for social transformation (World Bank 2012). By and large, economic imperatives are still seen as important, especially when social protection is linked with 'managing social risk' which might otherwise impact on the market (Heltberg et al. 2008).

However, there are strong pessimisms about these institutional approaches by some as it is seen as providing 'potentially illusory expectations' and optimism about future growth and wealth for all, a process Beckert (2020, pp. 319–320) refers to as 'promissory legitimacy'. The argument here is that these institutions draw on social protection narratives to project an illusion of humanitarianism and corporate social responsibility, which serves to conceal their implicit austerity intent.

Another major weakness of the market-based strategy to social protection is its failure to address power dynamics as it is assumed that the market has a self-regulatory levelling effect (Hathaway 2020; Viana and Silva 2018). This view overlooks the fact that there are marked power differentials between providers and recipients, manifested in different ways such as ownership of process, the motives of actors, incentives, reasons for implementation and impact on political relations and context (Mccord 2009; Hickey 2007; Zucco 2009; Devereux and White 2007). At the national level, social protection can even be a lever to reinforce state hegemony, developmental reach, legitimacy and dominance (Darcy 2004; Harvey 2009; Harvey and Holmes 2007). Thus, social protection policies that are imposed from above can have the effect of reinforcing power inequalities, and can be used as insurance against potential subaltern resistance.

The underpinning power relations coupled with the primacy of the market approach, especially the emphasis on economic risks such as financial shocks and recession,

overshadow the significance of communal capital and other important social issues such as gender inequality, domestic violence, social tension and racial discrimination at the community, household and intra-household levels (Holmes and Jones 2009). This has prompted (Waring et al. 2013) to call for a more 'anticipatory' and 'transformative' approach that incorporates gender-responsive and human rights-based approaches. The anticipatory aspect refers to putting in place preventative measures to respond to future crises. With regards to COVID-19, the anticipatory response was very low and much of the world was ill-prepared to respond to the pandemic. The transformative aspect refers to how social protection can be proactively utilised as a fulcrum for progressive structural changes to address inequality and social exclusion beyond the mere philanthropic and charitable niceties 'where the poor are patronised as 'beneficiaries' of the generosity and social conscience of the market' (Ratuva 2014, p. 43).

Market strategies also differ in relation to the different ideological and political approaches of states. For instance, in the US, the neo-liberalisation of public health means social protection in relation to health is left largely in the hands of corporate entities involved in insurance and other well-being services (Fullman et al. 2018). In comparison, New Zealand has a robust public health system, despite its neoliberal stance in economic development, and thus its public health-related social protection policies are far more comprehensive and well-being based. In both states, though, there is an inherent contradiction (a characteristic of the market-driven health system) where health as a social good and health as a private good compete for centre stage (Viana and Silva 2018).

The global crisis of 2008 which was associated with the dramatic increase in fuel and food prices and exacerbated by the financial crisis, further exposed deficiencies in market-based social protection systems, which failed to cope with increasing demand, leading many people in the Global South to fall back on community-based social protection systems for survival and prompting a major rethink of alternative well-being and people-centred approaches by development experts and international aid agencies (Slater and McCord 2009; Davies and McGregor 2009; Parks and Abbott 2009). Alternative modes of social protection, as suggests, 'flows from endowment of mutually respecting and trusting relationships' and 'depends on the quality of the set of relationships of a social group'. A further aspect is that, to be empowering and effective, social protection needs to be rooted in an organic way within the cultural norms of local communities (Schiller and de Wet 2019). This may involve community-based coping mechanisms relating to cultural practices and behaviours drawn from peoples' indigenous cultures and sometimes synthesised with contemporary experiences in adaptation to evolving social environments (Ratuva 2010; Schiller and de Wet 2019).

