More than just a jab

Evaluation of the Māori Influenza vaccination programme as part of the COVID-19 Māori health response

Prepared by Research Evaluation Consultancy

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Report Information

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Tuku mihi ki a koutou katoa.

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1. The Ministry of Health (the Ministry) developed the Māori Influenza Vaccine Programme (MIVP) in response to COVID-19. MIVP is one of a number of initiatives that responds to Whakamaua: the Māori Health Plan 2020-2025[1].
2. The Government set aside up to $9.5m for district health boards (DHBs) and Māori health and disability providers. The programme aimed to increase access to the influenza (flu) vaccine for vulnerable Māori groups entitled to free vaccinations, particularly kaumātua over 65 years. Improving equity for Māori was the driving principle for the funding allocation.
3. The Ministry allocated $6.972 million, of the total available funding, across 19 DHB regions. Eighteen providers received direct funding of $2,061,618, while in eight DHB regions a further 40 providers were allocated $4,910,845.
4. The evaluation aimed to understand the impact of the programme on Māori flu vaccination rates and more broadly on equity. At an operational level, there was a further objective of testing new funding approaches and processes.
5. The evaluation used a mixed-methods, rapid insight cycle approach. Methods included two online surveys, qualitative interviews and review of the programme application and monitoring data. Flu vaccination data from the National Immunisation Register (NIR) was used to track changes in flu rates and equity.

Addressing the needs of Māori

6. There are significant barriers to Māori accessing GPs and primary healthcare services. MIVP aimed to address these barriers. These well-known and well-documented barriers are listed below. They include:

    - Cost such as consultation costs and prescriptions charges, and the loss of income due to having to take time off work to seek care
    - Access to services such as service locations and the distance to travel for care, suitable appointment times, long waiting times, lack of transport including public transport, and childcare availability and cost
    - Poor service experience such as whānau feeling: unwelcome or disrespected (typically by reception staff), whakamā (embarrassed) because of poor compliance with prescribed treatment, or of being rushed or pressured to keep the appointment brief
    - Cultural barriers such as whānau shyness, reticence to challenge authority, a 'wait and see' attitude towards sickness or injury that is often related to cost and prior bad experience and a preference for Māori clinicians or Māori providers
    - Poor health literacy such as whānau feeling whakamā because they do not understand the questions asked or the information shared with them
    - A clash between western and Māori models such as Māori models of wellbeing and the medical, disease-oriented model, which can result in whānau and non-Māori clinicians talking past each other and having differing perspectives on patient needs and the appropriate course of action.

[1] Whakamaua: the Māori Health Plan 2020-2025 guides implementation of He Korowai Oranga to ensure health and wellbeing outcomes improve and address persistent equity gaps for Māori. He Korowai Oranga: the Māori Health Strategy has the overall aim of ensuring Māori enjoy high standards of health and wellbeing.

Key finding

7. The evaluation found that overall, **the Māori Influenza Vaccination Programme made a worthwhile and valuable contribution to improving Māori flu vaccination equity rates.** In 2020 NIR recorded significantly higher vaccination rates for Māori than in previous years. Flu vaccination rates for Māori aged over 65 increased from 45.8% in 2019 to 59% in 2020. This increase is significant, given the small improvement observed between 2015 and 2019. The overall flu equity gap for Māori aged over 65 improved by 3.7 percentage points from -12.1% to -8.4%. While some of this change will be due to COVID-19, the evidence suggests that the MIVP also contributed to the increase.

Strategies that made a difference

8. Three core strategies used by providers and DHBs as part of the MIVP made a difference for Māori: mobilisation, taking a whānau-centred approach and a focus on Māori workforce capability.

9. First, **providers mobilised their services**. They went out into communities to vaccinate whānau. They used a combination of data and community networks to identify unvaccinated whānau. They reduced barriers by offering multiple access points, going to where whānau gather or live, and transporting them to clinics. **Importantly, the evaluation found there is no one-size-fits-all method**: each region did their outreach differently. There is an opportunity to collate the range of different approaches and facilitate regions learning from each other (almost as a form of backbone support).

10. Second, **successful DHBs and providers took a whānau-centric approach.** Whānau needs drove engagement; provider approaches were intentional and inclusive and took a long-term view. Māori staff were at the forefront of whānau engagement and their cultural and clinical knowledge created a welcoming and safe environment for whānau. These providers extended eligibility to all whānau rather than an individualised focus, prioritising Māori flu vaccination equity rates overall over cost recovery. Adaptive and agile leadership within Māori providers meant they were responsive and took a holistic approach, offering a range of health and support services as well as the flu immunisation.

11. Third, some **providers and DHBs focused on building Māori workforce capability and capacity**. Some providers had a limited pool of Māori nurses and staff who could vaccinate. Māori health providers have historically been underfunded, given the strategic importance of their work to support and increase health outcomes for Māori in their communities. Constrained funding means provider leadership often faces tough decisions: whether, for example, to hire more staff, deliver staff training, offer higher wages (often to match DHB or non-Māori, non-Pacific organisations), or reimburse petrol costs for home visits in rural areas. Providers often prioritise initiatives for whānau over activities that would improve their own longer-term organisational sustainability, such as workforce development.

12. The limited pools of suitable staff became more of a factor when delivering mobile outreach services. The programme helped augment the workforce of vaccinators who can work with Māori communities, and the free online vaccination training for flu and other selected immunisations was useful in some regions. In some instances, the DHB acted as a coordinator of activities and vaccines and this was also valued.

13. Continuing to build the capacity and capability of the Māori health workforce to provide vaccinations will need ongoing resourcing and support. Almost half of providers and DHBs signalled that to deliver similar programme activities in 2021, they will need to offer staff vaccination training and also training on vaccine storage and management.

Learning, to inform implementation in 2021

14. Providers and DHBs see a need for additional funding to operationalise delivery of the outreach and other initiatives funded through the MIVP in 2020. In particular, the funding would enable

them to recruit more staff to run the programme, extend the hours of service delivery, acquire vaccine and organise transportation to reach whānau.

15. If the Ministry decides to fund the MIVP in 2021, learning to inform implementation includes:

- **Offer the Programme earlier in the year**, so DHBs and providers have more time to plan
- **Get funding out earlier**
- **Continue the dual funding options** to get funding to the sector
- **Attach performance criteria to DHB contracts**, so funding is more rapidly distributed and providers do not miss opportunities to vaccinate whānau
- **Provide more targeted support to regions where vaccination rates have been static or slow to increase**
- **Revisit the funding allocation model** to incorporate a more nuanced understanding of the complexity of the regional Māori population, equity and equity trends, and demonstrated provider and DHB performance or lack thereof.

Key learnings for the Ministry

16. Following are the key learnings for the Ministry and some suggested action points.

What we found	Action points
• The programme timing in 2020 was sub optimal. Planning by some DHBs and providers was undertaken in November and December 2019. • Awareness of eligibility for programme funding was mixed. Communication to providers was primarily the responsibility of DHBs, on behalf of the Ministry.	• Providers and DHBs benefit from having as much notice as possible, assuming the Ministry elects to roll out the programme in 2021. • Allow more time for more planning, collaboration, sharing of ideas, staff training and engaging with leaders, networks and communities. Start the process as soon as possible. • Make sure communication is widespread to ensure all those who could support the initiative know of it and have time to apply.
• Direct funding of providers by the Ministry was timely. • Funding DHBs adds another layer of bureaucracy which can slow down the deployment of funds and services. • Some DHBs were slow to get funding out to providers, and vaccination opportunities were missed. • There is an underlying aspiration for Māori providers to receive direct funding.	• Retain dual funding as it offers two possible channels to get funding out quickly into the community. • Explore having service-level agreements with DHBs which commit them to agreed funding delivery timeframes for the programme. • Identify what further support the Ministry could offer to DHBs to achieve more timely contracting with providers.
• **No one funding model is more strongly associated with positive outcomes than another**. There is no one best way to fund for success. • There is no clear relationship between the contracting approach and flu vaccination rate increases; whether funding providers directly, funding through DHBs, or a combination of the two.	• Consider facilitating sharing of knowledge about what worked on the ground to offer valuable insights for DHBs and providers. Possible methods include: o developing top tips, practice examples, and case studies o facilitate connections between representatives of high-performing regions and those needing more

• The programme needs to respond to the variable levels of provider and DHB capability, and offer support as part of any future roll-out of the programme.	support, or between regions with similar contexts o facilitate sharing ideas and data, where possible, between regions o fund knowledge sharing and mentoring (formally or informally), to recognise the additional effort and time this can take • Fund providers and DHBs to build their capability to deliver programme outreach and other funded initiatives. In particular, they need additional trained staff to run the Programme, to extend hours of service delivery, and to acquire vaccine and transportation to reach whānau.
• The current funding approach takes account of Māori regional population and equity rates.	• Revisit the funding allocation formula to take a more nuanced approach, including taking account of vaccination and equity trends, provider and DHB performance in 2020 (and historically), and their capability to use the funding to best effect.
• There were some regions that made little movement in flu vaccinations and equity, regardless of the amount of funding allocated. This inability to lift outcomes suggests that extra funding is insufficient to make progress. They appear to be struggling and may need other forms of support.	• Focus on the regions where little movement in flu vaccinations and equity rates and trends. • Consider offering struggling regions more targeted and tailored support to unpack their regional context and seek to identify what might work, given the unique features of the region, its people, resources and relationships.
• There were regions that performed well, including those that built on strong foundations of previous years' efforts and some who made significant gains in 2020.	• Recognise the regions who have succeeded in lifting outcomes and continue to support their endeavours and learn from their successes. In regions that are performing well, beyond due diligence, consider offering sufficient funding and the autonomy to use it responsively. These DHBs and providers know what they are doing and have demonstrated they are competent and trustworthy.
• It is difficult to distinguish the attribution of programme-administered vaccinations from those delivered by non-Māori, non-Pacific organisations and thereby achieve a strong assessment of impact. • Providers and DHB staff at times find accessing the NIR challenging, particularly when they are out in the field.	• Consider developing an online form for providers and DHBs to enter the total number of immunisations completed on a weekly basis. • Consider how providers and DHBs may better access the NIR.

Key learnings for DHB's

17. These are the key learnings for DHBs and some suggested action points.

What we found	Action points
• DHB applications did not always list providers who were part of the application. This means the evaluators could not accurately gauge and report on programme reach, or elicit feedback from this group of providers.	• Revise the application form and reporting systems to be able to clearly attribute the programme outcomes and impact to the providers and DHBs involved.
• Some DHBs did not get MIVP funding out to providers until August or September 2020. This undermined the intended impact of the MIVP.	• Identify any system barriers to contracting out quickly. Find ways to get funding out to providers in a timelier fashion so that opportunities are not lost.
• Providers and DHBs need vaccination training and training on vaccine storage and management.	• DHBs can provide longer-term, ongoing support and training to build a Māori workforce to undertake vaccinations. • Investigate what other funding might be accessed for this training
• More timely and accurate data about outreach activities (delivered and planned), vaccine stock location and vaccinations delivered enabled DHBs to forecast vaccine demand and source vaccine as needed for planned activities. As a result, they could more efficiently manage their limited vaccine stock overall.	• There is a critical coordination role for the DHBs. Investigate how the learnings from some DHB regions might be shared with other regions.
• One DHB set up a central store of vaccines that providers could access with notice, for any outreach activities. This allowed providers to deliver vaccinations in community sites that had limited or no suitable storage, such as churches.	• Determine if this is possible in all regions.
• Some providers and DHBs spoke of the physical assets needed to deliver temporary clinics or mobile services and used the funding to buy needed resources. • Purchases included cold chain resources such as chilly bins and fridges or physical assets needed to run a pop-up clinic.	• DHBs can support providers in sourcing equipment for outreach activities and equipment to manage vaccines.
• There is no process for capturing information about whānau that decline vaccinations, particularly in outreach activities.	• Investigate how a record of vaccination declines might be developed for all regions.

• Without a consistent way to record an individual's decline to receive a vaccine, they may receive repeat targeted communications and this increases the risk of frustration and disengagement from health providers.	

Conclusion

18. The Māori Influenza Vaccination Programme responded to long-standing inequity as part of a COVID-19 Māori health response. It contributed to increased Māori flu vaccination rates and improved equity. More than just increased flu vaccinations, as valuable as these are, the programme provided the opportunity for providers and DHBS to innovate, design new service responses and to adapt existing services. It identified key strategies, principles and core service elements.

19. What made the difference was the programme reduced barriers and improved access. Most flu vaccinations are administered by GP services and Māori providers and DHBs responded to the well-known barriers for Māori of access to services, cost, poor service experience, cultural barriers, poor health literacy and the clash of Western and Māori worlds. The programme displayed the effectiveness of mobilising primary care services, in combination with a whānau-centred approach, alongside Māori workforce development, to reduce barriers and improve access to flu vaccinations for Māori.

20. The MIVP demonstrated the effectiveness of mobilising primary care services, in combination with a whānau-centred approach, to reduce barriers and improve access to flu vaccinations for Māori.

> *A mobilised, whānau-centred approach offers a new lever in the health delivery system alongside GPs and pharmacies. Over and above flu vaccinations it has the potential, to make a radical difference to Māori experiences of primary health care, Māori health outcomes and equity.*

21. Currently, most Māori are not receiving equity of health care, and the significant disparity in equity rates for flu vaccinations is important. Some regions are closing the gap using a mobilised, whānau-centred approach. **The critical learning from the Māori Influenza Vaccination Programme is that delivery of vaccinations is more than just a jab. The MIVP delivers the ingredients for system transformation.**

The Māori Influenza Vaccination Programme

Introduction

22. This document contains the findings of a Rapid Insight Cycle Evaluation of the Māori Influenza Vaccination Programme (MIVP). The Ministry of Health (the Ministry) developed MIVP in response to COVID-19. The government set aside up to $9.5m for district health boards (DHBs) and Māori health and disability providers. The MIVP is one of a number of initiatives that responds to Whakamaua: the Māori Health Plan 2020-2025[2]. The MIVP aimed to increase access to influenza (flu) vaccine for vulnerable[3] Māori groups who were eligible for free vaccinations. Eligible Māori included kaumātua aged over 65 years, hapū māmā and those with pre-existing conditions. Equity was the driving funding allocation principle, specifically improving Māori flu vaccination equity.

Context

23. "In Aotearoa New Zealand, people have differences in health that are not only avoidable but unfair and unjust. Equity recognises different people with different levels of advantage require different approaches and resources to get equitable health outcomes."[4] Therefore, doing 'more of the same' is rarely effective for social groups whose needs are not met. Instead, different social groups need targeted interventions, policies and programmes designed to meet their specific needs.[5] This is the premise of the MIVP.

24. Over-representation of Māori occurs for almost every type of illness, and every known determinant that leads to poor health. They experience inequitable rates of many chronic conditions and co-morbidities and, as a result, are at an increased risk of COVID-19 infection and mortality should a community outbreak occur. Also, past pandemics (the Spanish Flu, the H1N1 Virus) have disproportionately impacted Māori. The unequal distribution and exposure to the determinants of health further increase the risk for Māori.

25. For these reasons, the Government assigned around $50m for a COVID-19 Māori support package to protect and uplift Māori health during the pandemic. Up to $10m of this fund was set aside for MIVP to increase access to influenza (flu) vaccine for vulnerable Māori groups.

26. Equity, and specifically improving the Māori flu vaccination equity rates, was the driving funding allocation principle. As flu vaccinations rates were low across the country, all regions were eligible for funding. Division of possible funding was based on the Māori population in each region.

MIVP application process and funding

27. Funding was available to DHBs and Māori health and disability providers. There were two funding streams:

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[2] Whakamaua: the Māori Health Plan 2020-2025 guides implementation of He Korowai Oranga to ensure health and wellbeing outcomes improve and address persistent equity gaps for Māori. He Korowai Oranga: the Māori Health Strategy has the overall aim of ensuring Māori enjoy high standards of health and wellbeing.

[3] Influenza vaccine is free to kaumātua 65 years and over, hapū māmā, whānau with underlying medical conditions such as with diabetes, heart and lung conditions, cancer, are immuno-compromised or have other illnesses or chronic disease, children aged 4 years or under who have had a stay in hospital for measles, asthma or other breathing problems and health care workers

[4] Bloomfield, A, (2019). *Achieving equity.* https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity

[5] Health Quality and Safety Commission NZ, (2019). He tirohanga ki te ōritenga hauora o te Māori | A view on Māori health equity. Wellington: Health Quality and Safety Commission.

- providers could apply directly to the Ministry and contract with Ministry[6]
- providers could work in partnership with their DHB, be included in the DHB application and contract to their DHB.

28. The Ministry approved 31 of the 36 applications received, including two collaborative applications for services across two or more regions. Five applicants later decided to become sub-contractors to local DHBs. That left 26 organisations for the Ministry to contract with, comprising 18 providers and eight DHBs.

29. The Ministry awarded $6.972 million across19 DHB regions. Funding was earmarked for all regions based on the regional Māori populations. Only one region, South Canterbury, did not receive funding[7]. Of the remaining:

- 18 providers received direct funds of $2,061,618.00
- eight DHBs (including 40 providers) received $4,910,845.20.

30. Funding ranged from $17,849 for a single provider to $2.314m for a joint application from Auckland, Counties Manukau and Waitematā DHBs. Table 1 outlines the funding awarded to each DHB region.

Table 1. MIVP total funding allocation by DHB regions; and the split between DHB and Direct Funded providers[8]

DHBs	Funded applications	Total regional funding allocated	DHB allocation	Direct funded provider allocation
Northland	1	$ 965,000.00	$ 965,000.00	
Counties Manukau	2	$ 936,546.40	$ 771,386.40	$ 165,160.00
Waikato	6	$ 867,510.00		$ 867,510.00
Auckland	2	$ 795,241.40	$ 771,386.40	$ 23,855.00
Waitemata	1	$ 771,386.40	$ 771,386.40	
Hawke's Bay	1	$ 481,457.00	$ 481,457.00	
Bay of Plenty	3	$ 419,951.00	$ 383,000.00	$ 36,951.00
Capital and Coast	1	$ 352,904.00	$ 352,904.00	
Lakes	1	$ 216,825.00	$ 216,825.00	
Taranaki	1	$ 193,500.00		$ 193,500.00
Whanganui	1	$ 181,150.00		$ 181,150.00
Hutt Valley	1	$ 138,836.00		$ 138,836.00
West Coast	2	$ 121,625.00	$ 121,625.00	
Southern	1	$ 110,632.00		$ 110,632.00
MidCentral	1	$ 94,160.00		$ 94,160.00
Tairawhiti	1	$ 87,285.00		$ 87,285.00
Nelson Marlborough	1	$ 84,250.00		$ 84,250.00
Wairarapa	1	$ 78,329.00		$ 78,329.00
Canterbury	1	$ 75,875.00	$ 75,875.00	
South Canterbury	0	$ -		
TOTAL	29	$ 6,972,463.20	$ 4,910,845.20	$ 2,061,618.00

31. The MIVP funding allowed providers to set up clinically safe, culturally responsive and community and whānau-centred flu vaccination approaches, to achieve the greatest possible outreach to Māori. Services included: pop-up clinics and drive-through vaccination stations at community venues, mobile clinics, home visits and transport to clinics. A key feature of delivery was mobilising services and going out into the community.

[6] Some Ministry direct funded providers, were also contracted by DHB to deliver influenza vaccination services to Māori.

[7] There were two applications that included initiatives in South Canterbury, but neither were funded.

[8] There were two collaborative applications: i) Canterbury and West Coast DHBs, contracted through Canterbury DHB; and ii) Auckland, Counties Manukau and Waitematā DHBs, contracted through Counties Manukau. The figures shown apportion total contract value in equal amounts to all regions involved in a collaborative application.

32. The Ministry at first intended for services delivery to occur between May 2020 and June 2020, in line with the flu season. Delays in completing contracts pushed the timing out and the formal programme timeframe for delivery of MIVP services was June to September 2020, inclusive. In practice, however, most providers (12/17) reported starting delivery of their MIVP services before MIVP contracts were sent out by the Ministry. Some started as early as February and March; about half started between April and June. All providers (17/17) reported starting before receiving funding. They reported the reasons for this were they saw the importance and urgency to vaccinate whānau and wanted to take advantage of vaccination opportunities as part of COVID-19 testing and whānau support activities.

