MINISTRY OF HEALTH
MANATŪ HAUORA

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6 August 2021

Scott

By email: fyi-request-15571-da3dea56@requests.fyi.org.nz
Ref: H202106406

Tēnā koe Scott

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to the Ministry of Health (the Ministry) on 26 May 2021 for:

> *"copies of all COVID-19 Immunisation Implementation Advisory Group meeting minutes, dated from December 2020 to February 2021."*

On 22 June 2021, under section 15A of the Act the Ministry extended the timeframe to respond to your request to 22 July 2021.

Six minutes (and one attachment) have been identified within the scope of your request and are outlined in Appendix 1 attached to this letter. The documents are released to you in full.

The Immunisation Implementation Advisory Group (IIAG) was established in 2020 to provide independent, practical advice to the Ministry on how to plan, prepare and implement a COVID-19 immunisation campaign, in the event suitable vaccines became available. This group represented a range of sectors and skills who contribute towards providing practical advice to support the COVID-19 Immunisation Programme, particularly with a focus on Māori and Pacific communities. The feedback from the IIAG proved invaluable in developing the programme and additional resources were dedicated to communication with Māori and Pacific communities as a result.

I trust this information fulfils your request. Under section 28(3) of the Act you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Ministry website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

Jo Gibbs
National Director
COVID-19 Vaccine and Immunisation Programme

Minutes/Actions

Date:	11 December/ Hakihea 2020
Time:	1:00 pm – 4:00 pm
Chair:	Te Puea Winiata,
Attendees:	Dr Helen Petousis-Harris, Dr Angela Ballantyne, Silao Vaisola-Sefa, Dr Api Talemaitoga; Nicky Birch, Taima Campbell, Kevin Pewhairangi, Vince Barry, Dr Jan White, Dr Rawiri Jansen, Loretta Roberts and Dr Nikki Turner Kelvin Watson, Casey Picket, Debbie Edwards, Carl Billington, Mathew Parr, Ana Bidois, Mike Stewart, Matthew Zhong; YiYan Chuah
Apologies:	

Item	Agenda Item
1	**Introduction** • IIAG input and feedback on the golden thread. • Welcomed further input to inform programme thinking
2	**Equity discussion (Ana)** • The Director-General noted the need for the equity to be explicit across the programme and the pillars • Programme will start with Te Tiriti and the practical considerations for each of the pillars • The programme will need to be more transparent and look to use the IIAG to strengthen the equity discussion <u>Meaning of Equity to incorporate WHO definition?</u> • The Ministry's current definition of equity recognising people with different levels of advantage. • PHARMAC: "the absence of avoidable, unfair or remediable differences" **Action**: Suggest the WHO definition adds or replaces the current MoH definition • Noted the programme is fast moving, but ongoing clarity of equity is needed. • Currently the treaty is absence in programme documents, having it in the written plan is important but not sufficient, it must be enacted at every stage <u>Request:</u> Across the seven pillars: how does it help the equity agenda and how does each pillar incorporate it • Ministry aims to answer Treaty in each of the pillars and acknowledges further work needs to be done

3	**Sequencing Framework (Casey)**
	<u>Outlined thought process behind the sequencing</u>
	• Development based on those most at risk of contracting or transmission
	• Noted that the first shipment (225,000 courses) will cover tier 1 and part of tier 2. Decisions on particular groups who are easier to distribute for a two-dose vaccine could be considered.
	• There is ordering within tiers there is if lettered (a,b,c).
	• There are unknowns to sequencing:
	  ○ how long we will be 'sequencing' before non-sequenced roll out
	
	<u>Household contacts rationale discussed</u>
	• Household contacts of tier 1 was included given the increase risk of contracting and transmitting the disease.
	• Household of Pregnant women – uncertainty whether they were able to vaccinated, therefore vaccination of household to protect transmission to them.
	• Households were estimated numbers and were increased beyond average household size in New Zealand. It is likely overestimated, but data difficult to confirm.
	
	<u>IIAG – Feedback and Notes on sequencing</u>
	• Household contacts does it help in the long-term OR is it better to save the vaccine and immunise people in tier 2?
	
	• Noted the actual operational implementation is difficult
	  ○ Reaching overstayers - Sequencing team has recommended regardless of visa status, the vaccine is available (accounts for overstayers)
	  ○ how to find out **who is a close contact or household contact** of tier 1 is difficult.
	  ○ **Identifying comorbidities is difficult**: GP databases are not easily fit for this purpose
	  ○ **IIAG noted Alternatives exist**: Using community services card holders as proxies
	
	• Frontline public sector needs to be clarified to first responders (Police and firefighters) to avoid any misinterpretation
	
	• Equity: Notes that over 65 is not a consistent indicator across different ethnic groups (Maori and Pasifika life expectancy is lower) not a scientific basis.
	
	Actions: IIAG Request:
	Whether the sequencing framework will be refined more from this (Yes)
	• **Whether a geographic approach should be considered –** at certain
	  ○ parts of the country are far away from the border
	  ○ parts adjacent to the high risk areas border/ports/MIQ should be prioritised
	  ○ Noted the ease on operational roll out possibly eased through this approach
	• Any changes to sequencing are made available to the group over the break

4	**Service Design (Mike Stewart)** **Feedback** Principles: • Treaty and equity need to be stronger; as well as including DHBs and other providers. We need the right people engaged through the process and not just DHBs. • Need to ensure DHBs do not leave Maori and Pasifka off; use good examples of DHBs working well in partnership • Providers who are vaccinating on the frontline need to be engaged – cited measles campaigns as DHB led programs which could be improved Workforce *Concern the flu campaign in March – May will divert workforce*. • Early planning is the Flu workforce will be able to switch to COVID which will match the increase in deliveries and broadening of the sequencing. • Consider: using novel approaches – a non-regulated but credentialed workforce which is mobile and able to deliver the vaccine closer to the community. *For the first workforce Pfizer vaccine has logistics, scale challenges* • Vials unable to be split means large sites may be preferred *Roadblocks in expanding the workforce exist including* • APC for paramedics • DHBs holding aged care contracts to get those nurses into the programme • Nursing Council – to have nursing graduates and students involved. • **Action: Programme to engage with IMAC on roadblocks** *Rationale for workforce must be correct* • Primary care is already delivering flu vaccine and additional tasks. • Best use of time must be clear (i.e. requirement for pop-up testing resulted in low turnout but required staff to be present/ready throughout) • **Agreed**: programme look to use comms and messaging to avoid low turnout. Aims to not impact BAU *Data 2019 model -* • Rawiri outlined a novel data prediction model created within his PHO which predicted vaccinations in 2020. Model used 2019 data and could be expanded to COVID-19 vaccinations • Benefits of model: identified groups which require early or extra effort to vaccinate. • **Action:** Model could be made available to a national level for national promotion and alternative models of delivery. *Noted: Maori providers will impact community uptake* • Chair notes Maori providers play key role and develop relationships with the community. **Consumers** *Noted: Barriers to access cover leave to attend events* • Availability: Annual/Sick leave or the time to attend a vaccination will impact lower socio-economic communities and jobs disproportionately. This must be factored in service design.