A further issue with the market-based SPI assessment framework is its primary focus on quantifiable formal social protection systems that are state-based and is silent on the diverse range of informal, community and indigenous systems which have served as means of social safety net for centuries. . This may be due to the subconscious cultural bias endemic in many official policy discourses and this could have long-term consequences in reinforcing inequality and marginalisation of minority groups and indigenous knowledge systems (Ratuva 2009). A new way of capturing indigenous forms of social protection is needed and this requires a deep understanding of cultures, meanings and systems of resilience (Ratuva 2010). Fundamental to how social protection should be

approached are issues of equity, inclusiveness and human dignity, beyond just ticking the official humanitarian box (Waring and Carr 2011).

Despite the global dominance and imposition of the neoliberal ethos, we must realise that people still construct the world in diverse ways and this should be recognised as a basis for framing alternative means of building a culture of resilience and sustainability (Barrientos and Hinojosa-Valencia 2009; Devereux and Cipryk 2009; Köhler et al. 2009). This should also require greater control of resources, transformational capacity and empowerment by local communities (Norton et al. 2001; Shepherd et al. 2004). In a world where COVID-19 is a major human security factor, on top of the threat of the climate crisis, inequality and conflict, social protection based on community needs and aspirations needs to be redefined and readapted to suit the ever-changing realities (Davies et al. 2008; Raworth 2007; Heltberg et al. 2008).

In New Zealand, health-related social protection toward Māori and Pacific communities are based on an integrated approach involving the state, NFPOs and the community. This model is informed by a number of key ideological narratives. The first is Te Tiriti which values biculturalism and respect for indigenous identity. While this is principally focused on Māori as tangata whenua (indigenous people), it has indirect resonance for Pacific communities through their cultural connections and their minority and disadvantaged status in the nation's socio-economic stratification. Secondly, New Zealand's philosophy on welfare capitalism still provides room for state social protection policies for Pacific and Māori communities. This welfare-based public policy approach has been enhanced under the Labour Government's 2019 Well-being Budget (Ministry of Treasury 2019).Thirdly, in the context of their diaspora status, Pacific communities have been able to build a resilient transnational cultural base and identities, which, along communal capital and traditional social protection systems, provides the basis for social protection for Pacific communities to address the consequences of inequality and marginalisation.

Inequality and COVID-19 amongst Pacific communities

Framing innovative social protection strategies should involve an understanding of the institutional and systemic issues of inequality, access and power and how these impact on health outcomes (Behrendt and Nguyen 2018). Socio-economic conditions and position within the societal hierarchy of power can shape people's well-being as well as perception and attitude towards each other. Research on historically marginalised minority groups shows that explicit and implicit cultural biases, social marginalisation and lack of opportunities can lead to individual and collective stress which may be passed down through generations either through family socialisation or even changes to genetic responses (Sullivan 2013).

The coronavirus pandemic has unveiled the stark reality of inequality in societies where Pacific communities find themselves at the bottom of the social stratification. In the US state of California, for instance, Native Hawaiians and Pacific Islanders (NHPI) had the largest increase in the poverty rate from 2007 to 2012; at 97%, higher than any other racial group. The average increase in rate of poverty over the same period was 31% (U.S. Census Bureau 2008). At the same time, the number of unemployed amongst NHPI increased 158%, again, higher than any other racial group.

These inequalities are reflected in COVID-19 figures where the rate of COVID-19 hospitalisation for Pacific communities in the US is up to 10 times the rate of other racial groups (Jackson 2020). This is for a group which makes up only 0.5% (1.5 million) of the total population of almost 330 million. Poor socio-economic conditions have forced Pacific communities to live together in large extended family groups, which, together with high rates of chronic diseases, lack of insurance, exclusion from Medicaid due to immigration status, and the fact that many Pacific communities are involved in frontline essential work such as the military or security and service industries, make the Pacific community more vulnerable to the pandemic (Jackson 2020). Worse still, the invisibility of the Pacific community as a designated official category at the US federal level means the federal government is not able to allocate funding for Pacific communities. Underpinning the bureaucratic hurdles that they have to overcome is systemic racism against minorities of colour (Jackson 2020).

