MINISTRY OF HEALTH
MANATŪ HAUORA

133 Molesworth Street
PO Box 5013
Wellington 6140
New Zealand
T+64 4 496 2000

20 January 2022

s 9(2)(a) [redacted]

Ref: H202117382

Tēnā koe s 9(2)(a) [redacted]

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to the Ministry of Health (the Ministry) on 8 December 2021. You asked:

> *"In the affidavit of Dr Bloomfield to the Waitangi Tribunal there is a reference to: "COVID-19 Response: Updated Strategy for moving to minimisation and protection" dated 11 November 2021.*
> *Under the OIA I seek a copy of that strategy please"*

The document you have requested is attached as Appendix 1 and has been released to you in full.

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

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

Nāku noa, nā

Maree Roberts
Deputy Director-General
System Strategy and Policy

Appendix 1

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Memo

COVID-19 Response: Updated strategy for moving to minimisation and protection

Date:	11 November 2021
To:	Dr Ashley Bloomfield, Director General of Health Maree Roberts, Deputy-Director General, System Strategy & Policy Bridget White, Deputy Chief Executive, COVID-19 Health System Response Dr Caroline McElnay, Director of Public Health, Director Public Health Dr Ian Town, Chief Science Advisor, Health System Improvement, and Innovation
From:	Steve Waldegrave, Group Manager, Covid-19 Policy
For your:	Action

Purpose of report

1. This paper seeks your decisions regarding the transition away from an elimination strategy to the "minimisation and protection" approach. This includes setting out how the operational response will need to adapt to work alongside and support the introduction of the new COVID-19 Protection Framework (CPF). This memo incorporates your initial feedback, and a seeks to reflect the results of a discussion with your Executive Leadership team earlier this week.

Background

2. New Zealand's elimination strategy has been highly successful. The use of strong public health measures, such as Alert Level 3 and 4 lockdowns when needed, has allowed us to keep cases, hospitalisations, and death rates very low by international standards.
3. This approach was necessary for responding to COVID-19 prior to vaccines being widely available. To protect New Zealanders' health, the health system and the economy from the worst impacts of COVID-19, trade-offs against certain personal freedoms and economic activity have been required.
4. Maintaining the elimination strategy has bought time to increase vaccination rates and to prepare for the next phase of the response where less widespread restrictions are needed to manage the virus.
5. New Zealand is now entering that next phase as we near 90 percent vaccination rates across the country.

Covid Protection Framework

6. On 18 October 2021, Cabinet agreed to replace the elimination strategy with the "minimisation and protection" approach and to replace the Alert Level Framework with the new CPF [CAB-21-MIN-0421]. The framework seeks to enable greater freedoms with fewer population-wide restrictions once New Zealand reaches high vaccination rates.

7. Cabinet agreed in principle, subject to consideration of both the operational and legal implications of operating two frameworks simultaneously, for Auckland to move to the CPF once all DHBs in Auckland reach full vaccination for 90 percent of those eligible. Other parts of the country would move once all other DHBs outside Auckland reach 90 percent full vaccination of those eligible [CAB-21-MIN-0421].

8. Since these decisions were made, the outbreak in Auckland has continued to grow. The Delta variant has proven much harder to eliminate than previous variants.

9. The elimination strategy has helped to dampen the outbreak and contain or stamp out cases in other parts of the country. The utility of maintaining an elimination strategy is also declining as high rates of vaccination are achieved.

How is our strategy changing?

Why are we moving from an 'elimination' strategy to a 'minimisation and protection' approach?

10. This paper sets out a strategy for a minimisation and protection approach, as we transition away from our 'getting to zero' elimination strategy. This new approach recognises that:

    a. Delta has meant lockdowns are less effective at eliminating the virus as they need to be longer and require very high levels of compliance to be effective.

    b. Testing, contact tracing and MIQ are under constant pressure (e.g. laboratories are currently operating at 167 percent of their baseline capacity) and nearing breaking point.

    c. COVID-19 is now finding its way into more vulnerable communities, sometimes undermining the effective use of certain public health control measures (such as timely contact tracing).

    d. Social license for the elimination strategy is slipping:

        i. Public opinion research has suggested many people are tired of long lockdowns. Furthermore, such lockdowns are both socially and economically costly (particularly if lost social license undermines their efficacy at eliminating the virus),

        ii. The effectiveness of vaccination at reducing hospitalisations and mortality means that our health system is in a better position to manage COVID-19; and

        iii. Overall, the case for continuing to infringe on civil liberties (in particular, movement and activities like gatherings) is weakened with high vaccination rates.

