

Appendix 2

Summary of paediatric products and projected timeline for receipt

Date:	4 November 2021
To:	COVID-19 Vaccine Ministers
From:	Allison Bennett, Manager, System Enablers, System Strategy and Policy
Subject:	Summary of paediatric products, and projected timeline for receipt

Purpose of report

1. This memo provides:
 - a. an overview of the current understanding of Pfizer's paediatric product and how it differs from the adult product; and
 - b. indicative timeline for access to the paediatric product.

Context

2. To date, New Zealand has been rolling out a Pfizer based Immunisation Programme. The Pfizer vaccine has been approved by Medsafe for those aged 12 years and older.
3. New Zealand has secured access to 10.85 million doses of Pfizer in to 2021, and also secured 4.7 million doses in 2022. ^{S9(2)(b)(ii)} [REDACTED]

Medsafe has not received an application for 5 – 11-year-olds and Pfizer have informed us that it will be a separate product

4. Pfizer will be submitting regulatory approval for paediatric version of the Comirnaty vaccine for the 5 – 11-year-olds. The paediatric version is different to the current "adult" version.
5. The differences include changes to the ingredients, the amount of the ingredients in the vial including the concentration of mRNA (active ingredient.) Therefore, this product is not merely a 'more dilute' version of the adult vial.
6. Pfizer have advised that the paediatric version was used in clinical trials to generate safety and efficacy data in the 5 – 11-year-old age group. Therefore it is unlikely that the existing adult formulation will be regulated for this younger cohort.
7. Pfizer have indicated that their paediatric product may have a shelf-life of 6 months at -70 degrees, and 10 weeks once defrosted at 2-8 degrees. They have also indicated that the paediatric product will be two doses, and there will be 10 doses per vial which will require dilution.

Why is Pfizer developing a separate paediatric vaccine?

8. There are several potential technical reasons why Pfizer has developed a specific paediatric version, including that the:
 - a. the existing adult version may not be stable at the dilutions required for paediatric doses;
 - b. the practicality of administering a lower volume of the same concentration of the existing adult vaccine; and
 - c. using a diluted or smaller volume of the adult vaccine would require the vial bung to be punctured a large number of times. For other medicines we know this increases the risk of small parts of the bung entering the solution or introducing bacteria into the solution.
9. A meeting between our Science and Technical leads and Pfizer's is being co-ordinated to further understand Pfizer's paediatric product.

If the adult version is used in 5 to 11's, there are a number of potential risks

10. If the adult version is used off label, there are a number of potential risks included. This is because:
 - a. There are no clinical trials to demonstrate safety and efficacy of the whole formulation (including the content and quantity of other ingredients). This means there would be no data supporting the safety, efficacy and quality of the existing vaccine vials when used in 5 – 11-year-olds;
 - b. the vaccine may have degraded before being administered (less viable mRNA leading to limited to no immune response); and
 - c. there is a risk of bacterial contamination as noted above.

Timeline for accessing a paediatric product

11. The table below presents a possible timeframe for bringing paediatric doses into New Zealand. Please note, these timeframes are subject to change and are largely dependent on Pfizer.
12. The key steps to receive doses for 5 to 11's include:
 - i. Pfizer submitting their application to Medsafe and providing all necessary data
 - ii. Medsafe's assessment and regulatory decision
 - iii. Notification of Medsafe approval to Pfizer to fill the order
 - iv. the COVID-19 Vaccine Technical Advisory Group assessment and recommendations
 - v. Decision to Use for this cohort
 - vi. Receipt of Vaccine

13. The table below outlines the high-level timeline for access to paediatric vaccine

Timeframe	Task	Status	Comment
W/C 8 November	Medsafe receives Pfizer's application for 5- to 11-year-olds	<i>Not yet started</i>	Dependent on Pfizer submitting the data to Medsafe
November	Scientific deep dive on the differentiation between the Pfizer adult/child doses	<i>Not yet started</i>	
November	Medsafe commence assessment and provide timeline	<i>Not yet started</i>	Timeline for assessment will be known once we have the data.
November	S9(2)(b)(ii)	<i>Not yet started</i>	Modelling with CVIP
January	MAAC meeting and regulatory decision	<i>Not yet started</i>	Note, a MAAC meeting has been scheduled for mid-December in case the assessment is complete this year
January/February	S9(2)(b)(ii)	<i>Not yet started</i>	30-day lead time from Medsafe approval
February	CV-TAG make recommendations for use of the Paediatric product	<i>Not yet started</i>	
February	Decision to Use Cabinet Paper considered for the paediatric product	<i>Not yet started</i>	CV-TAG recommendations
Quarter 1	S9(2)(b)(ii)	<i>Not yet started</i>	S9(2)(b)(ii)
February/March	Announcement	<i>Not yet started</i>	Decision to Use
March	Commencement of vaccination of 11-15 years	<i>Not yet started</i>	S9(2)(b)(ii)

Next steps

14. Officials will keep continue to work with Pfizer to reduce the lead-in time for delivery following regulatory decision.
15. Officials will keep you abreast of developments in timelines for access to Pfizer's paediatric product.

Recommendations

It is recommended that you:

1.	note	that Pfizer is developing a separate paediatric product for use in those aged 5 to 11 years
2.	note	That Pfizer have not submitted an application for regulatory approval for their paediatric product to Medsafe

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COVID-19 Vaccine and Immunisation Programme

Proposed implementation approach for vaccine rollout for 5–11-year-olds

Date:	26 November 2021
To:	COVID-19 Vaccine Ministers
From:	Jo Gibbs, National Director, COVID-19 Vaccine and Immunisation Programme
Subject:	Proposed implementation approach for vaccine rollout for 5–11-year-olds

Purpose of report

1. This paper seeks to update you on the high-level approach and implementation plan for the COVID-19 vaccine rollout for the 5-11 age group in New Zealand, subject to regulatory approval, CV TAG advice and Cabinet's decision to use.

Context

2. The Pfizer COVID-19 vaccine has demonstrated its safety and effectiveness against people contracting the virus and becoming seriously ill or transmitting the virus to others. Until recently, the vaccine was not approved by any regulator for use in children under the age of 12.
3. In September 2021, Pfizer released positive top-line results from their trial of the COVID-19 vaccine in 5-11-year-olds. International regulatory process has since been underway, with the Food and Drug Administration (FDA) approving the use of Pfizer for this age group in late October in the United States.
4. Medsafe are currently working through an application to allow the use of the vaccine with the 5-11 age group in New Zealand.
5. We note that Australia could commence the rollout of vaccines for this age group before the end of 2021 or in early 2022.
6. To be prepared for rollout as soon as possible, the CVIP programme has commenced operational planning for this population cohort. Planning for this rollout is taken in consideration of other current programme priorities:
 - a. Completing the rollout of two doses to the eligible population of New Zealand, aiming to achieve 90% percent vaccination across Aotearoa.
 - b. Ensuring that AstraZeneca is available for those who are eligible.
 - c. Deploying booster doses for the c. 465,000 people who are eligible before the end of 2021 and ensuring prioritisation for those most at risk.
 - d. Focus on the equitable, safe and well considered implementation plan for the vaccination of 5–11-year-olds, that aligns with the regulatory approval, Cabinet decision, and supply from Pfizer.

Implementation

7. We are undertaking operational planning activities for the 5- to 11-year-old COVID-19 vaccine rollout with the assumption that Medsafe and CV-TAG advice are expected by mid to late December 2021. The programme has developed a proposed high-level implementation approach that will continue to evolve throughout December 2021.
8. We expect that the rollout will be able to be technically and operationally commenced from as soon as 17 January 2022. We will aim to secure the product as soon as possible in order to create certainty of supply as soon as practical.
9. The time between supply arriving and the beginning of our rollout will allow time for the workforce training, updates to operating and handling guidelines and to ensure the logistics are in place. S9(2)(f)(iv) [REDACTED]
10. This planning window also allows us to thoughtfully plan our equity approach, create effective communications for potentially hesitant parents, and to begin the rollout before this age group returns to school. We will aim to find opportunities to improve this timeline.
11. Our Te Tiriti o Waitangi obligations continue to be an essential element of the planning phase before the rollout commences. We will leverage lessons learned from the programme to date and by leveraging our existing partnerships. We are meeting with Pandemic Response Iwi Chairs next week and will continue to engage them as we develop the rollout and implementation plan.
12. We are also exploring options for prioritising areas of New Zealand in the first phases of the rollout. Where practical, we will also endeavour to align this rollout with the booster campaign (leveraging the whānau-based approach) and other immunisation programmes, such as MMR.
13. Early implementation activities have been undertaken, including preliminary policy work, an impact assessment of the required technology changes and supply discussions with Pfizer.
14. We are working to an assumption that supply could be available S9(2)(b)(ii) [REDACTED]. Our logistics and workforce workstreams have confirmed they are able to support the delivery of the product within this timeframe.
15. Established service delivery models (via Hauora, primary care and community centres) will be the main sites used to administer doses. They have sufficient capacity to manage the expected demand of an estimated ~500,000¹ 5-11-year-olds. Some hospitals, particularly those in outbreak regions, may choose to provide additional on-site capacity for staff.
16. A high priority for the programme will be to complete the majority of first doses for this cohort ahead of or as early into the school as possible.
17. A targeted communications campaign will support the delivery of this rollout. An assessment of specific channels, stakeholders and providers that will reach the parents and guardians of this population cohort is underway.
18. Strategic communications planning is also underway to prepare for timing announcements, and likely media reaction as other jurisdictions commence their rollout for this age cohort.

¹ Stats NZ 2021 population projection (2018 Census)

Risks

19. The programme must plan for equity from the beginning of the planning phase of the paediatric COVID-19 vaccine rollout.
20. International experience suggests that hesitance could be higher for the paediatric COVID-19 vaccine amongst parents. A careful and thoughtful implementation plan and public communications plan at the beginning of the rollout will be essential to increasing uptake throughout the programme.
21. The safety and delivery of the vaccine will be especially important and sensitive for the rollout to younger age cohorts and must be carefully managed both within the programme and the public.
22. It is possible that the delivery timeline of the product is delayed if the Medicines Assessment Advisory Committee (MAAC) requires additional data from Pfizer before making a decision.
S9(2)(g)(i)
23. Global supply chain or Pfizer supply disruption could delay the time frame for the rollout.

Next steps

24. Officials will continue to work on detailed implementation planning.
25. A further update on this work will be provided by 10 December 2021.
26. A decision to use is expected to be submitted to Cabinet as soon as practical.

Recommendations

It is recommended that you:

1	Note	The risks associated with the 5- to 11-year-old rollout planning and timeline.
2.	Note	That the Ministry of Health will continue to progress operational planning and readiness activities for the COVID-19 vaccine rollout to 5- to 11-year-olds.
3.	Note	The current timeline and high-level implementation approach for COVID-19 vaccinations for 5- to 11-year-olds.
4.	Note	That rollout for 5- to 11-year-olds is subject to a Medsafe regulatory decision, CV-TAG advice, and Cabinet's decision to use the Pfizer vaccine for 5- to 11-year-olds.

Appendix 1: Estimated Timeline for assessment and delivery of Paediatric Vaccine

Please note: these timeframes are subject to change and are largely dependent on regulatory approval and Pfizer.