The evaluation

33. This evaluation aimed to understand the impact of the MIVP on Māori flu vaccination rates and on equity rates for vulnerable Māori groups, particularly those aged 65 years and over.

34. The key evaluation questions were:

- Did MIVP impact on the equity of Māori flu vaccination rates?
- What aspects of the MIVP implementation made a difference for Māori?
- What are insights that providers and DHBs can use to improve the MIVP or similar programmes and services targeting Māori?
- What are the considerations for the Ministry to improve the MIVP or similar programmes and services and to increase equity for Māori?

35. The evaluation design used a combination of four rapid insight cycles, an evaluation-specific methodology and a mixed-methods research approach. Each cycle was around six weeks duration, with a collaborative sense-making workshop with the Ministry at the end of each cycle. The evaluation used data from the National Immunisation Register databases and the 2013-Based Population Projections (NIR Population). Thirty-one semi-structured interviews were conducted with Ministry, DHB and Māori providers. Two online surveys were conducted: one with DHB managers, immunisation coordinators and staff (n=18) and one with Māori providers (n=34).

Limitations of this evaluation

36. The evaluation collected and analysed a mix of qualitative, quantitative and administrative data for all 21 DHB regions. The evaluation did not collect whānau feedback on their experience of taking part in the programme. The evaluation was not able to collect the same data in all regions, so there are some information gaps (see Table 12 in Appendix 1 for description of data collected). This is particularly the case in Canterbury and the Auckland regional cluster. Further, the evaluation design intentionally focused on trying to understand success and its enablers, and less resource was available to analyse regions with poor performance in 2020 and historically.

37. The evaluation used the NIR to track changes in Māori flu vaccination rates. The evaluation does not report on the number of vaccinations administered by providers, as NIR does not capture data in this way. Further, while some MIVP providers reported the number of vaccinations administered as part of MIVP to the Ministry, the data is not utilised in this evaluation due to issues of completeness and our overall confidence in the data.

38. The evaluation only has NIR data for people aged over 65 as other vulnerable groups are not captured within NIR. However, data from some providers indicates they worked with other eligible cohorts.

The impact of MIVP on Māori flu vaccination[9] and equity rates

A snapshot

Flu vaccination rates increased significantly for Māori aged over 65 in 2020 compared with previous years. The 13.2 percentage point change is notable, particularly given the small improvements observed between 2015 and 2019. Some of the change will be due COVID-19, but MIVP also contributed to the increase.

Flu vaccination rates increased earlier and faster in 2020 than in 2019, and the increase in the earlier weeks occurred more for Māori than non-Māori, non-Pacific. The gap between Māori and non-Māori, non-Pacific people by the end of 2020 is less than the gap at the end of 2019. This suggests that the **MIVP activities contributed to increased vaccinations among Māori aged over 65 in 2020.**

Comparing 2020 with 2019, substantial gains were made in vaccinating Māori aged over 65 in Hawke's Bay, Lakes, Whanganui DHB regions, and Northland in particular. The absence of similar increases in the non-Māori, non-Pacific vaccination rates in these regions suggest that **specific targeting of Māori in these regions in 2020 was effective.**

There were variable changes in vaccination rates and equity across DHB regions.

- Whanganui and Hawke's Bay regions had the highest rates of flu vaccination in 2020, with 86.05% and 78.11% respectively. These regions were coming off a high base in 2019 with vaccination rates of 67.02% and 55.61%.
- Northland showed great progress in 2020. Ranked the fifth lowest (16/21) performing region in 2019, Northland was the fourth highest (4/21) in 2020 with increased flu vaccination rates of 17.53 percentage points. Gains in Northland made a positive overall impact on national flu equity rates, as Northland has the second-largest population of Māori over 65 years.
- Waikato performed creditably in 2020 with Māori flu vaccinations up 13 percentage points on 2019; and compared favourably to an increase of 10.49 percentage points for non-Māori, non-Pacific over the same period. Waikato has the largest population of Māori over 65 years in a single DHB region, and so gains in Waikato also have a positive impact on national flu equity rates.
- The greater Auckland DHB regions (Auckland, Counties Manukau and Waitematā) continue to be amongst the five lowest performing regions for Māori in 2020, as also in 2019. Of the three, Counties Manukau achieved the highest flu vaccination rate of 52.95% for Māori aged over 65. Waitematā saw the biggest increase compared to 2019 (48.54% vs 35.9%). Auckland was well behind with vaccination rates in 2020 of 40.18% for Māori aged over 65. All three regions continue a trend of comparatively poor performance since 2015. This is of concern given that the largest number of Māori over 65 live in these three regions.

In 2020, **flu vaccination rates improved overall for Māori aged over 65** as well as for non-Māori and non-Pacific aged over 65. Programmes such as the MIVP helped lessen the disparity between Māori and non-Māori and non-Pacific aged over 65 by 3.7 percentage points, from -12.1% to -8.4%. While this is a 30.6% improvement on the previous year, **there remains a sizeable disparity of -8.4% between the flu vaccination equity rates of Māori and non-Māori and non-Pacific aged over 65 which needs addressing**. This is particularly important in regions such as Auckland, which has a high population of Māori aged over 65.

The impact of the Māori Influenza Vaccination Programme on Māori flu vaccination rates

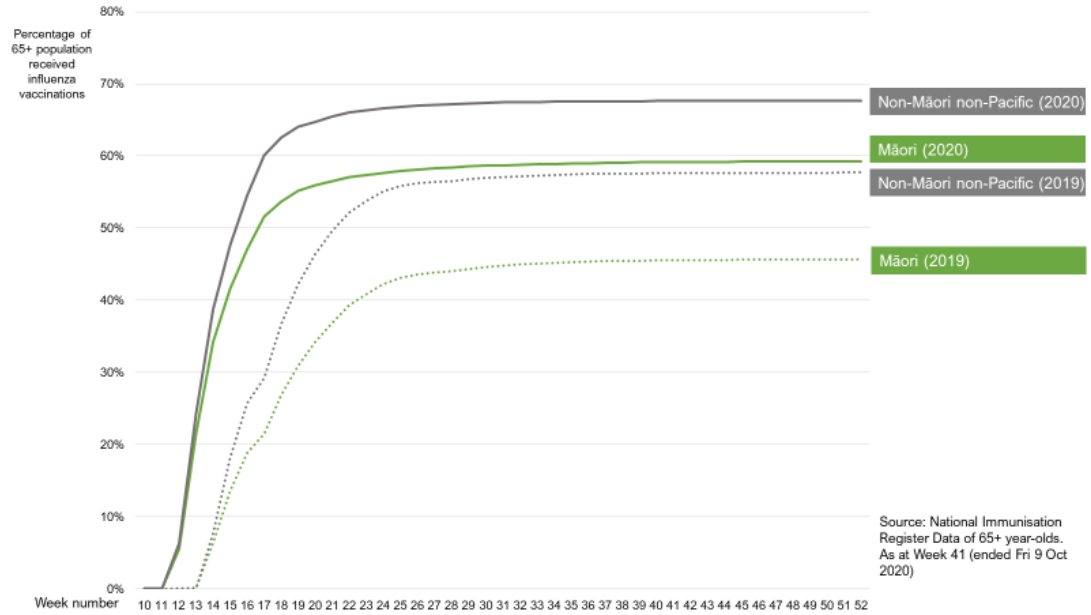
40. This section explores the impact of the programme on Māori flu vaccination rates and the extent to which it contributed to improved equity for Māori. It sets out the evidence that demonstrates the programme's contribution to the increased Māori flu vaccination rates, discusses the overall impact on equity, and looks at the pattern of changes in DHB regions for the 2019–2020 period.

Vaccination rates up for Māori 65+ in 2020 compared with earlier years

41. In 2020, the National Immunisation Register (NIR) recorded significantly higher vaccination rates for Māori than in previous years. While some of this increase will be due to COVID-19, the evaluation found evidence that the MIVP also contributed.

42. Figure 1 draws on data from the National Immunisations Register (NIR). It shows the national 2020 vaccination rates for Māori aged over 65 contrasted with non-Māori compared with 2019.

Figure 1. National flu vaccination rates for Māori and non-Māori over 65 years for 2020 and 2019



43. There was a significant increase in flu vaccinations for both Māori and non-Māori, non-Pacific people in 2020. Of note:

- Flu vaccination rates increased earlier and faster in 2020 than in 2019: while some of this will be because of COVID-19, the evaluation data suggests that some providers were carrying out vaccinations as part of their programme activities before their June or July contract start dates
- The increase in the earlier weeks occurred more for Māori than non-Māori, non-Pacific people, and further suggests that some providers undertook activities specifically for Māori before their June or July contract start
- The gap between Māori and non-Māori, non-Pacific people by the end of 2020 is less than the gap at the end of 2019 which suggests that new or extra activities in 2020 likely had a positive impact in helping address the equity gap.

44. Despite a strong increase in flu vaccination rates for Māori over 65 years in 2020, the increases in flu vaccinations for non-Māori, non-Pacific mean the equity gap remains largely unchanged. The

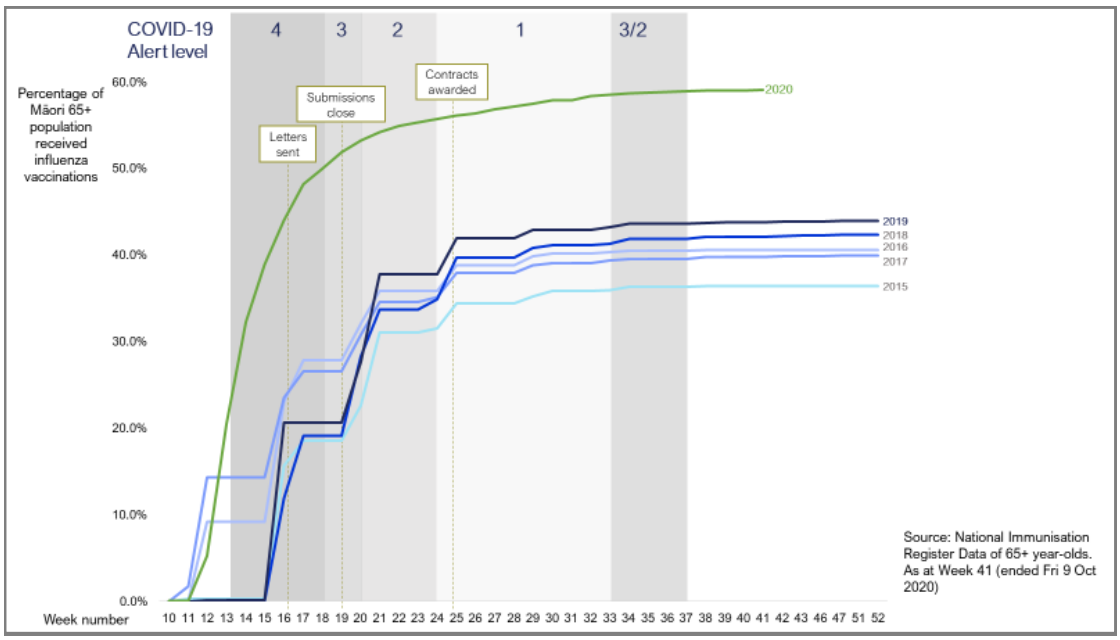
[9] Vaccination rates pertain to Māori aged 65 years and over, unless otherwise stated.

equity gap reduced by 3.7 percentage points in 2020 from -12.1% to -8.4% (comparing NIR data as of Week 37), as seen in Figure 1.

MIVP positively impacted on flu vaccination rates for Māori over 65 years

45. Overall, the MIVP contributed to increased Māori flu vaccination rates for Māori over 65 years, compared with previous years. The change in the 2020 flu vaccination rates for Māori aged over 65 is significant (up from 45.8% in 2019 to 59.0% in 2020 as of Week 37), particularly given the small improvement observed between 2015 and 2019.

Figure 2. Flu vaccination rates for Māori 65+ in 2020 compared with 2019



46. Figure 2 shows the timing of the increase and the stages of the MIVP roll-out. While some of this increase will be due to COVID-19, the evidence suggests that the MIVP also contributed to this increase, as outlined below.

47. The MIVP contracts from the Ministry started between mid-June to mid-July, and they ran till 30 September 2020. MIVP contracts between DHBs and providers started after this date. However, many providers (direct-funded and DHB-funded) began their MIVP activities well before confirming their contract or receiving funding. For some, they were concerned about the heightened risk to whānau associated the COVID-19 pandemic.

> *We felt pretty confident and started before the contract was signed. We couldn't wait with COVID-19 and everything. We had to work with whānau as soon as possible. So we started. Our board was good, and they supported it until funding came in. (Provider – direct-funded)*

> *So we were already actually doing things different within our rohe already based on our response to COVID-19… We already kind of seen an impact about how [to do it] that was actually working quite well. So it was to be able to continue to deliver that, in a manner that we'd already seen had been successful. There was a lapse between the work and getting the contract but I'm fortunate enough to have people who deal with contracts and money and that, so I could carry on. (Provider – direct-funded)*

48. There are two forms of evidence that providers acted in good faith, starting work ahead of their MIVP contracts and assuming the funding would follow. Firstly, most providers (68%) said they

had either already started work or intended to start within a week of putting in their application when making their applications. Secondly, in the survey, a similar proportion of providers reported they began outreach activities early. Many (12/17) said they started giving flu vaccinations before the Ministry or DHB confirmed their contract started; a few, (7/17) started between February and April, and others between June and July (5/17). A limited number (5/17) said they did not start until August 2020.

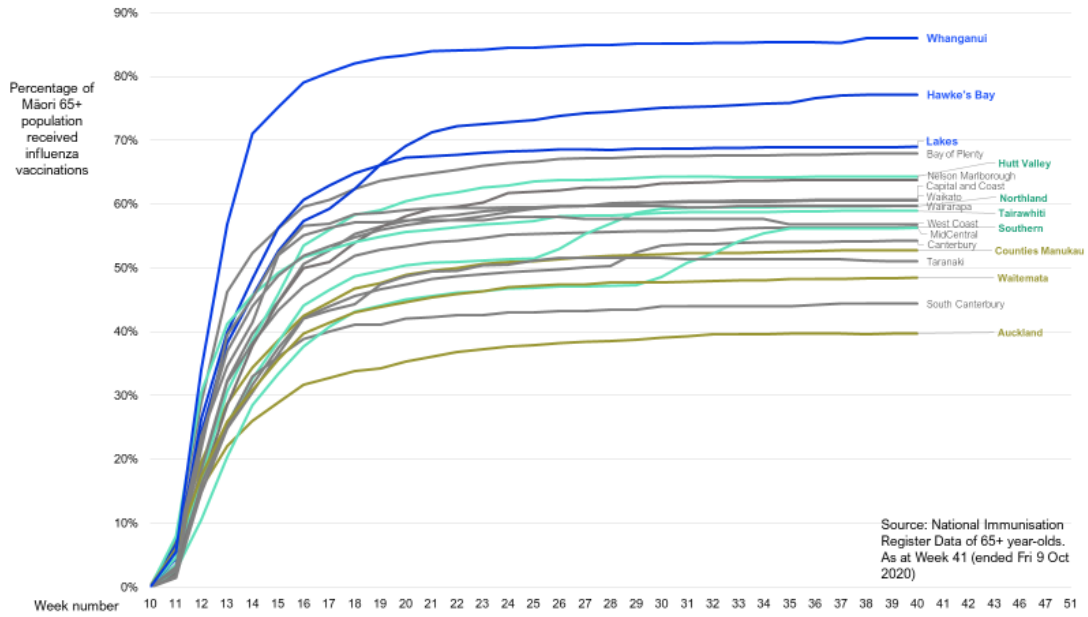
49. The MIVP extended the time period beyond the typical cut-off date for flu vaccine campaigns, so providers continued to vaccinate Māori to 30 September 2020. While weekly new vaccination numbers were relatively low, providers continued to vaccinate. Therefore, flu vaccination rates did not flat-line or tail off to the same extent compared to previous years.

> *From Weeks 17, 18, 19, we may see some lifts in there that we could attribute to MIVP. (Ministry Data Analyst)*

2020 flu vaccination rates for Māori aged over 65 vary across regions

50. In assessing the impact of MIVP on equity, we looked at the different regional patterns of change in the flu vaccination rates. Figure 3 uses the NIR data to show the proportion of Māori vaccinated in each DHB region and compare regions overall, regardless of whether vaccinations were delivered by DHBs or providers.

Figure 3. Flu vaccination trends for Māori 65+ across the different DHB's for 2020



51. Whanganui, Hawke's Bay, Lakes and Bay of Plenty DHB regions achieved the highest vaccination rates for Māori over 65 years in 2020. There is a significant gap in flu vaccination rates between these regions and the lowest performing regions: Auckland, South Canterbury, Waitematā, Taranaki and Counties Manukau. (See Table 2, page 17) and for a more detailed discussion).

52. There was a noticeable shift in flu vaccination rates in and around the MIVP contract period (weeks 25 to 40) in Nelson Marlborough, Northland, Southern DHB regions and to a lesser extent Canterbury DHB.

53. For a year-on-year view of region-specific changes in flu vaccinations, the starting point for each region needs to be considered. Table 2 shows the difference and overall change in vaccination rates, by DHB region, for Māori aged 65 years and over, between 2019 and 2020, compared to non-Māori, non-Pacific people.

Table 2. Differences in flu vaccination rates between 2020 and 2019 for both Māori and non-Māori, non-Pacific aged 65+ (as at Week 46). Results presented by highest-to-lowest difference for Māori.

DHB	Maori (2019)	Maori (2020)	Difference (Maori)	non-Maori non-Pacific (2019)	non-Maori non-Pacific (2020)	Difference (non-Māori non-Pacific)
Hawke's Bay	55.61	78.11	22.50	59.85	72.95	13.10
Lakes	49.26	68.99	19.73	53.47	63.64	10.17
Whanganui	67.02	86.05	19.03	66.99	77.67	10.68
Northland	42.17	59.70	17.53	51.63	64.48	12.85
Tairawhiti	44.56	59.00	14.44	56.67	69.25	12.58
Capital and Coast	46.41	60.64	14.23	58.04	66.77	8.73
Nelson Marlborough	49.55	63.68	14.13	61.28	73.02	11.74
MidCentral	42.64	56.39	13.75	59.97	70.11	10.14
Bay of Plenty	54.45	68.01	13.56	65.13	75.10	9.97
Hutt Valley	51.12	64.41	13.29	54.74	66.38	11.64
Waikato	47.78	60.78	13.00	59.38	69.87	10.49
Waitematā	35.90	48.53	12.63	51.32	60.79	9.47
West Coast	44.69	56.57	11.88	59.51	75.08	15.57
Southern	44.48	56.34	11.86	53.66	62.80	9.14
Taranaki	39.63	50.80	11.17	58.23	67.91	9.68
Counties Manukau	42.44	52.95	10.51	52.31	62.39	10.08
Canterbury	44.17	54.35	10.18	65.19	75.28	10.09
Auckland	32.78	40.18	7.40	53.00	62.33	9.33
Wairarapa	53.28	60.00	6.72	68.15	76.67	8.52
South Canterbury	40.00	44.42	4.42	60.72	57.88	-2.84

54. In 2020 compared with 2019, the flu vaccination rates improved considerably for Māori in all regions and for non-Maori, non-Pacific people in all regions except South Canterbury.

55. Table 2 shows the substantial gains made in Hawke's Bay, Lakes, Whanganui, and Northland in particular. The bigger increases for Māori suggest that specific targeting for Māori flu vaccinations in 2020 was effective due to the absence of similar increases in the non-Māori, non-Pacific vaccination rates.

56. Whanganui and Hawke's Bay regions had the highest rates of Māori flu vaccination uptake in 2020, with 86.05% and 78.11% of the Māori over 65 population respectively (as at Week 46). These regions were coming off a high base in 2019, with Māori flu vaccination rates, with 67.02% and 55.61% respectively (as at Week 46).