What should be our key aims from here?

11. The overarching strategic aim for the health system remains to minimise illness and pressure on the health system, including minimising hospitalisations and fatalities.

12. We propose the following strategic objectives guide the next steps for the health system, as government moves towards implementing the CPF:

    a. Suppress and minimise spread of COVID-19,

    b. Target support for vulnerable communities,

    c. Ensure the health system has the capacity and capability to manage COVID-19 cases appropriately, and

    d. Enable non-COVID-related healthcare to continue (e.g., cancer treatment) to the greatest extent possible.

What should be the guiding principles?

13. When moving to the new Protection Framework, it is important that government, and the wider health sector, are clear about the underpinning principles that will guide decision-making from here on.

14. The following principles are widely accepted internationally, and already guide much of what government does in New Zealand. We propose that these same principles should guide the decisions about how and when to move to the new Protection Framework:

    a. Respect for human rights (e.g., relating to freedom of movement, association, religion and freedom from discrimination),

    b. Equity – recognising that different people with different levels of advantage required different approaches and resources for equitable outcomes,

    c. Inclusivity and community participation,

    d. Meeting government's obligations to its Treaty of Waitangi partner, and

    e. Transparency, openness and accountability.

How will our new 'minimisation and protection' approach be different from elimination?

15. The operational response model will need to adapt, including preparing to manage more COVID-19 in the community. Preparations are already well underway in Auckland, as well as in other DHBs and PHUs across the country.

16. To minimise the impact of the virus, we will still need effective and efficient case and contact management systems and processes. This will be an essential approach for limiting the spread of the virus when restrictions in Auckland are relaxed and there is greater movement around the country.

17. Work is underway to revise strategies for testing, contact tracing and isolation, focusing our resources where they are most effective to support the health system to avoid becoming overwhelmed in certain communities.

18. More efficient and targeted use of resources, technologies and management strategies, such as rapid antigen testing, shorter quarantine and isolation periods, community level management and wrap-around health and welfare services for people quarantining or isolating at home will be some of the tools to enable a more rapid and local response.

19. We note that for some communities, localised restrictions (such as local lockdowns or restrictions on movement) may still be required in addition to the standard package of measures of the 'public health toolkit' set out below. Ideally these kinds of more restrictive public health measures will be reserved for situations where the health and wellbeing risks from COVID-19 are higher (e.g. in communities where vaccination rates are low and the risks of hospitalisation and fatalities are consequently greater).

What is the health advice around timing for shifting to the CPF (traffic lights)?

20. Cabinet has already agreed the indicative thresholds for movement within a region at each level of the framework. These are:

    a. Green: case numbers kept low through testing, contact tracing and quarantine, and hospitalisations at a manageable level

    b. a shift to Orange would occur with increasing community transmission, increasing pressure on the health system, or increasing risk to vulnerable populations;

    c. a shift to Red would occur when Orange is no longer containing the virus in the original outbreak areas, and further action is needed to protect the healthcare system, and the health of communities or vulnerable populations.

21. Like the Alert Level framework, we propose that the Director-General of Health be responsible for providing public health advice to the Government on any changes in Levels. Ideally, as under the current Alert Levels framework, a decision about whether to shift should follow an assessment by a panel of public health experts as well. In short, public health considerations should remain central, and the Director-General should inform all decisions with respect to the CPF and any changes in colours.

22. We would expect that, in addition to considering the criteria above, that the Director-General of Health (following advice from a panel of public health experts) consider the following factors when offering advice to Ministers on any potential colour changes:

    a. Vaccination coverage across the populations and area of concern, including the equity of coverage,

    b. An assessment of demand for care for the sick against capacity of the health and disability system, and the community, to manage. This includes consideration of the numbers of cases, hospitalisations and any fatalities in each community, and any other local system pressures such as cyber security events, natural disasters, other demands for hospital level care (eg influenza), and sufficient staffing and other resources. This would span primary care, community services, and secondary care,

    c. Availability of testing, contact tracing and case management capacity in the community of concern, and

    d. Transmission of COVID-19 within the community of concern, including its impact on key populations in terms of hospitalisations and need for ICU beds and ventilators.