Item	Date
Draft Cabinet paper for agency consultation	1 December 2021
Draft Cabinet paper for Ministerial consultation	3 rd December 2021
Minister's Office for lodgement	9 th December 2021
IIAG engagement on implementation approach and equity considerations	26 th November & 10 th December 2021
SWC Update on timeline and decision to delegate to Ministers for Decision to Use	15 th December 2021
MAAC meeting (current schedule)	14 th December 2021
Medsafe decision (earliest possible date dependent on timely information provided by Pfizer)	17 th December 2021
CV TAG final recommendations provided to Director-General of Health (dependent on Medsafe decision)	21 st December 2021
Child Impact Assessment Finalised	21 st December 2021
Advice provided on Decision to Use and implementation plan for delegated Ministers	22 nd December 2021
Decisions and Announcements confirmed by Ministers	23 rd December 2021
S9(2)(b)(ii)	
Potential start of rollout for 5- to 11-year-old age cohort (likely in prioritised regions first)	17 th January 2022



CVIP 5 to 11 Vaccination Plan

Pfizer paediatric rollout

02 December 2021

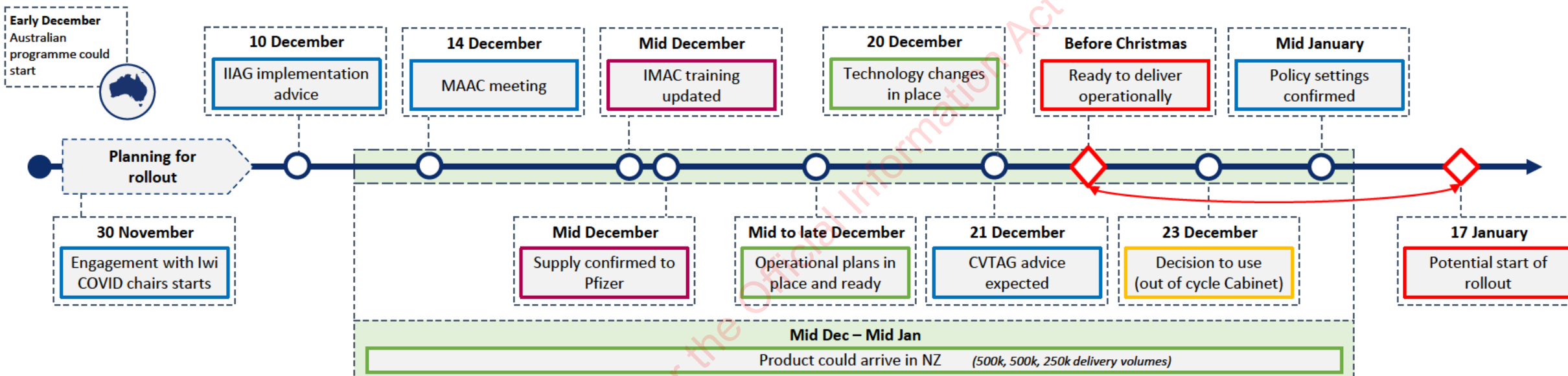
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Timeline for the 5 to 11 age group as at 02 Dec 2021, all dates TBC

Immunising tamariki is complex – we must get this right from the beginning in order to maintain confidence in the programme and to achieve the highest possible rates of uptake, not only of COVID-19 vaccines but also of other childhood immunisations. Over the last 18 months, childhood immunisation rates have declined.

International experience shows that the childhood COVID-19 campaign is markedly different from the 12+ campaign; e.g., hesitancy amongst parents is higher, communications for caretakers and children must be different and that public scrutiny is higher for this population cohort.



Context

- COVID-19 is likely to be widespread across New Zealand
- Risk v Benefit for the 5 to 11 age group could be different in 2022 than it is now
- Many 5 to 11 year olds across the world will be immunised as we commence
- Our previous decision on 12 to 15 age group was similar to this process

Assumptions

- MedSafe + CVTAG will follow their usual process
- S9(2)(b)(ii)
- Eligibility will not be sequenced for this age cohort
- Deliver as soon as possible – pre-winter / as a high priority / targeted campaign
- Uptake will remain voluntary
- Higher wastage will be experienced v adult programme

Service Delivery Models

- Plan to use existing infrastructure – DHB, Primary Care and Community centres as the primary delivery mechanisms
 - We will use schools as delivery sites, where appropriate
 - We can begin the rollout in “red” areas or those with low vaccination rates
 - There will be differences in approach based on locality

Risks

- Equity must be considered from the outset
- Medsafe and CVTAG decisions could take longer than shown here
- MAAC could require additional data which would delay the rollout start
- Pfizer could be slow to respond to requests for data and vaccine supply
- Having adult and childhood vaccinations simultaneously at the same site could create (solvable) logistic challenges

Implementation planning for the 5 to 11 age group actual data as at 02 Dec 2021

The 5 to 11 implementation will focus on using the existing infrastructure, service delivery models, vaccinators and channels in a bi-modal approach from the outset. This includes a broad reach across Aotearoa and a simultaneous, targeted focus on equity and areas with low vaccination rates.

1 Targeted focus on equity and areas with low vaccination rates

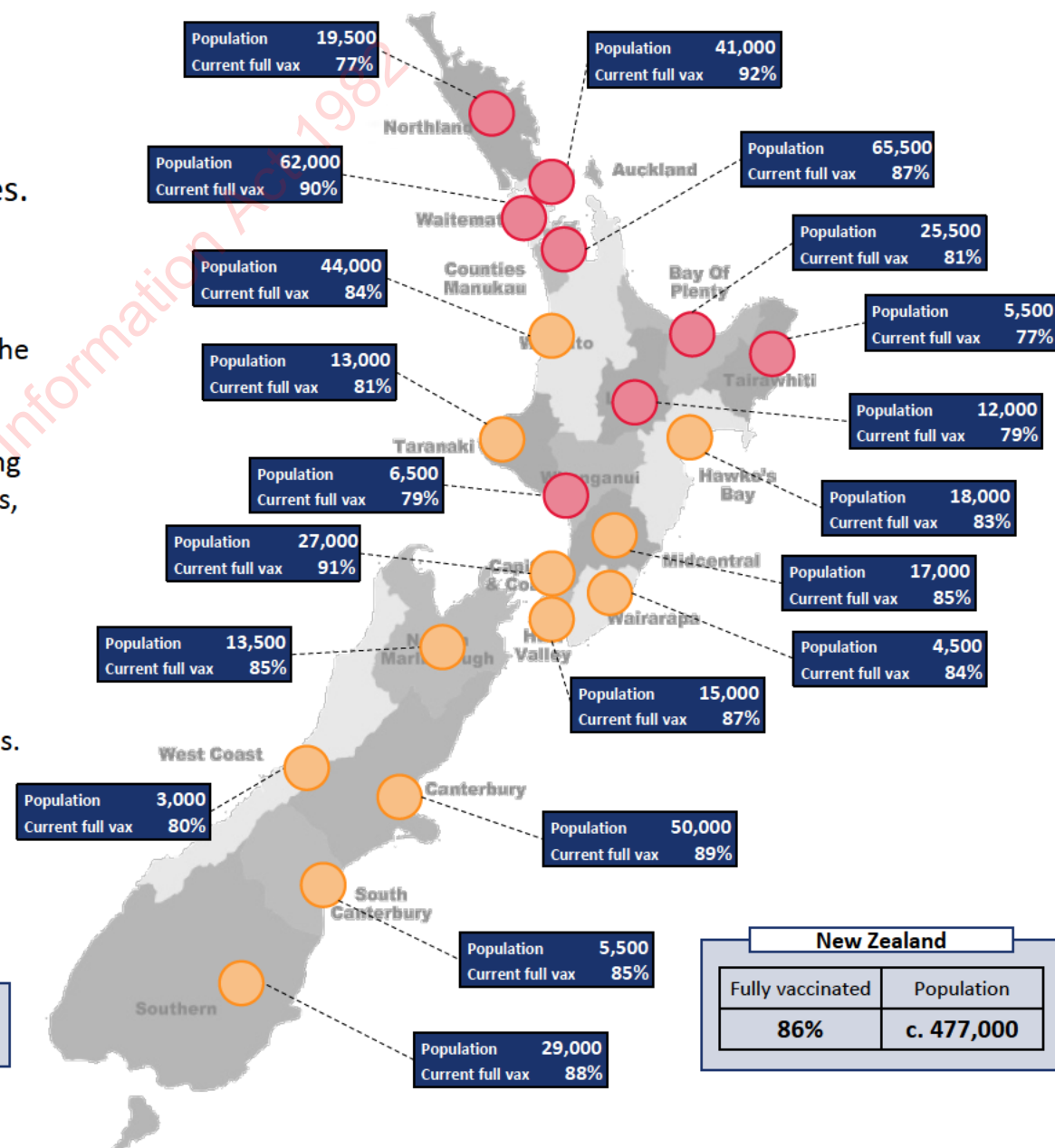
We will commence the rollout with a targeted focus on the areas that are “red” under the COVID-19 Protection Framework and those with low vaccination rates.

This will include use of the means that have reached these population groups well during the 12+ COVID-19 vaccination programme – community-based centres, Marae, churches, drive throughs, pharmacies, etc. These outreach mechanisms will differ by region and local needs and provider plans.

2 Broad reach across Aotearoa

We have spent the last year establishing and refining models that reach our population and provide COVID-19 vaccinations at scale, including in traditionally hard to reach areas. We anticipate a certain portion of this population cohort will be eager to be vaccinated and will use the existing infrastructure shortly after the announcement of availability.

Communications and outreach will be key across the 5 to 11 year old campaign.



CPF Status

- Red
- Orange

Memo

COVID-19 paediatric vaccine use for children 5 to 11 years

Date:	15 December 2021
To:	Vaccine Ministers
From:	Maree Roberts, Deputy Director-General, System Strategy and Policy
For your:	Noting

Purpose of report

1. This memo informs you of progress in considering use of Pfizer's paediatric COVID-19 vaccine and advises on key points highlighted by a child wellbeing impact assessment and implications for immunisation rollout under the COVID-19 Protection Framework.

Background and context

COVID-19 immunisation in New Zealand

2. COVID-19 immunisation provides the most significant personal protection against illness from COVID-19 and especially against severe illness and long-lasting impacts. Close to 90% of the eligible population in New Zealand (76.5% of the total population) are now fully immunised. Vaccination coverage is increasing yet remains inequitably distributed.
3. In the current New Zealand outbreak, the majority of cases have been in unvaccinated (64%) or partially vaccinated (20%) peopleⁱ. Similarly, most of those hospitalised have been unvaccinated (72%) or partially vaccinated (21%). This is despite unvaccinated people currently making up just 23.5% of the total population.
4. Over the full course of the pandemic in New Zealand, Māori (17.1% of the New Zealand population) have been significantly over-represented in cases (36%), hospitalisations (38%) and deaths (30%)ⁱ. Pacific peoples (8.2% of the New Zealand population) have also been over-represented in cases (29%), hospitalisations (36%) and deaths (24%).
5. Children and young people are over-represented in cases (37% under 20 years including 20% under 10 years). At the time of infection, most of these children and young people would have been ineligible or newly eligible for vaccination and, currently, those aged under 12 years (15% of New Zealand's population) remain ineligible.
6. While children and young people most often have mild if any symptoms of COVID-19, 10% of New Zealand's hospitalised cases have been in those aged under 20 years.

ⁱ Case data are as provided on the Ministry of Health COVID-19 case demographics web page as at 12 December 2021 <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-case-demographics#vaccinations-details>

Paediatric COVID-19 vaccine and impact on immunisation coverage

7. Medsafe is considering an application by Pfizer for its paediatric vaccine to be approved for use in 5 to 11 year olds. Medsafe expects to make a decision on this application at the end of this week. The COVID-19 Vaccine Technical Advisory Group (CV-TAG) is developing advice on use of Pfizer paediatric vaccine in New Zealand. If Medsafe approves use of the vaccine, CV-TAG will finalise its advice shortly afterwards.
8. The availability of a paediatric vaccine for children aged 5 to 11 years would leave only those under 5 years of age (6% of the total population including 10% of Māori and 8% of Pacific peoples) not eligible for COVID-19 vaccination.
9. With the new larger eligible population, achieving 90% coverage would mean that 84% of New Zealanders have personal protection against COVID-19. Only a handful of countries (Chile, China, Cuba, Portugal and the United Arab Emirates) are reported to have reached this level of population coverage to date.
10. However, equitable immunisation coverage across whole communities would require 100% vaccination of eligible Māori (as 10% of Māori are aged under 5 years), and over 98% of eligible Pacific peoples (as 8% of Pacific peoples are under 5 years).