57. Northland showed great progress in 2020 coming from being the fifth lowest performing in 2019, with increased flu vaccination rates for Māori over 65 years in 2020 by 17.53 percentage points. Over the same period, flu vaccination rates for non-Maori, non-Pacific increased by 12.85 percentage points (as shown in

58. Table 2), indicating a successful dedicated effort to target Māori. Gains in Northland have a positive overall impact on national equity, as Northland has the second-largest population of Māori over 65 years (see

59. Table 10, page 58).

60. Waikato has the largest population of Māori over 65 years in a single DHB region (see Table 10 page 58), also achieved strong gains for Māori, up 13 percentage points from 2019 compared to 10.49 percentage points for non-Maori, non-Pacific over the same period. Gains in Waikato have a positive overall impact on national equity, given the Waikato region has the largest population of Māori over 65 years.

61. The greater Auckland regions continue to be amongst the five lowest performing regions in 2020, as in 2019. Of the three, Counties Manukau achieved highest flu vaccination rate for Māori over 65 years (52.95% as at Week 46). Waitematā saw the biggest increase compared to 2019: 48.54% vs 35.9% (as at Week 46). Comparatively Auckland achieved lower flu vaccination rates of 40.18%, well behind both other neighbouring regions.

62. South Canterbury's vaccination rates are low for both groups, and they were the only region where health providers did not apply for the MIVP funding.

Despite improvements in flu vaccination rates, significant disparity exists in equity rates

63. There were significant improvements in flu vaccination rates for Māori aged over 65 in many regions. However, the overall equity gap between Māori and non-Maori, non-Pacific flu vaccination rates did not close.

64. Table 3 shows the change in equity by DHB region over 2020, between Māori and non-Maori, non-Pacific flu vaccination rates. In particular, it compares the equity gap at the beginning of MIVP (Week 13) and the end of most MIVP-funded activities (Week 46), to illustrate the DHB regions that have achieved overall equity change in 2020.

Table 3. Biggest changes in equity between Māori and non-Maori, non-Pacific from week 13 to week 45 in 2020[10]

DHB	Week 13 (Māori)	Week 13 (non-Māori non-Pacific)	Difference (equity gap)	Week 46 (Māori)	Week 46 (non-Māori non-Pacific)	Difference (equity gap)	Overall change (Week 13 to 46)
Hawkes Bay	28.82	29.41	-0.59	78.11	72.95	5.16	5.75
Lakes	26.90	26.17	0.73	68.99	63.64	5.35	4.62
Whanganui	34.26	26.31	7.95	86.05	77.67	8.38	0.43
Hutt Valley	17.48	17.82	-0.34	64.41	66.38	-1.97	-1.63
Northland	18.92	20.99	-2.07	59.70	64.48	-4.78	-2.71
Tairawhiti	31.45	38.84	-7.39	59.00	69.25	-10.25	-2.86
Waikato	24.03	30.13	-6.10	60.78	69.87	-9.09	-2.99
Southern	12.10	14.51	-2.41	56.34	62.80	-6.46	-4.05
Nelson Marlborough	16.75	21.42	-4.67	63.68	73.02	-9.34	-4.67
Capital and Coast	19.26	20.48	-1.22	60.64	66.77	-6.13	-4.91
MidCentral	18.30	26.69	-8.39	56.39	70.11	-13.72	-5.33
Counties Manukau	19.83	23.82	-3.99	52.95	62.39	-9.44	-5.45
South Canterbury	16.05	23.24	-7.19	44.42	57.88	-13.46	-6.27
Bay of Plenty	29.92	30.50	-0.58	68.01	75.10	-7.09	-6.51
Waitematā	18.01	23.46	-5.45	48.53	60.79	-12.26	-6.81
Wairarapa	22.46	30.54	-8.08	60.00	76.67	-16.67	-8.59
Taranaki	14.66	22.19	-7.53	50.80	67.91	-17.11	-9.58
Auckland	16.18	26.92	-10.74	40.18	62.33	-22.15	-11.41
West Coast	22.86	29.30	-6.44	56.57	75.08	-18.51	-12.07
Canterbury	16.80	23.88	-7.08	54.35	75.28	-20.93	-13.85

65. The most significant changes in equity rates that occurred in 2020 were in Hawke's Bay, Lakes and Whanganui. Whanganui continued to build from a strong base, having the highest flu vaccination rates in the country for both Māori and non-Maori, non-Pacific people.

66. Canterbury saw a significant increase when compared with other regions (see Figure 3, page 18). Canterbury's share of combined MIVP funding with West Coast DHB was $76,000. They significantly increased the total number and proportion of vaccinated Māori. However, vaccination

[10] Understanding equity rates: A positive result means the coverage is higher for Māori, a negative result means the coverage is higher for non-Māori, non-Pacific.

efforts in Canterbury also improved uptake by non-Maori, non-Pacific over 2020. Therefore, despite increases in vaccination rates of Māori aged over 65, the overall equity gap worsened for Māori.

67. Overall, Auckland, Counties Manukau and Waitematā regions have historically performed poorly compared to other regions. In the main, Auckland and Waitematā have been in the lowest five regions of flu vaccination rates for Māori aged over 65 years, since 2015. Individually these regions have high numbers of Māori in this age group (see Table 10, page 58) and collectively the greater Auckland region equates to the largest cluster of Māori nationally. For the flu equity gap or rates to reduce nationally, it is imperative that vaccination rates improve in these regions.

68. The collaborative application between Auckland, Counties Manukau and Waitematā received a total of $2.48m, more than a third of the $6.94m MIVP funding allocation. Looking at the funding amounts allocated to the three Auckland DHBs and comparing them to regions having a similar Māori population or funding, the Auckland DHBs did not achieve results commensurate with the comparison regions. While there were some known factors that impacted on implementation, e.g. two COVID-19 alert level 4 lockdowns, delays in getting funding out to providers and a lack of Māori provider capacity, these factors are likely to provide only part of the explanation, given the historical under-performance. Research is required to better understand the context, barriers and impediments to increasing flu vaccinations within and across Auckland, Waitematā and to a lesser extent Counties Manukau DHBs.

Aspects of the MIVP implementation that made a difference for Māori?

A snapshot

General Practitioners (GPs) have administered more than 80% of all influenza vaccinations in New Zealand for close to a decade and during this time there has been minimal overall change in flu vaccination rates for Māori aged over 65. **The barriers to Māori accessing GP services and primary health care are well documented** and include cost, access to services, poor service experience, cultural barriers, poor health literacy and a clash between western models of health and Māori models of hauora (wellbeing).

MIVP reduced barriers to access. A range of tactics were employed by providers and DHBs to identify unvaccinated Māori and to communicate, engage with, and vaccinate vulnerable Māori groups, particularly Māori aged 65 years and over.

Three strategies were evident:

- **mobilising services to go into the community**
- **taking a whānau-centred approach**
- **focusing on workforce capability.**

A key feature of delivery was mobilising services by providers and going out into the community. They increased the accessibility of services by:

- **going to where whānau gather** and locating temporary clinics in places where whānau go to work, pray, socialise, shop, and learn. This included marae, supermarket carparks, sports grounds, schools, churches, and workplaces.
- **going to where whānau live** such as individual whānau homes or aged care residences as well as hotels, homeless shelters, and gang locations.
- **bringing whānau to services**, offering and providing individual or group transport to temporary sites or clinics.

They also offered extended or flexible service hours combined with whānau-centred and holistic services.

Most providers used MIVP funding to deliver new activities as well as expanding existing approaches. Aware that MIVP funding might be a one-off, some providers and DHBs focused on ensuring the sustainability of any new or adapted approaches or using the funding to address pre-existing sustainability issues, such as workforce capability. The MIVP also encouraged different groups within DHBs to work together better and to work with providers. This resulted in improved coordination of services in some regions

Strategies used

69. This section discusses the three main strategies employed by providers and DHBs in implementing MIVP: mobilising of services, taking a whānau-centred approach and focusing on workforce capability. It notes the prevalence of General Practitioners (GPs) as the main providers of funded flu vaccinations and the impact of this approach on access for Māori. It then discusses each of the strategies in turn and how they increased accessibility by reducing barriers for whānau.

GPs administer most funded flu vaccinations

70. From 2012 to 2020, GP practices carried out most funded flu vaccinations. This pattern is changing. Since 2017, pharmacies have the authority to administer funded flu vaccinations – and pharmacy-administered vaccinations doubled from three to six percent from 2018 to 2019. Of

providers eligible to claim for administering a funded flu vaccine in 2020, GP practices were the main channel accounting for 82% of funded flu vaccinations,[11] [12] while pharmacies gave the remaining 18%.

Māori experience many barriers to accessing health services through GP's

71. There are significant barriers to Māori accessing GPs and primary healthcare services.[13] We list these well-known and well-documented barriers below. They include:

- **Cost** such as consultation costs and prescriptions charges, and the loss of income due to having to take time off work to seek care
- **Access to services** such as the service locations and the distance to travel for care, suitable appointment times, long waiting times, lack of transport including public transport and childcare availability and cost
- **Poor service experience** such as whānau feeling unwelcome or disrespected (typically by reception staff), whakamā (embarrassed) because of poor compliance with prescribed treatment, a feeling of being rushed or pressured to keep the appointment brief
- **Cultural barriers** such as shyness, reticence to challenge authority, a 'wait and see' attitude towards sickness or injury that is often related to cost and prior bad experience; and a preference for Māori clinicians or Māori providers.
- **Poor health literacy** such as whānau feeling whakamā – not understanding the questions asked or understanding the information shared with them.
- **A clash between western and Māori models** such as Māori models of wellbeing and the medical, disease-oriented model. This can result in whānau and non-Māori clinicians talking past each other and having differing perspectives on patient needs and the 'right' course of action.

MIVP reduced barriers to access

72. Māori providers are active in their communities and have strong relationships with the communities they serve. They have in-depth knowledge of the community context and the strengths and challenges faced within their communities. They are highly aware of the disparities that whānau experience across all services, including health, education and employment. In the health context, Māori providers know, based on experience and research evidence, that whānau are less likely to go to a GP clinic or access primary health care.

73. Through MIVP, Māori providers addressed the barriers to access through mobilising and taking their services out into the community, combined with whānau-centred holistic services. They offered extended or flexible service hours and visited whānau in their homes. And where possible,

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[11] Claims made under the Primary Health Organisations Service Agreement and Integrated Community Pharmacy Services Agreement 1 March to 30 September 2020, provided by the Ministry of Health

[12] 'GP' claims refers to any claims made under the Primary Health Organisations service agreement. This may include Māori and Pacific health providers as well. When claims for people aged 65 and over are compared with NIR data for the same group, claims for Māori are always lower than the NIR, whereas for other population groups they are much higher.

There are two possible explanations. One, is that significantly more Māori aged 65 years and over are immunised against influenza through DHB led programmes that don't claim the administration fee. While this is possible, it does not seem plausible, over the long term, given the auditing and quality assurance processes of PHOs and DHBs. The other explanation is that some providers that are entitled to claim for the vaccination administration fee, are not doing so. The sense is that they are likely to be Māori providers as they happen to be the ones vaccinating the most Māori.

[13] Jatrana S. & Crampton P. (2009); Mauri Ora. (2009); Lambert M, Luke J, Downey B., Crengle S, Kelaher M, Reid S. & Smylie, J. (2014); Jansen, P., Bacal, K. & Buetow, S. (2011); Jeffreys, M., Irurzun-Lopez, M, Russell L., Smiler K, Ellison-Loschmann L, Thomson M. & Cumming J. (2020); Russell L, Smiler K, Stace H. (2013); Health Quality and Safety Commission NZ. (2019).

they provided these services free to the recipient. Māori providers had the advantage of having good numbers of Māori on their teams, who engaged well with whānau.

> *Because there was also times that the nurse, who went into a whānau and saw they needed kai. Then she was able to come back to us and then we are able to wrap around [extra services]. So it can start a whole lot for Māori, just having somebody going into the home. So yeah, so although the focus was on immunisation, she is experienced enough to know that if there's something more that this whānau needs [to do it]. As well as encouraging them, because she knows how hard it is. (Provider – direct-funded)*

> *Yeah it was just really that movement working inside our communities and working with the strength of the communities, in places that they were very familiar with. Particularly the marae. So, it was a place that was familiar to whānau, not necessarily all of our clinicians were familiar with it but our whānau were. Which you know in hand is a good, it was a good shift, it was a great place. (Provider – direct-funded).*

Strategy 1: Mobilising services to go into the community

74. The MIVP activities addressed barriers to access by taking services out to Māori communities and homes and making it easier for whānau to come to services. Some providers and DHBs took a systematic approach to identify eligible whānau. They used information about local populations to plan strategically, target communications, develop communications activities to build awareness, and select locations for temporary or mobile clinics. Some providers also used this information to begin conversations and relationships with local community representatives.

75. Key to delivering mobilised services is both infrastructure (the physical resources to deliver services) and people (the number of trained and qualified staff).

76. Some providers shared that lack of physical assets hampered their ability to mobilise. For example, some providers have previously struggled with inadequate vehicles for rural areas and a lack of cold chain storage facilities and, subsequently, cold chain accreditation. Providers and DHBs variously used funding to purchase cold chain storage assets, such as chilly bins and refrigerators, as well as equipment for temporary drive-through clinics, such as gazebos, tents and tables.

77. Providers and DHBs shared that the ability to deliver mobile and outreach services depends on their overall workforce and capacity. In some regions, they had identified they needed nurses who could give vaccinations, particularly Māori nurses, and also sufficient staff to enable safe home delivery by having two staff make each visit. Funding was used to increase vaccinator capacity and capability. Providers reported that mobile services also increases the administrative workload, and some providers also said, on reflection, they needed ongoing administrative support to manage the paperwork and data entry.

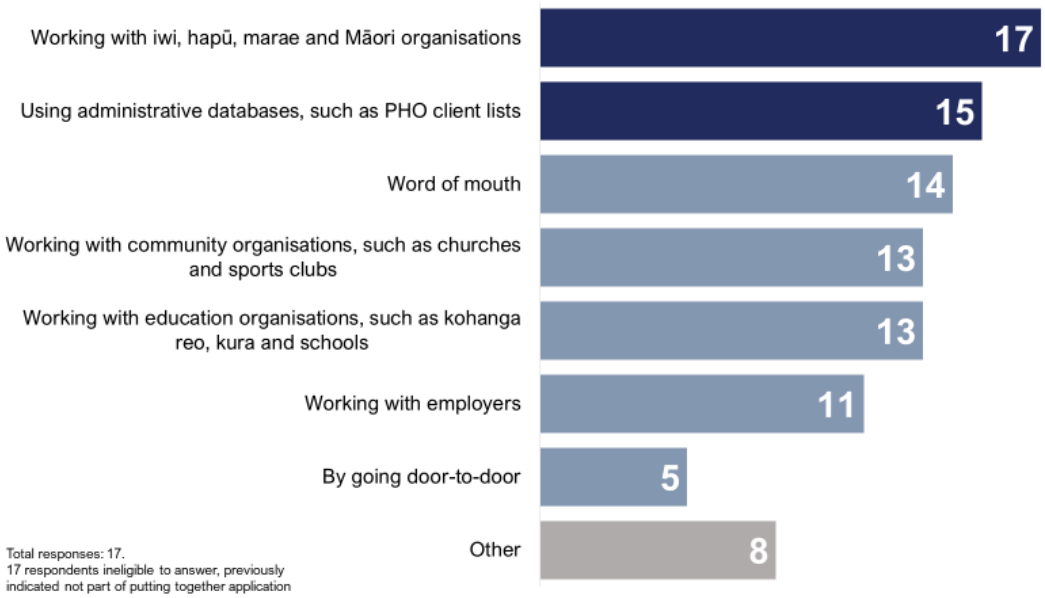
78. In some regions where there are relatively high immunisation rates for Māori, providers spoke of wanting to reach the "last 20% that takes 80% of effort". In these regions providers used a combination of data-driven and innovative approaches to find Māori in the community. In communities with lower Māori populations, this was sometimes difficult to achieve.

79. Some providers and DHBs shared that MIVP enabled some new ways of working and they now use these approaches and relationships for other campaigns and activities. Some providers spoke of communities inviting them back as a sign of positive impact.

Multiple methods used to identify whānau

80. Providers typically used four or five different methods to find whānau, as shown in Figure 4. The key to identifying whānau was networking and reaching out to a wide range of organisations. Providers identified many settings: places where whānau go to work, pray, socialise, and learn. They contacted leaders in these organisations seeking their support to promote flu vaccinations to their members. COVID-19 heightened leaders' motivation to support the wellbeing of their members. Sometimes providers used existing relationships; at other times they started new relationships.

Figure 4. Providers use a range of approaches to find whānau



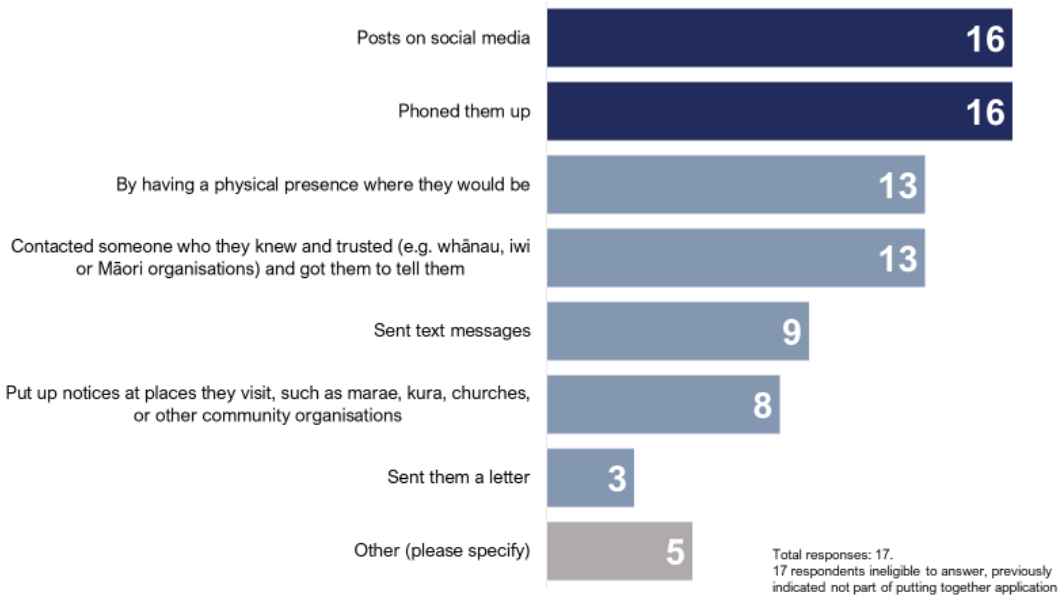
81. Some providers spoke of using data to help identify where whānau are and gather. They used administrative databases such as provider and Primary Health Organisation (PHO) client lists to identify specific individuals. This information was also useful for targeted communications. They used administrative databases and NIR tracking to highlight underserved areas and communities. This information was useful for selecting locations for outreach activities.

82. Providers highlighted going to community locations where whānau gather, collaborations with iwi and Māori organisations, and using databases as the most effective strategies for finding Māori who had not received flu vaccinations.

Multiple communication channels used to engage whānau

83. Providers and DHBs used several methods to take the message about flu vaccinations to whānau. Public-facing communications were a mixture of targeting specific individuals and more general approaches. They included a variety of communication approaches and technology, as illustrated in Figure 5.

Figure 5. Communication approaches that are effective ways to reach Māori



84. Targeted communications often used data, such as patient lists sourced from GPs, PHOs, clinics or providers. These targeted communications included phone calls and mail-outs. In one region, providers used "vouchers" that confirmed someone's eligibility for a free vaccination and listed local clinics. Providers used this approach to ensure all Māori seeking vaccination at a local clinic received a shot. This approach ensured others in the health system did not interpret the eligibility criteria differently and turn them away. They aimed to ensure that whānau were not embarrassed or hesitant to present for vaccination.

85. Mass communications relied on social media, mail drops and word of mouth to spread messages through the community. In some regions, the messaging focused mainly on the vaccine being free. In other regions, the messaging talked about the benefits to whānau and iwi from receiving the vaccine. For example, Northland expanded a region-specific health communications campaign to highlight that vaccines 'protect our whakapapa'.