	○ *Discussions across Government are occurring, likely MBIE policy decision versus an MoH decision.* • Communities face different access concerns (distance and time to reach a vaccination point). Suggests mobile units, availability in community settings (marae) • These barriers may prevent the willingness of certain groups to be vaccinated. **Providers** Provider Colleges must be notified and not just DHBs. Solely using DHBs creates risk if provider groups are not informed and suggests the following are notified • Nursing Council • College of GPs • Pharmacy Guild DHBs Letter: mindful of Christmas and early January break • Suggests sensitivity when engaging and being mindful the sector is stretched through its COVID-19 response. • However DHBs should be engaged and clarity on what MoH is looking for should be given
5	**Communications and Stakeholder engagement (Carl)** **Overview** *Focuses* • Proactive messages before end of year • Early work on content plans to get messages through summer and quarter 1 • Broader campaign on Q2 and throughout 2021 • Campaign work in 2022 – this is to acknowledge the length of protection; multiple vaccines that come on in different stages. *Approach or lenses for announcement* • Specialist outreach to Maori: devolved model to those with community reach • Specialist outreach to Pacific: as above • Health workforce: IMAC and Ministry channels • Aotearoa New Zealand: Ad agencies (Clemenger type) *Feedback* • Request for joint fronting of media of DG, Maori, Cabinet and Pasifika instead of having separate timings – Carl to put the request forward • Weakness of ad agencies: they do not have Maori and Pacific experience or capability; while not used for specialist outreach won't have the ability to tailor messages to be inclusive to broader minority groups. *Comms strategy* *How it is Informed by research is limited so far* • initial piece of research by Horizon identified low Maori uptake • Follow up research has been completed: looking at attitudes, sources of trust and what is required to encourage vaccinations • Noted research does not account for increased PR activity by vaccine manufacturers and Political announcements.

	How to counter known low uptake – elderly Asian population has low flu vaccination uptake? • Meeting with DIA ethnic community managers • Welcomes IIAG and others to suggest further channels *How is health line being used?* • Health workforce will be engaged and supported • Outgoing channel to deal with the queries and questions received to be developed *Adverse reactions expectations – need to be outlined to allow ability to communicate* • Essential surveillance activities such as background rates of adverse events of special interest or other effects should be prepared. • This preparation will help inform and prepare the programme and communications to ensure confidence • Programme: noted met with adverse reaction monitoring pillar and have some initial understanding on how it will be designed and captured • Acknowledges novel challenges exist when administering in non-clinical settings
6	**Closing (Te Puea)** • Noted open to contact before the next meeting (22nd January 2021) • Receiving information before this date is welcomed (sequencing changes) • There are issues with multi-dimensional communications plan to reflect Aotearoa New Zealand • Challenges with the vaccine: including the process around adverse risks through Medsafe is linked to our comms. • Noted Medsafe will be fielding a high volume of requests

Document 2

IIAG Minutes/Actions

Date:	22 Kohitātea/January 2021
Time:	1:00 pm – 4:00 pm
Chair:	Te Puea Winiata
Attendees:	Dr Helen Petousis-Harris, Dr Angela Ballantyne, Silao Vaisola-Sefa, Dr Api Talemaitoga, Nicky Birch, Taima Campbell, Kevin Pewhairangi, Vince Barry, Dr Jan White, Dr Rawiri Jansen, Loretta Roberts, Dr Tristram Ingham Mathew Parr, Casey Picket, Carl Billington, Ana Bidois, Mike Stewart, Kris Golding, Matthew Zhong, Lillias Henderson
Apologies:	Nikki Turner

Item	Agenda Item
1	**Introduction and welcome** • This is the first meeting of 2021 • Welcomed Dr Tristram Ingham to the meeting. He has strong ties with the disability sector and will bring his expertise to the group • Te Puea acknowledged the team who worked over the break to ensure this mahi progressed at pace *Mat Parr (MoH) provided an update on the Programme* • Medsafe continues to have a robust approvals process and is working to ensure we have access to a safe and effective vaccine. Their process has already been expedited and are accepting rolling submissions from manufacturers. They are also working closely with Australia's TGA to share data • We are placing pressure on our suppliers to ensure they deliver on the batches that they have committed to providing • Operational readiness is on track for 1 March and this is becoming a very real date and where possible we will be prepared sooner • The new variants are also a threat and we are being mindful about what this means for Māori and Pacific communities • DHBs plans for rollout are due with us today <u>Group discussion</u> • Mat confirmed that IIAG is the only advisory group for the vaccine, and noted that Steering Group makes decisions based on advice from IIAG • Recent trial data from Norway raised concerned about vaccine safety. New Zealand needs to be prepared for this. Medsafe is focusing on safety and efficacy and will likely give conditional approval to the vaccine, meaning there are a list of conditions that will be similar to Australia. STAG is also providing clinical advice about the population that will be best suited for the vaccine

2	**Minutes from previous meeting** • No amendments to previous minutes.

3	**Decision to Use Framework decisions, roles and responsibilities**
	
	Kris Goulding (MoH) gave an overview of the Decision to Use Framework
	• Medsafe will be approving the vaccine for use, however we still need to decide whether or not to use the vaccine. This decision-making framework is in addition to what Medsafe is preparing
	• Decision to Use focuses on who gets the vaccine, how, and when
	• Key components of the framework that will inform the decision include:
	  ○ Context – we need the most up to date information about New Zealand's current situation etc
	  ○ Timing – we may be assessing multiple vaccines at once and we will need to decide when is right to use each one
	  ○ Information – is needed in order to make the best decision
	  ○ Assessment – provide our overall advice about the decision
	• The Ministry proposes that two advisory groups will support the Decision to Use
	  ○ IIAG – to focus on implementation
	  ○ Science and technical group (yet to be formed) – focus on the clinical and technical aspects
	• There is a chance that as things progress the IIAG may need to convene more often than on a fortnightly basis
	
	<u>Group discussion</u>
	• Information sharing across the groups needs to be connected. Important that the IIAG is informed by what the STA group advises, and vice versa. This should include a formal advice mechanism that is reflected back to Ministers
	• Equity of access will need to be cross referenced between a science and technical group and IIAG to ensure both groups are on the same page about who is best placed to receive the vaccine
	• The framework makes sense as a place to authorise and provide advice so Ministers can make a wider decision
	• IIAG members may need to attend additional meetings to get the decision finalised in a timely manner, and possibly a joined-up meeting with the science and technical group
	
	<u>Wider group discussion on other topics</u>
	• Minor changes to the sequencing framework but these will be discussed later in the hui
	• There is no specific control group for trialling the vaccine in New Zealand specifically. However, we are in a good position compared to other countries and we can learn from what is happening there
	• Hesitancy of healthcare workers overseas is a risk that we should be aware of. We will implement catch up vaccinations for those who decide they want it later in time. This could develop into a wider communications issue for the broader public if there is hesitancy among medical professionals
	• Flu vaccine will not be administered at the same time as the COVID-19 vaccine. This is something the science and technical advisory group can advise on and can assess data from overseas
	• Members are already hearing concerns in the community about the cost of the vaccine
	
	Endorsed the framework.