The US scenario is used here to provide a comparative lense in relation to similar vulnerable situations of Pacific diaspora in New Zealand. Two major lessons we can draw from these are the significant roles of systemic racism and the debate relating to health as a private or public good. While there are systemic inequalities and subconscious biases within both systems, what worsens the US case is the fact that health care is a private corporate commodity compared to New Zealand where it is still regarded as an essential public good. This requires a more detailed analysis of the health equity situation of Pacific communities in New Zealand, we deal with this next.

Research on the ethnic (single prioritised) breakdown of poverty in New Zealand shows that Pacific communities are heavily represented in the lowest socio-economic bracket, with 11.6% of the Pacific community classified as 'poor' compared to 5.9% for New Zealand Europeans (Plum et al. 2019, p. 5). In-work poverty for males is 5.7% for New Zealand Europeans and 10.1% for Pacific communities, and for females 6.8% and 11.0%, while the figures for children are 7.5% and 17.7% respectively (Plum et al. 2019, p. 4). This inequity is also reflected in housing amongst the in-work poor; only 17.3% of the Pacific community own houses compare to 51.1% of New Zealand Europeans, 28.9% Māori and 41.65 Asian (Plum et al. 2019, p. 23). Other figures show that rates of low income for Pacific communities are consistently higher than those for New Zealand Europeans. Household Economic Survey (HES) data from 2013 to 2015 shows 36% of Pacific children lived in low-income households compared with 14% of European/Pākehā and 32% of Māori children (Perry 2017).

This long-standing structural inequality is also evident in health conditions and outcomes which are well-documented (Walsh and Grey 2019; Ajwani et al. 2003; Moui 1999); research on the life expectancy gap between Pacific and non-Māori non-Pacific revealed the proportion of all potentially avoidable deaths is twice as high for Pacific communities (47.3%) compared to non-Māori non-Pacific populations (23.2%) (Walsh and Grey 2019). This is partly due to the high incidence of diabetic conditions. Figures for 2015 show the rate of diabetes for Pacific adults (20–79 years) was 20%, the highest amongst all ethnic groups (Māori 10%, Asian 8% and NZ European 6%) (Bloomfield 2017). This is also connected to the high incidence of strokes and multimorbidity (Millar et al. 2018; Ryan et al. 2019).

Given these conditions, Pacific communities were assumed to be among the most at risk of COVID-19, yet during the first outbreak the Pacific community was largely

'insulated' from the virus, which in the first wave was largely associated with Pākehā returning from travel (Ma'ia'i 2020). This 'second wave' proved to be a different story, and was not only specific to Auckland where most Pacific communities in New Zealand live, it also hit the Pacific community hard. The ethnic breakdown of this 2nd wave of infection (Table 1) reveals a pattern almost similar to the US cases as we saw earlier. As of 24 August 2020, Pacific communities made up 75% of the Auckland cluster, the largest coronavirus cluster in the country.

Leading Pacific medical expert Colin Tukuitonga warned of a possible 'wild fire' scenario amongst the Pacific population if pandemic responses were insufficient (Smith 2020), given Pacific communities high risk of infectious diseases. During the measles outbreak in 2019, Pacific communities were 14 times more likely to contract measles than those of European descent (Smith 2020). In addition, Pacific communities tend to be concentrated in service industries, including as service workers in healthcare and the social assistance industry (MBIE 2020).

The high proportion of Pacific communities infected compared to other ethnic groups is partly because Pacific communities are more likely to live in overcrowded and multigenerational households (Steyn et al. 2020; Te Pūnaha Matatini 2020). It is calculated that amongst those considered 'poor', the average size of a Pacific household is 5.41 compared to 2.84 for Europeans, 3.85 for Māori and 3.54 for Asians (Plum et al. 2019).