Reserving lockdowns for situations where healthcare resources are reaching capacity

23. While the CPF does not include lockdown measures as an option within the framework, there remains a need for the Government, on the advice of the Director-General, to reserve the use of lockdown measures to protect communities if the health system is nearing its care capacity limits. Assessing the need for a lockdown in a community would likely need an evaluation of healthcare capacity (both within the health sector and the community) against demand for healthcare.

24. We propose to develop a set of early warning indicators (e.g., including in relation to COVID-19 related hospitalisation demand versus capacity) to support determinations around when lockdowns might be required. Such indicators might also be used to provide advice in relation to any additional supports the health and welfare sectors may need to protect vulnerable communities.

What's likely to happen when we move to the new framework?

High rates of vaccination should protect many from the most severe impacts

25. There is now a significant body of available evidence suggesting that being vaccinated provides very good protection from serious illness, hospitalisation, and death due to COVID-19. There is also evidence available suggesting that vaccination leads to fewer symptomatic COVID-19 cases, which may also reduce transmission risk.

26. However, while the vaccines available now are effective at reducing the risk of serious illness and death from COVID-19, they do not completely remove the risk of transmission and unlikely to achieve complete elimination in the context of the Delta variant.

27. This means that although high rates of vaccination in the eligible population should help to significantly reduce the harm caused by COVID-19, certain public health measures will continue to be required alongside vaccination to minimise transmission as much as possible and protect the most vulnerable.

Some of these cases will lead to more hospitalisations around NZ

28. Widespread restrictions on people's lives, such as long-lasting lockdowns clearly come at a significant cost to livelihoods, mental and broader health and wellbeing. Being able to provide more certainty for most people, without lockdowns as much a possible, is increasingly important to people over time.

29. High vaccination rates provide a strong level of population protection, and along with maintaining other public health measures. Together, they can enable more certainty going forward. Of course, moving beyond the elimination strategy requires us to manage the impacts of more COVID-19 in the community, even if less severe, as well. More COVID-19 in the community will no doubt create its own uncertainties also, though the impacts will likely be distributed differently.

30. Moving to a 'minimisation and protection' strategy provides an opportunity to reset the strategic aim of the ongoing pandemic response. It involves moving away from the aim of getting to zero cases, and towards managing COVID-19 as safely as possible in the community, given high rates of vaccination.

31. This does not mean that the virus is left to spread uncontrolled, rather the response needs to maintain intensity but shift to a new operating model.

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So, we will need to protect the most vulnerable parts of the community

32. High vaccination rates provide a level of population and individual protection from COVID-19. However, those who are vulnerable will face inequities that require additional layers of support and protection as widespread restrictions are relaxed.

33. The Ministry of Health recommends that the vulnerability of areas is considered when decisions are made about the level of protection each community may need. This would be over and above the usual public health measures included in the CPF (i.e. Traffic Lights).

Defining vulnerability

34. As COVID-19 becomes more prevalent in New Zealand, even the fully vaccinated population who have existing vulnerabilities will experience more severity of illness and require more support.

35. Various underlying factors have the potential to impact on the health outcomes and thus impact on how we might define 'vulnerability' when it comes to COVID-19. These include the considerations such as age (older people 65+), ease and proximity to health services, socio-cultural and socio-economic factors.

36. In column 1 below, vulnerability for a given community is defined in terms of an evenly-weighted average of several different indicators. The indicators are: vaccination rate, distance from available healthcare services, deprivation level and percentage of the population over 70.