	Action for Mat and Kris to consider how meeting logistics might occur over the next month.

4	**Sequencing Framework: proposed evidence reviews and advice on risks for Māori and Pacific peoples**
	
	Casey Pickett (MoH) presented updates to the sequencing framework
	• Prior to Christmas the Steering Group considered IIAG's feedback about lowering an age for Māori and Pacific eligibility. Their view was that decisions around ethnicity need to be steeped in evidence and we should rely on the best epidemiological evidence across jurisdictions
	• We have established an internal working group to consider the scope, nature and strength of the risk for Māori and Pacific people. This group has commissioned evidence that investigates the risks to Māori
	• Evidence from the new working group will be collated and submitted to Ministers for their view on options
	• Questions posed to the IIAG: is there anything we should be reviewing? How would you like to work with us? Open to your guidance about how we engage and consult
	
	<u>Group discussion</u>
	• When considering international data, you need to be careful – it should eb considered on social and ethical grounds rather than biological
	  ○ Although we can look at similar international indicators such as deprivation and social housing, they are applied in a different context
	  ○ Ethnicity is a proxy measure for a number of social and cultural aspects
	  ○ Consider other risks such as exposure and where cases are coming from, biological risk, communication risks
	• IIAG would like a role in commissioning the research to determine what information is needed. This will be particularly important moving forward, as this is only one component of the vaccine rollout
	• If pakeha under 65 are eligible in each scenario, an equivalent age must be determined for Māori and Pacific people
	• Māori epidemiologists should be involved with a peer review of the sequencing framework
	• Different facilities have varying levels of risk profile depending on the level of interaction between staff and patients
	• Prison inmates should be explicitly included as a cohort because the state has an additional ethical obligation towards them having removed their rights
	• DHBs will have to make key decisions based on these broad categories. This will be supported by the definitions submitted to the previous IIAG hui and will be subject to ongoing refinement. There will be some level of discretion given to DHBs to implement
	• DHBs have not always been able to successfully deliver for the disability sector during the COVID-19 response, as was evident with PPE. Would caution that their success may be limited
	• The Framework has been updated to include Aged Residential Care workers as a result of an evidence review focused on risk factors for segments of the population. This was discussed at the IIAG, then at Steering Group, returned to IIAG for consideration and will soon be submitted to Cabinet
	• Important to engage with the wider disability sector on the sequencing framework as Tristram doesn't represent all views

	Action for Casey to investigate the funding request to allow the IIAG to commission research. This may include topics such as international evidence of COVID-19 transmission in residential and prison settings, as well as identifying underlying factors that cause that risk. **Action** for Casey to talk to Rawiri offline about Māori epidemiologists who can complete a review of the report. **Action** for Casey to consider an age threshold for Māori and Pacific populations should one be implemented for the wider pakeha population. **Action** for Casey to touch base with Tristram about aged residential care residents. **Action** to update the Framework to include prisoners. **Action** to commission a disability report about the types of risks and international evidence. **Ensure** we are being equitable in the standard of scrutiny that is applied when making decisions around changing tiers of the sequencing framework. **Ensure** the underlying principle of the vaccine rollout is reiterated in memos, which is focused on risk and minimising harm. **Note** caution should be exercised when extrapolating findings when linking things to ethnicity, especially in a different context to New Zealand given the social and cultural factors. **Note** that relying on DHBs to distribute to Māori, Pacific and disability cohorts may not be the most effective at promoting uptake.
5	**Readiness and border workforce immunisation roll out plan** *Mat Parr presented an update about the immunisation rollout plan* • Kelvin Watson is no longer the GM responsible for this workstream and we are actively recruiting for someone to step into this role • We are trying to get ahead of the size and scale of the programme and sharing information weekly with DHB CEs and PHUs • The slides show that we have more than enough vaccine available for the whole country, but it will depend on delivery schedules as to when we can actually inject people • We have carried out workforce modelling to match it to system capacity, and additional modelling is being done to detail the granular level • NZDF has been included in the emergency services category as they interface with the MIQ facilities and have offered their vaccinators in return who can help us reach rural locations <u>Group discussion</u> • Māori distribution networks need to be looped in to ensure the equity measure is represented • New vaccinators have a health background of some form, even if they have not previously given a vaccination. The training they receive includes how to use the CIR, but we are expecting that administrators will also be needed to enter data into the CIR

	• Consider how a non-regulated workforce could be mobilised across a wider Māori and Pacific network to distribute the vaccine further • There is a delay if we are having to wait until DHBs are ready to deliver, because only after that point will they engage with providers • Communications are needed that relates to the impact on other immunisation programmes, such as the measles programme. This requires clear messages from Ashely to share with the sector, and ensuring that people are on standby ready to deliver the vaccine as soon as it arrives • Ethnicity data can be used to tell a story and determine what success looks like for Māori. An update for the group would be useful about the CIR and the role of ethnicity data • Concern that people may change their ethnicity to become eligible for the vaccine. There is an operational challenge with recording data in the system as of a certain date, and we have to accept that the occasional person will sneak through the system **Action** for the Ministry to pull together a view for Māori and Pacific providers which will be brought back to the IIAG. **Action** for Mat to organise an update for the group about the CIR to discuss at the next meeting. **Action** for Mat to present what the reporting will look like at the next meeting. **Action** for the policy team at the Ministry to ensure that non-registered vaccinators are able to deliver the vaccine to Māori and Pacific communities. **Action** for Carl to coordinate with the Ministry to ensure clear messaging around other immunisation campaigns.
6	**Māori and Pacific immunisation delivery strategies** *Ana Bidois (MoH) presented an update on the Māori and Pacific immunisation strategy* • The Māori and Pacific strategy has a focus on a separate comms plan, and we can also look to develop a disability strategy • Welcome feedback about service delivery models in order to promote uptake among Māori and Pacific communities • Further updates will be provided at the next meeting <u>Group discussion</u> • Costings for Māori providers may not include funding for infrastructure, such as fridges etc if similar services are already provided • Confirmed that the wider New Zealand comms include the Māori population and will not solely target pakeha • We want to take a whānau approach to delivering and ensure that people who are high risk are protected • Will pharmacies be used as a delivery point? This is one of the main contact points for whānau and it is important that it is made accessibly • There is a strong preference for comms to come directly from the Ministry rather than from DHBs • Where possible, the Ministry should seek to utilise existing provider networks, especially in the disability sector • Concern that there could be low uptake among Māori with current public sentiment, and the comms strategy will be critical for this. Positive messages