Child wellbeing impact assessment

11. The Ministry is completing an assessment of the impacts on child wellbeing of COVID-19 immunisation for children 5 to 11 years old. This will inform decisions on use of the COVID-19 paediatric vaccine for this age group, subject to Medsafe approval and CV-TAG advice. A draft of the assessment report is attached.

Key points

12. The draft impact assessment has highlighted that:

Immunisation of the population protects children and promotes their wellbeing

- a. COVID-19 has had, and will continue to have, significant impacts on children's health, education and development, relationships and lives; both COVID-19 and measures taken to mitigate the impacts of COVID-19 (for example restrictions on in-person learning) impact significantly on children's lives and development.
- b. Immunisation of our wider population against COVID-19 is the most significant protection against the impacts on children's lives and development.

Immunisation of children adds protection and promotes children's development

- c. With or without high levels of population immunisation, immunisation of children (subject to Medsafe approval of the vaccine and CV-TAG advice to assure safety, quality and effectiveness) adds additional protection against the impacts on children's lives and promotes their development.
- d. Tamariki Māori, Pacific children, children with disabilities and health conditions, children living in poverty and children in the care of Oranga Tamariki are at higher risk of exposure to COVID-19. Disruption due to COVID-19 mitigation is also likely to have higher impacts on these groups. Immunisation adds additional protection for these groups and strongly promotes their development.

Vaccination of tamariki Māori is a high priority

- e. Given higher risk factors for Māori and the very young population structure with 10% of Māori under 5 years, vaccination of tamariki Māori is a high priority. Vaccination through whānau-centred approaches, designed to encourage iwi, hapū and Māori in a variety of settings, can promote vaccination of Māori whānau alongside tamariki, and should be given urgent priority and resource.

S9(2)(f)(iv)

Vaccination of children should, where possible, promote whānau wellbeing

- h. Promotion of children's development via immunisation would be enhanced by delivering vaccines in whānau-centred ways that offer a range of health and social development opportunities and services, without undue delay. Examples include whānau health checks, concomitant immunisation of whānau members with COVID-19 and other vaccines, and promotion of a range of housing, social, financial and legal assistance where possible.

Consistency with WHO guidance

13. WHO issued an Interim statement on COVID-19 vaccination for children and adolescents (updated 29 November 2021)ⁱⁱ. It states that:
- a. Countries should consider the individual and population benefits of immunising children in their specific epidemiological and social context
 - b. Benefits go beyond direct health benefits – minimising disruptions to education and maintenance of overall well-being, health and safety are important
 - c. Attaining high coverage of high-risk groups such as older people, those with chronic health conditions and health workers, including booster doses, should be prioritised before children and adolescents
 - d. Global sharing through the COVAX facility should be prioritised before vaccination of children and adolescents who are at low risk for severe disease.

14. The child wellbeing impact assessment is being informed by this WHO guidance.

Balancing the benefits of COVID-19 vaccination for children aged 5 to 11 years old

15. Compared to adults, children have a lower risk of serious illness from COVID-19. While most children appear to have mild symptoms, the potential risk of transmission to immunocompromised children, adults and vulnerable family or community members

ⁱⁱ <https://www.who.int/news/item/24-11-2021-interim-statement-on-covid-19-vaccination-for-children-and-adolescents>

16. Internationally, many recent large COVID-19 clusters have been centred in schools, including primary schools (for example in the UK and Australia).

17. Balancing the benefits of vaccination against any consequences for those who are not vaccinated requires careful consideration.

S9(2)(f)(iv)

18.

19. Without careful consideration of some of these issues, there is the risk of increasing equity gaps for children (whether directly or indirectly), when we know these gaps are disproportionately harmful for children compared with adults.

S9(2)(f)(iv)

20. Drawing on the Child Wellbeing Impact Assessment, and with the currently limited scientific evidence,

S9(2)(f)(iv)

21. Schools in New Zealand already gather general vaccination data from all students at enrolment. High schools are requesting COVID-19 vaccination data from students to help them plan and manage any potential outbreaks. Primary schools are likely to request this information also, once children aged 5 to 11 years are being vaccinated.

S9(2)(f)(iv)

22.

23. Outside of schooling, children in the 5-11 years age group are likely to be accompanied by vaccine pass carrying adults when entering premises that require vaccine passes.

S9(2)(f)(iv)

24.

25. With the evolving nature of the pandemic and new COVID-19 variants emerging, this situation may change.

S9(2)(f)(iv)

S9(2)(f)(iv)

26.

Preparing for implementation

27. Planning is well underway for the vaccination rollout so there will be minimal delay once decisions have been made, most likely over the Christmas/New Year holiday period, on offering the paediatric vaccine. This work includes the following:
- a. The Immunisation Advisory Centre (IMAC) are developing training modules and resources for use of the paediatric vaccine that can be finalised for workforce groups from early in the New Year. Additional training will be strongly recommended.
 - b. Logistics and facilities for vaccine storage and distribution are well advanced.
 - c. Suitability for children is being assessed and guidance developed across the range of different vaccination delivery models. For example, drive-through vaccination suits some families including many Pacific families; additional guidance on observation and surrounding facilities and staffing is being developed, and dry runs and trial runs will be needed to adapt.
 - d. DHBs and providers have gained experience across a wide range of community-friendly vaccination delivery models with adaptations for particular communities and localities. Most of these models are likely to be used in the paediatric vaccine rollout.
 - e. Engagement with Hauora Māori and Pacific providers and family and community groups will facilitate promotion and acceptability of paediatric immunisation models.
 - f. Some communities are only now getting to high uptake among younger adults who are likely to be well-represented in parent groups for 5 to 11 year olds. While this may provide good opportunities for whole whānau vaccination and other health and social services, there is likely to be some delay in higher vaccination uptake for children in these communities.
 - g. Schools and home education providers are keen for early guidance. Some are happy to host vaccination efforts, others have already been the target of anti-vaccination protests. Finding ways to de-escalate or remove potential conflicts over vaccination of children will be a high priority.
 - h. S9(2)(f)(iv)

Next steps

28. The Ministry is preparing advice for delegated Ministers to support decisions on whether to use the Pfizer paediatric vaccine for children aged 5-11 years in New Zealand.
29. That advice will include further details on the advice from Medsafe and CV TAG as well as more details on the planning for the roll out of delivery of COVID-19 vaccines for children in this age group.
30. Cabinet is considering its delegations for these decisions this week.

Signature



Date: 15/12/21

Maree Roberts

Deputy Director-General, System Strategy and Policy

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National Immunisation Programme

UPDATE: 5 – 11-year-old vaccination rollout

Date:	13 January 2022
To:	COVID-19 Vaccine Ministers
From:	National Immunisation Programme,
Subject:	5 – 11-year-old vaccination roll out

Background

On 20 December 2021, Cabinet agreed to use the Pfizer COVID-19 paediatric vaccine for children aged 5-11 years with a rollout planned to start from 17 January 2022 (CAB-21-MIN-0557 refers). On this date, approximately 477,000 children between the ages of 5 and 11 will become eligible to get their first dose, with a second dose to be administered eight weeks later.

As part of this decision, officials committed to reporting back to the group of Ministers with the power to act over the holiday period on the implementation approach prior to opening up invitations for children aged 5-11 years. This report back was to reflect the lessons learned in the initial phase of the vaccination programme and include an update on the ongoing co-design process currently underway with hauora providers and iwi representatives.

Approach

Rolling out the vaccine to 5–11-year-olds will make use of the vaccination infrastructure – delivery models, workforce, technology and logistics – that has been built over the COVID-19 vaccine programme to date. This will enable both a broad reach across Aotearoa and a simultaneous, targeted focus on our priority populations and can be achieved due to the capacity that has been built throughout 2021 and sufficient supplies of the paediatric vaccine, now in the country, to provide a first dose all eligible children.

International experience shows that childhood COVID-19 vaccination campaigns are different from those of older children and adults. For example, hesitancy amongst parents is higher, and communications for caretakers and children must be different. Also different to the roll-out of COVID-19 vaccination to adults, children aged 5-11 will not receive individual invitations to receive a vaccine. The emphasis will instead be on communications for whānau and communities, advising of the benefits and availability of the vaccine for 5–11-year-olds. A whanau-based approach will be strengthened by providing opportunities for families to be vaccinated together, bringing together the 5-11 roll-out, COVID-19 boosters and other scheduled vaccinations wherever possible.

Through the roll-out of the vaccine to the general population in 2021, the system has learnt to keep monitoring the delivery of COVID-19 vaccinations and adjust the approach where needed based on feedback and results. The roll-out to 5-11s will be the same. For example, 5-11 vaccinations will commence before the start of the school year, but the Ministry and partner agencies will keep under review the role schools and school sites might have in maximising uptake of the vaccine.

The initial roll-out of the COVID-19 vaccine also highlighted the importance of local providers and trusted community leaders leading vaccination efforts and adequate resourcing for these efforts. To

date, funding has been assigned for specific communications for the 5-11 roll-out, but no other resources have been identified as required above and beyond what is already available for the COVID-19 vaccination programme more broadly.

A cross-agency approach has also been proven to be effective in supporting the vaccination effort and the wider community needs associated with responding to COVID-19. The Ministry is working across government, including with the Ministry of Education and Oranga Tamariki on approaches to reach children.

Communications

We are taking a three-stage approach to the introduction of the child (paediatric) Pfizer vaccine for COVID-19, based on research and insights, including on-the-ground insights from providers and communities.

1. Inform and prepare

- The first phase (current) runs for a month over the summer, across press, radio, social and digital, including community newspapers and ethnic radio stations. Media activity has included the announcements of the Medsafe approval and Cabinet decision to use.
- Its purpose is to provide positive, high quality information for parents and caregivers on the importance of having their tamariki immunised in 2022 without being overly persuasive or applying pressure.
- The leading voices are paediatricians, particularly Māori and Pacific, and we have worked closely with the Iwi Comms Collective (ICC) and Maori communications specialists from the three Auckland district health boards (via the NRHCC) on the advertising campaign. In particular, two ICC members and two members of the NRHCC have worked alongside CVIP on the campaign with our agency (Clemenger BBDO) to ensure a Māori communications perspective is included from the start.
- The work is also informed by a group of communications specialists who meet regularly – members are from NIP (including our disability comms specialist), the NRHCC, Ministry of Education, Te Puni Kōkiri, Ministry of Pacific Peoples, Te Hiringa Hauora (Health Promotion Agency) and the ICC.

2. Engage and vaccinate

- The second phase starts on January 17 when vaccinations for 5–11-year-olds begin.
- Its purpose is to encourage parents/caregivers to book an appointment for their children (or walk up at sites offering walk-ins or drive-throughs) and to take other whānau members who need boosters or their first or second doses.
- Vaccination sites will have products for children (including stickers and activity packs) and take-home information for parents/caregivers to support a good vaccination experience.

Phase 2 overview:

- January 17 will begin with a PR (issued Sunday and embargoed) and morning media round featuring one or more of our key paediatricians.
- The Book My Vaccine website will be updated with prominent information on the home page and there will be updated information on the MOH and UaC websites. DHBs and providers will also update their websites and other information.