> *So, it's using a lot of Māori whakataukī, which is whakapapa Te Ora – which [messaging] is, 'Immunisation is one way to protect your whakapapa'. So, changing it from, 'If you don't get this you'll get sick', but 'Come in and get this; this is really good for your whakapapa and protection; not just for the individual, but for everyone.' (DHB Immunisation Coordinator)*

86. Providers highlighted that collaborating with iwi and community organisations worked well. Leveraging these relationships effectively got the message to Māori and helped to identify those not vaccinated.

> *A part of our strength and network is that we have a network of Māori iwi providers… in terms of getting our whānau to location. So that was pretty, you know, fundamental. And then of course it was just making community locations a thing, so working with kōhanga reo, kura kaupapa, wānanga, marae, supermarkets – so just diversifying the locations in which the vaccinations would normally be delivered. (Provider – direct-funded)*

87. In summary, going to community locations where whānau gather, collaborations with iwi, Māori, and community organisations and the use of databases were highlighted by providers as the most effective ways for finding Māori to be vaccinated. Providers used multiple targeting and communication methods, leveraging new and pre-existing relationships and data to find unvaccinated whānau, or find connectors to whānau.

So we subcontracted out to the pharmacist, who was doing opportunistic vaccinations – people just walking in the door. And we had an outreach going out into the homes, educating, vaccinating, yeah. So we took that opportunity that she was going out, as well as all the other areas, you know, like visiting, you know, marae and agency, you know other places where Māori are – other practices, you know, that were not in our PHO. (Provider – direct-funded).

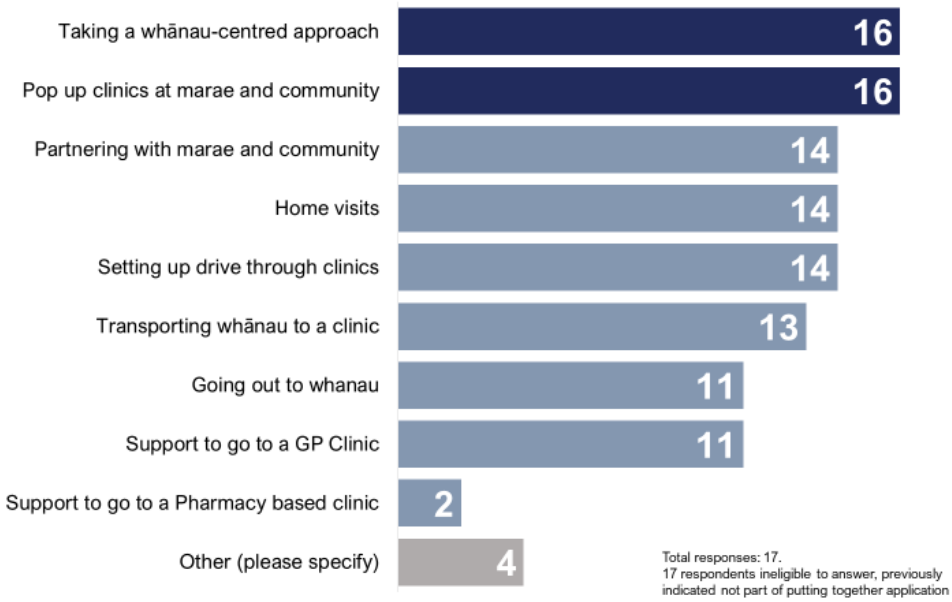
Seeing people who have multiple roles working together… the iwi were helping with the traffic and putting up the gazebos and making sure everybody had cups of tea, you know. [And] through to my Whānau Ora navigators who were already in that community and already knew the people in that community and were really, really effective in terms of connecting with the people in that community. Let alone the nurses, the administrators and the doctors who are giving the flu immunisations. (Provider – DHB-funded)

The core components of the MIVP mobile outreach service

88. Overall, as Figure 6 shows, providers and DHBs spoke of using a combination of approaches, leveraging new and pre-existing relationships and data in their MIVP activities. Almost all organisations incorporated an element of mobile outreach into their approach. This included:

- Going to where whānau gather with temporary clinics, such as pop-up or drive-through clinics; locating clinics in places where whānau go to work, pray, socialise, shop, and learn; delivering services in marae, supermarket carparks, sports grounds, schools, churches, and workplaces
- Going to where whānau live with in-home vaccinations, either to individual whānau homes or aged care residences, and in one region staff delivering vaccines in hotels where homeless people were sheltering and in known gang locations
- Bringing whānau to services, offering and providing individual or group transport to temporary sites or clinics.

Figure 6. MIVP activities focused on going out to whānau and communities



89. Providers identified community-focused and whānau-centred approaches as most effective, and mobilising services and going out into the community was critical to increasing access to ensure Māori accessed vaccinations.

90. In many regions, providers combined vaccinations. In one region, the DHB told us the MIVP funding enabled providers and DHBs to take up in-home vaccination approaches already used for childhood immunisations for the flu vaccination, combining multiple vaccine offerings for the whole whānau in one trip. Providers planned for opportunistic vaccinations, but not necessarily as an intentional part of a home visit strategy.

91. In some instances providers also extended clinic availability hours. In one region, providers organised a temporary vaccination site for whānau, but learned after they began that DHB nurses did not work on weekends.

92. For some providers, setting up temporary clinics was new. Some providers and DHBs spoke of the need for physical assets to deliver temporary vaccination clinics. For example, in one region the DHB coordinating the regional response used MIVP funding to purchase furniture and equipment to set up a pop-up or drive-through clinic, including tables, gazebos and signage. This DHB made this "vaccine kit" available for providers to use, rather than providers having to hire equipment themselves. And some regions, providers received funding to buy their own equipment or to hire equipment.

Strategy 2: Taking a whānau-centred approach

93. Whānau Ora and a whānau-centred approach refer "to an approach that is culturally-grounded, holistic, focused on improving the wellbeing of whānau and addressing individual needs within the context of the whānau."[14] A whānau-centred approach:

- puts whānau needs and aspirations at the centre of services that are integrated and accessible
- sets up and maintains effective relationships that benefit whānau
- is strengths-based and affirms the capability of whānau, with support where needed, to design and lead their development to achieve rangatiratanga
- uses or develops a culturally competent and technically skilled workforce able to adopt a holistic, whānau-centred approach to supporting whānau aspirations
- includes supportive environments such as funding, contracting and policy arrangements, and effective leadership from government, iwi and providers to support whānau aspirations.

94. Table 4 provides detailed examples of whānau-centred services offered by providers. Through strategic leadership and delivery of cultural and clinical competent services, whānau are connected to the services and supports they need.

Table 4. Provider examples of whānau-centred services

MIVP Whānau-Centred Delivery	Provider examples
Whānau-centred services place whānau needs at the centre of integrated and accessible services	A nurse enters a home hoping to give koro his flu vaccine as part of MIVP. She is experienced and has a good level of understanding about how to work with whānau, ways to connect and communicate with them so they feel comfortable, safe and involved. Before the visit, to ensure that she has a good understanding of the whānau she is visiting, she talks with a colleague who knows the whānau. Although the purpose of her visit is to administer the flu vaccination, she goes prepared to provide support in other areas if needed. After talking with

[14] Te Puni Kōkiri. (2015). Understanding whānau-centred approaches. Analysis of Phase One Whānau Ora research and monitoring results. Wellington: Te Puni Kōkiri. p.7.

	the whānau, she learns that the B4School checks and other vaccines have not been completed. The nurse can administer the vaccines needed and tells the whānau that she will talk with a colleague who can provide further support with their permission. Once she returns to the office, she links the whānau to the needed services and revisits them to drop off a kai box. In conversation with the whānau, she noted that things were tough financially. This kai box is not expected and has not been asked for. It is given as a koha to acknowledge and value the whānau.
Whānau-centred services require leadership and strategic vision to leverage relationships in a way that connects whānau to the services and supports they need	A CEO sees MIVP as an opportunity to do more, to maximize the time and engagement with whānau. Armed with a deep understanding of whānau, including their health and social needs, the organisation plans to reach and engage whānau. As they sit with whānau and list the health checks that need to occur, such as rheumatic fever, measles vaccinations, flu, diabetes assessment, a service plan starts to emerge. A responsive approach is envisioned that considers social needs as well: housing, food and transport. They feel deeply that a service in a whānau context cannot just involve a single vaccination. As an organisation, they must be prepared to deliver on broader whānau needs. Assessment forms are developed to ensure that the whānau receive what they need. The CEO discusses the service with providers in other sectors that work with whānau, asking for a contribution so whānau can receive kai and hygiene packs. Home visits occur, and whānau are given the space to explore their needs and receive services at no cost. The flu vaccine is administered along with hygiene and kai packs. Whānau who are not eligible for the flu vaccine can get vaccinated at no cost. Whānau are given information about rheumatic fever, and checks are carried out with tamariki. No-one is overlooked.
Whānau-centred services are affirming and personalised, supporting whānau to make positive health and wellbeing decisions	A DHB considers their MIVP response in the context of hapū mama, their pregnancy and their role in the whānau. As individuals, hapū mama are important in their own right. However, within the whānau, they can also be influencers and champions of wellbeing. Recognising that the immunization journey can start with mama to pēpi and tamariki, the DHB set about to break down the barriers for hapū mama to access vaccinations. Instinctively this means working with the whole whānau. Firstly, DHB staff, including nurses, attend the marae-based antenatal programme. The programme is attended by grandparents, parents and kaumātua supporting the younger women. Often there is tamariki there as well. Vaccination information is shared through a whakapapa lens of protecting mokopuna. Hapū mama, nanny and even the ringawera decide to get vaccinated. During this time, DHB staff also provide other health information relevant to the whole whānau. For those who are still unsure, there is a follow-up phone call. Phone calls and face-to-face hui with Lead Maternity Carers (LMCs) offer support for administering flu vaccines. Based on the hapū mama's location, phone calls are made to local pharmacies to check supply. In the cases where pharmacies lack supply,

	vaccines are re-distributed to reflect where hapū mamas are likely to visit regularly, such as shopping mall pharmacies.
Whānau-centred services provide culturally and clinically competent services and support to whānau	An iwi provider is partnered with the DHB and another local provider to run a community-based COVID-19 testing clinic. The iwi provider is applying a Whānau Ora approach. They have a deep understanding and strong connection with Māori whānau in the rohe. Through the clinic, they saw an opportunity to integrate their MIVP flu vaccinations. With a Dr and whānau ora kaimahi on-site, the uptake of flu vaccinations increases. Although whānau are triaged clinically, a significant part of the assessment is their social needs. The iwi provider identifies whānau struggling to buy food, those no longer employed, and any broader health issues. Tamariki are treated for skin infections and toothaches. As the testing rates slow at the clinic, kaimahi take the opportunity, through MIVP, to became accredited vaccinators and mobilise the service. Home visits to whānau in remote rural areas, those with disabilities, no transport, or who cannot drive do not have to explain or feel whakama about their situations. The kaimahi connect with their whānau and ensure that they have what they need. They bring kai and water packs and vaccines, for the whole whānau if required. Two significant barriers, costs and access to treatments, are eliminated.

MIVP whānau-centred delivery components

95. The evaluation identified nine delivery components that underpin the MIVP whānau-centred approach. Overall, providers responded holistically to the wellbeing needs of whānau, providing integrated care. Each approach reflected the provider's context, their cultural and clinical knowledge, and their understanding of whānau needs in their community.

96. Key components of a MIVP whānau-centred approach included:

1. Whānau first, that is, whānau needs drive engagement. This underpinned all actions, communication and delivery. Whānau needs drove service development, including planning and delivery. Despite contract specifications and allocated resources, providers delivered to whānau needs. This meant that providers connected whānau to other services and providers too. Although an individual might access the service for a particular health issue, in this case a vaccination, providers treated the whole whānau holistically and considered the wider health and social needs.

> *Because providers deal with whānau all the time, and you know they might be delivering drug and alcohol services for example but they're not just dealing with that. They're dealing with you know everything in the whānau.(DHB GM Māori)*

2. Intentional and inclusive focus. Provider approaches to whānau were targeted and purposeful. Although providers offered vaccines or other health and social services without knowing beforehand exactly which would be required, the intent was to always respond broadly to whānau needs, being inclusive of who was in the home, the car, or room at the time.

> *This was good because [it] was a focused area for us. It just gave us more opportunities to get [the vaccine] out you know. Whereas normally you'd only just do it if somebody was coming in. You know normally, I mean we've got Tamariki Ora, we've got you know, we've got kaumātua programmes and we've got you know, we've got lots of different services but you know a lot of them are*

all over the place. So it's good having immunisation outreach, just going… out [to whānau]. (Provider – direct-funded)

3. Prioritise long-term relationships. Relationships between providers and whānau are critical when taking a whānau-centred approach to vaccinations. For some providers, the flu vaccinations were a useful way to approach whānau, and providers sometimes vaccinated whānau for the first time. However, providers also used the opportunity to offer other services, which allowed them to develop and build their relationship with whānau for future engagement.

And the marae was great because they were saying, 'Oh you go Toby you go and get the vaccine; you've never had it Toby.' It was kind of really good cause they said, 'But you know you got sick last year remember Toby.' And I was thinking 'Oh shivers this is nothing like what would happen in a GP practice', but it worked… They just kind of enjoy it; the banter and the camaraderie of people around you rather than worrying about it like when you go to a GP practice. It's probably the way I would like to have my health services. (DHB Immunisation Coordinator)

4. Leverage networks. Providers are connected to their communities and have strong relationships with iwi, hapū, marae and other service providers. Providers leveraged their networks and relationships to support whānau. Approaches were developed by collaborating and working towards common goals.

I think there was a bit of testing the waters between the different providers that were providing services there, you know, sort of working their relationships out and ways of working together. But after that it went really well. (DHB GM Māori)

5. Extend eligibility to whānau. All providers are aware of the eligibility criteria for free vaccinations. Most providers did not turn away whānau who did not meet the eligibility criteria and presented for flu vaccinations. Aware of the generally low rates of flu vaccinations among Māori, providers considered it important to take the opportunity to extend protection to whānau and to improve equity for Māori.

Theoretically you needed to be over 65 or in the vulnerable category to get a free vaccination. But whānau rock up and then there's nanny and koro who are over 65, and there's maybe you know a pepe who's got asthma, and yet the caregiver doesn't meet the vulnerable criteria, but if they get sick you know they're the one that does the shopping and stuff. If they get sick they're going to impact the whole whānau. And so it's kind of like, [you give the vaccine] or else you go 'Oh it's free for you, it's free for you, oh $30 bucks (for you) thank you.' (Provider – direct-funded)

6. Vaccination opportunity prioritised over cost recovery. Many providers did not ask whānau members who did not meet the free eligibility criteria to pay. For providers, the priority was to extend the protection of the vaccination to whānau. To vaccinate some whānau within a household while others remained unvaccinated was considered a missed opportunity. Also, the likely negative impacts on whānau dynamics by providing vaccinations free of charge to some whānau members and not others seemed unfair and counterproductive to the goal of building and maintaining long-term relationships with whānau.

It was one of those questions that we were able to ask, 'So you want us to go out there, and you know we don't have an eftpos machine, and I don't want one either. But you know the opportunity has to be for all.' So from the outset, even when we didn't even have our contract from the Ministry, the CE of our Hauora said 'Free'…' So yes it was for all, but we had to make it more accessible and more easy for whānau. (Provider – direct-funded)

7. Expert and experienced Māori staff. Māori staff have the cultural and clinical knowledge and relation skills to create a welcoming and safe environment for whānau. They could provide information to whānau in a way that whānau understood. Providers knew that affirming and

recognising whānau improves uptake and access to healthcare services. Providers experience and knowledge of the health sector enabled whānau to receive quicker, seamless support.

> *You know I've seen, when you go to the hospital and I've walked past Māori patients, and you know the nurse will talk to them and they're a perfectly competent nurse and very, very capable. And the doctor talks to them, nothing wrong with those people and then the Māori health worker comes in and says "Kia ora whaea, pēhea koe?" and you get an entirely different response. And you know that Māori health worker, the use of te reo Māori that's the sort of thing that can engender a whole different engagement with the nurse when she comes along next and then the doctor when he comes along next. And Māori providers do that and then Māori [whānau] who engage with them can be who they are from the moment they come through the door. (DHB GM Māori)*

8. Māori staff lead engagement. Māori staff are at the forefront when providers engage with whānau. Whānau prefer and are more open to engaging with Māori.

> *We work closely with our iwi providers. So, as the district health board, we would facilitate them to run their own outreach services however they think. We've had a really good success because they know that population best and what's working for them, so we're just keen to facilitate what they need. (DHB – Immunisation Coordinator)*

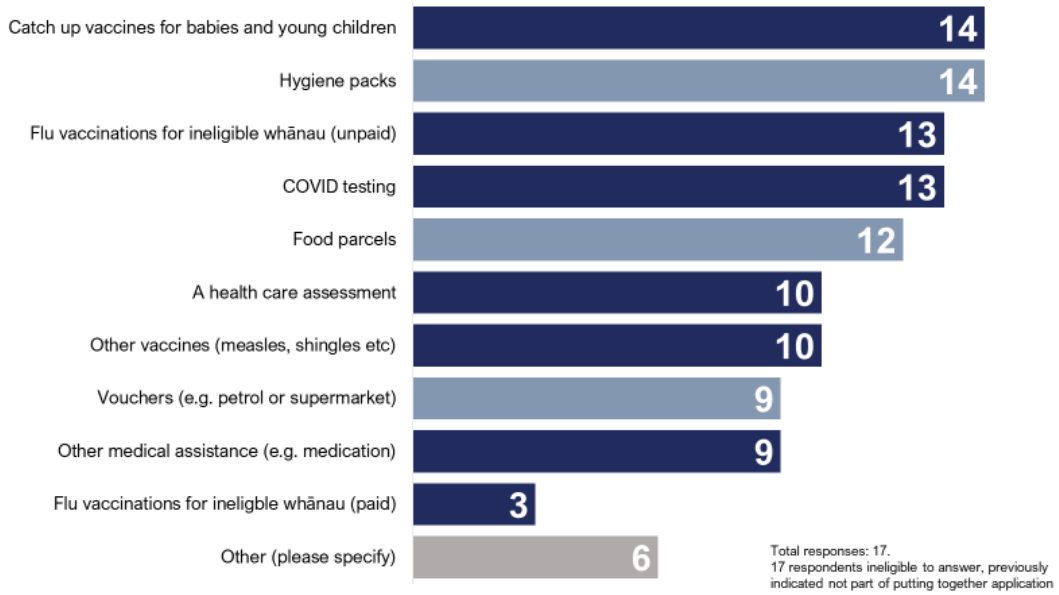
9. Adaptive and agile leadership. Leadership within Māori health providers is responsive. They are aware of the system, health sector, and community and whānau needs. Leadership within Māori health providers act and adapt with innovation and intuition to provide responsive services for whānau – but also comment that they are not often well enough resourced.

> *And I think if you want to be whānau-centred or patient-centred, you need to have flexibility and adaptability in the way that you're delivering these services. (Provider – direct-funded)*

MIVP whānau-centred services are holistic

97. Rather than just focusing on vaccinating, providers took a holistic approach to whānau wellbeing and wrapped in other support and services in response to whānau needs. (See Figure 7).

Figure 7. Additional services offered together with flu vaccinations to eligible Māori



98. Providers spoke about taking the opportunity to be in a whānau home or the whānau presenting to a site to ask them about their needs, then offering support there and then, or agreeing to follow up with them later.