	that speak to collective whānau and encourage people to look out for each other resonate with the community **Action** for Ana to confirm the service delivery mechanisms and follow up whether pharmacies will be involved. **Action** for Ana to get a copy of the Māori Influenza report from the Māori Health Directorate at the Ministry. **Action** an update on the financially modelling including the equity and rural adjuster **Action** for Mat to speak to the Disability Directorate at the Ministry to ensure the are involved with this work.
7	**Communications and stakeholder engagement update** *Carl Billington (MoH) presented a comms and engagement update* • A new team has come on board to support specifically with Māori and Pacific comms • Clemengers will partner with the Ministry to deliver the wider New Zealand campaign, that will have a specific Māori view baked into it • The campaign will start from 15 February and consistent high-level framing will apply across messaging that is delivered nationwide, as well as to Māori and Pacific audiences. Messaging will continue to evolve over the following weeks <u>Group discussion</u> • The group would like an update at the next meeting about our global obligations and how we are supporting smaller countries who may need vaccines more than us • A deliberate engagement approach is required for working with stakeholders • Getting ahead of the messages that we expect will come from individuals is important **Action** to provide an update at the next meeting about how our leftover vaccines could be made available for the global market.
8	**Any other business and next steps** • Exposure is a risk for the disabled community • We need to be clear at what point we open the borders again. There will be increasing public pressure once vaccine rollout commences and it will be important for us to weigh up the level of risk
9	**Closing** • Te Puea thanked members for their time and contributions • Noted the group may convene more frequently than in a fortnight.

Action Tracker 21 January

Item	Action	Lead	Due Date
3	• Mat and Kris to consider how meeting logistics might occur over the next month.	Mat Parr	5 February 2021
4	• Casey to investigate the funding request to allow the IIAG to commission research. This	Casey Pickett	5 February 2021

	may include topics such as international evidence of COVID-19 transmission in residential and prison settings, as well as identifying underlying factors that cause that risk. • Casey to talk to Rawiri offline about Māori epidemiologists who can complete a review of the report. • Casey to consider an age threshold for Māori and Pacific populations should one be implemented for the wider pakeha population. • Casey to touch base with Tristram about aged residential care residents. • Update the Framework to include prisoners. • Commission a disability report about the types of risks and international evidence.		
5	• Ministry to pull together a view for Māori and Pacific providers which will be brought back to the IIAG. • Mat to organise an update for the group about the CIR to discuss at the next meeting. • Mat to present what the reporting will look like at the next meeting. • Policy team at the Ministry to ensure that non-registered vaccinators are able to deliver the vaccine to Māori and Pacific communities. • Carl to coordinate with the Ministry to ensure clear messaging around other immunisation campaigns.	Mat Parr & Carl Billington	5 February 2021
6	• Ana to confirm the service delivery mechanisms and follow up about whether pharmacies will be involved. • Ana to get a copy of the Māori Influenza evaluation report from the Māori Health Directorate at the Ministry • An update on the financial modelling including the equity and rural adjusters • Mat to speak to the Disability Electorate at the Ministry to ensure the are involved with this work.	Ana Bidois	5 February 2021
7	• Provide an update at the next meeting about how our leftover vaccines could be made available for the global market.	Mat Parr	5 February 2021

Document 3

IIAG Minutes/Actions

Date:	29 Kohitātea/January 2021
Time:	9:00 am – 10:00 am
Chair:	Te Puea Winiata
Attendees:	Taima Campbell, Kevin Pewhairangi, Dr Rawiri Jansen, Dr Tristram Ingham, Nicky Burch Casey Picket, Debbie Edwards
Apologies:	Mathew Parr, Ana Bidois

Item	Agenda Item
1	**Introduction and welcome** • Tristram opened the hui with a karakia • The discussion today will focus on the options presented in the document emailed by Debbie which presents different options for the Sequencing Framework

2	**Sequencing Framework Options**
	
	Casey Pickett (MoH) introduced the table and options for Sequencing
	• The discussion today will focus on several options for the IIAG to discuss and share your feedback. We would like your feedback about what has been presented and whether to refine or add in other options to help understand your preferred option
	• Eventually these options and accompanying advice will be presented to Ministers. More than one option can be presented
	• A separate session will take place with the Pacific members of the IIAG
	
	<u>Options Analysis</u>
	• Options 1, 2 and 4 are preferable with some changes needed to the framing
	• Option 1: Lower age threshold for Māori and Pacific older adults compared to rest of older adult population in the sequencing
	  ○ Reword to something along the lines of “the Māori age will be X which is compared to the Pakeha age of X”
	• Option 2: Reserve/ring fence a portion of available vaccines for relevant service providers with guidelines to deliver to vulnerable Māori and Pacific communities
	  ○ This could be successful
	  ○ Need appropriate resourcing and engagement from whānau, iwi and communities
	• Option 3: Immunisation of cohorts with relevant underlying conditions with a focus on prioritising Māori and Pacific older adults first
	  ○ A combination of options 1 and 2 and less relevant

- Language needs tweaking
- Option 4: Target vulnerable communities (e.g. based on deprivation index or geographical location) which include high populations of Māori and Pacific peoples
  - A viable option but language needs to be adjusted – focus on equity and needs
  - Currently implies racial profiling and would caution avoiding this language and words such as “deprivation”, or “hard to reach”
  - Alternatives could include “most in need”
  - Suggestion that we could use a Community Services Card as a measure, but this has been tested with the community and there was considerable push back