Risk Profile Assessment – factors to determine vulnerable regions

		Risk Score	Vaccination rate	Accessibility	Deprivation remainder	Age profile of remainder group	Age profile of remainder group
DHB	Fully vaccinated	Aggregated risk score (qualitative)	Weekly percent of population vaccinated	Distance to vaccination sites (km)	Avg. deprivation of remainder pop.	Total remainder of population over 70	% of remainder of population over 70
New Zealand	79%		3.4	5.1	5.7	42,15[illegible]	6.[illegible]
West Coast	71%	1.000	3.4	10.0	6.8	385	8.2
Northland	69%	0.754	3.6	4.7	7.5	2,874	7.5
Whanganui	72%	0.643	3.2	3.7	7.4	696	6.7
Bay of Plenty	73%	0.641	4.0	5.8	6.8	2,993	7.3
Wairarapa	76%	0.624	2.7	6.2	5.4	479	7.1
South Canterbury	78%	0.615	2.9	6.0	5.5	509	7.4
Counties Manukau	81%	0.613	3.1	6.5	6.4	4,980	6.3
Waikato	77%	0.592	3.5	7.0	6.7	3,731	5.9
Mid Central	76%	0.583	3.2	6.7	6.3	1,576	6.0
Nelson Marlborough	79%	0.567	1.8	6.2	4.7	1,701	6.9
Hawke's Bay	75%	0.554	3.0	8.0	5.8	1,424	5.2
Lakes	71%	0.530	3.7	6.4	6.8	987	5.4
Auckland	88%	0.514	2.6	5.5	5.4	4,302	6.8
Tairāwhiti	68%	0.486	3.6	5.8	7.3	369	4.4
Waitemata	84%	0.466	3.0	5.5	4.5	5,659	7.5
Southern	81%	0.386	2.8	6.5	5.0	2,192	5.2
Taranaki	72%	0.304	4.7	5.5	6.0	985	5.8
Capital and Coast	84%	0.236	3.4	2.4	4.1	1,724	5.1
Hutt Valley	79%	0.132	4.0	3.5	5.3	987	5.2
Canterbury	80%	0.000	4.6	3.3	4.7	3,603	5.5

37. The results of the composite indicators above mostly fit with an intuitive understanding of which New Zealand communities might be more vulnerable to poor health outcomes due to COVID-19, based on a range of risk factors working together. It is worth noting that the following communities come out highest in terms of vulnerability using this analysis:

    a. West Coast (primarily due to distance from available healthcare)

    b. Northland

    c. Whanganui

    d. Bay of Plenty

    e. Wairarapa.

38. It is also worth noting that using a composite indicator approach likely provides a better indication of vulnerability than relying on just one indicator, such as vaccination status or deprivation. For example, while Tairawhiti would look high vulnerable when considered just in terms of vaccination rate or deprivation scores, this is mitigated by the younger population (which arguably reduces the likelihood of hospitalisation and fatalities from COVID-19).

39. Of course, ultimately judgement calls will be needed about which factors are considered most pertinent in defining vulnerability in relation to COVID-19, and thus where resources and additional community supports should be prioritised. For example, those who are not vaccinated, which currently includes all New Zealand children under 12 years, are more likely to become a case. However, severity of illness will be influenced both by vaccination status but also by other factors such as age and co-morbidities. By drawing on the kind of information above, hopefully public health advice on such matters can be informed by a robust consideration of the range of factors.

Those who are not vaccinated (and/or may not be able to be)

40. Despite additional effort to increase vaccination uptake, there remain parts of the country where vaccination rates have not yet reached the government's 90 percent target. It will be important to ensure that these communities and the local health systems that support them, continue to have the capacity and capability to respond given the potential for more cases and hospitalisations going forward.

41. Inequities in vaccination coverage remain by age group and ethnicity. This includes Māori and Pacific peoples still having relatively low vaccination rates for the 12-19 and 20-34 age groups, and for those who have received a second dose.

42. It will be necessary to continue taking a targeted approach to boosting vaccination rates in vulnerable populations such as among young Māori and Pasifika.

How will our operational response need to change?

What further public health controls will be needed (beyond the traffic lights)?

43. There are a range of public health tools that still need to sit alongside the CPF measures (i.e. traffic lights) in the 'minimise and protect' phase of the response. These other public health tools remain vitally important as part of our strategy but are separate from the new Protection Framework itself. They include:

a. Surveillance measures (such as testing and contact tracing) aimed at rapidly identifying where COVID-19 outbreaks may occur,

b. Localised movement and activity restrictions, particularly focused on containing small outbreaks and enabling them to be stamped out rapidly,

c. Public advice on staying home if unwell, QR code scanning, appropriate face coverings for different settings, good personal hygiene (e.g. hand-washing),

d. Public health measures (e.g. pre-departure testing and vaccination requirements) to minimise transmission risk for those traveling from higher risk places (e.g. areas of known outbreaks) to lower risk ones, and

e. Public health measures to avoid the potential for super-spreader events (such as restrictions on mass gatherings (especially indoors), ventilation and physical distancing requirements).