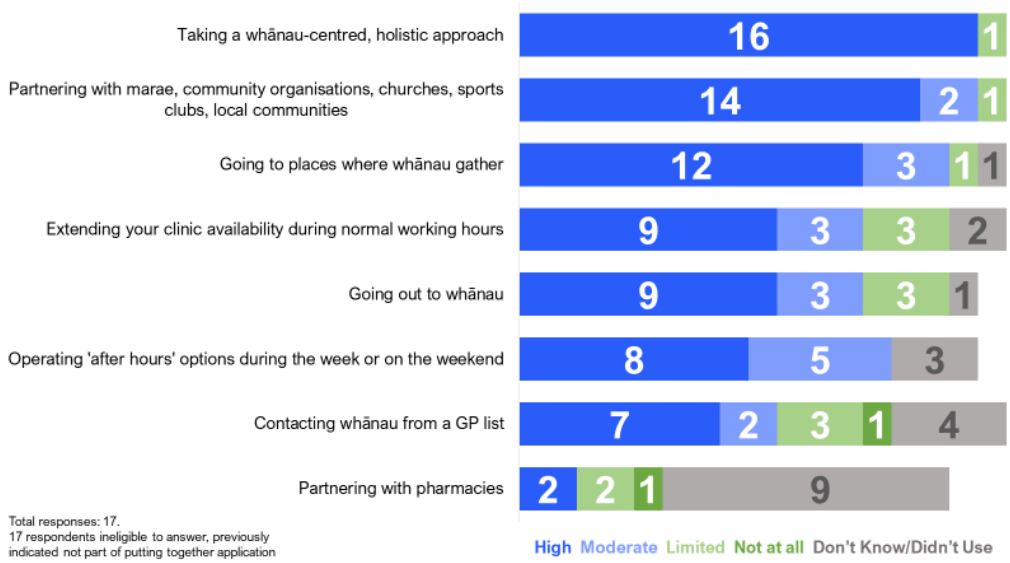
99. Many providers offered additional medical services, such as catch-up vaccines for pēpī and tamariki, COVID-19 testing flu vaccines, health care assessments and other vaccines for the whānau. A few providers spoke of providing access to mental health support services. Some providers were able to provide hygiene packs and food parcels as part of their COVID-19 response.

100. About half of all providers offered petrol and supermarket vouchers to whānau to increase access to service by reducing the cost of transport. Providers know that the cost of fuel can be a barrier to some whānau being able to travel to services. They offer petrol so whānau can put fuel in the car to travel to sites. They also offer supermarket vouchers, knowing that sometimes whānau may have taken money from their food budget to buy fuel.

MIVP whānau-centred services and outreach are effective

101. Almost all (16/17) providers indicated they took a whānau-centred approach as part of their MIVP-funded activities. Almost all providers (16/17) indicated that a whānau-centred approach combined with a community outreach focus was highly effective for getting whānau in their community vaccinated. (See Figure 8).

Figure 8. The degree to which the following approaches were effective for getting whānau in provider communities vaccinated?



Strategy 3: Workforce capability

Māori providers traditionally underfunded

102. Māori health providers have historically been underfunded, given the strategic importance of their work to support and increase health outcomes for Māori in their communities.[15] Constrained funding means provider leadership often faces tough decisions: whether, for example, to hire more staff, deliver staff training, offer higher wages (often to match DHB or non-Māori, non-Pacific organisations), or reimburse petrol costs for home visits in rural areas. Providers often prioritise initiatives for whānau over activities that would improve their longer-term sustainability, such as workforce development.

An expert and experienced Māori workforce is critical

103. As a result, some providers have a limited pool of Māori nurses and staff who can vaccinate. The limited pools of suitable staff are exacerbated when delivering mobile outreach services, requiring more staff to deliver services safely and effectively.

104. As noted earlier, many whānau prefer Māori health providers and Māori vaccinators who reflect them and their community. Providers believe an expert and experienced Māori workforce is critical. Whānau are more open to engaging, relationships are easier to develop and trust builds quicker. This in turn, increases whānau access to vaccination services.

105. Some regions recognised that increasing the Māori vaccinator workforce was key to achieving vaccination equity. This is why they included capacity and capability development activities as part of their MIVP-funded approach.

[15] Waitangi Tribunal (2019). Hauora: Report on Stage One of the Health Services and Outcome Kaupapa Inquiry. Wai 2755 Waitangi Tribunal Report 2019

MIVP funding helped build vaccinator capacity and capability

106. In some regions, MIVP helped augment the workforce of vaccinators, and the free online vaccination training for flu and selected other immunisations was useful. Some regions (providers and DHBs) used funding for training to upskill staff in their organisations or partner organisations, including paying for travel to training locations.

107. In one region, the DHB coordinated the training of nursing students, midwives and nurses working with providers in the region. A primary driver for this was to increase numbers of local vaccinators in the short-term and increase longer term sustainability of the vaccination workforce for flu and possibly other immunisations. Senior leaders in this region suggested that DHBs have other existing funding pools that could (and should) be directed towards increasing the overall capacity and capability of Māori vaccinators.

108. In another approach, the DHB organised for vaccinators to sit alongside provider staff while providers upskilled their staff. And when providers signalled they were ready, DHB staff stepped back.

109. In contrast, in one region where the DHB was funded, the contracted provider was not supported to increase their vaccination capability. Instead, the provider organised temporary clinics and nurses from the PHO administered vaccinations. But this limited the options for vaccinating on the weekend as PHO nurses "don't work after-hours". This region experienced an overall improvement for Māori flu vaccinations but overall a much stronger improvement for non-Maori, non-Pacific people.

MIVP funding helped build vaccination and mobilisation capability

110. In some regions, MIVP funding enabled training in administering and managing vaccines. Some providers received funding and support, particularly from DHBs, to achieve cold chain accreditation to store and manage vaccines themselves. In one region, the DHB spoke of setting up a central store of vaccines that providers could access with prior notice for any outreach activities. This allowed providers to deliver vaccinations in community sites that had limited or no suitable storage, such as churches.

111. Temporary pop-up clinics were new to most providers. Providers and DHBs hired or purchased physical assets needed to deliver services such as gazebos and tables and cold chain equipment such as chilly bins and fridges.

112. Some regions spoke of a need to empower providers to deliver vaccines by including vaccinations in their contracts.

Data unlocks responsive decision-making, efficiency and effectiveness

113. Knowing where to find Māori to vaccinate, both generally and also specific individuals, was a core part of MIVP-funded approaches in many regions. Providers and DHBs used administrative databases to identify whānau and eligible Māori for communications activities and to identify locations where whānau and eligible Māori would likely be for outreach activities.

114. DHBs, in particular, talked about the challenges of accessing data – and the unwillingness of some PHOs and provider organisations to share data. At an individual organisation level this makes sense. However it made it difficult to take a regional overview to support the planning and coordination of vaccine and services.

> *The data – it's data sharing – is a major barrier for improvement. Yeah. And I did raise it with the Māori Directorate and said, 'We have to do something differently moving forward around the willingness to share information so that we can make improvements.' (DHB – GM Māori)*

> *During [the COVID-19] Lockdown it was really easy to get their registers and their whānau because they own their GP practice. However [PHO] is a different*

situation in that they're all independent businesses and you have to go through proper ownership structures and then they have to agree at that end and then come back with their registers. So it was a much, much lengthier process. (DHB – Project Coordinator)

115. Quick and reliable access to NIR and other related data was crucial. Some providers and DHBs improved their data infrastructure and systems while participating in the MIVP. In one region, the funding enabled IT training and support for data administration.

116. Capturing and entering patient data when delivering outreach and mobile services is challenging but important for getting reliable and timely NIR data. Some regions spoke of relying on paper forms, which could be unwieldy when outdoors. Paper forms also increased the possibility for whānau to enter inaccurate personal details when completing a form for a whānau group. A possible solution was to buy electronic devices to capture information – if there was enough funding and a reliable internet connection to update databases. In one region, the DHB developed an app to enable data and reporting to be as close to real-time as possible. In another region, DHB staff spoke of ensuring providers in the region had access to the NIR and setting up alternative means to enter where necessary.

117. In one region, providers collaborated on a shared database of Māori they served, because existing databases from PHOs did not capture Māori in the areas local providers served. As a result, they could monitor progress down to individual households.

We were able to give impact reports on households, whereas that's never ever been captured. We were able to look at the makeup of our whānau and from that we've been able to build a resilience plan for [our] Māori.(Provider – direct-funded)

118. A focus on accurate and timely data capture provided one regional collective with regular and reliable information to monitor their progress and performance. This enabled the collective to reflect on their successes, generally and compared to other regions. This positive acknowledgement of their effort created further positive motivation during the campaign. It also enabled them to identify which activities and approaches seemed effective, any areas needing intervention or troubleshooting, and which providers appeared to be sufficiently capable or needed extra support.

We were getting so excited because we were thinking, 'Oh my God it's working you know.' So the whole group was getting all enthusiastic, we're checking our results every week 'Oh my God we're up another', and we kept looking at the other you know DHBs thinking 'Oh how come they're not going up you know?' So we suddenly noticed we were shooting up and everybody [else] had kind of stabilised, but we kept climbing and I think it was that enthusiasm once we had got ourselves together. (DHB – Māori Health)

119. In one region, the DHB coordinated activities and vaccines. More timely and accurate data about outreach activities (delivered and planned), vaccine stock location and vaccinations delivered enabled them to forecast vaccine demand and source vaccine as needed for planned activities. As a result, they could more efficiently manage their limited vaccine stock overall.

120. There remains a challenge of capturing information about whānau who decline vaccinations, particularly as part of outreach activities. Without a consistent way to record an individual's decline to receive a vaccine, they may receive repeat targeted communications and this may increase their frustration and risk of disengagement from health providers.

121. Broader systemic challenges of the reliance on census data for population figures hamper the use of NIR data. Māori are historically under-reported in national censuses, and this reduces the usability of NIR.

122. Data capture and sharing raises concerns of data sovereignty and governance. A lack of trust exists between some providers, PHOs and DHBs (Māori directorates and other units). As a result,

some providers and DHBs spoke of an unwillingness to share data with other parties in their region.

The design and implementation of the MIVP

A snapshot

Overall, providers were positive the application process; DHBs less so. The dual funding approach mostly worked to get funding quickly out to the sector. However, some DHBs were slow to get funding out to providers. This resulted in missed vaccination opportunities.

MIVP has supported the creation and strengthening of some relationships in some regions, while in other regions this did not occur. Also, there was also variability in the networking relationships within DHBs and their support of MIVP.

Providers and DHBs have expressed interest in participating in MIVP in 2021. They would largely deliver the same suite of services and activities, and most providers and DHBs have indicated they would need the same amount of funding or more. A few indicated they would need less funding, as some capacity or infrastructure (such as gazebos and refrigerators) is now in place and could be utilised in 2021, and alternative funding sources also identified (e.g. DHB and other workforce development funding).

If MIVP is to be implemented in 2021 providers, DHBs and the evaluators have put forward the following considerations:

- Increase awareness of MIVP to attract more applications
- Improve communications about MIVP to assist providers and DHBs to apply for funding, especially about the two participation options for providers so they can make an informed decision
- Encourage and support DHBs to work with providers to develop collaborative applications
- Review the DHB attestation process for confirming provide capability
- Review the MIVP assessment processes, systems and criteria to support provider innovation and innovative approaches
- Look to get funding out to DHBs and providers as early as possible
- Consult with DHBs about how the Ministry can support them to get funding out to providers in a timely manner and set performance expectations and timeframes for DHBs to get funding to providers.

There is a need to revisit the funding allocation formula. The current funding approach takes account of Māori regional population and equity rates. However, a more nuanced approach is needed that takes account of vaccination and equity trends, as well as provider and DHB performance in 2020 (and historically), and their capability to use the funding to best effect.

Three main expectations

123. This section explores the broader MIVP design intent and programme implementation. As well as the goals of increased flu vaccinations and improved equity, the Ministry had three main design and implementation expectations for the programme. Firstly, the MIVP application process aimed to be timely and straight forward for providers to complete. Secondly, the programme offered greater flexibility in a dual funding model. Thirdly, the Programme aimed to support relationship-building between DHBs and providers and within DHBs. This section reflects on progress against these expectations. It also captures provider and DHB interest and needs if they were to implement MIVP in 2021.

Broader MIVP expectations

124. MIVP was implemented at pace as part of the Initial COVID-19 Māori Response Action Plan. The aim of MIVP was to increase access to the flu vaccinations for vulnerable Māori groups, particularly kaumātua aged over 65 years. MIVP aimed to get funding out to the sector as quickly as possible, given the recognised and added health risk for Māori.

125. The broader design intent of MIVP was to test funding approaches and processes. MIVP therefore provided an opportunity to:

- test the application process and the responsiveness of the Ministry to:
  - develop an easy to complete application process for DHBs and Māori providers
  - provide enough information for the Ministry to assess applications robustly
  - get funding out quickly (that is, procure, assess and contract quickly), support innovation and respond to unique provider contexts and opportunities.
- test the efficacy of the dual-funding model
- support collaborative applications between DHBs and providers (who decided to be part of a DHB application) resulting in:
  - providers and DHBs having a shared understanding of what was happening in their region
  - a regionally coordinated approach, playing to the strengths of individual providers.
  - strengthen relationships between DHBS and providers.

Even where providers elected to apply directly to the Ministry, it was hoped they would have a good understanding of what assistance their local DHB could offer and explore opportunities to work together.

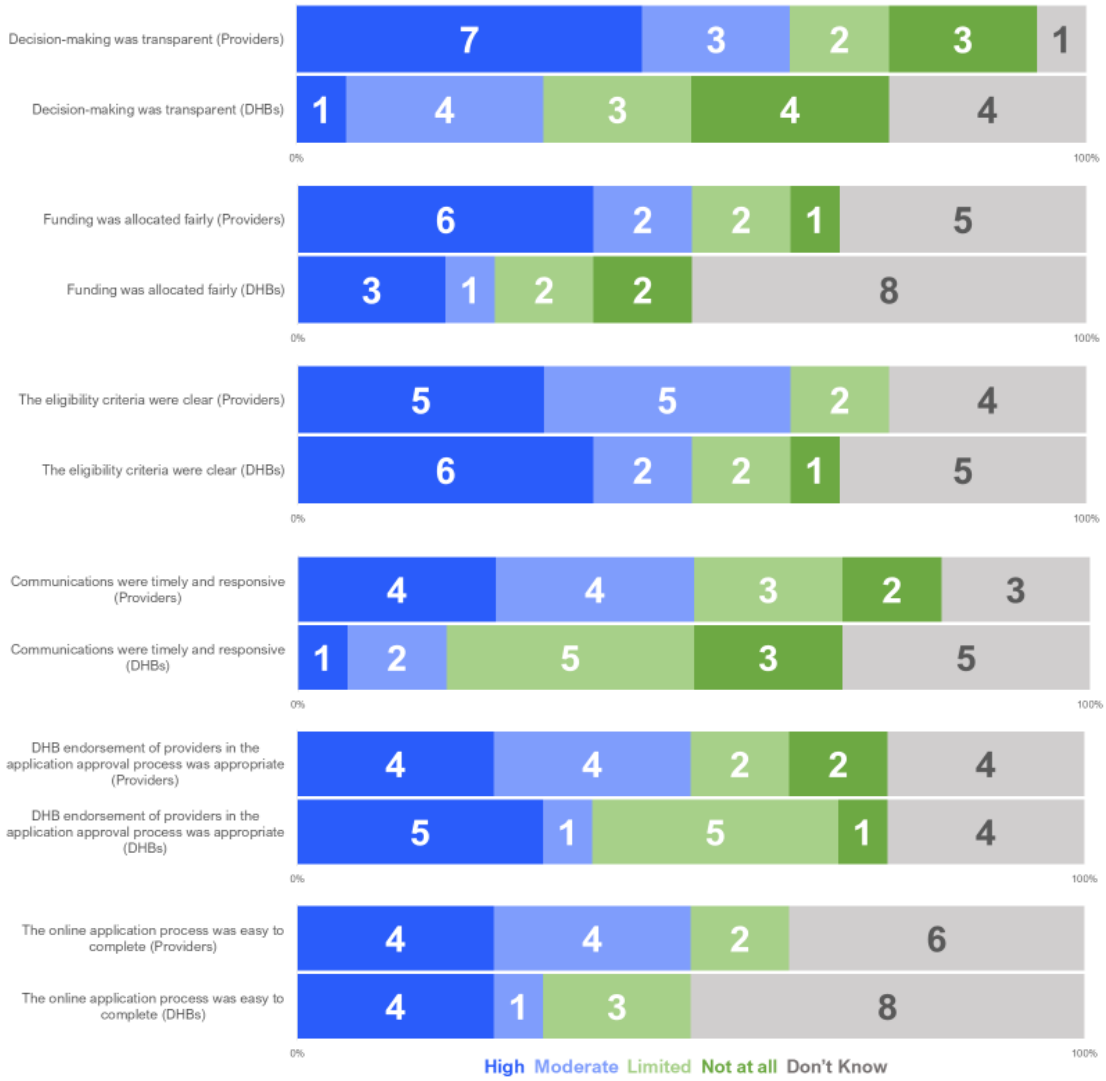
Providers were positive about the application process; DHBs less so

The MIVP included a trial of an online application form. Providers who applied directly first had their application checked by their DHB. Overall, providers were positive to a high or moderate degree as illustrated in Figure 9, and consistently more positive about the application process than DHBs.

Specifically, providers said:

- Decision-making was transparent – more than half (10/16) of providers compared to less than a third (5/16) of DHBs
- Funding was allocated fairly – half of providers (8/16) compared to a quarter (4/16) of DHBs
- The eligibility criteria were clear – more than half (10/16) of providers compared to a half (8/16) of the DHBs
- Communications were timely and responsive – half the providers (8/16) compared to a few (3/16) DHBs
- DHB endorsement of providers in the application process was appropriate – half the providers (8/16) compared to some (6/16) DHBs
- The online application process was easy to use – half of the providers (8/16) compared to some (5/16) DHBs.

Figure 9. Feedback from providers and DHBs on the administration and implementation of the MIVP by the Ministry



Total DHB responses: 16. 2 respondents chose not to respond.
Total Provider responses: 18. 1 respondent chose note to respond. 17 respondents ineligible to answer, previously indicated not part of putting together application.

Reflections and considerations for procurement and contracting of MIVP in 2021

126. Table 5 summarises the key implementation learnings around the application and implementation process. It draws on provider and DHB feedback and analysis by the evaluation team. It puts forward key points for the Ministry to consider if it was to implement MIVP in 2021.

Table 5. Reflections on the 2020 MIVP procurement and contracting process: Considerations to inform the application process in 2021

On the one hand…	On the other hand…	Considerations for the Ministry
Awareness of MIVP		
All DHBs were aware of the MIVP programme through the DHB Māori GM network. Providers found out about MIVP through letters sent by the	A total of 35 applications were received from providers and DHBs, fewer than the estimated of 70. MIVP achieved coverage	Increase awareness of MIVP to attract more applications from providers through DHBs or direct to the Ministry.