<u>Group Discussion</u>

- What is the purpose of our immunisation programme? There are a number of answers:
  - To protect whānau and the people of Aotearoa
  - To support the Elimination Strategy and keep COVID-19 out of New Zealand
  - To protect the health system and communities in the process
  - Minimising transmission is a consideration but is not the primary focus at this stage due to the lack of information about whether vaccines can reduce transmission. This evidence is not expected for some time
- The Sequencing Framework is trying to acknowledge that Māori have had worse outcomes and have been disproportionately impacted by COVID-19. Need to ensure we are doing the best by Māori
- Clearer messaging is needed from the Government. We are currently seeing different messages from iwi, for example, where the Government has retained Northland at Level 1 but iwi are advising their own people to behave as if they are at Level 2. We should make things simple for whānau and deliver messages that resonate
  - Ensure that mainstream communications don’t undermine the message that is delivered to Māori and Pacific communities
- Language for all the options needs refining and Nicky will support Debbie and Casey with this
- Changes to language can also be reflected throughout other Ministerial advice, such as in the current Cabinet paper
  - This is an opportunity to be explicit with Ministers when we talk about the Māori population being “at risk”
  - Exposure risk – people who have a risk of being exposed to COVID-19 if they are working in MIQ, for example
  - Risk of impacts caused by COVID-19 – includes characteristics such as comorbidity, immune deficiency, reduced access, a health system that doesn’t meet needs
  - Transition from “vulnerable” to “needs”
  - IIAG would be happy for the Ministry to directly say they have received advice on this and need to change the way we do things
- Māori and Pacific cohorts need to be addressed as distinct groups. While they are similar in the way they mobilise their communities, the methods of engagement are different and may require different solutions
- Desire to be innovative in the delivery solutions, such as commissioning for outcomes directly with providers. We could allow Māori to implement their own sequencing because there are already cultural examples in play, such as how a

	marae works. There may be opportunities to commission parallel streams so some areas have better access than other providers • Māori know their own people and should be trusted to deliver it to those who need it most. This conversation needs to take place with DHBs • There is a challenge as to how we can truly achieve equity when vaccine stocks are limited • It is important that we constantly review the framework and include the most up to date information where we can, especially given the number of unknowns • There is danger in being too prescriptive and people need flexibility and room to make their own decisions • A range of levers will be required that can be utilised depending on the scenario. Includes elements such as direct commissioning, clear communications to build on the national narrative, and building on the success of the Māori immunisation campaign • Next steps will be to present these options, or a combination of options, and eventually submit to Ministers for their consideration. IIAG is able to make strong recommendations that the Ministry will incorporate into its advice • Will resume this conversation at the IIAG meeting next Friday 5 December **Action** for Nicky to work with Debbie to tidy up the language under the options headings. Debbie will recirculate and test with the group. **Action** for Casey to follow up again with the Māori Health Directorate and source a version of the influenza report that can be shared with the IIAG.
3	**Closing** • Te Puea thanked members for their time and contributions

Action Tracker 29 January

Item	Action	Lead	Due Date
2	• Nicky to work with Debbie to tidy up the language under the options headings. Debbie will recirculate and test with the group • Casey to follow up again with the Māori Health Directorate and source a version of the influenza report that can be shared with the IIAG	Debbie Edwards Casey Pickett	5 February 2021

IIAG Minutes/Actions

Date:	5 Hui-tanguru/February 2021
Time:	1:00 pm – 4:00 pm
Chair:	Te Puea Winiata
Attendees:	Nikki Turner, Loretta Roberts, Beth Williams, Rhonda Sherriff, Kevin Pewhairangi, Silao Vaisola-Sefo, Dr Tristram Ingham, Nicky Birch, Vince Barry, Angela Ballentyne, Dr Helen Petousis-Harris, Taima Campbell, Dr Rawiri Jansen, Apisalome Talemaitoga Mathew Parr, Carl Billington, Mike Stewart, Debbie Edwards, Ana Bidois, Michael Dreyer, Edward Falloon, Luke Fieldes, Joe Bourne
Apologies:	

Item	Agenda Item
1	**Introduction and welcome** • Kevin opened with a karakia • The group noted additional members of Rhonda Sherriff and Vince Barry attending this meeting • Today's agenda is very full as the programme is working at pace towards the delivery date. Any immediate feedback is welcomed
2	**Minutes from previous meeting** • Minutes from the previous meeting are accepted
3	**Programme Update** *Mat Parr (Programme Director) provided an update about the programme* • Today's discussion involves a lot of highly sensitive information and we would appreciate you keep this to yourselves, especially information that relates to timeframes • Latest delivery schedules indicate the vaccine will arrive during the week of 15 February, with a possible vaccination start date of 20 February • Medsafe approved the Pfizer vaccine for use earlier this week, and approvals for the AstraZeneca and Janssen vaccines have been received and are being worked through by Medsafe • Training has been brought forward and will commence next week • Where possible we are working to the sequencing framework to ensure the vaccine is received by those who need it most • Three distinct delivery phases which will increase in scale to adjust to demand: ○ Phase 1 – Pfizer vaccine will be arriving in weekly doses (55,000 initially). Border workers and high-risk health workers will be vaccinated

	first, and DHB staff will be immunised in this cohort. DHB sites will be brought online in a staged and controlled manner ○ Phases 2 and 3 – delivery ramps up and we will begin to engage with community providers with targeted outreach. Delivery of vaccines increases in May/June with other vaccines becoming available • We expect that enough vaccines will have arrived by September to vaccinate the NZ population. Initial work is being done to consider our options for donating vaccine if we have too much • Planning is underway to set up daily reporting mechanisms <u>Group discussion – overlap with other vaccine programmes</u> • What is the impact on other vaccine programmes? Flu season is also approaching, and MMR campaigns are underway but if we proceed with these there is a risk that we undermine the COVID-19 vaccine programme • Clinical advice recommends a 2-week gap between COVID-19 and flu, and a 4-week gap between COVID-19 and MMR • Border workers may be in the cohort who are scheduled to receive a MMR vaccine • The group agreed COVID-19 is a bigger risk than flu and MMR and should take priority over other vaccination programmes. To support this, clinical advice is urgently needed from the Ministry to DHBs and providers as a priority. DHBs are currently under pressure to deliver the MMR campaigns and there needs to be clarity about what is expected and when. IIAG is prepared to support with this • Need to be mindful of the opportunity cost of delivering COVID-19 vaccines • Not running with the flu vaccine would be highly confusing. It should be delivered to those who are at highest risk rather than the private sector • Capacity is an issue for delivering multiple immunisation programmes, particularly when it comes to storage • If people who have long-term conditions are unlikely to receive the COVID-19 vaccine initially, this would be a good opportunity to ensure they get a flu vaccine • We need to be mindful of whānau who will be making choices about whether they take the vaccine or not, especially if cost is a factor. Layering three vaccines is complex and needs to resonate with communities • Is there an opportunity to use the flu vaccine as a dry run for COVID-19 and get people used to the idea of immunisation? <u>Group discussion – general</u> • Vaccine suitability is a question that lots of people will be concerned about – is there a brand that is better suited for some populations? At this stage we don't have enough information about them, but it is likely people won't have a choice • General population will be wanting to receive the most effective vaccine and this needs to be factored into the comms • What work is being done in relation to frontline workers who choose not to take the vaccine? The impact on employers who may need to stand people down hasn't yet been finalised and this has been a focus in the media. The Crown is seeking advice from the Solicitor General, but this is an issue for the private sector rather than for the Crown. PM has been clear that the vaccine is not mandatory, but it is up to individual employers to decide what they want to do • To ensure equitable access for the disability community we need to be deliberate about asking harsh questions about people's disabilities. The Washington Group Question Sets are the preferred method for data screening