Fundamentally, addressing the determinants of poor health and social disadvantage amongst Pacific communities is a way of addressing the long-term effects of future pandemics. This includes using well-targeted social protection strategies relating to education, housing, occupation, nutrition and other forms of lifestyles (Stats NZ 2013). While the Labour government's well-being budget has moved away from focusing on just economic prosperity, with a strong focus on 'tackling the long-term challenges we face as a country, like the mental health crisis, child poverty and domestic violence' (The Treasury 2019, p. 5), there is still room to unpack systemic and institutional impediments that may undermine a human-centered approach to social protection. COVID-19 has demonstrated that ethnic inequality is one such systemic challenge and that health is more than just a case of physical wellness; it is social, economic, political, psychological and cultural in interconnected ways. Notably, among the factors that have mitigated the effects of COVID-19 is the impact of cooperation between state social protection strategies, NFPOs and community solidarity, as discussed below.

Social impact of COVID-19 on Pacific communities

The impact of the pandemic on the Pacific community should be understood in terms of both social, economic and psychological effects *and* how these are balanced out by

Table 1. Auckland August cluster by ethnicity as at 24 August 2020.

Ethnicity	Number of cases	Percentage of cases
Māori	12	12
Pacific communities	76	75
Other	13	13
Total	101	100

Source: Ministry of Health (2020).

community resilience mechanisms. Some impacts such as unemployment are visible and measurable but some, such as psychological effects and isolation as a result of lockdown are more difficult to identify. Research undertaken during lockdown by Ngāti Whātua (Hunia et al. 2020) found a lack of access to digital and internet-enabled devices negatively impacted Māori students' mental health and resilience, with students reporting increased anxiety and disengagement from learning. This reduced mental well-being is supported by research that speaks to the psychosocial harm done to disadvantaged individuals and groups by the digital divide during lockdown (Hunia et al. 2020, p. 17) and similar effects are likely to be found among Pacific youth, who, alongside Māori youth, are among the most at risk of digital exclusion. This requires longer term and more in-depth ethnographic study, which is beyond the scope of this paper.

Pacific communities were already disadvantaged before COVID-19: their unemployment rate of 6.4% was the highest in New Zealand, their employment rate (59.8%) was lower than all the other ethnic groups, their median weekly income ($NZ954) was lower than other ethnic groups, and nearly one in five (19%) reported not having enough money to meet their daily needs such as accommodation, food, clothing and other basic requirements (Plum et al. 2019; MBIE 2020).

The issue of Pacific community's food insecurity in ANZ has also been critical. A national survey conducted in 2011 showed that Pacific communities were the most insecure and disadvantaged with respect to food was accessibility and affordability (Parnell et al. 2011). Results indicate that food insecurity amongst the Pacific communities were higher than other ethnic groups. Pacific households (53.9%) frequently ran out of food, compared to 13% of New Zealand European and other (NZEO) households. Pacific households (47.7%) also mentioned that they ate less because of lack of money, compared to 10.2% of NZEO households. A large proportion of Pacific households (60.4%) stated that lack of money was affecting the types of foods that they consume, compared to 27.8% of NZOE households (Ministry of Health 2003). This issue is continuing to grow, with recent figures showing that 37.1% of Pacific households with children were food insecure, compared to 16.2% of non-Pacific children (Ministry of Health 2019). It is important to note that while food security is linked to lack of food, the issue of poor choice of food could also impact on health and well-being.

As a result of the COVID-19 pandemic, many people including students that work have lost their jobs and the demand for food relief significantly increased in March 2020. Rather than being able to use well-established social protection mechanisms, many Pacific communities in need had to seek help from food banks. The Pasifika Futures Whānau Ora programme delivered packages of support to 10,326 vulnerable families in need during the COVID-19 pandemic and reached 56,521 individuals. The packages of support included household items and food supplies. Financial support to help pay off power bills, rent or internet were also offered (Pasifika Medical Association 2020).