Ministry to approved Māori health and disability providers and some through their DHB.	across 19 of the 20 DHB regions. More provider applications are needed to ensure full coverage across the country.	• *Consider sending out communications to a broader range of organisations and not just Māori health and disability providers and DHBs who might promote awareness of MIVP or partner with providers and DHBs, such as Whānau Ora Commissioning Agencies.* Address information barriers to applying for MIVP by improving communications about MIVP to assist providers and DHBs to apply for funding • *Consider providing more information resources such as FAQs, costing guideline, a pricing schedule, successful strategies, top tips and case studies.*
Awareness of the two ways providers can participate in MIVP (dual funding model)		
Providers could apply directly to the Ministry, or they could be part of their DHB's application.	Many providers were unaware that they could apply directly to the Ministry.	Improve communications about the two ways providers can participate in MIVP so they can make informed decisions. • *Consider providing information about the pros and cons of each option.* • *Consider tasking DHBs with the responsibility to ensure providers are aware of the two funding options.*
Collaborative applications between DHBs and providers		
The Ministry envisaged that the process would support collaborative applications between DHBs and providers who decided to be part of a DHB application.	Few DHB applications were clearly collaborative.	Encourage and support DHBs to engage collaboratively with providers. • *Consider providing examples of how DHBs have successfully supported and worked with providers to showcase the benefits of a collaborative approach for providers and for whānau.*
DHB endorsement of provider capability		
Providers applying directly to the Ministry needed to secure endorsement of their delivery capability and community connectedness from their DHB,	It is not clear whether needing DHB sign-off reduced the possible pool of provider applicants – particularly in regions without existing	Revisit the DHB attestation process for confirming provide capability. • *Consider seeking DHB feedback on provider*

as part of the application process.	relationships, where they were strained or where the provider and DHB might be seen as being competitors. Some providers filed their application without securing their DHB's endorsement. The Ministry followed up with DHBs to confirm provider capability and community connectedness.	*capability as part of the application assessment process (that is, not as part of the application process).* • *Consider identifying other quality assurance and feedback mechanisms that could be used by the Ministry to attest to provider capability and community connectedness.*
Encouraging innovation, managing perceived risk		
MIVP encouraged applicants to propose innovative approaches.	However, risk mitigation at the application and approval process stages potentially dampened opportunity for genuine innovation. *"Some of their analysis was, well, over the top.,. and innovation was getting pushed back to the wall." (DHB Manager)* DHBs and providers suggested that the Ministry did not always have a good sense of what innovation looked like on the ground. *"Their desktop analysis was far removed from the realities we're working in" (DHB Manager)*	Review the MIVP assessment processes, systems and criteria to support innovation. • *Consider assessing applications at a strategic or macro level. For example, they could be assessed against the three core MIVP strategies (mobilisation, whānau-centred and workforce capability) as opposed to at a micro level or a highly detailed assessment.* • *Consider how risk and innovation can be better balanced when assessing applications.*
The timeliness of the application process and distribution of funding		
Both providers and DHBs reported the Ministry processed most applications relatively quickly, including addressing legal and technology challenges. *"If you compare the Ministry resources for this programme compared to ourselves [DHBs], gosh, and calculate our time and paths, the Ministry was very timely and responsive." (DHB GM Māori)*	Vaccinations were a new area of work for the Ministry contract managers, and this sometimes impacted on the approval response time. There was a wide variation in costings because no indicative pricing schedule accompanied the application form. Processing improved over time as the contract managers gained an improved understanding of the flu vaccination context. They also developed a pricing schedule. There were delays in developing contracts and this resulted in funding getting out	Consolidate the system and process learning to further streamline assessment, contracting and distribution of funding.

	to providers and DHBs later than planned. Some vaccination opportunities were lost, for example a possible combined approach with COVID-19 testing or COVID-19 whānau outreach. The Ministry is now in a better position to process and approve applications, develop contracts and distribute funding more quickly, because they know more about flu vaccination services and costs.	
Distribution of funding to providers and DHBs		
The MIVP contacts ran from I July to 30 September 2020.	Providers and DHBs suggest that funding needs to get out earlier if MIVP goes ahead in 2021. One provider reported starting their planning for 2021 flu vaccinations in November or December 2020. Confirming whether MIVP will run again in 2021 in a timely way would allow for improved planning and sharing of ideas between providers and between DHBs, and it would support regionally coordinated or collaborative applications.	Look to get funding out to DHBs and providers as early as possible. • *Consider advising the sector as soon as possible – even in the absence of a detailed implementation plan – if MIVP funding will be available in 2021.* • *Set realistic timeframes for each phase of the MIVP process – and communicate these to the sector.* • *Ensure there is sufficient resource to meet the stated timeframes.*
Funding from some DHBs was slow to get out to providers		
Providers and DHBs said the Ministry MIVP applications, contracts and funding were timely (within the extended timeframes advised by the Ministry).	However, some DHBs were reported as very slow at developing contracts and getting funding out to providers, as late as August 2020 for one DHB. Some providers started their MIVP activities in advance of a contract or funding – and carried the financial burden until funding came through. Some providers were not in a position to implement them MIVP activities and therefore lost early vaccination opportunities.	Consult with DHBs about how the Ministry can support them to develop contracts and getting funding out to providers in a timely manner. • *Consider setting clear timing expectations for DHBs to contract with their MIVP providers.*

Monitoring and reporting on MIVP progress, outcomes and impact		
The MIVP online application form provided good information about providers who applied directly and DHBs. The Ministry uses NIR data to track all flu immunisation rates.	The list of providers who were funded as part of DHB applications was incomplete. Without this information it is not possible to accurately gauge and report on programme reach; or to elicit feedback from this group of providers. NIR does not capture immunisation data by individual providers. This means it is not possible to clearly attribute MIVP administered vaccinations from those delivered by non-Māori non-Pacific organisations; and therefore the impact of MIVP. Developing an online system to capture *total weekly immunisations* by providers would remedy this. As providers and DHBs are already entering this information into NIR, it will be important to keep the information required to the absolute minimum.	Revise the MIPV data capture and provider/DHB reporting systems to improve attribution of MIVP funding to outcomes. • *Consider revising the DHB application form to ensure they identify all of the providers who are part a collaborative application* • *Consider requiring all providers to electronically provide the total number of immunisations completed on a weekly basis.*

Dual funding model

127. The Ministry recognised that relational trust issues exist between some DHBs and providers. The risk was that without a dual funding model, the contracting process might lock out some providers. Losing the vaccination capacity of those providers would directly impact on whānau and Māori communities' ability to access flu vaccinations. Therefore, the MIVP dual funding model allowed providers to choose to apply directly to the Ministry for funding or to be part of a funding application with their DHB. The Ministry direct-funded 18 providers while another 40 providers were part of eight applications by DHBs. (See Table 1, page 13).

128. There were four additional reasons for the dual funding model. Firstly, the funding aimed to get flu vaccination services into Māori communities as quickly as possible. Having two funding streams provided two distribution channels. Also, DHB contracting processes are sometimes considered slow, and the Ministry wanted to be sure it would have quick options. In the event, as noted earlier, slow contracting processes by some DHB resulted in some lost vaccination opportunities and some providers having to carry the costs until funding came through from their DHB. For 2020 therefore, this supports the value of the dual funding approach – and direct funding of providers.

129. Secondly, the fund aimed to offer equal opportunities for DHBs and providers constraining neither by bureaucracy. The Ministry aimed to ensure its processes were fair, timely and efficient. Thirdly, MIVP created an authorising environment for providers to innovate and develop their own ideas, without having to justify these to their DHB. Fourthly, the Ministry recognised that not all providers feel respected and supported by DHBs.

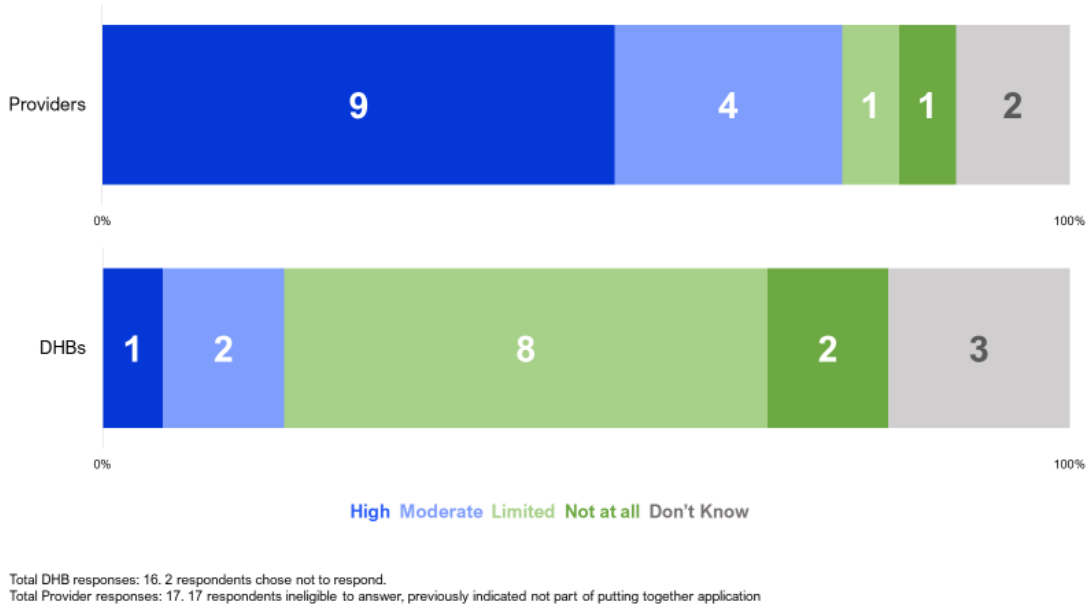
130. The quality assurance process for direct-funded projects was that DHBs checked providers' applications and then attested their capability to the Ministry. However, the assessment panel kept a right of review to revisit any DHB endorsements or lack thereof. There were a couple of applications where providers had signalled they had discussed their application with their DHB, yet DHBs reported not being familiar with the application. When this occurred, the Ministry consulted with the relevant DHB as part of the panel assessment process.

131. At the outset, the dual funding approach was not universally popular with DHBs. However, DHBs got on-board, accepting that they did not have an automatic monopoly on designing and approving funding and that they had to work differently with their providers. Post the implementation of MIVP in 2020, funding providers directly remains less popular with DHBs (see Figure 10).

Providers more than DHBs thought the dual funding model was a good idea

132. In terms of applications, Providers and DHBs were asked whether allowing funding applications from DHBs and Māori providers was a good idea. Many (13/17) providers believed allowing funding applications from both DHBs and providers was a good idea. DHBs were less convinced, with only a few (3/17) indicating yes, to a high or moderate degree.

Figure 10. The degree to which allowing funding applications from DHBs and providers was a good idea.



Total DHB responses: 16. 2 respondents chose not to respond.
Total Provider responses: 17. 17 respondents ineligible to answer, previously indicated not part of putting together application

133. Some DHB and provider staff shared that there was confusion about eligibility to apply. On the one hand, many providers (16/19) funded indirectly through their local DHB were not aware that they could have applied directly for funding. On the other hand, one direct-funded provider told us a DHB invited them to collaborate, but they had already prepared their own application as they had been unaware that funding was available for DHBs.

134. In practice, having a dual funding model resulted in three funding and relationship platforms for engagement.

Platform 1: DHB did not apply for MIPV funding and the Ministry direct funded providers

135. For this approach, providers first knew they could apply for direct funding. They believed in their own capability to design and deliver a high-quality whānau service. The DHB who did not apply for MIVP funding, supported their application.

136. In some regions, strong, collaborative relationships between Māori providers and iwi were already in place, and often long-standing. In one region, the positive relationship had been in place for

more than a decade, and there was a shared understanding and expectations about roles, ways of working and sharing information. In this region, the DHB saw providers and provider leadership as highly capable, needing little on-the-ground or in-community support. The Māori leaders in the DHB fully supported the provider leading the MIVP local engagement.

> *We have a very good relationship with Māori providers. And so when this RFP came out, there was no way that I could see other than funding should happen other than to go through the Māori provider channel… The risk you run I think is that you've got to be careful that you don't blow out the provider, you know, around their capability and capacity. (DHB – GM Māori)*

137. Factors contributing to strong relationships included DHB Māori leadership perceptions that:

- providers were highly competent, had adept leadership and their autonomy should be encouraged
- providers were best placed to work with whānau
- the DHB could best support this work by advocating for providers and whānau internally within the DHB and externally with other partner organisations such as PHOs.

138. In some areas, direct funding to providers enabled capable and connected providers to do more of what they already knew worked and faster. However, the sense check of provider applications by DHBs was not enough to ensure collaboration and communication of approaches in all regions.

Platform 2: DHB received MIPV funding and Funded Providers

139. In this approach, there are two relationship patterns. Firstly, providers choose to be part of the DHB MIVP application. They saw benefits in the DHB managing the contract, helping to coordinate resources across the region and better support and connect providers to vaccination training, cold chain support and vaccine supply. Timing because of COVID-19 meant that some providers lacked the capacity to apply directly to the Ministry; prioritising offering support to whānau and community.

140. In some regions, the way that DHBs approached their MIVP application supported developing new relationships or re-kindling past ones. This included DHBs undertaking joint planning with providers, reflecting providers' ideas in the application and submitting the application. Further, in some areas, direct funding to DHBs allowed them to act as coordinators of resources, efforts and data. In these regions, DHBs connected with providers, particularly those that needed added support.

141. Relationships between DHBs and providers were impacted by the need for DHBs to have control while providers sought autonomy. At times DHBs struggled with this, given they are accountable to the Ministry for the use of MIVP funding but this needed to be balanced against the independence of providers.

142. In an alternative pattern, some providers did not know that they could submit an MIVP application directly to the Ministry. Some DHBs 'automatically' swept providers into a contract. In this relationship scenario, sometimes DHBs meaningfully involved providers in developing the application and other times less so. While providers were appreciative of the funding and other support provided by the DHB, they expressed surprise to discover they could apply in their own right.

143. This approach revolves around DHB control and sharing of information. One, where providers know they can apply directly to the Ministry for MIVP funding; and two where providers do not know they can apply to the Ministry. Both involve some level of engagement by providers.

144. We asked providers in the survey, "Did you know it was possible to apply to the Ministry of Health for MIVP funding. Most (16/19) said no they did not know, a few (2/19) said yes they did know, and one person responded "don't know" to the question. Whether by omission or intent, it seems somewhat disingenuous for DHBs not to advise providers that they could apply direct. Trust could

erode when providers found out about information not shared with them. This lack of transparency had the potential to undermine any relationship bonding that occurred.

Platform 3: Direct/Ministry Funded Provider/s, DHB received MIPV funding

145. This approach combined both Model 1 where providers applied and were funded by Ministry and Model 2, where DHBs were the applicant and then funded providers who were part of their application.

Building relationships between DHBs and providers and within DHBs

146. The Ministry considered relationships as a critical aspect of MIVP, both as an enabler and as an outcome. The Ministry envisaged that MIVP would help strengthen DHB relationships with providers, within DHBs and across DHBs. To a lesser degree, the Ministry also assumed that MIVP would support relationships between providers.

147. The dual funding model means that for MIVP there are different combinations of relationships and inter-relationships.

- DHB–DHB funded provider
- DHB–direct (Ministry)-funded provider
- DHB–internal DHB relationships
- DHB–external relationships
- Provider–provider

148. Views were mixed about the extent relationships strengthened, as described in Table 6.

Table 6. Perspectives on relationships between providers and DHBs

On the one hand we heard about…	On the other hand we heard about…
Low-trust, fragmented and strained relationships between DHBs and providers.	High-trust relationships between providers and DHBs; and sometimes PHOs.
Providers waited to deliver MIVP services until they had a signed contract and had received funding.	Providers started delivering MIVP services well before receiving a contract and funding.
Providers experienced a genuine, ongoing challenge to build and preserve capacity to vaccinate.	DHBs supported providers to upskill their workforce including vaccination training and cold chain accreditation. DHBs built current and future vaccination capacity locally, such as trained midwives and student nurses.
A belief that Māori providers can't vaccinate because they don't have the capability, and this task should be one for district nurses.	DHB nurses and contracted vaccinators who only work Monday to Friday and standard business hours resulting in vaccination times that are not accessible were a barrier to whānau.
Some providers expressed distrust or lacked confidence in their DHB to be inclusive, transparent and behave equitably.	Other providers had or developed positive, respectful and responsive relationships with their DHB.
Providers had difficulty accessing vaccine and at times had to cancel planned vaccination clinics.	DHB Immunisation coordinators (and sometimes PHOs) coordinated the supply of vaccine regionally (when needed).

Burnt by experience, some providers applied in their own right, seeing DHBs as more of a hindrance then a help. These providers saw themselves as capable and able to deliver a strong flu vaccination programme with a complimentary set of services and support.	Some providers chose to be part of their DHBs application. They saw benefits where the DHB managed the contract, helped to coordinate resources across the region and better-connected providers to vaccination training, cold chain support and vaccine supply.

149. Each DHB had a unique relational whakapapa, and there were important variations in how they operated. At the same time, providers had their own institutional memories and relational whakapapa. When relational whakapapa and institutional memories between DHBs and providers honoured, respected, and valued one another, they enabled positive ways of working. In these instances, collaboration, knowledge and resource sharing supported engagement and outreach.

150. To a certain extent, the evaluators found that MIVP operated as a change agent supporting improvements in relationships and greater collaboration across DHBs and providers (either direct funded or DHB funded). These positive relational changes were obvious in some regions and not in others.

151. There was evidence in some regions of new and re-established connections and networks. Providers and DHBs successfully and collaboratively implemented MIVP initiatives. Providers leveraged ways of working together to reach Māori communities. Internal DHB interactions joined better, based on common goals. DHBs made links and communicated with each other around MIVP. All these variations supported providers to develop whānau-centred approaches to carry out flu vaccinations.

152. Perhaps one of the providers' most significant points of contention, regardless of the quality of the relationship with DHBs, was that typically DHBs did not take a genuine partnership approach to assign funds and resources. Instead, providers thought DHBs shared funds and resources using an "incremental transactional process" that did not reflect equity nor support transformational, long-term change.

153. However, providers viewed MIVP as a step to ensuring that knowledge, resources, and the locus of control were "fairly" distributed to reflect Māori communities' needs.

> *It's almost like you're set up to fail if you're not given full access to, you know, all the knowledge and resource that you need to know to do a good job. In saying that, you know, even having this conversation now is a step in the right direction. And having the DHB actually giving [us] a contract, even though it was very, very late [was good]. So, we're now coming to the end of the flu season and we have only just got our contract two and a half weeks ago. (DHB-funded provider).*

154. Of note, relationships seemed to influence the overall impact.

- On the one hand high trust relationships were associated with a positive impact on vaccination rates and provider capability development.
- On the other hand both high-trust and low-trust relationships were described in regions with high vaccination rates.

155. And relationships seemed to have been impacted by MIVP.

- On the one hand, some regions used MIVP to initiate new, broader and deeper relationships and collaborations.
- On the other hand some relationships remained relatively unchanged (whether high or low-trust before MIPV).

156. Regardless of relationship type, MIVP was successful when relationships worked well, built on trust and respect, and recognised provider mana and status through the equitable sharing of resources. MIVP gave providers the resources and tools to design and drive approaches to deliver whānau-centred services. Releasing resources in this way supported providers to re-build

trust in a system that previously let them down. Providers showed the multiple ways they built trust with whānau around health care delivery.

> *To build trust takes time and I think we've got a better opportunity through our Māori, our kaupapa Māori providers to build trust in the system, rather than through mainstream systems. And yeah, we need a better slice of the resources, and they should go directly to our providers. (DHB GM Māori)*

Implementing MIVP in 2021 and funding considerations

157. This section briefly outlines provider and DHB views about participating in MIVP or a similar programme in 2021 and their needs if delivering MIVP in 2021.

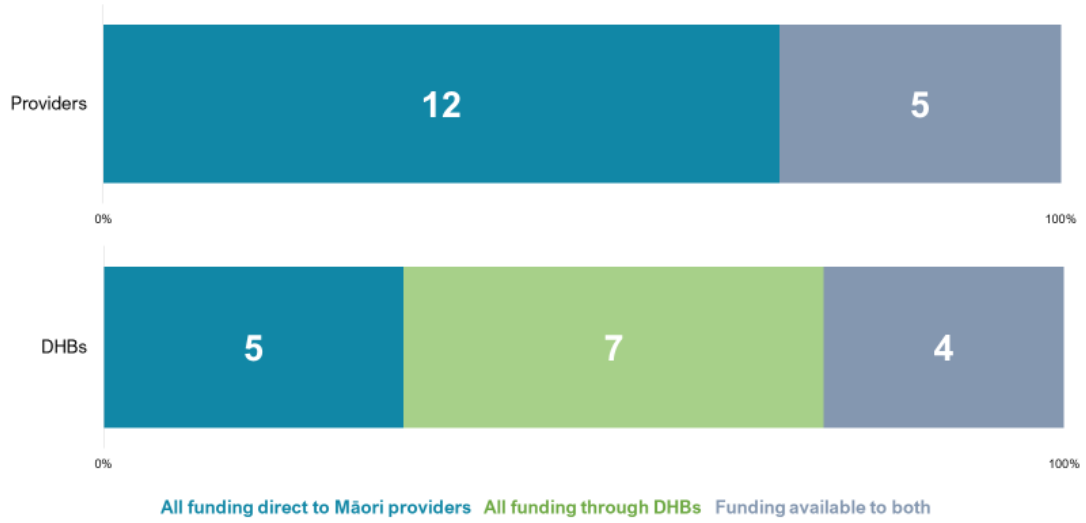
158. Both providers and DHBs expressed interest in participating in MIVP in 2021.

MIVP funding model

Providers support dual funding; only DHBS supported all funding going through DHBs.