	• Even though we are delivering at pace, the sequencing framework cannot be ignored • Is there an opportunity to commission a piece of work to explore the vaccine rollout across disability and mental health sectors? This would also look to leverage the flu vaccine report from the Māori health directorate at the Ministry **Action** for the programme to draft a memo based on IIAG feedback and share clinical advice with the sector about overlap with other immunisation campaigns and reiterate that COVID-19 is the priority.
4	**Update on the COVID-19 Immunisation Register (CIR)** *Michael Dreyer (Group Manager, National Digital Services) presented an update on the CIR* • Michael has been responsible with running the national IT system and leading the COVID-19 response with border testing and contact tracing solutions • We have developed a system that will eventually replace the National Immunisation Register • The CIR will eventually become the new National Immunisation Solution once the data is migrated across from the NIR • Capability for the CIR will continue to improve over the phased rollout of the vaccine to supportCOVID-19 vaccine delivery • We are also working to ensure that CARM has the capacity to deliver post-event monitoring *Edward Falloon presented a live demonstration of the CIR* • We have designed it to make it paperless, but acknowledge there may also be circumstances that affect functionality, and this can be managed manually • Three phases of the vaccination event where the CIR will be used: reception, vaccination and recovery • The waiting time as part of the recovery will be 30 mins • It has been designed to make it easy for the vaccinator • The programme works in real time and connects to people's NHIs <u>Group discussion</u> • We need to be clear with individuals that they can't opt out of having their data put into the system, and this needs to be shared upfront • Would be useful for people to have the opportunity to complete the form themselves • Some areas need to be worked through in more detail to ensure suitability for the disability sector • The question relating to symptoms is very broad in nature • Providers can experience challenges outside their control which means technology isn't feasible e.g. Adverse weather conditions, technology failure. How can we account for this? We will always need a wat to capture things on paper as a last resort and IMAC are developing a paper version of the online system • There are likely to be additional staffing implications of using this system depending on the number of people being vaccinated in one site. This will be taken into account during DHB planning • We are using an existing GP notification system

	• Migration with GP systems is challenging. At this stage it will be additional to those systems and GPs will be required to log into a separate portal before it can be migrated into the newer NIR **Note** if members have further questions on the CIR they can contact Michael Dreyer at Michael.Dreyer@health.govt.nz.
5	**Update on reporting** *Luke Fields (Lead, COVID-19 Vaccine Reporting) presented on the Ministry's plans for reporting* • This work is separate from the technology component but there is overlap with some of the data that we need • We are focused on getting high quality data that can ensure we have accurate, robust and timely reporting that can be used for analytics and decision making. The credibility of data results in credibility for the programme, so we need to be putting out numbers that we have confidence in • There are a diverse range of stakeholders who are interested in this and we need to share information with stakeholders as it becomes available • We are establishing processes to ensure we can deliver on the analytics once vaccination begins • We have created templates for standardised reporting. The CIR system is based on Salesforce and has limited reporting capabilities, so we will report through Snowflake that can support more advanced analytics • As we don't have any current data the first test will be when we go live on Day 1 • Daily reporting will be the focus, but we will have the ability to access more up to date information should we need it • Presentation attached here: 5. Reporting update for IIAG 5 Feb 2021.pp <u>Group discussion</u> • Missing reporting measure is the number of people who have received the first dose vs the second dose • We need to keep in mind the audience – we may have to tailor information to different audiences • Privacy should be top of mind if we are using different datasets • The highest value for reporting will be when providers are having conversations with people on the ground and can share the most up to date information • May want to consider how we screen people and align them to the different groups in the sequencing framework. This was missing in the CIR fields and means it will be difficult to report on it **Note** if members have any feedback on reporting mechanisms they can get in touch with Luke at Luke.Fieldes@health.govt.nz.
6	**Report back on sequencing** *Debbie Edwards (Principal Advisor, System Strategy & Policy) provided an update on the sequencing framework* • Further discussions have been had to ensure we are upholding our Te Tiriti obligations and ensuring equity of access

	• A meeting took place with Māori members on Tuesday, and with Pacific members on Thursday • Ideas were put forward at each meeting which have been very helpful and improved the framework • Nicky provided some helpful language that is strengths based and more positive which has been shared with the comms team so they can influence their language also • We have proposed that an allocation of vaccine is set aside in Tier 3 that can be distributed to Māori and Pacific communities nationally by providers who are best placed to determine where it goes. This looks at a locality system, rather than the focus being aged-based and is a whānau-centred approach • Need to consider questions such as infrastructure and IT support so that it can be delivered in time • Plan to have additional meetings over the coming weeks to refine further <u>Group discussion</u> • Connecting with Māori networks will be important, especially to ensure rural communities have access, and means we can be more agile when distributing • Allows for us to have conversations with whānau about vaccine hesitancy and what it means for them • It is critical that the Crown lands the correct messaging to give context to the message, and this is reflected in the changes that Nicky suggested to the wording • There is not one strategy over others that will lead to success. We need a combination of options to make meaningful impact • Need to be mindful of closing the gap to prevent some cohorts from falling being exposed to risk. Examples include uber/courier drivers • Varying approaches are necessary to capture the different population groups across locations • The iwi comms collective is leading the messaging for Māori and is concerned that they have fallen behind the narrative because announcements have already been made • Further guidance is needed about what is considered a “household contact”
7	**Action tracker/round table updates from teams** *Carl Billington (Lead, Stakeholder Engagement) presented an update on the comms workstream* • Nicky’s feedback about the language has been taken on board • Although we are trying to push the wider team on their assumptions of who is included in a household it is still challenging and we would appreciate your feedback • We are working through ways we can actively seek community input and put them into action • The focus for the past week has been on border workers and employees who have been very engaged. This has helped us to get feedback about the workforce will look like • A public campaign will commence on 15 February and has had input from Clemmengers, Mahi Tahi and other agencies, and Carl will circulate these draft plans with the IIAG. The underlying message is that we reached this point by standing together, and people are carrying the risk for us • Resources within the Ministry are still coming on board but there is a considerable amount of work for a small team to get through