- Radio (attached) will run across all networks – including Iwi stations and other ethnic stations with translations.
- TV (storyboard visuals attached) will begin on the 17th, and social and digital advertising will change its message to talk about getting your children vaccinated 'now' (storyboard visuals attached).
- Our brochure will be distributed through places parents and children visit regularly, including GPs and Hauora providers, schools and kura, councils, and agencies such as MSD and Kainga Ora.
- Later in January (dates to be confirmed) we will hold a Facebook Live Q&A session hosted by S9(2)(a) and will do a nationwide household letterbox drop with a combined message on getting your whānau protected against COVID-19, particularly Omicron – promoting boosters, child vaccinations, and generally encouraging people to make sure everyone in their whānau is up to date with their vaccinations.

3. Target and motivate

- From early February, communications activity will evolve to make the case for paediatric vaccination to different groups of parents/caregivers – based on new consumer research (in the field in late January), stakeholder insights and vaccination data.
- The purpose of this phase is to strongly motivate parents/caregivers and address any barriers to deciding to vaccinate their children.
- Influencers and community champions, including parents/caregivers will feature alongside clinicians and we will use specific strategies to respond to misinformation, guided by research and insights.

Pacific communities

The implementation approach for vaccination of Pacific children will build on the success of the equity response and the lessons learned from the vaccination approach for Pacific adults. Primarily this approach was premised on high engagement, community ownership and leadership and ethnic specific communications. To this end, the first Pacific health sector zoom fono was led by Minister Sio in December 2021. The fono provided Pacific health providers and leaders with the indicative timeframes for the rollout of the vaccination for children. This week another national zoom fono led by Ministry for Pacific peoples and Moana Research with Kids First Paediatric specialist, Dr Teuila Percival and supported by Director Pacific Health, Gerardine Clifford-Lidstone is being held.

The Pacific Health team have boosted the Prepare Pacific Community Vaccination Fund with a further investment of \$1m to support Pacific child vaccinations. The purpose of this fund is to directly support Pacific community-led initiatives towards increasing vaccinations. The Fund is commissioned by the Ministry and administered by The Cause Collective in Auckland. The fund enables communities to develop and define their own approaches to improving vaccination rates within specific cohorts. The additional investment is specifically for improving vaccination rates with Pacific 5–11-year-olds.

Communications plays a very important role in mobilising the Pacific community. Working with the NRHCC Pacific team, a further investment of \$1m has been made to provide ethnic specific communications and social media for the Pacific community for booster shots and child vaccinations. While this investment will focus on the northern region where two-thirds of the Pacific population reside, a lot of the information will be shared across the country on various ethnic specific

communication platforms. A smaller allocation of funding has also been provided to CCDHB and HVDHB, regions which also have a higher proportion of Pacific communities.

The Ministry for Pacific Peoples has commenced translation of information for Pacific communities and has developed a specific work programme to support Pacific child vaccinations.

Vaccinating Tamariki Māori

The approach to vaccinating tamariki Māori builds on the learning that more engagement and co-design in the early stages is likely to achieve a more successful vaccination campaign. To date in planning for the roll-out to 5-11s, there has been wananga and feedback received from: Iwi chairs; Māori teachers and principals; Māori pandemic response group, NZ Māori council; and Hauora providers. Over the holiday period, data was compiled (including risk maps, vaccination data, co-morbidity stats, school data) and discussed with the Māori pandemic response group to enable better targeting of efforts in regions.

The following key principles have emerged from engagement to guide the 5-11 roll-out programme, with a particular emphasis on an events-based approach:

- Whānau orientated - the programme will be inclusive of the entire whānau and employ a festival atmosphere that includes Kai, music fun activities, back to Kura Kits and health checks and vaccination.
- Back to school initiatives and support – back to school preparation and packs are encouraged.
- Data driven - this programme will be data driven with data being shared with iwi. A separate Māori data group has been formed with data being shared and collaboration on plans and target areas.
- Communications - The Iwi Communications Collective, Iwi and agency communications teams will work together to design and implement a communications campaign that will enable local communications by providing tautoko from national teams. We will also look to kick off the programme in regions with a strong communications network to ensure information is being provided to whānau.

A range of events have been organised to begin from 17 January, with an increase in events and activities during February. These include events arranged after school and on weekends that are celebration focussed and include the whānau. A detailed update about events and percentage of the population targeted with these events will be provided in the coming weeks. A specific event with Minister Henare is being planned for late January.

Vaccinating disabled children

To date through the delivery of the COVID-19 vaccination programme, significant efforts have been made to ensure vaccination sites are accessible for disabled people. This work provides a good basis for supporting the vaccination of children with disabilities.

DHB readiness

The Ministry has been working with DHBs to prepare for the roll-out to 5-11s. An operating policy for 5–11-year-old vaccinations and operating guidelines were uploaded to the Ministry's website for DHBs to access prior to Christmas. Using this guidance, each DHB will be providing assurance on their operational and clinical readiness to start vaccinating this age group by 17 January.

DHBs have also been asked to provide an implementation plan for the COVID-19 vaccine rollout to 5-11s to the Ministry by 17 January. This will provide a broader picture of each DHB's planned approach

to extending the existing vaccination delivery system to reach 5–11-year-olds with a particular focus on priority populations.

Vaccination sites and vaccine supply

504,000 doses of paediatric Pfizer COVID-19 vaccine arrived in New Zealand on 8 January 2021 as planned. S9(2)(b)(ii)

DHBs were asked in mid-December 2021 to identify the sites that would initially administer paediatric doses from 17 January 2022. This was to allow sites to be able to order paediatric doses and be made available on Book My Vaccine for paediatric appointments. DHBs were asked in particular to consider the location and nature of providers to support achieving equitable outcomes, focus on areas with low vaccination rates and promote access.

Some sites are expected to be available to walk-ins from 17 January, but there will also be sites that will be bookable on Book My Vaccine from 17 January. Sites initially available will be those already delivering COVID-19 vaccinations to adults. Other sites such as schools will likely be added as the roll-out progresses.

Distribution of the paediatric vaccine to DHBs began on 11 January.

Workforce training

The training module for 5-11s was made available on the IMAC website on 23 December 2021. This allows the existing vaccinator workforce (excluding the COVID Vaccinators working under supervision) to complete the appropriate training on-line. The focus for COVID-19 Vaccinators Working Under Supervision will remain for now on vaccinating adults, including delivering COVID-19 vaccine boosters.

Next steps: Testing of systems and processes prior to 17 January (wet runs)

Between 13 and 16 January, two trial runs of systems and processes will be undertaken before vaccinations are open to all eligible children on 17 January:

- The children of border workers in Auckland will be vaccinated between 13 and 16 January. This trial of systems and processes is being run in conjunction with MBIE and the Auckland metro DHBs.
- Children in Te Kuiti will be vaccinated on 15 and 16 January in a test of systems and processes run by Waikato DHB and a local GP.

The findings from these test runs will be shared with DHBs as part of ongoing learning and process improvement.

Child Wellbeing Impact Assessment

COVID-19 immunisation for children 5 to 11 years

20 December 2021

Released under the Official Information Act 1982

Overview

Childhood immunisation programmes are an essential part of protecting children in New Zealand and around the world from a range of preventable diseases. These include diseases that have high mortality (tetanus, meningococcal), high transmissibility (measles and chickenpox), long term effects (hepatitis B, polio and HPV), or are particularly dangerous for very young children (whooping cough and rotavirus).

From time to time, new vaccines are developed, adding to the tools available to protect our health. Normally, these address endemic diseases that we have considerable experience with and depth of understanding about. The COVID-19 pandemic means we have had to make rapid decisions about how to deploy vaccines as they became available.

The impacts of COVID-19 immunisation on child wellbeing for children 5 to 11 years old was assessed to inform decisions on whether and how to use the COVID-19 paediatric vaccine for this age group. These decisions, and the impacts noted in this report, are subject to Medsafe approval of the vaccine and advice from the COVID-19 Vaccine Technical Advisory Group (CV-TAG) to assure safety, quality, and effectiveness of the vaccine.

Key points

Immunisation of the population protects children and promotes their wellbeing

- COVID-19 has had, and will continue to have, significant impacts on children's health, development, relationships, and lives. Both COVID-19 disease and measures taken to mitigate the impacts of COVID-19 disease significantly impact children's lives and development.
- Immunisation of Aotearoa's population against COVID-19 is the single biggest protection against the disease's impacts on children's lives and development.

Immunisation of children adds protection and promotes children's development

- With or without high levels of population immunisation, immunisation of children (subject to Medsafe approval and CV-TAG advice to assure safety, quality, and effectiveness) adds individual protection against impacts on children's lives and promotes their development. These protections are especially significant for children at high risk of severe outcomes, including tamariki Māori, Pacific children, disabled children and children with health conditions, children living in poverty, and children in the care of Oranga Tamariki.

Immunisation of tamariki Māori requires concerted focus

- To date, Māori have suffered high impacts of COVID-19 and remain at high risk, given both multiple risk factors for severe COVID-19 illness, and the very young

population structure with 10% of Māori being aged under 5 years and ineligible for the paediatric vaccine.

- Immunisation of tamariki Māori requires strong focus given their greater risks from and impacts of COVID-19.
- Immunisation of tamariki Māori through whānau-centred delivery that is designed to be culturally competent for iwi, hapū, and Māori in a variety of settings can promote the immunisation of Māori tamariki and whānau, and should be given urgent resourcing.

Immunisation of children should be supported, but not subject to associated restrictions for any children

- Promotion of children's development through immunisation is optimised where immunisation of children is supported and accessible, parents and guardians are active participants in the decision for their children to be immunised, and children themselves are informed about immunisation in a way that is appropriate for their age and development.
- Promotion of children's development by immunisation would potentially be undermined and worsened overall by any restrictions, mandates, certification, record keeping requirements, or other measures that single out children based on whether or not they are immunised.

Immunisation of children should promote whānau wellbeing

Promotion of children's development through immunisation would be enhanced by delivering immunisation in whānau-centred ways that offer a wide range of health and social development opportunities and services, without undue delay. Examples include whānau health checks, simultaneous immunisation of whānau members, and providing of a range of supports to meet whānau needs and aspirations (e.g., nutrition, housing, social, financial, and legal assistance).

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Section A: Proposal details

Summary

This impact analysis examines impacts on child wellbeing of offering COVID-19 immunisation with the approved paediatric vaccine product to children aged 5 to 11 years:

- subject to Medsafe conditions, COVID-19 Vaccine Technical Advisory Group (CV-TAG) advice and a decision to use
- with provision through a range of child- and whānau-centred providers and settings to promote uptake among all children and their whānau
- with special attention to promoting uptake for children at higher risk and children in communities at higher risk from COVID-19, particularly tamariki Māori, Pacific children, children in poverty, and disabled children and long-term illnesses
- while upholding rights and wellbeing of all children including those who are not immunised.

Context

The chief context of this proposal is the COVID-19 pandemic in New Zealand, and its impacts on children, their whānau, and communities. Additional context includes other childhood vaccines available on New Zealand's National Immunisation Schedule.

Pandemic impacts

The COVID-19 pandemic and efforts to manage it have had significant impacts for New Zealand children to date. Impacts for New Zealand children have been considerably lower than for children in many other countries because of the elimination approach taken up until widespread immunisation could be achieved. However, these impacts may increase as the Delta variant (among others) continues to spread in communities.

Impacts cross all wellbeing domains, including family, social and peer relationships, learning and development, economic and poverty-related, health (including mental health, impacts of family violence, and deferred healthcare), and human, cultural and recreational participation.

Negative impacts for children have been greatest for those living in poverty or situations of high family stress. Māori and Pacific children have been disproportionately impacted by COVID-19 illness among community members, and the social and economic consequences of the pandemic have exacerbated pre-existing inequities for these communities.

This differential impact is expected to continue or increase as these communities are at relatively higher risk from COVID-19 because of lower vaccination rates (especially among

young adults and older children), higher rates of underlying health conditions and disabilities, and of high-contact living conditions.