That disadvantage has been exacerbated by COVID-19. MBIE figures for June 2020, at the height of the pandemic in New Zealand, showed a decrease of 1.7% in overall 'labour force participation rate' (MBIE 2020, p. 1), which was most marked amongst those aged between 15 and 44, while early reporting showed a sharp rise in the number of Pacific communities claiming jobseeker benefits (Ministry of Social Development 2020). Additional figures showed that young people not in education, employment or training

rose 12,700 from 16.0% to 18.4% (Ministry of Social Development 2020), and Pacific communities are likely to be disproportionately affected given their young age profile (Stats NZ 2018).

Considering the disruption to young people's education and training during lockdown, there is a case for more targeted interventions for Pacific communities to mitigate the combined effects of ethnic disadvantage and lockdown generational cohort (UN 2020). The lockdown period had a significant impact on Pacific communities because it isolated members of extended families in smaller bubbles and splintered community solidarity, typically sustained through face-to-face gatherings and physical-social closeness for collective cultural affinity. While many could connect digitally, Pacific communites' higher rates of digital exclusion (along with Māori), make them most likely not to have internet access (Grimes and White 2019) and this puts many at greater risk of isolation.

The assumption that everyone has access to the technology required to maintain connections – and receive important information about COVID-19 – is not the case for many Pacific families. Where virtual connectivity was possible, Pacific families developed rituals that fostered solidarity, understanding and cooperation. Parents spent more time with their children. Some parents of university students experienced for the first time and developed an appreciation of what tertiary studies entailed including self-directed learning and the often erratic sleeping and eating habits which posed health issues (NZUSA 2020).

An ironic, or one might say, a resilient aspect of the Pacific community ethos was that even under the stresses of COVID-19, they still had their responsibilities to their relatives in the islands by sending remittances. These family obligations added extra strains on their ability to survive under very trying circumstances, especially for those in the lower socio-economic categories. Balancing broader communal obligations with one's own family well-being has been a major challenge amongst Pacific communities and this burden worsened under the pandemic lockdown and loss of jobs.

Interface between state social protection and community solidarity

COVID-19 social protection for Pacific communities in New Zealand is best understood in the context of the interface between three levels of engagement. The first involves the state with its public resources and expertise which are often provided in the form of advisers, finance, testing stations, masks and medical personnel. The second is communal capital, which refers to 'the array of social and cultural norms, institutions, innovations and resources, which are embedded in and mobilised by communities to satisfy their basic needs, sustain social solidarity and develop resilience' (Hauofa 1994; Bataua 1995). Pacific communities maintain aspects of communal capital as part of their diasporic culture which have genesis in their home islands. The pre-colonial, colonial and post-colonial evolution of island communities has nurtured resilient forms of communal capital to enable people to survive in changing environments (ILO 2006; Crocombe 2000). Examples include kinship-based social networks, reciprocal goods exchange, collective labour, group land-ownership, cosmological connections, and common ethical principles and shared intellectual property. Many of these have been modified to suit the New Zealand environment, although some basic strands are still visible and

operational in adapted ways as they are passed down through generations. For the diaspora Pacific community, communal capital, to some extent, shapes their mode of adaptation, sense of resilience and cultural identity and is often mobilised as part of a response mechanism in times of crisis.

While the reach of the state may trickle down into Pacific communities through laws, public services and well-being policies, the Pacific communities' everyday cultural sphere is dominated by the complex interplay between kinship networks, use of communal capital for daily survival and the Church. Although, foreign in origin, the Church has been adapted as an agency of communal capital to provide both institutional organisation and ideological norms for communal identity (Manfred 2012; Newland 2009). Church leaders have been the voice of comfort and their leadership crucial. Indeed, the efforts of church leaders (for example, organising pop-up virus testing stations to service church members) likely played a part in Pacific communities' leading all ethnic groups in testing rates (Ma'ia'i 2020).