44. In particular, a central element of the public health response to COVID-19 has been the test, trace, isolate and quarantine (TTIQ) system. This system – comprising contact tracing, case management, COVID-19 testing and isolation or quarantine arrangements for community cases – has been a key set of tools underpinning the sustained success of the elimination strategy throughout most of 2020 and 2021.

45. At a high level, we note that TTIQ system will need to play a different role to support the minimisation and protection approach. It will need to:

a. minimise the spread of COVID-19, and enable outbreaks to continue to be stamped out, where practical to do so;

b. protect the most vulnerable communities and individuals from the disease; and

c. ensure the health system has sufficient capacity and capability to support communities and protect the most vulnerable, and in doing so, protect all New Zealanders who rely on the health system from significant harm.

46. Consistent with the minimisation and protection framework, the overall objective of the TTIQ system will need to shift from stopping the spread of COVID-19 to reducing serious illness (e.g. requiring hospitalisation) and death due to COVID-19.

47. A separate Health Report back to the Cabinet Social Wellbeing Committee (SWC) provides full details on the concomitant resource prioritisation and operational changes to testing, case investigation and contact tracing arrangements. That report back will be consistent with the strategic direction proposed in this memorandum.

How will we ensure the health system is prepared for more cases and hospitalisations?

48. Vaccinations are key to unlocking the new way forward. Those who are vaccinated are less likely to contract the virus, spread the virus, and much less likely to get seriously ill, require hospitalisation or die from their infection.

49. New Zealand's access to vaccines has improved significantly over the last year. The vaccination programme has now also exceeded initial expectations. New Zealand is entering a phase where there are high vaccination rates across much of the population. This provides a both individual and a population-level of protection that will significantly reduce the likely impact of COVID-19 on many New Zealanders.

50. Efforts need to continue for vaccinating as many people as possible, including through approaches that are inclusive, accessible and that reach into all parts of the community, as well as roll out booster doses and be ready to extend the programme to 5–11-year-olds if this is recommended and agreed

Healthy system readiness work

51. The Health System Readiness Programme, which is already underway, aims to prepare for any increase in hospitalisation as we move towards the 'minimisation and protection' strategy. This includes providing the necessary health and social supports for the less severe COVID-19 cases which can be handled effectively in primary and community settings going forward.

52. The key elements of the Readiness Programme include workforce capacity and innovation; testing and surveillance; hospital readiness, capacity, facility and equipment supply; data and digital; maintaining a strong focus on equity; primary and community level models of care for the management of COVID-19; and equitable distribution of resources across communities and regions.

How can protect the most vulnerable as we transition?

53. Significant cross-government and community effort, beyond just the health system, is required to support vulnerable communities going forward. The proposed Community Protection Plans could, for example, include central government support (and law-making) to enable tailored local supports to facilitate rapid community-level testing, contact tracing, enhanced welfare support and support for local quarantining/isolation options.

54. As the Government moves to introduce the CPF, it will be important and useful to engage with iwi/Māori and local authorities on their views around how to protect their communities. This includes central government and local communities working together to identify the approaches considered most effective. Of course, engaging on such matters would not replace the need for a public health expertise to remain central to the response in each community.

55. In addition, it might be possible to explore a partnership approach between central government, vulnerable communities and iwi/Māori in those communities. This would ideally involve utilising existing partnerships, networks and programmes (e.g. supporting the implementation of the $120 million the government recently allocated for Māori) rather than creating new ones.

56. We note that for some communities localised restrictions (such as local lockdowns or restrictions on movement) may still be required. Ideally these kinds of more restrictive public health measures will be reserved for situations where risks are higher (e.g. in communities where vaccination rates are lower).

What supports might be offered to vulnerable communities?