Pandemic mitigation and role of immunisation

Immunisation represents the most effective protection available against COVID-19, other than very restrictive measures such as isolation. Other protective measures such as mask-wearing and social distancing have significant impacts on children's activities, peer relationships, and opportunities for social development.

Broader social, ethical and legal issues around immunisation

Because COVID-19 immunisation is the main protection from disease circulating in the community, both for individuals and for the wider community, including children and people at high risk, it has been mandated for people working in certain at risk or public-facing roles (including for school teachers). It has become a divisive topic in some quarters and the source of some conflict.

Issues to be examined include:

- the ethics (benefit to children versus benefit to general public) – children aged 5 to 11 years make up some 14% of the NZ population and their immunisation would add to total coverage for the population and potentially impact the rates of transmission – in analysing whether to offer immunisation to this population, it is crucial to know what the risks and benefits are
- producing information designed for children as well as for parents, including disabled households.
- consent – mandatory vaccination is appropriate in far-fewer contexts for children than for adults; mandates are unlikely to change behaviour of this age group, who are unlikely to be making own decisions around vaccination. Significant proportions of caregivers of 5 to 11 year olds have expressed hesitancy or intention to not vaccinate their 5 to 11 year old.¹ Consent/refusal to consent from guardians should not raise consequences for children such as potential exclusion of unvaccinated children from developmentally important activities (school, sports, clubs, parties etc) that is not in accordance with the evidence of risk (though it may align with adult messaging), and risk of increasing equity gaps for children given we know that these gaps are disproportionately harmful for children compared with adults
- careful consideration of the access to information about vaccine status of a child and how that information might be used. Unvaccinated children could be at heightened risk of exclusion informally or formally (in education settings) and of bullying

¹ <https://www.health.govt.nz/system/files/documents/pages/horizon-research-covid-19-vaccine-survey-october-2021-1dec2021.pdf>

- anxiety about COVID and about the nature of the vaccination debate being played out in public and how to support children deal with anxiety and stress

Advancing children's rights and meeting Children's Convention principles

Children live, learn, and grow, not in isolation but as part of families, whānau, hapū, iwi, and communities. Children have the same basic human rights as adults, but they also have additional rights in recognition of their special need for protection. Children – particularly younger children – are dependent on adults, like parents and teachers, to support them to develop and thrive. These rights are established in the United Nations Convention on the Rights of the Child. New Zealand has ratified these rights, and they apply to all persons under the age of 18 no matter their sex, sexual orientation, culture, religion, wealth, language, or disability status. Below is an analysis of the relevant rights in the convention and the implication of the proposed immunisation programme on these.

The proposed immunisation of 5–11-year-olds does appear to enhance the rights of children. The Pfizer paediatric COVID-19 vaccine has a favourable safety profile with similar side effects to those observed in the 16-25-year-old population.

However, there should not be unintended consequences for children in terms of participation in events or access to locations based on vaccination status, as this risks exclusion and an inability to fully participate in activities crucial for development such as schooling and extracurricular activities. Such exclusions would likely impact communities already experiencing disadvantages and where current vaccination rates are poor, potentially breaching Te Tiriti o Waitangi principles of equity and tino rangatiratanga (by removing the ability for Māori to exercise autonomy). Consideration is required regarding mandates, vaccine targets, and COVID-19 vaccine certificates, and the impacts these will have on different populations.

A rights analysis is outlined in Table 1, below.

Table 1: Rights analysis under the United Nations Convention on the Rights of the Child

Children's Convention Article	Analysis
Article 2	This proposal applies to those ages 5 to 11.
Article 3	This proposal requires adults as duty bearers to consider children's best interests as a primary consideration
Article 6	Immunisation will help to achieve children's rights to life, survival and development
Articles 9, 10	Vaccination enhances children's right to live with their family, particularly making co-habitation safe for family/whānau of varying degrees of pandemic risk.
Article 12	Many children will have the opportunity to discuss vaccination with their parent or caregiver. Health decisions, in accordance with the age and maturity of this population, will rest with those guardians.
Article 13, 17	The proposal considers how children are able to seek and find appropriate information about vaccinations.
Article 16	Children's rights to privacy as it relates to the sharing of vaccination data will be considered as part of the proposal.
Article 23	The proposal aims to support high risk populations, including disabled children, protecting the right to a full and decent life. This includes access to information in accessible and culturally appropriate formats, and the potential to return to in-person education.
Article 24	Children have the right to the best healthcare possible. This policy enhances this right by providing a means to vaccinate against COVID-19. Technical advice will demonstrate whether this is the 'best' healthcare option for children.
Articles 28, 29	Research shows children (especially socioeconomically deprived, Māori, Pacific, and disabled children) are losing weeks' worth of curriculum progress due to lockdowns and online education. Furthermore, the same populations are being kept from school after re-openings by concerned parents. This policy has the potential to restore confidence in the safety of in person education and thus children's right to access this.
Article 30	This proposal includes consideration of Māori as tangata whenua to have information provided in te reo Māori and to have tikanga considered in how an immunisation programme is delivered.
Article 31	The proposal enhances the safety of gatherings such as sports and cultural activities and is likely to provide confidence to family and whānau who are avoiding these types of activities to protect children.

Section B: Data, evidence, and stakeholder views

Evidence of proposal impacts

The impacts of immunisation against COVID-19 in 5–11-year-olds are numerous, both direct and indirect, and have effects not only children but also their whānau, family and communities.

Direct impacts for children of COVID-19

Health

COVID-19 disease is only rarely severe or fatal in children aged between 5 and 11 years who will commonly have no, or only mild, respiratory symptoms. However, COVID-19 is still a significant public health issue in this age group. The risk to this age group is not negligible and include several health outcomes of concern.

- Throughout the 2021 Delta outbreak there have been over 2200 cases under 12 years of age (unable to be vaccinated) with 36 hospitalisations. Children aged 5 to 11 have made up 14.9% of cases in the current Delta outbreak.
- Over the full course of COVID-19 in New Zealand, Māori have been significantly over-represented in cases (36%), hospitalisations (38%) and deaths (30%). Pacific peoples have also been over-represented in cases (29%), hospitalisations (36%) and deaths (24%). In the current Delta outbreak, Māori have made up 52% of cases in 5-11-year-olds, and Pacific children have made up 30% of cases among 5-11-year-olds.
- Childhood immunisation rates have dropped in New Zealand during the COVID-19 pandemic, especially among Pacific peoples and Māori. If diseases such as Measles re-enter New Zealand, this could have significant impacts. The risk of such preventable disease outbreaks is increased with New Zealand's borders becoming more relaxed in early 2022.
- Children with pre-existing health conditions or comorbidities, low socioeconomic status, or of ethnic minority status (including tamariki Māori and Pacific children) are at greater risk of severe disease, hospitalisation and ICU admission. Comorbidities in children with the highest relative risk include:
 - asthma
 - obesity
 - chronic respiratory disease
 - neurological or neuromuscular disorders

- immune disorders
- metabolic disease.
- Tamariki Māori are over-represented in each of these disease risks.
- Incidence of the severe post-infection Multi-system Inflammatory Syndrome in Children (MIS-C) is highest in the 5 to 11 age group. MIS-C has occurred more frequently in children from ethnic minorities in the United States.
- Children can have long-persisting symptoms once acute infection with COVID-19 has cleared (Long-COVID). Symptoms can be debilitating and distressing for people with Long-COVID. Even if rates among children is low, if transmission becomes widespread then the impact of persisting symptoms would be considerable.
- Engagement in non-urgent health services has also dropped (likely in most deprived, and minority populations, risking increasing health inequities).²
- Globally mortality from COVID-19 among children is low, ranging from 1/10,000 cases in high-income countries to 20/10,000 in low-medium income countries and 100/10,000 cases among infants in low-medium income countries. In the current NZ outbreak, the majority of cases have been in unvaccinated (64%) or partially vaccinated (20%) people. Similarly, most of those hospitalised have been unvaccinated (72%) or partially vaccinated (21%).
- Children and young people are over-represented in cases (37% under 20 years including 20% under 10 years). At the time, most of these children and young people would have been ineligible or newly eligible for vaccination., Currently, those aged under 12 years (15% of NZ's population) remain ineligible. While children and young people most often have mild if any symptoms of COVID-19, 10% of New Zealand's hospitalised cases have been in those under 20 years.
- Over 20% of all cases and more than 7% hospitalisations have been in under-12s.

Social and emotional

The COVID-19 pandemic has had significant impacts on how children socialise with families and communities, with flow on effects to how they handle the emotions of this irregular period:

- For many the impacts have been neutral, for some even positive as families have spent increased quality time together in lockdowns.³

² Blake, D., et al (2022) Accessing primary healthcare during COVID-19: health messaging during lockdown, *Kōtuitui: New Zealand Journal of Social Sciences Online*, 17:1, 101-115, DOI: [10.1080/1177083X.2021.1950780](https://doi.org/10.1080/1177083X.2021.1950780)

³ Life in Lockdown: Children and young people's views on the nationwide COVID-19 level 3 and 4 lockdown between March and May 2020. <https://www.occ.org.nz/assets/Uploads/LifeinLockdown-OCC-Nov2020.pdf>

- However, many children have suffered increased anxiety and social, cultural and family relationship stressors, especially those living in poverty prior to the pandemic or with family violence, addiction and other adverse social contexts.
- A small minority have lost whānau members who have died from COVID-19. Others have been unable to visit sick and dying whānau members or attend tangi with gathering restrictions.
- Many children have had to isolate and/or been separated from immediate family members when whānau have contracted COVID-19, interrupting family and social relationships.
- Social relationships outside the family with other children have been impacted during lockdowns and school closures. This is particularly challenging for disabled children and those without reliable or stable internet access or access to a device. International border restrictions have separated some children from their families which has had created stress.
- 6% of children reported worsening relationships with their families⁴. Large proportions reported not having anyone in their bubble to talk to about feelings, and not being listened to.⁵

Cultural

Children experience a range of cultural impacts during the pandemic, due to both lockdowns and general COVID-19 restrictions. These include:

- Limits on gatherings and gathering sizes, including at church, tangi, social and cultural groups.
- Changes to tikanga and other cultural practices to reduce risk of transmission of the virus.
- Generally speaking, whānau, hapū and iwi systems have responded well to measures aimed at reducing transmission and risk of COVID-19, through quick mobilisation to identify at-risk whānau and unmet need. Iwi and hapū have often taken a more cautious approach than that set by health authorities, for example, through choosing not to re-open marae for events if the community feel the risk is still too high (even if permitted to under the alert level setting).

⁴ Life in Lockdown: Children and young people's views on the nationwide COVID-19 level 3 and 4 lockdown between March and May 2020. <https://www.occ.org.nz/assets/Uploads/LifeinLockdown-OCC-Nov2020.pdf>

⁵ Meissel K, Bergquist M, Kumarich J, et al. The Growing Up in New Zealand COVID-19 Wellbeing Survey: Part 2: Education. Auckland: Growing Up in New Zealand, 2021.

Economic

Children have been affected by the economic impacts of the COVID-19 pandemic. These include:

- Economic impacts of COVID hit most disadvantaged more substantively, widening existing inequities for the most deprived, Māori, Pacific, insecurely employed etc.
- Growing Up in New Zealand (GUiNZ) COVID-19 wellbeing survey highlighted anxieties around household income as a common theme among participant responses⁶.

Educational

Children demonstrate abilities to adjust to changes in everyday life due to lockdowns and pandemic restrictions. However there are impacts on education including:

- 75% children report lower satisfaction with education during lockdown, including anxieties around falling behind due to remote learning periods.
- Deprivation impacted access to education due to inequitable access to necessary technologies in the learning from home era (the digital divide) ⁷. Use of apps increased throughout digital learning, including a high use of apps with age 13+ restrictions.

Direct impacts for children who are immunised

There are a range of likely outcomes for children from receiving the COVID-19 vaccine. Some are adverse but not serious, and some are clear benefits.