The third component is the NFPO sphere, which often provides the bridge between state bureaucracy and the community as intermediaries and providers of state services to communities. This is a dynamic space where individuals and groups share or compete for state resources, favour and legitimacy to leverage control over community resources and activities such as health, education and other forms of well-being and human security. As both sub-contractors of state services and sources of finance for communities, they are powerful powerbrokers with a significant hegemonic presence at different levels of the community. It is important to note that while the NFPOs are independent organisations, they can also be part of the community, with members who are from the community, have families in the community and who are culturally attached to the community. This is where the relationship can become quite complex, sometimes sensitive and even exploitative.

The interface between these three spheres are manifested in recent social protection projects for Pacific communities. For instance, the COVID-19 recovery package for the Pacific community in the 2020 budget provides NZ$195 million for a range of services such as education and training, job security, and housing development, as well as funding in support of Pacific culture and heritage. From the government perspective, it aimed to generate more community innovation and build on the gains from the 2019 Budget (Sio 2020). The minister responsible for Pacific communities William Sio said, 'It is now more important than ever before, that we work quickly and at pace, to achieve our collective vision of a confident, thriving, prosperous and resilient Pacific communities' (Sio 2020, p. 1).

While the initiatives were generous, the issue here is how the resources are intended to 'trickle down' to ordinary members of the community. For instance, the NFPO, Pacific Futures has positioned itself strategically to become a power broker and filtering agent through which the state's Whanau Ora funding will trickle down to families. Like New Zealand government operations, aid and community help programs have been subjected to neoliberal reform and NFPO that were originally set up for community well-being have transformed themselves into commercial sub-contractors. The communities in whose name the funding has been given are at the lowest strata of this neoliberal process, and it is debatable how much may actually reach them in a 'trickle down' social protection approach. Unsure of the benefits of state services, many Pacific

communities have resorted to communal capital in response to COVID-19. For instance, the church, through its centralised and coherent structure and extensive social network, has been an active community social protection agency, with South Auckland churches launching a mass effort to provide 40,000 face masks for the Pacific community (Dreaver 2020). A COVID-19 response that relies on volunteer efforts in this way, however, raises concerns about the funding mechanisms that exist to distribute resource where it is needed, not only during a crisis, but also in what could be termed 'normal' times. However, while the church has played a pivotal role in facilitating well-being projects, it has also historically placed some burden on members of the Pacific community through financial contributions, which in some cases are mandatory through the biblical tithe system.

An important aspect of community capital is cultural intelligence, which enables communities to understand their own vulnerabilities, limitations and strengths. The knowledge that they carry a higher risk in relation to COVID-19 because of the social and cultural determinants of health (as evidenced by their high rate of infection of H1N1) (Power et al. 2020) has provided Pacific communities with a sense of awareness and determination to develop resilience. For example, Pacific organisations collaborated with District Health Boards to provide COVID-19 information to Pacific communities to help fight against coronavirus via social media, discussion panels, and video's from Pacific doctors (Prepare Pacific 2020).

A point that needs stressing here is that the various NFPOs used their deep and extensive connections with Pacific communities to deliver vital services, even during lockdown. Some of the innovative ways NFPOs engaged with patients included meeting in patients' driveways (while abiding by physical distancing rules) with guitar or ukulele to sing songs to lift the spirits of people in their lockdown bubble, live-streaming exercise and dance moves for home exercise to address social isolation and ill health, and nursing by phone (Cassie 2020). These tailored activities were intended to mitigate the psychological impacts of lockdown, which particularly affected Pacific families and communities for whom churches, and their associated networks, are the centre of communal gravity.

In addition, though the lockdown period meant that Pacific communities could not engage in the same communal activities as they did prior to lockdown that did not mean that their network of activities ceased to operate. Rather, communities found other ways of maintaining social connections. Churches offered religious services via Zoom and used the live stream platform to provide official advice to parishioners. By providing food and nutrition parcels to Pacific families and communities, churches and community organisations also found innovative ways to continue to engage with their members, while also mobilising a dedicated volunteer base.