159. In terms of future funding channels, most providers (12 of 17) and some DHBS (5 of 16) support funding providers directly or making funding available to both. Only DHBs (7 of 16) supported all funding going through DHBs in the future.

Figure 11. Support for funding to go to both DHBs and providers



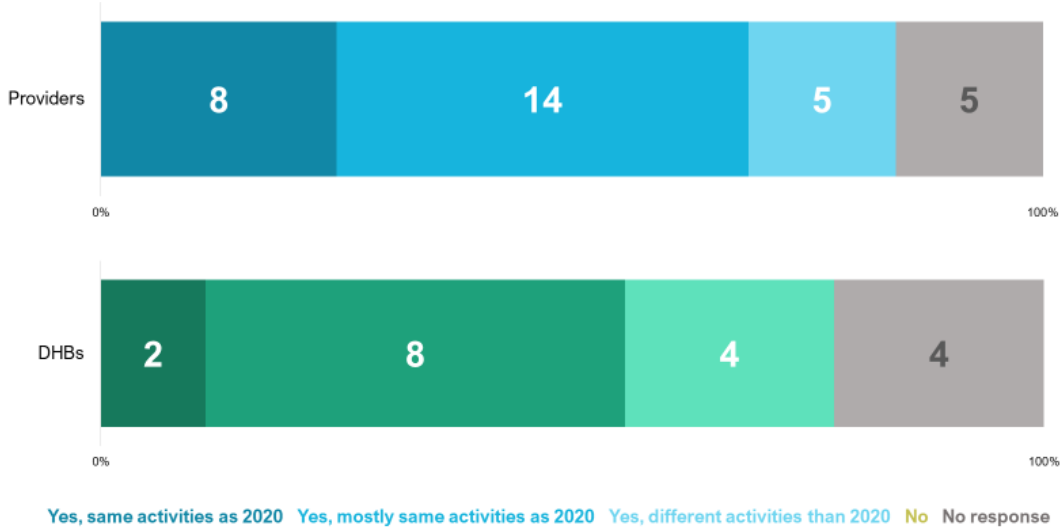
Total DHB responses: 16. 2 respondents chose not to respond.
Total Provider responses: 17. 17 respondents ineligible to answer, previously indicated not part of putting together application.

MIVP services

Providers and DHBs indicated they would mostly do the same things in 2021.

160. If they were to deliver MIVP in 2021, both providers and DHBs indicated they would mostly do the same things. This was the case for more than half of providers (22/32) and just over half of DHBs.

Figure 12. Interest in delivering MIVP activities again in 2021, if funding were available



Total DHB responses: 18. 4 respondents chose not to respond.
Total Provider responses: 32. 5 respondents chose not to respond. 2 respondents ineligible to answer, previously indicated had not submitted an application.

MIVP Funding needs

Support for vaccine management , workforce and outreach costs.

Providers indicated that if they were to implement MIVP in 2021, in the main they would need additional funding support to operationalise activities funded by MIVP in 2020. In particular, they need funding for vaccine management and for workforce-related costs. DHBs also indicated they would use funding for staff and outreach-related costs. (See Figure 13 and Figure 14).

Figure 13. Support needed by providers to deliver MIVP in 2021

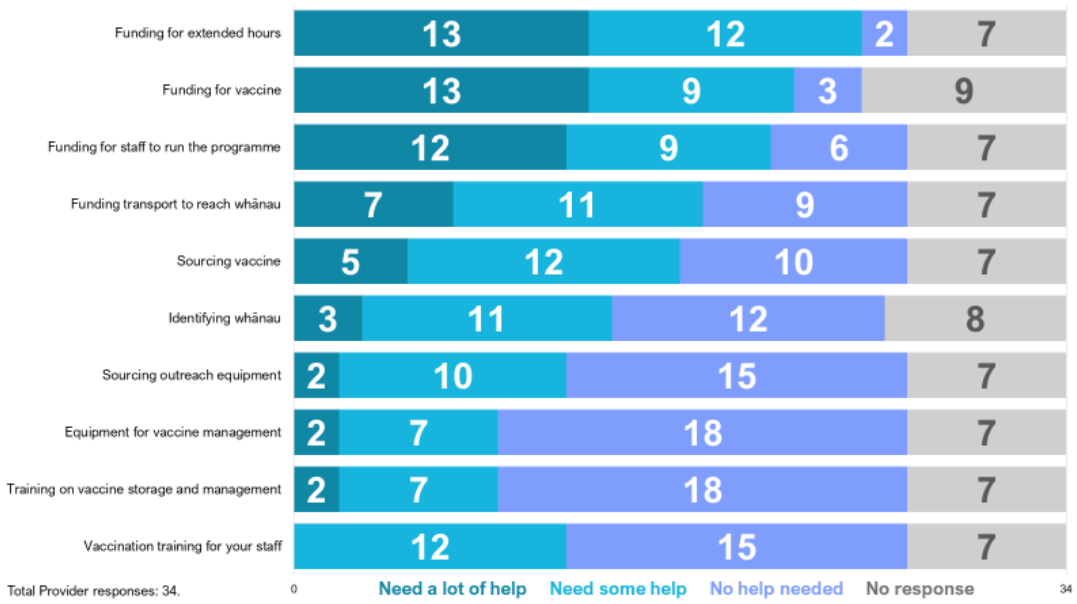
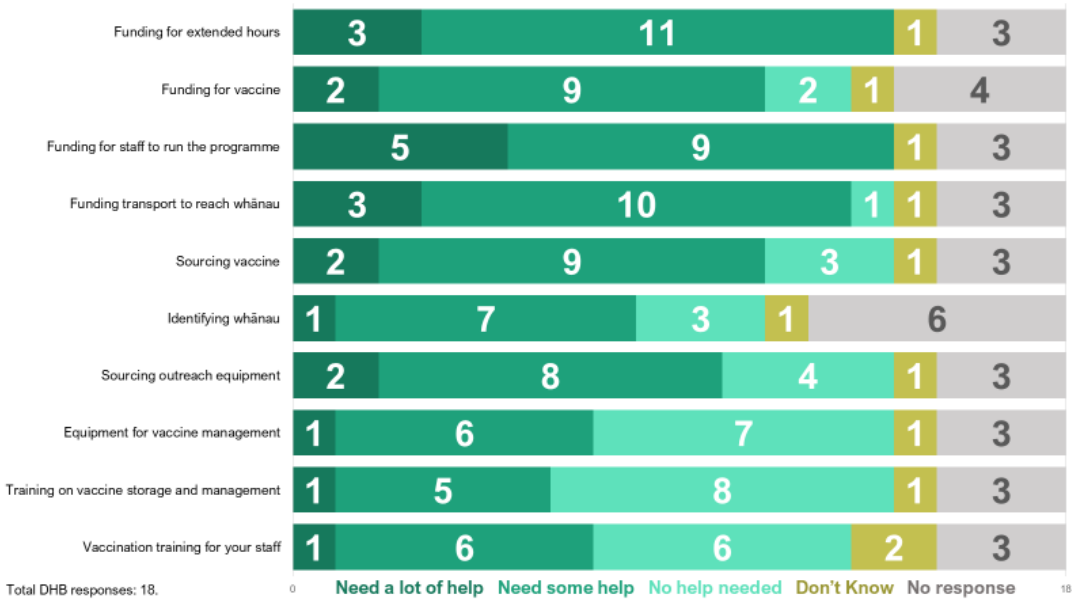


Figure 14. Support needed by DHBs to deliver MIVP in 2021

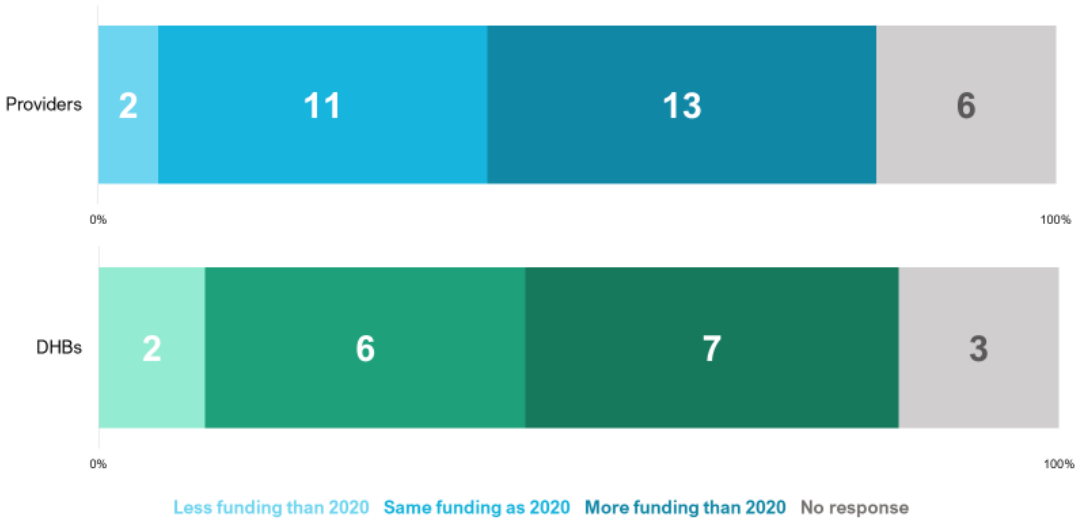


MIVP Funding amounts

Providers and DHBs indicated they would need similar or more funding in 2021.

161. Around half of providers and DHBs indicated they would like more funding. A small number indicated they would need less funding.

Figure 15. Funding needed by DHBs and providers to deliver MIVP in 2021, in comparison to funding received in 2020



Total DHB responses: 18. 3 respondents chose not to respond.
Total Provider responses: 32. 2 respondents ineligible to answer, previously indicated had not submittd an application.

162. DHBs and to a lesser extent providers suggested that less funding was needed as some capacity had been developed in terms of equipment and resources, such as fridges and gazebos, and would still be available in 2021. However, some of this equipment might need to be replaced or upgraded, for example fridges instead of chilly bins and better quality wet-weather gear.

163. DHBs also identified existing sources of funding such as the Māori Provider Development Scheme (MPDS) or DHB workforce development funding, which might be used to support training as well

as funding allocated through MIVP. Also some DHBs and providers did not use all of their funding due to context factors such as the second period of COVID-19 Alert Level 1 in Auckland and services providers not able to take up contracts due to the lack of capacity.

Funding implications and considerations for 2021

164. This section presents a series of tables by region, and a combination of funding allocations, context for funding decisions and outcomes observed by DHB region. (See Table 15, in Appendix 2 for a single table of all variables).

165. Table 7 provides an overview of the criteria for indicative funding allocation by region and the actual funding awarded to each region. The total funding awarded to each DHB region is shown in two ways: the funding awarded per region based on the number of unvaccinated Māori over 65 years as at 8 May 2020[16] and total funding awarded to each DHB region[17].

Table 7. Funding awarded by DHB region (assuming equal split allocation for collaborative applications) with corresponding population and equity gap data

DHB	2019 Equity gap	Māori 65+ Population	Funding awarded per unvaccinated as @ 8 May 2020 (Week 19)	Total funding awarded
Waikato	-11.09	6420	$281.88	$867,510.00
Northland	-7.57	5300	$355.30	$965,000.00
Counties Manukau	-8.05	5180	$309.97	$936,546.40
Bay of Plenty	-7.18	4770	$234.09	$419,951.00
Canterbury	-24.18	3720	$37.49	$75,875.00
Waitemata	-11.70	3610	$375.01	$771,386.40
Auckland	-21.07	3300	$401.93	$795,241.40
Hawkes Bay	-4.63	2970	$431.41	$481,457.00
Lakes	4.73	2680	$230.42	$216,825.00
Tairawhiti	-10.86	2410	$78.78	$87,285.00
MidCentral	-13.39	2410	$81.24	$94,160.00
Southern	-12.99	2380	$81.71	$110,632.00
Capital and Coast	-6.93	2020	$391.25	$352,904.00
Taranaki	-18.66	1760	$197.45	$193,500.00
Hutt Valley	-3.86	1430	$232.95	$138,836.00
Whanganui	7.00	1290	$780.82	$181,150.00
Nelson Marlborough	-9.70	1170	$156.31	$84,250.00
Wairarapa	-14.80	650	$290.11	$78,329.00
South Canterbury	-14.65	430	$0.00	$0.00
West Coast	-15.58	350	$810.83	$121,625.00

166. Indicative funding totalled $9.45m and was allocated relative to population of Māori over 65 years in each region. However, actual funding was awarded based on applications received and approved (See Table 1, page 13) As a result, **funding awarded reflects the number of MIVP applications** and was not always proportional to the population of Māori over 65 years in each region.

167. The average total funding awarded to each region was $366,971. The average amount per unvaccinated Māori as at 8 May 2020 was $303.10.

[16] 8 May 2020 (Week 19) was the date that MIVP application submissions closed and represents the 'target population' for MIVP-funded activities and the amount of funding per intended recipient of MIVP-funded activities

[17] Assuming an equal split between regions for collaborative applications and incorporates both funding awarded to both DHBs and directly to providers)

168. Of note, Canterbury has the fifth highest population of Māori over 65 years. Two applications were received related to delivering services in Canterbury, and only one was funded. As a result, despite its relatively high Māori population (3720), when compared to regions with a similarly high population of Māori over 65 years (Waitematā, 3610 and Auckland, 3300), Canterbury received significantly less MIVP-specific funding.

169. Table 8 shows the funding awarded per region based on the number of unvaccinated Māori over 65 years as at 8 May 2020[18] and actual funding awarded to each DHB region[19]. In addition, funding decisions are compared against two outcome markers: the percentage of Māori over 65 years who received the flu vaccination before Week 46 2020 and the resulting equity gap in that region as at Week 46 2020[20].

Table 8. Funding awarded by DHB region (assuming equal split allocation for collaborative applications) with corresponding percentage of Māori over 65 years population vaccinated and equity gap as at Week 46 2020

DHB	Funding awarded per unvaccinated as @ 8 May 2020 (Week 19)	Total funding awarded	Percentage vaccinated Māori 65+ (2020)	2020 Equity gap (as @ Week 46)
Whanganui	$780.82	$181,150.00	86.05	8.38
Hawkes Bay	$431.41	$481,457.00	78.11	5.16
Lakes	$230.42	$216,825.00	68.99	5.35
Bay of Plenty	$234.09	$419,951.00	68.01	-7.09
Hutt Valley	$232.95	$138,836.00	64.41	-1.97
Nelson Marlborough	$156.31	$84,250.00	63.68	-9.34
Waikato	$281.88	$867,510.00	60.78	-9.09
Capital and Coast	$391.25	$352,904.00	60.64	-6.13
Wairarapa	$290.11	$78,329.00	60.00	-16.67
Northland	$355.30	$965,000.00	59.70	-4.78
Tairawhiti	$78.78	$87,285.00	59.00	-10.25
West Coast	$810.83	$121,625.00	56.57	-18.51
MidCentral	$81.24	$94,160.00	56.39	-13.72
Southern	$81.71	$110,632.00	56.34	-6.46
Canterbury	$37.49	$75,875.00	54.35	-20.93
Counties Manukau	$309.97	$936,546.40	52.95	-9.44
Taranaki	$197.45	$193,500.00	50.80	-17.11
Waitemata	$375.01	$771,386.40	48.53	-12.26
South Canterbury	$0.00	$0.00	44.42	-13.46
Auckland	$401.93	$795,241.40	40.18	-22.15

170. What Table 8 illustrates is that **there is no clear relationship between the amount of funding awarded to a region, whether in total or by intended recipient, and flu vaccination outcomes.**

171. The five regions that received the most funding (Northland, Counties Manukau, Waikato, Auckland and Waitematā) achieved varied results in terms of percentage of Māori over 65 years vaccinated or change in the regional equity gap.

- Northland achieved the fourth largest increase in percentage vaccinated compared with 2019 (17.53 percentage points) and shifted from 16th in 2019 to 10th position nationally in 2020.
- Waikato increased from 7th to 6th position nationally, with 13 percentage point increase, which is important given that it has the largest regional Māori population over 65 years (6420).

[18] 8 May 2020 (Week 19) was the date that MIVP application submissions closed and represents the 'target population' for MIVP-funded activities and the amount of funding per intended recipient of MIVP-funded activities

[19] Assuming an equal split between regions for collaborative applications and incorporates both funding awarded to both DHBs and directly to providers)

[20] Week 46 is the final week that NIR data for 2020 was available for the evaluation

- In contrast, Auckland remains last nationally in terms of percentage of Māori over 65 years who received a flu vaccination, with the third lowest increase in vaccination rates for Māori over 65 years from 2019 to 2020 (7.4 percentage points) and the worst equity gap nationally as at Week 46 2020.
- Waitematā and Counties Manukau achieved a slightly higher increase (12.63 and 10.51 percentage points respectively) and slightly higher percentage of population vaccinated (48.53% and 52.95% respectively), but remain in the bottom five regions nationally.
- The two regions that received the most funding per unvaccinated Māori person over 65 years (Whanganui and West Coast) had almost opposite results.
    - Whanganui built from a strong history and foundation of flu vaccination equity, to achieve the highest percentage of vaccinated Māori over 65 years and equity outcome in 2020 with more Māori than non-Maori, non-Pacific receiving a flu vaccination.
    - In contrast, West Coast received the most funding per unvaccinated Māori over 65 years and shifted from 10th position in 2019 to 12th position in 2020 nationally in terms of percentage Māori who received a flu vaccination, and the third worst equity gap as at Week 46 2020.

172. The average amount of funding awarded per unvaccinated Māori as at 8 May 2020 across all regions was $303.10. The average amount of funding per unvaccinated Māori person over 65 years for the five regions that achieved the highest percentage of vaccinated Māori 65+ was $381 per person. For the five regions that achieved the highest equity improvement, the average amount of funding per unvaccinated Māori person over 65 years was $375 per person. This suggests that to drive equity deeply and achieve 70-80% flu vaccination rate, the cost per person is comparatively high.

173. Table 9 shows actual funding awarded to each DHB region[21] and the total funding awarded to DHBs or providers funded directly from the Ministry. Funding decisions are compared against two outcome markers: the percentage of Māori over 65 years who received the flu vaccination before Week 46 2020, and the resulting equity gap in that region as at Week 46 2020.

[21] Assuming an equal split between regions for collaborative applications and incorporates both funding awarded to both DHBs and directly to providers)

Table 9. Funding awarded by DHB region (assuming equal split allocation for collaborative applications), separated by DHB and direct-funded provider allocations, with corresponding percentage of Māori over 65 years population vaccinated and equity gap as at Week 46 2020

DHB	Total regional funding allocated	DHB allocation	Direct funded provider allocation	Percentage vaccinated Māori 65+ (2020)	2020 Equity gap (as @ Week 46)
Whanganui	$181,150.00		$ 181,150.00	86.05	8.38
Hawkes Bay	$481,457.00	$ 481,457.00		78.11	5.16
Lakes	$216,825.00	$ 216,825.00		68.99	5.35
Bay of Plenty	$419,951.00	$ 383,000.00	$ 36,951.00	68.01	-7.09
Hutt Valley	$138,836.00		$ 138,836.00	64.41	-1.97
Nelson Marlborough	$84,250.00		$ 84,250.00	63.68	-9.34
Waikato	$867,510.00		$ 867,510.00	60.78	-9.09
Capital and Coast	$352,904.00	$ 352,904.00		60.64	-6.13
Wairarapa	$78,329.00		$ 78,329.00	60.00	-16.67
Northland	$965,000.00	$ 965,000.00		59.70	-4.78
Tairawhiti	$87,285.00		$ 87,285.00	59.00	-10.25
West Coast	$121,625.00	$ 121,625.00		56.57	-18.51
MidCentral	$94,160.00		$ 94,160.00	56.39	-13.72
Southern	$110,632.00		$ 110,632.00	56.34	-6.46
Canterbury	$75,875.00	$ 75,875.00		54.35	-20.93
Counties Manukau	$936,546.40	$ 771,386.40	$ 165,160.00	52.95	-9.44
Taranaki	$193,500.00		$ 193,500.00	50.80	-17.11
Waitemata	$771,386.40	$ 771,386.40		48.53	-12.26
South Canterbury	$ -			44.42	-13.46
Auckland	$795,241.40	$ 771,386.40	$ 23,855.00	40.18	-22.15

174. Table 9 illustrates that **there is no clear relationship between the contracting approach (whether funding providers directly, funding through DHBs or a combination of both) and flu vaccination rate increases**.