- Non-serious, short-term adverse side-effects of the vaccine, generally comparable to those in adolescents and adults. ^{8,9}
- Protection from serious COVID-19
- Reduced risk of hospitalisation/long-term sequelae especially for children with specific comorbidities or high-risk contexts (e.g., housing).

⁶ Walker N, Dubey N, Bergquist M, et al. The GUiNZ COVID-19 Wellbeing Survey: Part 1: Health and Wellbeing. Auckland: Growing up in New Zealand, 2021

⁷ Life in Lockdown: Children and young people's views on the nationwide COVID-19 level 3 and 4 lockdown between March and May 2020. <https://www.occ.org.nz/assets/Uploads/LifeinLockdown-OCC-Nov2020.pdf>

⁸ Alamer, E., et al. (2021). "Side Effects of COVID-19 Pfizer-BioNTech mRNA Vaccine in Children Aged 12-18 Years in Saudi Arabia." *Vaccines* 9(11) DOI: <https://dx.doi.org/10.3390/vaccines9111297>

⁹ <https://www.pfizer.com/news/press-release/press-release-detail/pfizer-and-biontech-announce-positive-topline-results>

- Protection from long-term consequences of COVID-19, such as Long-COVID
- Reduced time spent isolating at home, greater school attendance, learning, socialising and relationship development.
- Potentially greater connection with vulnerable whānau and family members where socialisation or access might otherwise be restricted (eg, in rest home care).
- Potentially greater health service connection and benefits from uptake of wider healthcare, including greater school attendance and learning.
- Rates of certain rare adverse events among other age groups (eg, myocarditis) have only become apparent following widespread roll-out. These are not expected to be higher for the 5 to 11 years age group, and the risk is considerably lower than risks of the same events from COVID-19. Further data on potential rare side effects will progressively become available as roll-out continues among children globally.

Indirect impacts for all children of some children being immunised

- Lower likelihood of severe COVID-19 and hospitalisation among children at higher risk (eg, disabled children or children with health conditions)
- Probable reduced restrictions on education and recreational activity settings (eg, school or sports facility closures)
- Reduced need and flow-on impacts of other protections that can interfere with activities and peer relationships, eg, social distancing, isolation and face-coverings.
- Potential exposure to adverse social impacts, such as discrimination, blame or victimisation on the basis of immunisation status and/or conflict such as with protests in places where children gather
- if children are required to use a COVID-19 Vaccine Passport (CVC) there are implications around access to devices or hard copies, and implications around interacting with unknown adults. This is a significant matter for children with anxiety or socially implicated mental health issues.
- Potential reduction in transmission among children due to reduced exposure to COVID-19, although evidence is limited.¹⁰

¹⁰ Ainslie, K., et al. (2021). The impact of vaccinating adolescents and children on COVID-19 disease outcomes, medRxiv.

- Opportunities for engagement on crucial 'catch-up' immunisations from the national childhood immunisation programme.

Indirect impacts for whānau and communities of children being immunised

- Lower likelihood of COVID-19 among people at higher risk (eg, with underlying health conditions or disabilities) who are in contact with children (especially in households)
- Greater social connections with children for those at higher risk (e.g., whānau with underlying health conditions or disabilities), with potentially reduced risk of transmission (evidence is limited¹¹).
- Avoiding lost productivity through supervision of unwell/isolating children (women generally, especially sole mothers and wahine Māori who bear vast majority of burdens when children unwell)
- Opportunities to engage with other groups (older than 5-11-year-olds) in immunisation programme, to improve vaccination rates
- Higher immunisation uptake in communities with a high child population, through family-, whanau- and community-based engagement processes.
- Potentially greater health service connection for whānau of children and benefits from uptake of wider healthcare
- Potential risk of exposure to protests and associated immunisation programme interruptions when school sites are used as part of vaccination programmes; distraction to learning, and risk of anxiety in children.

Significant impacts on children and young people

COVID-19 immunisation has considerable positive impacts for children overall. The vaccine has a very good safety profile (though data is not yet available on large population cohorts in the 5 to 11 years age group). Immunisation of children will add to overall population protection which has been limiting the spread of COVID-19 and allowing a greater level of social, cultural, educational and economic freedoms for whānau and children.

Children's wellbeing is enhanced by COVID-19 immunisation as long as access and availability of opportunities remains open to all children. Any restriction on children's access and activities, such as to education or public places, impacts negatively on development. No such restrictions are justified based solely on whether or not children are immunised.

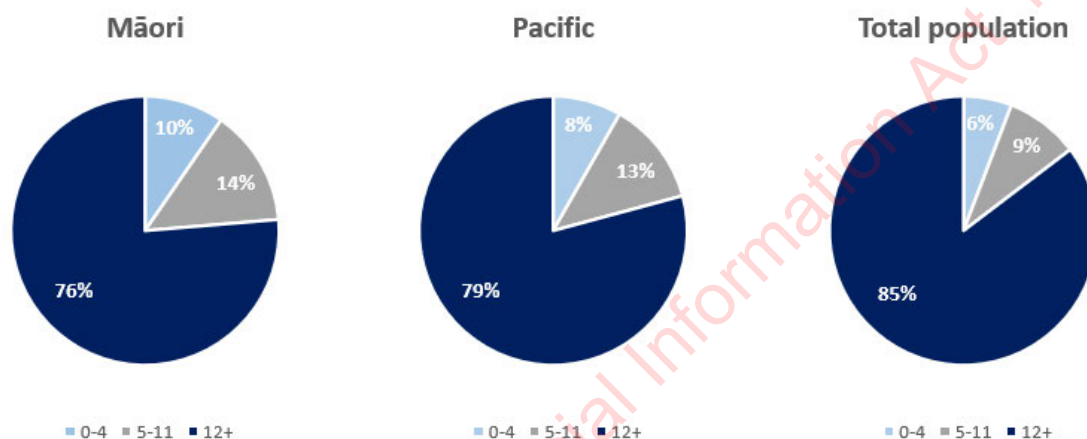
The positive impacts of immunisation are particularly strong for children in communities with:

- higher COVID-19 exposure, risks and impacts

- higher child populations, particularly where there are high numbers of younger children ineligible for immunisation
- children at significant risk such as disabled children and children with health conditions.

Māori and Pacific communities have young population profiles as shown in figure 1.

Figure 1: Children as part of the population: age structures for Māori, Pacific and the total New Zealand population



Impacts on different groups of children and young people

Māori

There are an estimated 115,562 tamariki Māori aged 5 to 11 years (14% of the Māori population and 24% of the NZ population of 5-11-year-olds). In the 2021 Delta outbreak, tamariki Māori have made up over half of infections under 20-years of age, suggesting disproportionate risk of infection and severe COVID-19 impacts. These impacts may be from higher exposure associated with inter-generational living, housing instability, household crowding and in-person connected communities, from higher rates of respiratory and other long-term health conditions such as rheumatic heart disease, disabilities, and from poor standards of care or discrimination within health systems. For similar reasons, tamariki Māori may have potential risk from at-home self-isolation measures.

Māori are highly represented in areas with both active transmission of COVID-19 and with lowest vaccination rates. The impacts of vaccination on tamariki Māori include reduced overall risk of severe disease, opportunities to reach whānau members who are yet to be vaccinated or receive second doses, through whānau-based implementation approaches.

Pacific

There are an estimated 49,398 Pacific people aged 5 to 11 years (roughly 17.5% of the Pacific population and 10.5% of NZ population aged 5 to 11 years). The majority of Pacific peoples reside in the Auckland region and 29% of cases and 37% of hospitalisations in the 2021 Delta outbreak have been in Pacific peoples. This suggests a disproportionate risk of infection and severe COVID-19 impacts for this group.

These impacts may be from higher exposure associated with inter-generational living, household crowding, in-person connected communities, higher pre-existing condition burden (including rates of respiratory and other long-term health conditions such as rheumatic heart disease), and disabilities. For similar reasons, Pacific children may have potential risk from at-home self-isolation measures. Over 25% of Pacific children are experiencing material hardship (highest of any ethnic group) and disproportionate rates of obesity, and preventable and chronic illnesses which increase risk of severe illness from COVID-19.

Pacific peoples are overrepresented in areas with active transmission, and vaccination rates in this population lagged that of more advantaged populations. Full immunisation rates for Pacific children at 2 years of age has dropped to 67.4 percent in July 2021 compared with 93.8 percent in December 2019. The impact of vaccination among Pacific children includes overall reduced risk of severe disease and subsequent hospitalisations, positive impacts on school attendance and educational attainment and opportunities to engage on childhood vaccine progress, and to reach family and community members who are yet to be vaccinated or receive second doses through community-based approaches. The overall youthful distribution of the Pacific population of New Zealand also means vaccination of this group contributes to greater overall vaccination rates for Pacific peoples.

Evidence suggests significant hesitancy to return Pacific children to school even outside school closure periods. Immunisation is likely to reduce this hesitancy and improve educational outcomes for Pacific children.

Similar risks and impacts would also apply to Pacific countries outside of Aotearoa New Zealand, such as in Cook Islands, Niue and Tokelau, which have proportionately high child populations.

Disabled children

As at the 2013 census, there are roughly 50,000 children between the ages of 5 and 11 with identified disabilities. Disabled people are at high risk of severe disease from COVID-19 infection. This risk is multifactorial, through increased risk from infection itself, reduced access to routine healthcare, and the adverse social impact of pandemic mitigation¹¹. Disabled children are more likely to live in poverty and in conditions which make respiratory

¹¹ [https://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(21\)00625-5/fulltext](https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)00625-5/fulltext)

illness more severe. Furthermore, Māori and Pacific children have higher than average disability rates, increasing their already increased overall risk from COVID-19.

The potential impact of vaccinating disabled children included reducing their overall risk from COVID-19 and opportunities to engage with whānau, family, caregivers and children themselves on opportunities to vaccinate whānau/caregivers, broader health and wellbeing, pandemic impacts (education, social services etc) and the possibility for engagement with available support services/packages. There is growing evidence of parental hesitancy to vaccinate children with neurodevelopmental disabilities (some of the highest-risk children) against COVID-19. Tailored communications will be required to confer the proposed benefits to this group.^{12,13}

Long-term illness

A number of chronic conditions increase the risk of infection with COVID-19. The WHO identify older age, obesity, type 2 diabetes, asthma, heart/pulmonary disease, neurological, neurodevelopmental and neuromuscular¹⁴ conditions. Maori are over-represented in many of these disease risks. Paediatric cancer patients are at increased risk due to immunocompromising disease and treatments, as well as delays in treatments.¹⁵ It is difficult to estimate how many children in New Zealand have any type of chronic condition, and the amount of intersectionality in these populations. Examples, however, include 11.9% of children under 14 with Asthma, 30.8% of children under 14 who are obese or overweight – both of which disproportionately impact Māori and Pacific children. Furthermore, diseases of poverty such as bronchiectasis, rheumatic fever and rheumatic heart disease are all vulnerabilities for severe COVID-19 and almost exclusively impact Māori and Pacific.

The potential impacts of vaccinating children with chronic conditions include reduced risk from infection and severe illness from COVID-19, and, as with disabled children, provides opportunities to engage with children and families on COVID-19 vaccine status, disease-management throughout the pandemic, and eligibility for support.