57. The Ministry of Health proposes that the most vulnerable (including those under 90 percent fully vaccinated) communities are offered community protection plans. Above we have outlined some of the likely indicators of vulnerability. We will report back shortly with an analysis and heat map describing which communities should be considered most 'vulnerable' from a COVID-19 response perspective going forward. We propose that those communities be prioritised for engaging to ensure the health and welfare systems in those locations can respond effectively to potential outbreaks.

Appendix 1

How should we manage the transition?

When to shift to the CPF?

58. Modelling indicates that Auckland should reach the 90 percent vaccination target by mid December 2021. It will likely take considerably longer for all other DHBs in the country to reach 90 percent fully vaccinated. Restricting freedoms longer may be disproportionate to the restrictions in place.

59. From a public health perspective, there is marginal additional community protection from waiting for rates to increase by 1-2 percent, especially if a considerable time is taken to reach the last few percent. Rather, it may be more appropriate to loosen restrictions, i.e., move Auckland to the CPF and boost targeted support for the communities that are known to be vulnerable (i.e., those with significantly lower vaccination rates).

7 days after 90 percent target to ensure full immunity

60. Best practice health advice is that it takes 7 days for an individual to be fully immunised following their second vaccination. Therefore, the date to move to the CPF should be 7 days after the 90 percent target is reached.

Moving the country onto the framework simultaneously

61. The Ministry of Health's view is that the whole of New Zealand should move to the CPF simultaneously, and a minimum of two weeks after Auckland DHBs reach 90 percent fully vaccinated.

62. From an operational and public messaging perspective, consistency and simplicity of public communications will be much better by moving to the new framework across all of New Zealand at once, rather than attempting to operate two frameworks for a time. For those parts of the country with low vaccination rates, and/or which are considered vulnerable due to their ability to respond if cases were to emerge then they should move into 'Red'.

63. Over time, the threshold for shifting up from green, to orange or red, under the CPF should be higher than it has been under the Alert Level framework. This is because we are no longer pursuing elimination, so simply having cases in the community should no longer be considered a sufficient trigger to escalate colour levels. Instead, the number of hospitalisations and available ICU bed capacity relative to demand, is likely to be a much more important consideration.

Moving away from hard boundaries

64. Focus should shift away from the use of hard boundaries to contain COVID-19 to protecting vulnerable parts of the country through a new operating model and applying the Red level setting as appropriate using soft boundaries.

65. We note that while we do not propose hard boundaries around the most vulnerable communities, we understand government is looking at a possible hard boundary for Northland, which could have implications for the health system regarding testing.

When should the boundary around Auckland be removed?

66. The Ministry of Health's view is that the current hard (or 'enforced') boundary around Auckland should be removed when Auckland and the rest of the country moves to the CPF, likely in mid-December 2021.

Should there be requirements to be tested and vaccinated before leaving Auckland?

67. The Ministry of Health's view is that requiring vaccination certification and/or testing to leave Auckland directs resources away from where they are most needed, particularly testing. This is based on recent experience around delays receiving test results for Northland due to over-taxed testing facilities and laboratories struggling to meet demand due to very widespread testing demands as part of the elimination strategy.

68. Ability to enforce the hard boundary around Auckland is the responsibility of other agencies. However, from a Ministry of Health perspective, attempting to check every vehicle movement for vaccination or testing status appears highly impractical, against the public health risk of COVID-19 transmission that it would pose. Spot-checking vehicles would likely have minimal impact and effectiveness for reducing the spread of COVID-19.

69. Specifically, on testing, we do not recommend that resources are allocated to testing unvaccinated people crossing the boundary. Instead, testing capacity should be prioritised to ensure quick turn-around of close contacts and those who are symptomatic to stamp out outbreaks as quickly as possible. This is particularly important given the speed of transmission associated with the Delta variant.

And easy access to RAT in 'Red' areas.

What communications will be needed?

70. Public messaging and community engagement will continue to very important public health tools during the next phase of the response.

71. Throughout the response, simple messages such as "stay home" and "get vaccinated" have been critical to drive population-based action. In this new phase, there will need to be a similar approach to public messaging with a focus on "being prepared" to test if unwell and to be prepared to isolate (albeit for shorter periods of time in the community).

72. The messaging should stress that the job is not done and that there will be ongoing challenges, even for those who are fully vaccinated, who may feel that they have done their bit. Although a highly vaccinated population provides options for more freedoms, there remains, if not more so, responsibilities on everybody - whanau, employers, and communities to minimise the spread of infection through testing, isolating and adhering to rules.