	Group discussion – communications and engagement • The PM has reiterated the message that Māori are concerned about the vaccine and we should be committed to working through these collectively • The group agreed we should be moving away from the "household contacts" language and instead focus on what people know but referring to a "bubble" which will resonate for more people, especially the disability community • IIAG members would be happy to participate in expert panels that could be presented to border agencies etc • The comms programme within the Ministry will need support from outside groups. The group agreed to support Carl with engagement and be available to prevent turnover from within the team. Comms is critical to building trust and we need to support Carl to deliver Group discussion – other business • Clarity is needed about the definitions of groups that fit at each level – who is a "border worker" etc. Anyone who is currently receiving a swab is frontline • Need to confirm whether the vaccinators have been vaccinated also. They will be vaccinated as they come into contact with the border workforce and we need to ensure their safety **Action** for Carl to share draft campaign planning with the IIAG. **Action** to share the most up to date definitions as agreed with DHBs with the IIAG so there is a clear breakdown of categories, noting this work is ongoing.\
8	**Closing** • Te Puea reiterated that the IIAG would be available wherever possible to support with the quick decision making that will be happening over the next two weeks, and the group will stand behind the Ministry • Nicky closed the hui with a karakia

Action Tracker 5 February

Item	Action	Lead	Due Date
3	The programme to draft a memo based on IIAG feedback and share clinical advice with the sector about overlap with other immunisation campaigns and reiterate that COVID-19 is the priority.	Joe Bourne	12/2
7	Carl to share draft campaign planning with the IIAG.	Carl Billington	12/2
7	The programme to share the most up to date definitions as agreed with DHBs with the IIAG so there is a clear breakdown of categories, noting this work is ongoing.	Mat Parr/Simon Everitt	12/2

Document 5

IIAG Minutes/Actions

Date:	11 Hui-tanguru/February 2021
Time:	4:30 – 5:30 pm
Chair:	Debbie Edwards
Attendees:	Nicky Birch, Silao Vaisola-Sefa, Dr Api Talemaitoga, Kevin Pewhairangi, Dr Tristram Ingham, Dr Rawiri Jansen Debbie Edwards, Ali Ajmal, Sam Austin, David Pickering, Lillias Henderson
Apologies:	Te Puea Winiata, Taima Campbell, Tamati Shepherd-Wipiiti, Casey Pickett

Item	Agenda Item
1	**Introduction and welcome** • Debbie welcomed everyone and acknowledged David who is attending from the Pacific Team at the Ministry of Health • Today's discussion will focus on sequencing and the options that have been collated to ensure Māori and Pacific communities are fairly represented in the vaccine rollout Note that the minutes reflect comments from the IIAG members unless otherwise noted.

2	**Sequencing discussion**
	
	Debbie Edwards provided a recap of what was covered in the previous sessions and where the group landed with sequencing
	
	• Previous breakout sessions were held with the Māori and Pacific cohorts and we agreed that a combination of options presented is most effective
	• The proposed approach developed by the IIAG members includes ring fencing the vaccine for Māori and Pacific communities, and supporting Māori and Pacific service providers with the necessary resourcing and infrastructure, and including a risk-adjusted age threshold
	• It was also noted that:
	  ○ Language being used is positive and strengths based
	  ○ Building on the capability of providers
	  ○ Adequate resources and service support are critical
	• Support would need to include guidance for providers so they can successfully deliver to the framework
	• Debbie noted that the current focus is on planning for the implementation of Tiers 1 and 2, and the policy team is shifting its focus to planning Tier 3 sequencing

	Group discussion
	
	• Need to keep in mind that the Treaty obligations focus on partnership and, with no disrespect, we shouldn't be bunching together Māori and Pacific whānau
	• Currently Tier 2 includes older people and those living with underlying conditions. Need to ensure this also includes people with disabilities. Tier 2 should also include people who are living in private hospital care who are not necessarily elderly, such as Māori with diabetes etc
	  ○ DHB modelling for older people focuses on ARC who are over 65 - would encourage the Ministry to test these numbers
	  ○ There is a large cohort of people who are not elderly living in ARC who should also be eligible for a vaccine under Tier 2. As they are currently not represented in this group, we are at risk of discriminating against those people (Debbie advised that if they are ARC residents they would be included in Tier 2.)
	• Is there an opportunity to roll out the vaccine according to location and deliver in certain regions first? We could identify areas of the country who are a priority and distribute in this way
	• The system needs to be responsive to Māori who change their mind and wait to receive a vaccine. As soon as they commit and want to receive it, we should be ready to deliver it
	• We should broaden the scope of Tier 3 to include Māori and Pacific people who are living in higher risk situations that are not necessarily ARC eg. Colocation, overcrowding etc
	• Evidence that is used needs to be carefully considered and should include publications that the Ministry may not have access to or may not look for in the first instance, such as the impact of COVID-19 in tribal lands in North America
	  ○ Debbie noted that the Ministry's Science and Technical Advisory group had undertaken the evidence review, taking a broad approach, and continues to monitor emerging evidence
	  ○ The Framework is evidence driven, and also reflects other considerations, such as expert advice and political decisions
	• Tiers 1 and 2 are risk-based, and potential vaccine volumes have been considered. Externalities mean the numbers for each tier may vary
	• Currently, progressing through Tier 2 quickly means we can reach Tier 3 sooner which is a large cohort
	  ○ Within this tier we should consider how we first offer the vaccine to Māori and Pacific with underlying conditions
	  ○ Distribution should be based on asking communities and providers who has the most need. Messaging this will be critical
	• We have an ethical responsibility to vaccinate prisoners. Even if it is not formally represented on the Framework, the Crown has a responsibility to include them as a priority group.
	  ○ Debbie noted that Aged care units within Corrections have been included under Tier 2
	• Should consider who is best suited for which vaccine eg. Whether ARC residents will receive Pfizer of AstraZeneca when research shows Pfizer would be most effective for them