¹² Aggarwal, S., et al. (2021). "Vaccine Hesitancy Among Parents of Children With Neurodevelopmental Disabilities: A Possible Threat to COVID-19 Vaccine Coverage." Journal of child neurology: 8830738211042133 DOI: <https://dx.doi.org/10.1177/08830738211042133>

¹³ Choi, K., et al. (2021). "Parent intentions to vaccinate children with autism spectrum disorder against COVID-19." Journal of pediatric nursing DOI: <https://dx.doi.org/10.1016/j.pedn.2021.11.019>

¹⁴ Aiano, F., et al. (2021). "COVID-19 vaccine given to children with comorbidities in England, December 2020-June 2021." Archives of disease in childhood DOI: <https://dx.doi.org/10.1136/archdischild-2021-323162>

¹⁵ <https://onlinelibrary.wiley.com/doi/full/10.1002/pbc.29397>

Children in the care of Oranga Tamariki

Approximately 2000-2500 children between 5 to 11 years of age are in the care of Oranga Tamariki. Children in care are predominantly Māori, Māori and Pacific, or Pacific peoples (68% have Māori as one of their recorded ethnicities). They are more likely to be disabled, and to have high and complex needs than the general population (including higher rates of mental health needs and of Fetal Alcohol Spectrum Disorder).

When children first enter care, there is a higher likelihood that they will be in placed multiple homes in a relatively short period of time and are often with multiple other children while more stable, enduring care is established. Family Group Homes pose a particular risk as the placements are often at short notice and in environments where there may be up to six children at a time.

Children entering care for the first time are less likely to be fully immunised when they come into care than the general population, indicating that they are less engaged with primary care. This means flexible and tailored ways of reaching children on the cusp of care and their caregivers/whānau are needed to ensure high vaccine uptake

For immunisation of children in care, Oranga Tamariki currently requires guardianship consent. Many children in care are in family/whānau care arrangements and only a few children are in sole guardianship with Oranga Tamariki. This means consent to vaccination is a complex issue and will require working through at an operational level. Special consideration needs to be given regarding the chief executive's responsibilities to children in the care of Oranga Tamariki.

Most children who contract COVID-19 will isolate at home with their parent/s and whānau. Children in care would isolate with their caregivers, so the requirement to isolate will have an additional impact on their ability to maintain their contact with their parent/s and whānau. There have already been significant disruptions to maintaining contact as a result of the lockdowns.

In summary, children in care are considered among the most vulnerable children in New Zealand. They are at greater risk of contracting COVID-19 and suffering more serious effects from it, than the general 5-11-year-old population. Achieving high rates of vaccination for these children provides the greatest chance of minimising these risks and protecting this group. This must be done in close consultation with whānau and caregivers, in a manner that upholds mana tamaiti, whakapapa and whanaungatanga.

The potential impact of vaccination of children in care is reduced risk for severe illness among a population with multiple risk factors.

Children in poverty or deprived communities

Nearly a quarter of New Zealand's children are growing up in households considered to be in poverty¹⁶, and one in five children are living in benefit-supported households, the majority

¹⁶ <https://dpmc.govt.nz/sites/default/files/2020-07/child-poverty-related-indicators-2020.pdf>

of which are sole-parent households¹⁷. High deprivation is associated with stress, chronic illnesses, low health-literacy and irregular and infrequent healthcare access and is a considerable risk factor for infection and severe-illness from COVID-19. As discussed in above section, tamariki Māori, Pacific children and disabled children are overrepresented in deprived communities and have a multitude of COVID-19 risk factors on top of poverty.

The impacts of immunisation for children growing up in deprived communities include an overall reduced risk of severe illness, opportunities to engage with whānau and families on vaccine status, and presents additional opportunities to engage and provide wellbeing and social support to at risk communities.

Children in multiple households

Similarly to children in care, children in shared custody arrangements are at an increased risk of exposure to COVID-19 due to the transitional nature of their custody (moving between homes on regular basis), especially during periods of active transmission in their communities. Furthermore, there is inevitable cross over between this population and other risk-factors such as deprivation and chronic illness.

The impacts of vaccinating this population include the reduced risk of severe disease, and a reduced risk of exposure and transmission between households and beyond (e.g., schools and communities). Further impacts include opportunities to engage with families on vaccination status, and provide engagement with other wellbeing and social services.

Implications for Tamariki Māori

To date, vaccination of Māori has been slower than for non-Māori, particularly for younger age groups. Furthermore, tamariki Māori represent roughly 27% of the 5-11-year-old population, and have made up over half of cases under 20 years of age in the current outbreak, likely due to their multifactorial risk profile. Their inclusion in the vaccine eligible population would represent a significant proportion of the Māori population yet to be vaccinated, and an equally significant proportion of the 5–11-year-old population for any paediatric COVID-19 vaccine immunisation programme to focus on reaching.

Te Tiriti o Waitangi obligations, including oritētanga (equity), tino rangatiratanga, options, active protection and partnership, continue to be essential in the planning of immunisation programme rollout, and lessons from the programme so far will be utilised in leveraging existing partnerships, including the COVID-19 response Iwi chairs forum.

While the Ministry plans to use existing infrastructure such as DHBs, Primary Care and Community centres as the primary delivery mechanisms, a multi-pronged approach will be undertaken to co-design this service with our hauora providers to meet the needs of tamariki and their whānau. In addition to receiving guidance and advice from our Māori experts on the IIAG, CV-TAG, and the Disability Advisory Group of Tātou Whaikaha, the Ministry (CVIP

¹⁷ <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/statistics/benefit/index.html>

Equity team and Māori Health Directorate) will engage with the existing Māori health providers to understand what additional supports and resources may be required to implement this service successfully to tamariki, including relevant Health Service User and CVIP engagement data required to target their efforts efficiently.

The implications of these proposals include cooperation on achieving equitable outcomes for Tamariki Māori, opportunities to engage with whanau and communities on vaccination, and the protection of tamariki as taonga and future kaiarataki (leaders) of hapu and Iwi.

National Distribution of 5 to 11 Age Group

Figure 2 illustrates the distribution of 5 to 11 years olds throughout New Zealand based on Health Service User data, with additional breakdown demonstrating the proportion of Tamariki Māori and Pacific children in each DHB region. Population distribution data will inform immunisation programme efforts for focus resources on reach high-risk populations.

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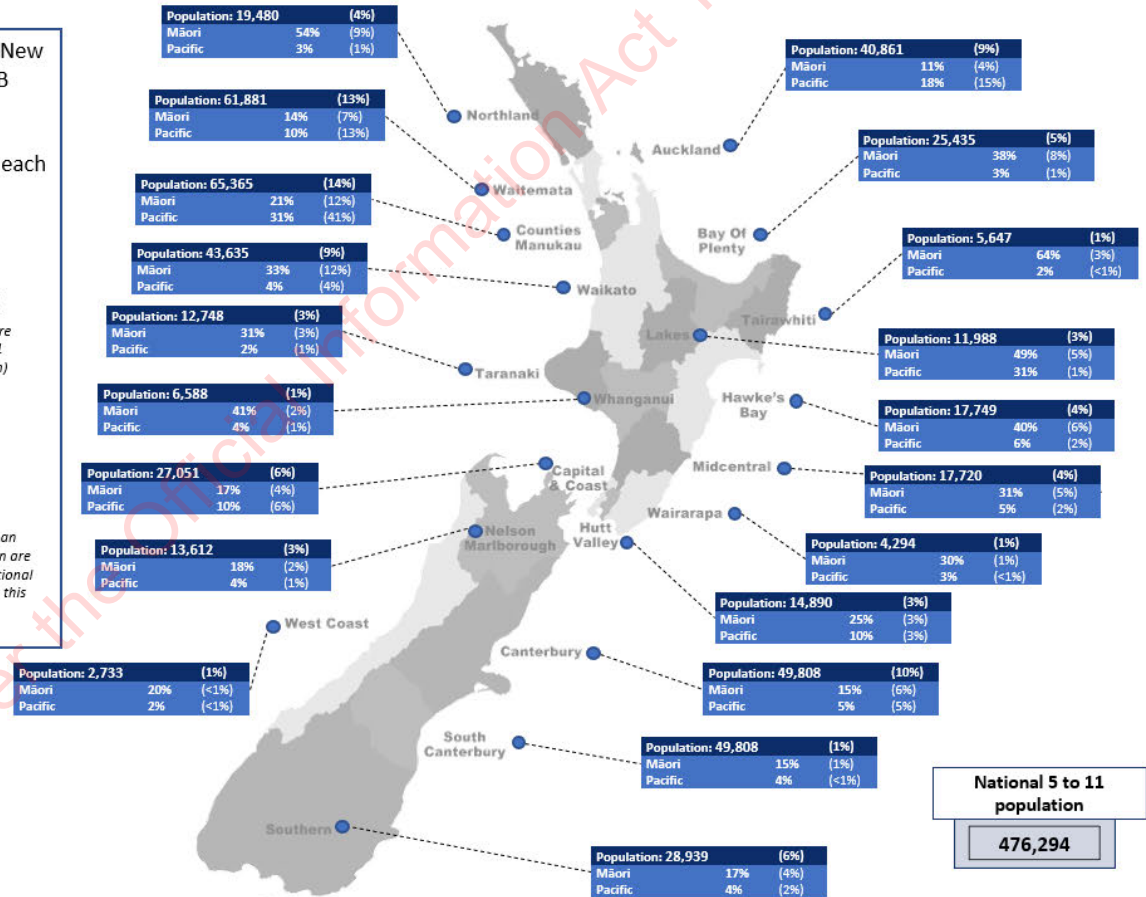
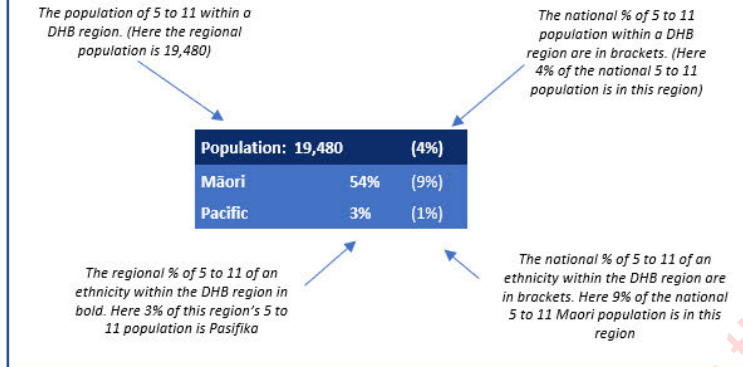
Figure 2: Distribution of 5 to 11 year olds throughout New Zealand



Overview

Based on HSU information, initial analysis on the 5 to 11 population of New Zealand has identified the population characteristics of each of the DHB regions.

The diagram shows the regional (in **bold**) and national (in brackets) for each of the DHB regions.



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Views of Children

Consultation with stakeholders with sources and experience on the views of children with respect to the pandemic and vaccination included a number of relevant themes.

- Enriched connection with family/whānau and friends through mutual support, and engagement on digital learning ¹⁸
- Exercising manaaki, connecting to culture and community in innovative and supportive ways
- Financially secure 'bubbles' – such as concerns about household income throughout the pandemic, and awareness and anxieties of constraints ¹⁹
- Flexibility and choice about the use of their time during lockdown and digital learning periods ²⁰
- Enjoying quiet, safe environments during lockdowns
- Making sense of the situation, integrating it into their life story
- Positive experiences through times of risk ²¹
- Supporting decision making for guardians of children aged 5 to 11 years by providing consumable and culturally relevant information about the vaccine, and how to discuss immunisation with children
- Children's ability to seek out their own information, subsequent exposure to misinformation, and providing accurate information in formats that children can digest

The proposed 5 to 11 years immunisation programme and the range of direct and indirect impacts would support a number themes present in the various reporting on children's views.