What role will vaccine certificates play?

73. Vaccine status underpins the new CPF. The planned date vaccination certificates will be ready for use by the public is 1 December 2021. As this will be an entirely new process the transition period may result in complexities for people and businesses/venue operators as the vaccine certificate process is embedded.

74. The Bill (COVID-19 Public Health Response Amendment Bill (No 3) 2021) and its associated Order will provide the legal basis for the use of vaccine certificates.

75. The Verification App that will scan certificates is planned to go-live on the Apple and Google store on 29 November.

What other issues need resolving? (events, funerals, disability)

Events

76. Further work is underway to determine appropriate public health settings in relation to the management of events under each colour level of the CPF. As these can lead to high-risk 'super-spreader' events, from a health perspective these require special attention, particularly high-risk indoor events. Protocols on how events can take place safely will be an important element of the Framework and as part of returning to a new normal. This work is also progressing in alongside the vaccine certificate work programme.

Funerals and Tangihanga

77. Similarly, the approach to funerals and tangihanga has required special consideration throughout our COVID-19 response. The nature and significance of these events has meant that our guidance has needed to balance the public health considerations with the expectations of grieving families.

78. We recommend that funerals and tangihanga have separate classification and consideration to typical gatherings such as private functions or public events because these will be a family's last interaction with a lost loved one, the CPF needs to consider the issues that have been identified with our current Alert Level setting approach and establish clearer and more considered settings for funerals and tangihanga going forward.

Protecting the rights of disabled people and others

79. We have received reports from the disability sector and from the Human Rights Commission of people with disabilities being treated harmfully by those seeking to enforce the rules around face coverings under the Alert Level Order, particularly in retail. This has involved retailers pressuring those who cannot wear face coverings for information why they are not wearing a face covering. There are concerns about the process for issuing this exemption, whether it is capturing appropriately those for who it is intended, and the public communications for treating those who cannot wear face coverings with respect. Further work in this area is required with urgency.

80. We also note that many of those who cannot be vaccinated, for example for a range of health reasons, are disproportionately comprised of Māori, given the higher prevalence of co-morbidities among this population.

Equity

81. Māori and Pacific peoples' vaccination rates continue to be lower than other population groups in Auckland and this is likely to contribute to disproportionate case numbers, hospitalisations and fatalities among Māori and Pacific peoples unless mitigations are put in place.

82. Māori Health Directorate engagements with some iwi/Māori have involved receiving the message from many stakeholders that transitioning to the CPF (and thus exposing Māori communities that have not yet reached the 90% vaccination target) goes against the Crown's Tiriti obligations and advice from core Māori experts.

83. However, we note that the risks to iwi/Māori associated with moving to the CPF may be mitigated to an extent by working with iwi/Māori to provide additional Community-level protections. This includes the community protection plans suggested above, ideally

developed for and with vulnerable communities. This might be considered a minimum requirement under active protection, partnership, tino rangatiratanga, and equity.

84. Vaccination rates among vulnerable communities need to increase. Additional resources and focus are being given to vaccination efforts in these communities, including targeted outreach / mobile vaccination services. A significant onus will continue to fall on the Māori health sector to deliver much of this protective work for their communities. Consequently, ongoing support will likely be needed from peripheral organisations such as pharmacies and non-Māori primary care to enable a sufficient response for iwi/Māori communities looking forward.

85. As we move to the proposed new minimisation and protection strategy, it is critical that equity of outcomes remains at the centre of government's decision-making criteria. Identifying and being clear about the vulnerable communities will be critical so that limited resources are directed to where they are needed the most. This is why, equity and meeting the government's responsibilities under Te Tiriti o Waitangi have been proposed above as key guiding principles and specific COVID-19 objectives for the health sector as we look towards a 'protection and minimisation' approach going forward.

Next steps

86. Based on your response to this paper, the Ministry will use the contents of the paper and the outcomes of your decisions to input to a DPMC-led Cabinet update on preparedness to implement the CPF on 15 November 2021.