	○ Debbie noted this is part of the Decision to Use process ○ The IIAG wasn't involved as had previously been agreed
3	**Other matters raised by the group** <u>Communications and engagement</u> • The Crown is issuing advice on sequencing and has channels for distributing information, but there are no reciprocal channels for Māori to provide feedback • Iwi were not given enough warning about yesterday's approval announcement. Whānau have questions and are turning to providers for information, but it is difficult to share this when we are not prepared and there is an information void. Iwi are coming up with general information to inform their people which is not good enough • Comms for this programme is running too far ahead of where whānau are and operating on the assumption that everyone will want the vaccine. Reality is that whānau are mixed in their opinions and iwi are tired of being left behind • The Crown is speaking to the process, not to people • Some iwi are directly advising their community on whether to get the vaccine, and others are focused on providing facts, and supporting informed choice • Iwi are reaching out to the Crown through other mechanisms to get their information, rather from the Ministry because we are receiving mixed messages • Poor communications can be a symptom of bigger challenges and there is a concern that we are starting off on the wrong foot – if the information coming from the Crown is poor now, this will only continue • View that the Ministry is disconnected from Ministers which means it is difficult for the sector to also remain updated • Pacific community is becoming increasingly concerned with the rollout due to the lack of information sharing, and conflicting information that exists in the community • The same issue applies to disability networks and there are directorates within the Ministry who are lacking information. As an example, an IIAG member has information that the Disability DDG has not seen • The Ministry should be focusing on a real time co-design process with iwi, that extends to co-develop and co-deliver • Suggest establishing a reciprocal point of contact for all information • They noted that Carl has been very responsive and great to work with, but their concerns go beyond him <u>IIAG's role</u> • Members wanted to communicate a strong message that the IIAG is a group of clinicians who are dedicating their clinical time at no cost to the Ministry and the group is being blind-sided by announcements • If Steering Group is making the real decisions that is fine, but they need to communicate their reasons for their decisions back to the IIAG • The group lacks confidence that sequencing discussions and options we have talked about today will actually be implemented • The IIAG agreed in a previous meeting that they would have a role to play in the Decision to Use process. This has not happened for the initial vaccine approval and

	instead has been a decision directly for Ministers. The group would like to see those processes adhered to • Would like to see some practice applying the Decision to Use Framework – step through it because delivery is likely to be "lumpy" and will need to make decisions part way through • There seems to be an additional pathway of approval for sequencing that is beyond the IIAG. This raises questions about the purpose of the IIAG whose main focus is on the sequencing framework • Noted their appreciation to Debbie for these hui on sequencing for Māori and Pacific communities – pleased with where its landed, but not confident that it will be progressed. Also for listening to their concerns <u>Confidentiality</u> • The confidentiality requirements make it difficult to honestly engage with the sector and receive feedback on implementation planning, which limits our ability to operate within our role as an advisory group • Need to confirm to what extent the IIAG papers are confidential. Agreed that it was suitable to share these papers within other parts of the Ministry but not beyond the IIAG or MoH • It is a symptom of a problematic communications network when an external person is sharing papers with a DDG at the Ministry **Action** for Debbie to share this feedback with the Programme and escalate upwards so the Steering Group has visibility of the IIAG's concerns.
4	**Closing** • Debbie thanked everyone for their participation and closed the meeting

Document 6

Māori sector hui/ Actions

Date:	22 Hui-tanguru/February 2021
Time:	10am – 12pm
Facilitator:	Tāmati Shepherd-Wipiiti
Attendees:	John Whaanga, Ana Bidois, Keriana Brooking, Nicky Birch, Dr Matire Harwood, Dr Rawiri Jansen, Dr Tristram Ingham, Te Ropu Smith, Te Puea Winiata, Kevin Pewhairangi, Chrissie Hape (on behalf of Ngāhiwi Tomoana) Tabish Hassan Ghani (Note taker)
Apologies:	Taima Campbell, Dr Sue Crengle, Dr Dale Bramley

The purpose of the discussion is to discuss the operational elements required to progress a Māori strategy/plan for the roll-out of the COVID-19 vaccines.

Group discussion

Actions:

1. Strategy components should provide a view of the journey of how it's been developed.
2. Vaccination staff and Māori providers should be captured and inform Operational Guideline development.
3. Strategy components draft to be completed and socialised with the stakeholders.
4. Arrange a follow up face to face hui (Ana to set it up)
5. Communications should be shown as parallel in Māori strategy components slide

Risks:

1. Lack of organisational resource and investment in disabilities to drive proper community response.
2. We may need to force the path with DHBs to expedite equity in our response.
3. Risk of community leaders spreading misinformation.

General Takeaways:

1. The 20% of health and disability staff are Māori.
2. Our equity response should be a collective for health and disability and informed with lessons learned from pandemic response.
3. The group suggested exploring an opportunity with Ashley and Māori providers and whānau occasionally to test the framing and track progress.
4. We need to demonstrate that we have an equity focus in all our tiers (e.g. taking a regional focus than a national focus).

5. As we think about implementation, Māori participation needs to turn into partnership and explore what iwi, pan iwi, hapū and DHBs are doing.
6. We need to frame implementation as partnership.
7. Māori strategy needs to be owned by the crown and partners.
8. IMAC's role is to provide culturally appropriate training.

Workforce:

1. We should take a long-term vision in building Māori workforce and capability. At a minimum we should have multi-disciplinary and diverse (Kaiāwhina etc) teams acting in various roles that provide our whānau culturally appropriate experience.
2. For DHB workforce we need to ensure that it has appropriate support and supervision so it's a culturally competent experience for whānau.
3. We should leverage our Māori pharmacists in regional pop ups.
4. Providers should explore the possibility of rotating workforce.
5. Workforce needs to have capability around disability (training etc) to deliver an effective experience.
6. Workforce needs credentialing to build qualifications.
7. We should prioritise Māori vaccinators through IMAC that are already qualified.
8. Consistency around the country is needed to show we have Treaty coverage.

Sequencing:

1. Initially planning around sequencing was done with logistics considerations and an equity lens is needed.
2. There is a lack of gold standard research in age differential for Māori and the remaining population.
3. Tier 2 should consider our rurally placed whānau.
4. Sequencing framework should help us obtain equitable results.
5. Feedback loop should be established with Marketing & Comms on how we continuously improve our Māori sequencing and uptake.
6. The Sequencing approach needs to be culturally and ethically appropriate.
7. We should apply lessons learned from HBDHB equity response.
8. Our Sequencing planning should protect whānau against other variants.
9. Informing our sequencing as the operational data comes through.

Communication:

1. MoH has a lack of resources to produce effective and balanced iwi comms. A holistic approach including a regional approach is needed. MoH has secured investment and Māori expertise to assist with comms development. We need to progress this with urgency and cohesive coordination.
2. Integrated Māori communication with the first drop is needed.
3. The comms should have coverage of whānau and be empathetic to the community.
4. The comms should be developed with a codesign approach that speaks to aspirations and commitments that resonate with whānau.
5. MoH has an existing challenge around effective and accurate translation of the comms collateral.
6. We have a challenge around effective coverage at national and regional level, this will be raised in plan and as an action item to highlight the tactical coverage.

Data:

1. Better visibility of Māori providers operational data is required.
2. Ethnicity and iwi affiliation information should be recorded in CIR.
3. We should leverage the work being done and lessons learned in the National Health System.
4. The COVID app users should be provided the opportunity to record ethnicity and iwi affiliation.
5. We should capture functioning enhanced questions as part of screening questions for effective data collection for visibility.
6. The priority of data capture should be quality of data first, then access and then analytics and then evaluation data.
7. Iwi data needs Māori data governance.