¹⁸ Life in Lockdown: Children and young people's views on the nationwide COVID-19 level 3 and 4 lockdown between March and May 2020. <https://www.occ.org.nz/assets/Uploads/LifeinLockdown-OCC-Nov2020.pdf>

¹⁹ A snapshot of Life in Lockdown: Children's Health, Wellbeing, and Education. Growing Up in New Zealand (GUiNZ) https://www.growingup.co.nz/sites/growingup.co.nz/files/documents/Wellbeing_Survey_Snapshot2-4b%20FINAL.pdf

²⁰ Life in Lockdown: Children and young people's views on the nationwide COVID-19 level 3 and 4 lockdown between March and May 2020. <https://www.occ.org.nz/assets/Uploads/LifeinLockdown-OCC-Nov2020.pdf>

²¹ Life in Lockdown: Children and young people's views on the nationwide COVID-19 level 3 and 4 lockdown between March and May 2020. <https://www.occ.org.nz/assets/Uploads/LifeinLockdown-OCC-Nov2020.pdf>

Consent to vaccination

The United Nations (UN) have asked governments to prioritise children's rights in the development of policy related to COVID-19 in a manner that is consistent with the UN Convention on the Rights of a Child. Article 5 of the Convention stipulates respect for the responsibilities, rights and duties of parents and guardians in a manner consistent with the evolving capacities of children.

While there is no lower limit to the age at which individuals can provide consent to vaccination, we anticipate children aged 5 to 11 years will be accompanied by parents or whānau members.

Other stakeholder views

Stakeholders have emphasised the importance of culturally acceptable communication and engagement throughout the implementation design and delivery so that all children have equal opportunities to be immunised.

Culturally appropriate and safe communication for tamariki Māori, whānau, hapū and iwi is essential in creating an equitable immunisation programme, communicating options, and informing decision making and tino rangatiratanga. Whānau-based approaches are essential and should be emphasised, including clear messaging that all whānau are welcome in the process, welcome to ask questions, and invited to participate in getting their vaccine. Messaging in te reo Māori is also essential.

Information for Pacific Aiga should include information tailored for Pacific children, emphasise the protection of children in its messaging, and focus on mothers as the primary decision makers regarding the health of children. Communications for disabled people should focus not only on materials for disabled children but also consider children living in disabled households and the needs of these family and whānau to understand the process, and the systems in place to support their participation in the immunisation programme.

Growing evidence suggests that vaccine hesitancy is highest among school-aged children and parents in socioeconomically deprived communities and populations, who consume more social media, and have feelings of isolation and marginalisation. These populations are already experiencing disadvantage and poor vaccine rates.^{22 23} Efforts should be made to

²² Fazel, M., et al. (2021). "Willingness of children and adolescents to have a COVID-19 vaccination: Results of a large whole schools survey in England." *EclinicalMedicine* 40: 101144 DOI: <https://dx.doi.org/10.1016/j.eclinm.2021.101144>

²³ McKinnon, B., et al. (2021). "Social inequalities in COVID-19 vaccine acceptance and uptake for children and adolescents in Montreal, Canada." *Vaccine* 39(49): 7140-7145 DOI: <https://dx.doi.org/10.1016/j.vaccine.2021.10.077>

tailor and target communications for these populations in order to maximise effectiveness and reach of immunisation.

Guidance on promoting child wellbeing during the pandemic

A number of stakeholders have raised the need for guidance on how to best provide for children's access and enjoyment of developmental, recreational, social, cultural and other activities and public places during the pandemic. This guidance is needed by a wide range of government, non-government and business operators, and applies to children individually and in groups.

The guidance will need to cover access for children in mixed age groups, where older children may have vaccine certificates and younger children not. It will be needed early after immunisation starts for this age group, especially by schools as they start planning for the 2022 school year.

Ongoing engagement through development and implementation

Stakeholders have informed the development of this Child Wellbeing Impact Assessment and will continue to inform the decision to use a paediatric vaccine product, the implementation approach and implementation plans at a District Health Board Level.

The high-level engagement plan for immunisation consideration and implementation is outlined in the table below.

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High level engagement plan

Stage of process	Description and purpose	Lead	Engagement				
			Purpose	Level	Who – internal	Who – external	Timeline
Child impact assessment Conducted in tandem with regulatory assessment and science and technical advice	Formal assessment of child wellbeing impacts, completed in order to inform a subsequent decision on whether and how to use vaccines for children aged 5-11 years	MoH SSP – System Enablers	Share information Improve proposals Understand reactions Generate support	Involve	CVIP, CHSR – STA Māori Health PHP – Pacific, FCH, Imms HSSI – H&D intelligence Disability, MHA	Office of Children’s Commissioner, Ministry of Education, Oranga Tamariki, Growing Up in NZ, Social Wellbeing Agency	Draft 10 Dec 2021
				Consult	IIAG CV-TAG Tātou Whaikaha Disability Advisory Group		Te Puni Kōkiri, Ministries for Pacific Peoples, Women, Ethnic Communities, Office for Disability Issues, Treasury, DPMC
Decision to use Pre-requisites include Medsafe approval for use and supplier agreement. Inputs include CV-TAG and IIAG advice	Advice to Cabinet Ministers with recommendations on whether and how to use vaccines for children 5-11 years, submitted after Medsafe has granted approval for the vaccine to be used in New Zealand	MoH SSP – System Enablers	Improve proposals Generate support	Involve	CVIP	Office of Children’s Commissioner Ministry of Education, Oranga Tamariki, Te Puni Kōkiri, Ministry for Pacific Peoples, MFAT, Treasury, DPMC	Draft 20 Dec 2021
				Consult	CHSR – STA Māori Health PHP – Pacific		Final 22 Dec 2021
Implementation approach	Service design approach for immunisation of children, including workforce, technology, delivery models, distribution, prioritisation	MoH CVIP	Identify problems / opportunities Improve proposals Build relationships	Collaborate Involve Consult	IMAC IIAG Tātou Whaikaha Disability Advisory Group	DHBs, Oranga Tamariki, Ministry of Education, Primary/community health	10 Jan 22 Plus ongoing through Q1 22
District implementation plans	Detailed plans for delivery models for the range of communities in the district, including providers, facilities, communication, promotion, tailoring to local needs and preferences	DHBs	Problem solve Improve proposals Build relationships	Empower Collaborate Involve Consult	Māori, Pacific, disability leads Paediatricians, PHO clinical leads	Iwi, hapū, local communities, health and disability communities, groups, gangs, Hauora, primary care, other health providers, Schools, kōhanga, child service providers, Crown agency regional and local branches, Health and social service providers, NGOs	Evolving ongoing through Q1 2022

WHO guidance

The World Health Organization (WHO) issued an Interim statement on COVID-19 vaccination for children and adolescents (updated 29 November 2021)²⁴. It states that:

- Countries should consider the individual and population benefits of immunising children in their specific epidemiological and social context
- Benefits go beyond direct health benefits – minimising disruptions to education and maintenance of overall well-being, health and safety are important
- Attaining high coverage of high-risk groups such as older people, those with chronic health conditions and health workers, including booster doses, should be prioritised before children and adolescents
- Global sharing through the COVAX facility should be prioritised before vaccination of children and adolescents who are at low risk for severe disease.

This child wellbeing impact assessment considers the individual and population benefits of immunising children in the specific epidemiological and social context of New Zealand and of population groups within New Zealand. It considers benefits beyond direct health benefits, including minimising disruptions to education and maintenance of overall wellbeing, health and safety.

The findings of this assessment support immunisation of the wider population as the most important protection for the group of children 5 to 11 years.

This assessment sits alongside New Zealand's plan to offer COVID-19 paediatric vaccine to the countries of Polynesia (the Cook Islands, Niue, Samoa, Tokelau, Tonga, and Tuvalu) to support their child immunisation plans. Most of these countries have high child populations and have indicated their strong interest in providing immunisation for their children.

It also sits alongside New Zealand's commitment to global equitable access to COVID-19 vaccines, including a contribution of over 2 million vaccine doses to the COVAX Advance Market Commitment to support vaccination of adult populations in developing countries worldwide.

²⁴ <https://www.who.int/news/item/24-11-2021-interim-statement-on-covid-19-vaccination-for-children-and-adolescents>

Section C: Summary of Impacts

Conclusion of impacts on policy proposal

COVID-19 has wide ranging impacts on children and young people across a variety of domains and presents a significant public health issue for children aged 5 to 11. The impacts of immunisation against COVID-19 for children are equally wide ranging and include:

- reduced risk of severe disease and hospitalisation, especially for high-risk populations including tamariki Māori, Pacific children, disabled children and children with health conditions, children living in poverty and children in the care of Oranga Tamariki
- protection from serious outcomes such as Multi-system Inflammatory Syndrome in Children (MIS-C) and Long-COVID
- educational stability and satisfaction
- opportunities to re-engage in the national childhood immunisation programme
- opportunities to engage with family and whānau on health and social support requirements.

COVID-19 does not impact all children equitably. Tamariki Māori, Pacific children, disabled children and long-term illness, and children in care are all at higher risk of severe disease, hospitalisation, and have a range of indirect impacts on their lives and development due to the pandemic. Immunisation therefore has differing impacts on each of these groups, reducing the inequitable risk they bear, and providing opportunities to engage them in various health and social services which can reduce the overall impact of the pandemic on them and their families and whānau.

Tamariki Māori bear a significant burden of the pandemic, including high rates of cases and hospitalisation. Focus is required in order to uphold the Crown's Te Tiriti obligations of equity, active-protection, partnership, options and tino rangatiratanga. A multi-pronged approach which includes engagement with iwi, hapū and community stakeholders and Māori health providers will enable cooperation on achieving equity and the protection of tamariki Māori as taonga.

Prioritising the rights of children is crucial when considering immunising this cohort. Analysis of this proposal against the Convention on the Rights of the Child indicates that immunisation of 5 to 11-year-olds should enhance the rights of children. However, including 5 to 11 year olds in vaccine mandates, requirements for COVID-19 vaccine certificates, or vaccine targets would risk children's ability to engage in activities crucial to their development.

The benefits to children of COVID-19 immunisation, while considerable, do not outweigh the benefits to their development of full access and participation in education, development, recreation and community activities and public places.

A wide range of stakeholder views have informed this impact analysis. These include:

- Office of the Children's Commissioner
- Ministry of Education
- Ministry of Social Development
- Oranga Tamariki
- Te Puni Kōkiri
- Ministry for Women
- Ministry for Ethnic Communities
- Ministry for Pacific Peoples
- Department of the Prime Minister and Cabinet
- Office for Disability Issues

Recommendations

Offering COVID-19 immunisation to children 5 to 11 years

Based on this impact analysis, it is recommended that:

- immunisation of the wider population continues – it is important to protect children and promote their wellbeing
- immunisation of children should proceed and be offered to all aged 5 to 11 years – it adds protection and promotes children's development with or without high levels of population immunisation
- immunisation of tamariki Māori requires high and timely focus – Māori have suffered high pandemic impacts, remain at high risk and have a high child population with 10% of Maori under 5 years old and ineligible for vaccine
- immunisation of children should be encouraged, but not subject to restrictions under the Protection Framework or any other restrictions based on vaccination status
- immunisation of children should where possible promote whānau wellbeing, be offered in multiple ways to suit a wide range of families and groups, and cater especially for Pacific peoples, disabled children, children with health conditions and children with family members who are disabled or have health conditions, children and families living in poverty, and children in the care of Oranga Tamariki.

Communication

Achieving equitable outcomes for the various groups explored in this analysis will depend on tailored and culturally appropriate communication at all levels and in all communities.

It is important that communications are designed in a way to make sure that parents or other decision makers are well-informed about the risks and benefits of vaccination when consenting on behalf of children.

Children have the right to appropriate guidance based on their capacities. Communications should therefore also encourage and guide parents and guardians in discussing immunisation with their child/children. As recipients of the vaccine, children require specific communications that help answer their questions such as on whether the vaccine is safe or what the process will be like; separate information should be developed that is suitable and user-friendly for this diverse age group.

Maximising opportunities for children's wellbeing and development

Children should enjoy full access and participation in opportunities and public places. It is unlikely restrictions that are solely based on whether or not a child is immunised will be justifiable.

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