These community initiatives were complemented by state agencies, such as the Ministry for Pacific Peoples which put out daily bulletins to the Pacific community that became a communication focal point, with community and church groups sending in information for wider distribution via multiple email, web and social media channels. District Health Boards collaborated with Pacific organisations to provide COVID-19 information to Pacific communities via social media, discussion panels, and videos from Pacific doctors (Prepare Pacific 2020) and in August, the government launched a New Zealand Pacific information campaign, which was rolled out via multiple Pacific news media and social media channels and used well-known Pacific community

members as 'influencers' to share insights and key messages to help protect Pacific communities from Covid-19 (Ministry for Pacific People 2020).

Collaborations like this, at the interface between the state, NFPO and local communities, formed the broader social protection network and mechanism that acted not only as safety net but also as a rehabilitation and collective therapeutic system. While the services rendered provided support for food and other necessities, they also gave people emotional support and moral purpose at a time when isolation within lockdown bubbles and lack of certainty about the future created stress and trauma (Tukuitonga 2020). Communal capital thus played a significant role in providing social support and sense of identity.

Moreover, COVID-19 has demonstrated the benefits of vibrant interrelationships. It has also underscored the inequitable position and vulnerability of Pacific communities in New Zealand, and raised serious questions about the power dynamics which underpin the relationship between the state, NFPOs and the community, and the long-term sustainability of the current social protection system. In the case of service delivery to Pacific communities in New Zealand, the government's practice is to work in a stratified way by identifying a major contractor which then distributes funds downwards using various layers of sub-contracting. This does not necessarily lead to equity, as resources can be distributed along channels approved by the main contractor, which centralises most of the power in relation to disbursement and delivery. This was the case during COVID-19 when some community workers and service providers did not receive funds and thus felt disempowered.

A way forward could be for the government and community stakeholders to review the process of social protection delivery to the community to ensure more equity in terms of resources and power distribution and control. Merely ticking a national budgetary box for Pacific well-being funding is not enough; providing a sense of participation and empowerment is also crucial for long-term and sustainable community outcomes and social enrichment.

Conclusion

COVID-19 has transformed the way social protection is conceptualised and articulated in many parts of the world including New Zealand. This is due to the fact that the paralysis of the market economy, massive job losses, increased poverty and heightened marginalisation has expanded the category of 'most vulnerable', which is often the target of social protection, to include even those in the well-to-do classes. Social protection strategies have included a massive wage subsidy and other government measures to save businesses and thus employment as a cushion against economic collapse and large-scale misery. While the New Zealand government was engaged in this strategy at one level, it was also involved in community-focused social protection through targeted social protection programs for Pacific communities, who were considered high risk during the pandemic because of their high prevalence of pre-existing health conditions that would be aggravated by COVID-19. New Zealand's welfare state system, apart from its comprehensive response mechanism and proactive leadership, was a major factor in its successful battle with COVID-19, the opposite of the US where the neo-liberalised health system, absence of a coherent response strategy and lack of reliable leadership led to unprecedented heath disaster.

There is some evidence to suggest that targeted protections need closer scrutiny to ensure they are both appropriately targeted and effective. There is evidence, too, that social protection for Pacific communities works best as an integrated partnership between the state, NFPOs and the Pacific community. Given the dynamics of this inter-relationship are complex and include factors such as power, self-interest and humanitarian concerns, a closer look may also be needed at the balance of power between partners and the effectiveness of funding mechanisms for distributing resources where needed (not only during a crisis such as the pandemic, but also in what could be termed 'normal' times). An agile system which supports a continuum of social protection responses to national and global disasters is needed to ensure that social inequities are not exacerbated.

COVID-19 has provided us with the opportunity to seek out creative and innovative alternative social protection strategies which are inclusive and participatory by allowing for people to directly involve themselves. Despite its shortcomings, the ISPA model provides a multi-stakeholder partnership system which could provide the alternative to the neoliberal social protection strategies which are often skewed towards the few who are able to afford health insurance and other luxuries of life.

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