Recommendations

It is recommended that you:

1.	**Note**	the CPF will shift the national COVID-19 response from elimination (zero community transmission of COVID-19) to a 'minimisation and protection' approach.	Noted ✓
2.	**Agree**	that the following principles should guide decisions relating to the minimisation and protection approach: i. Respect for human rights (e.g. relating to freedom of movement, association, religion and freedom from discrimination), ii. Equity – recognising that different people with different levels of advantage required different approaches and resources for equitable outcomes, iii. Inclusivity and community participation, iv. Meeting government's obligations to its Treaty of Waitangi partner, and v. Transparency, openness, and accountability.	Yes/No

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3.	**Agree**	that the primary aim for the health system remains to minimise illness and pressure on the health system, including minimising hospitalisations and fatalities.	Yes/No
4.	**Note**	that part of the original aims of moving to the CPF were to provide more certainty for all New Zealanders by reserving the use of lockdowns for limited situations when health system is nearing its capacity limits.	Noted
5.	**Agree**	that consistent with the aim above and to enable a sustainable and effective COVID-19 response, further strategic objectives should be to: i. Suppress and minimise spread of COVID-19, ii. Targeted support for vulnerable communities, iii. Ensure the health system has the capacity and capability to manage COVID-19 cases appropriately, and iv. Enable non-COVID-related healthcare to continue (e.g., cancer treatment) to the greatest extent possible.	Yes/No
6.	**Agree**	that the standard public health toolkit measures will still be required.	Yes/No
7.	**Agree** to advise that	that the Director-General of Health should retain responsibility for providing public health advice to the government in relation to level shifts under the CPF	Yes/No
8.	**Agree**	that the Director-General of Health should take the following factors into consideration when offering public health advice on level shifts under the CPF: i. Vaccination coverage across the populations and area of concern, including the equity of coverage, ii. An assessment of demand against capacity of the health and disability system to manage COVID-19 cases in a given community. This would span primary care, community services, and secondary care, iii. Availability of testing, contact tracing and case management capacity in the community of concern, and iv. Transmission of COVID-19 within the area of concern, including its impact on key populations in terms of hospitalisations and need for ICU beds.	Yes/No

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9.	**Agree**	that continuing the current vaccination drive will remain critical to the success of the strategy and implementation of the CPF, particularly raising vaccination rates in areas where rates are below 90 percent.	Yes/No
10.	**Agree**	that all DHBs in New Zealand should move to CPF simultaneously, rather than operating the current alert levels approach and CFP together.	Yes/No
11.	**Agree**	that the move to the CPF should take place 7 days after the date when all Auckland DHBs reach 90% fully vaccinated, to ensure the vaccinated are fully immunised. I don't think this is necessary	Yes/No
12.	**Agree** Fo advise	that the Auckland boundary should be removed when Auckland enters the CPF as there will be no public health justification to maintain a boundary around Auckland.	Yes/No
13.	**Agree**	to recommend that Auckland move to the new Protection Framework without requirements for testing or vaccinations in order for Aucklanders to be permitted to travel outside the area	Yes/No
14.	**Agree**	that strong public communications remains vital and that individuals and communities will still need to take responsibility for limiting COVID-19 transmission and caring for their whānau and community.	Yes/No
15.	**Note**	that various underlying factors have the potential for COVID-19 to impact on the health outcomes of people, which include age (older people 65+), ease and proximity to health services, socio-cultural and socio-economic factors.	Noted ✓
16.	**Agree**	that the above underlying factors as well as vaccination rates should used to identify vulnerable communities, noting that further advice on the specific definition will be provided shortly, identifying which communities we consider 'vulnerable'.	Yes/No
17.	**Agree**	to recommend to Ministers that the communities identified as vulnerable be offered additional 'community protection plans'.	Yes/No
18.	**Note**	that community protection plans could include, for example, central government support (and law-making) to enable tailored local packages for: rapid community-level testing, contact tracing capacity, and supporting local quarantining/isolation options.	Yes/No

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19.	**Agree**	the Ministry of Health work with DPMC to provide you with a plan for engaging the relevant communities on community protection offers as soon as practicable.	Yes/No

Signature _____ Date: 11/11/21
Steve Waldegrave
Group Manager, Covid-19 Policy

Signature _____ Date: 12/11/21
Dr Ashley Bloomfield
Director General of Health
Te Tumu Whakarae mō te Hauora