175. Significant increases and positive outcomes were observed in regions where:

- only providers were directly funded (Whanganui and Waikato)
- DHBs were funded and contracted providers (Hawke's Bay, Lakes and Northland)
- both DHBs and providers were funded (Bay of Plenty).

176. On the other hand, less positive outcomes were also observed in regions where:

- only providers were directly funded (Taranaki, Southern and Mid Central),
- DHBs were funded and contracted providers (Canterbury and West Coast)
- both DHBs and providers were funded (Auckland and Counties Manukau).

177. Table 10 presents the funding awarded per region based on the number of unvaccinated Māori over 65 years as at 8 May 2020[22] and actual funding awarded to each DHB region[23]. Funding decisions are compared against two decision factors: the 2019 flu vaccination rate equity gap and the regional population of Māori over 65 years and two outcome markers: the cumulative sum of Māori over 65 years who received the flu vaccination by Week 41 2020, and the resulting equity gap in that region as at Week 46 2020[24].

[22] 8 May 2020 (Week 19) was the date that MIVP application submissions closed and represents the 'target population' for MIVP-funded activities and the amount of funding per intended recipient of MIVP-funded activities

[23] Assuming an equal split between regions for collaborative applications and incorporates both funding awarded to both DHBs and directly to providers)

[24] Week 46 is the final week that NIR data for 2020 was available for the evaluation

Table 10. Funding awarded by DHB region (assuming equal split allocation for collaborative applications) with 2019 equity gap, population of Māori 65+, corresponding cumulative sum of Māori over 65 years population vaccinated in 2020 and equity gap as at Week 46 2020

DHB	2019 Equity gap	Māori 65+ Population	Funding awarded per unvaccinated as @ 8 May	Total funding awarded	Sum vaccinated as @ 9 Oct 2020 (Week 41)	2020 Equity gap (as @ Week 46)
Waikato	-11.09	6420	$281.88	$867,510.00	3898	-9.09
Northland	-7.57	5300	$355.30	$965,000.00	3163	-4.78
Counties Manukau	-8.05	5180	$309.97	$936,546.40	2732	-9.44
Bay of Plenty	-7.18	4770	$234.09	$419,951.00	3240	-7.09
Canterbury	-24.18	3720	$37.49	$75,875.00	2017	-20.93
Waitemata	-11.70	3610	$375.01	$771,386.40	1749	-12.26
Auckland	-21.07	3300	$401.93	$795,241.40	1312	-22.15
Hawkes Bay	-4.63	2970	$431.41	$481,457.00	2290	5.16
Lakes	4.73	2680	$230.42	$216,825.00	1849	5.35
MidCentral	-13.39	2410	$81.24	$94,160.00	1359	-13.72
Tairawhiti	-10.86	2410	$78.78	$87,285.00	1421	-10.25
Southern	-12.99	2380	$81.71	$110,632.00	1340	-6.46
Capital and Coast	-6.93	2020	$391.25	$352,904.00	1224	-6.13
Taranaki	-18.66	1760	$197.45	$193,500.00	898	-17.11
Hutt Valley	-3.86	1430	$232.95	$138,836.00	920	-1.97
Whanganui	7.00	1290	$780.82	$181,150.00	1110	8.38
Nelson Marlborough	-9.70	1170	$156.31	$84,250.00	746	-9.34
Wairarapa	-14.80	650	$290.11	$78,329.00	388	-16.67
South Canterbury	-14.65	430	$0.00	$0.00	191	-13.46
West Coast	-15.58	350	$810.83	$121,625.00	199	-18.51

178. **To effectively monitor progress towards equity, it is important to monitor the number of people vaccinated** and not just percentage vaccination rates. Table 11 illustrates that reporting on population percentages between regions can hide the true impact of equity on individual people. A different picture is evident when looking at the number of people vaccinated. Waikato (3893), Bay of Plenty (3240) and Northland (3163) are the top three regions in terms of number of people vaccinated. When looking at percentage vaccinated, these regions are seventh, fourth and tenth respectively.

179. Waikato stands out as a success story when viewed in terms of actual Māori people over 65 years who received a flu vaccination. They have the highest population of Māori over 65 years of any region, and successfully vaccinated the highest number of Māori as well. Further, they reduced the equity gap in 2020 between Māori and non-Maori, non-Pacific by 2 percentage points. To achieve equity nationally, regions with a high Māori population must be supported to achieve equity.

180. Canterbury has the fifth highest population of Māori over 65 years yet has the second worst flu vaccination equity rate nationally. In comparison to regions with a similarly high population of Māori over 65 years (Waitematā and Auckland), Canterbury has achieved higher number of actual vaccinations and a slight improvement in the equity gap with significantly less MIVP-specific funding. The MIVP was designed to award funding in response to applications, although indicative funding was earmarked to each region based on Māori population numbers. This suggests that:

- Canterbury may have relied on more mainstream or 'business-as-usual' approaches to reach Māori, that will likely have also reached non-Maori, non-Pacific people; hence the slightly improved but overall poor equity gap
- Canterbury DHB and providers may benefit from support to complete applications for programmes such as the MIVP, in order to receive comparatively appropriate levels of funding
- Canterbury DHB and providers may benefit from support to design approaches and build new relationships or partnerships to more effectively find and reach Māori in the community for programmes such as the MIVP, in order to see flu vaccination rates and overall equity outcomes observed in other regions.

What this data highlights is that **any future allocation of funding to improve outcomes will be complex and challenging**. It will require a nuanced approach, based on careful application of key insights.

181. Firstly, there is no clear relationship between the amount of funding awarded to a region, whether in total or by intended recipient, and vaccination outcomes, Nor is there a clear relationship between the contracting approach and flu vaccination rate increases; whether funding providers directly, funding through DHBs, or a combination of both.

182. Further, giving more money (per target person) and expecting better outcomes is not a proven winning formula (see Whanganui compared to the West Coast). Neither is giving more money overall (see Waikato and Northland compared to Auckland, Counties Manukau and Waitematā).

183. More money means providers and DHBs can do more, but they have to know what they are going to do with it, and be able to use that funding effectively. In regions where there is low equity and limited vaccination capability, as demonstrated in 2020, the evaluation suggests that **more than money is needed.** The sharing of strategies and ideas and support to develop responses tailored to provider, DHB and the local community context would be beneficial.

184. **There is a need to revisit the funding allocation formula.** The current funding approach takes account of Māori regional population and equity rates. However, a more nuanced approach is needed that takes account of vaccination and equity trends, as well as provider and DHB performance in 2020 (and historically) and their capability to use the funding to best effect.

Insights and reflections on MIVP 2020

185. MIVP is an equity-focused initiative. It responded to long-standing inequity as part of a COVID-19 response. MIVP contributed to increased Māori flu vaccination rates. However increased vaccinations rates were not evenly shared across the country, with some regions performing extremely well in terms of their impact on equity, e.g., Hawke's Bay, Lakes, Whanganui and Northland and other regions less so. More than just increased flu vaccinations, as valuable as these are, MIVP provided the opportunity for providers and DHBS to innovate and adapt existing services. It identified key strategies, principles and elements to drive change.

186. What made the difference in the MIVP was reducing barriers and improving access. Māori providers and DHBs responded to the well-known barriers to accessing GPs and primary healthcare as summarised in Table 11.

Table 11. How providers and DHBs reduced barriers and increased access to vaccination and other support and services

Barriers	MIVP reduced barriers by…
GPs	Supplementing GP and Pharmacy services by promoting community-based, nurse-led (in the main) vaccinations
Access to services	Mobilising services and going out into the community where whānau gather and live. They also transported whānau to services.
Costs	Reducing transport costs by going to whānau, reduced potential loss of income through offering vaccination services after hours or on the weekend, confirmed eligibility within the 'vulnerable' criteria and provided some vaccinations free of charge. Vouchers were used to increase access to services by meeting some of the transport costs.
Poor service experiences	Offering whānau-centred services offered flu vaccinations as well as other health and support services. Networked with community leaders to offer services responsive to whānau context and circumstances.
Cultural barriers	Using culturally and clinically competent mainly Māori staff who know how to engage well with whānau.
Poor health literacy	Developing tailored communications, delivered through multiple channels, such as print, online, community leaders etc.
Clash of western and Māori models and worldviews	Making a whānau-centred approach the norm and eschewing a solely individualised approach

187. Two overarching principles are evident: diversity and autonomy. Providers and DHBs used multiple ways to find whānau, communicate and engage with whānau. They worked individually, and they worked collaboratively. They delivered vaccinations in churches, on sports fields, in car parks and on marae. There is no "one size fits all". It is the diversity of access options that breaks down barriers for Māori, increases access and delivers equity overall.

188. Using deep knowledge of their communities and tapping into leaders and networks, providers and DHBs determined what would work best for whānau and their people. Diversity and innovation needs to be supported by autonomy. Provider autonomy needs to be encouraged and affirmed. The Ministry needs take a more strategic approach to assessment of applications. This could include for example assessing applications against the three core MIVP strategies (mobilisation, whānau-centred and workforce capability). The Ministry needs to trust providers, who know their communities and what to do. There is a need to stay open to new or unfamiliar ideas and the assessment of risk, so as not to stifle innovation.

189. The evaluation identified three core strategies that underpin MIVP: mobilisation and taking services out into the community, taking a whānau-centred approach and a focus on workforce development.

Mobilisation and taking services out into the community

190. By encouraging and funding innovation, MIVP demonstrated the efficacy of mobilising services and taking them into the community, as a one-off intervention. The potential of mobile services, as a component of primary health care for Māori, warrants consideration. Proof-of-concept funding should be considered to explore service design, workforce requirements and cost implications.

Whānau-centred approach

191. Existing long-standing rates of inequity for Māori signal that GPs and pharmacies alone are insufficient to ensure Māori receive the vaccination services they are entitled to. A whānau-centred approach delivers positive outcomes for Māori by offering multiple ways for whānau to access health services, alongside existing GP and pharmacy systems.

192. Successful DHBs and providers took a whānau-centric approach rather than focusing solely on Māori aged over 65. With equity as the focus, the Ministry should advocate for a change in eligibility criteria to a whānau-centric focus - shifting from the current PHARMAC model, which has an individual focus.

Workforce capability

193. The issue of Māori workforce capability, including vaccinations, is broader than MIVP. Historical underfunding of Māori providers has resulted in some providers trading off salaries and workforce development for service delivery resources and activities, in order to meet the needs of whānau. Some providers and DHBs intentionally focused on building Māori workforce capacity, both in the short and long-term to increase their vaccination workforce. Both providers and DHBs tell us that workforce vaccination capability development will continue to need ongoing support.

194. It needs to be said that the emphasis here is on the Māori workforce. The evidence tells us that whānau are more receptive, feel more comfortable and reassured when they see and engage with Māori staff. For MIVP and broader Māori health gains, having Māori staff who are culturally adept and clinically sound is essential.

Implementing MIVP in 2021.

195. Equity is the underlying imperative that supports MIVP implementation in 2021. At the same time, the insights and learning about what worked in 2020 provide a strong foundation to shape change and extend the reach and impact of MIVP. For implementation in 2021, the Ministry should plan to get funds out earlier in the year, retain dual funding, develop more tailored support to DHBs and providers in regions where improvements in equity rates have been slight or flat, and re-look at the criteria for allocating funds.

196. **Plan to get MIVP funding out early in the year.** In 2020, funding came too late for some providers to make best use of it. One highly performing region began planning for 2020 flu vaccinations in November 2019. Another highly performing region, began their planning at the same time as developing their MIVP application. Providers and DHBs would benefit from having as much notice as possible assuming the Ministry elects to roll out MIPV in 2021. More time allows for more planning, collaboration, sharing of ideas, staff training and engaging with leaders, networks and communities.

197. **Retain the dual funding.** Dual funding offers two alternative channels to get funding out quickly into the community. Direct funding of providers by the Ministry was timely. In contrast, DHBs were slow to get funding out to providers, reaching some providers when some planned opportunities had passed them by.

198. Funding DHBs adds another layer of bureaucracy to the rapid deployment of funds and services. Future changes signalled for DHBs are unlikely to deliver increased rapidity in contracting and funding providers, at least in the short-term. The Ministry could explore having service-level agreements with DHBs which commit them to agreed delivery timeframes as well as identify what support the Ministry could offer to support DHBs to achieve more timely contracting. However, there is an underlying aspiration for Māori providers to receive direct funding. This cannot be ignored.

199. No one funding model is more strongly associated with positive outcomes than another. When looking at the four top-performing regions for flu vaccination rates in 2020, (see Figure 3, page 18), Whanganui, Hawke's Bay Lakes and Bay of Plenty, no one model was more strongly associated with increased flu vaccinations and improved equity than another.

200. Different funding models ran in each region. In Whanganui, the Ministry direct-funded a Māori health provider, and the DHB did not make an application. For the Hawke's Bay and Lakes DHBs, the Ministry funded the DHBs who coordinated the work of Māori health providers. In the Bay of Plenty, the Ministry funded both the DHB and Māori health providers directly. The success in these regions shows there is no one best way to fund for success. It also suggests the need to respond to the variable levels of provider and DHB capability, and offer support, as part of any future roll-out of MIVP.

201. Sharing what worked on the ground offers valuable insights for providers and DHBS. There is an opportunity to:

- share approaches that worked by developing top tips, practice examples and case studies
- facilitate connections between representatives of high-performing regions and those needing more support and regions with similar contexts
- facilitate sharing ideas and data, where possible, between regions
- fund for knowledge sharing and mentoring (formally or informally), to recognise the additional effort and time this can take (which takes away from the core business of service delivery).

202. Develop more tailored support to assist DHBs and providers in regions where little movement in equity rates and trends suggest they are struggling. It suggests understanding the community context, defining the problems and identifying what is needed to bring about change are not sufficiently well understood. Little movement in equity rates might also indicate poor implementation. These regions need something more than just extra funding. It is not enough to try to drag and drop successful approaches from other regions. These regions need tailored support to unpack the regional context to identify what might work, given the uniqueness of the region, its people, resources and relationships.

203. Revisit the funding allocation formula. The current funding approach takes account of Māori regional population and equity rates. However, a more nuanced approach is needed that takes account of vaccination and equity trends, as well as provider and DHB performance in 2020 (and historically), and their capability to use the funding to best effect.

204. There is no clear relationship between, firstly, the amount of funding awarded to a region, whether in total or by intended recipient, and vaccination outcomes and, secondly, the contracting approach and flu vaccination rate increases: whether funding providers directly, funding through DHBs, or a combination of both. Neither, giving more money (per target person) nor giving more money overall (per DHB region) guarantees successful outcomes.

205. More money means providers and DHBs can do more, but they have to know what they are going to do with it and be able to use that funding effectively. In regions where there is low equity and limited vaccination capability, as demonstrated in 2020, the evaluation suggests that more than money is needed. The sharing of strategies and ideas and support to develop responses tailored to provider, DHB and the local community context is suggested as beneficial.

206. The Ministry needs also to recognise good performance. The opportunity for regions like Hawke's Bay, Lakes, Whanganui and Northland for example (See

207. Table 2 and Table 3 page 22) is to go from good to great, or great to excellence. **In these regions, beyond due diligence, give them sufficient funding and the autonomy to use it responsively**. They know what they are doing and have demonstrated they are competent and trustworthy.

208. **Revise the application form and reporting systems to be able to clearly attribute MIVP outcomes and impact.**

Consider revising the DHB application form and or assessment process, to ensure DHBs list all of the providers who are part of their application. Without this information it is not possible to accurately gauge and report on programme reach; or to elicit feedback from this group of providers. In addition, consider developing an online form for providers and DHBs to enter the total number of immunisations completed on a weekly basis. This data will enable the attribution of MIVP administered vaccinations from those delivered by non- Māori non-Pacific organisations, and a strong assessment of impact.

Conclusion

209. MIVP displayed the effectiveness of mobilising primary care services, in combination with a whānau-centred approach, to reduce barriers and improve access to flu vaccinations for Māori. This hybrid approach offers a new lever in the health delivery system alongside GPs and pharmacies. A whānau-centred approach combined with mobilising services has the potential to make a radical difference to Māori experiences of primary health care, Māori health outcomes and equity.

210. Currently, most Māori are not receiving equity of health care, and the significant disparity in equity rates for flu vaccinations is telling. Some regions are closing the gap using a mobilised, whānau-centred service approach. **The critical learning from MIVP is that delivery of vaccinations is more than just a jab. The MIVP pilot intervention delivers the ingredients for system transformation.**

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Appendix 1 – Evaluation Methodology

211. The evaluation design used a combination of four rapid insight cycles, an evaluation-specific methodology and a mixed-methods research approach. For this evaluation 'rapid' equates to M four-to-six-week duration. 'Micro' reports were developed to guide the collaborative sense making workshop with the Ministry at the end of each cycle.

212. Learning was iterative throughout the evaluation. Each cycle allowed the Ministry and the evaluation team to revisit the purpose of each cycle; and adapt if necessary, the focus or methods for upcoming cycles. The evaluation was able to respond to emerging information requests, which had not been anticipated at the planning and design phase.

Table 12. Evaluation phase and activities

Week Commencing	Phase	Activities
15-30 June 2020	Launch	Developing a possible plan of work
1-31 July 2020	RIC 1	RIC 1 focused on findings and emerging insights for sensemaking discussion from • 7 interviews with Ministry staff • a project orientation focus group with Ministry staff.
1-31 August 2020	RIC 2	RIC 2 focused on the analysis of the data from: • Interviews with Ministry staff • National Immunisation Register data bases • Population data: 2013-Based Population Projections (NIR Population) • DHB and Provider application forms.
1-30 September 2020	RIC 3	RIC 3 focused on the analysis of the data from: • National Immunisation Register data bases • Population data: 2013-Based Population Projections (NIR Population) • 15 interviews with Providers (directly and indirectly funded) and DHB.
1 October –mid-November 2020	RIC 4	This phase focuses on the analysis of the data from: • National Immunisation Register data bases • Population data: 2013-Based Population Projections (NIR Population) • 23 interviews with Providers (directly and indirectly funded) and DHB (includes an additional 8 interviews to those reported in RIC 3) • Survey responses from Providers (n=34) and DHB staff (n=18).
Mid- November - December 2020	Reporting	

Table 13. Data collection activities and regional coverage

Region	Interviews					Survey Responses	
	GM Māori	MIVP Coord	Imms Coord	Direct-funded Provider	DHB-funded Provider	DHB	Provider
Northland DHB		1	1		1		4
Auckland, Counties-Manukau, Waitematā DHBs	2	1		2		4	3
Waikato DHB				1			2
Bay of Plenty DHB	1	1		1	1	1	
Taranaki DHB						2	1
Lakes DHB							3
Tairawhiti DHB							1
Whanganui DHB	1			1		1	1
MidCentral DHB				1			1
Hawke's Bay DHB	1	1	1		1	1	3
Capital and Coast DHB						1	1
Hutt Valley DHB			1			2	1
Wairarapa DHB							
Nelson Marlborough DHB							2
West Coast DHB						1	
Canterbury DHB	1		1				
South Canterbury DHB							
Southern DHB						3	3

Limitations

213. The evaluation collected and analysed a mix of qualitative, quantitative and administrative data for all 21 DHB regions. The evaluation did not collect whānau feedback on their experience of MIVP. The evaluation was not able to collect the same data in all regions, so there are some information gaps (see Table 13, above) for a description of data collection by DHB region). This is particularly the case in Canterbury and the Auckland regional cluster. Further, the evaluation design intentionally focused on trying to understand success and its enablers and less resource was available to analyse regions with poor performance in 2020 and historically.

214. The evaluation used the National Immunisations Register to track changes in Māori flu vaccinations rates. The evaluation does not report on the number of vaccinations administered by providers as NIR does not capture data in this way. Further, while some MIVP providers reported the number of vaccinations administered as part of MIVP to the Ministry, the data is not utilised in this evaluation due to issues of completeness and our overall confidence in the data.

215. The evaluation only has NIR data for 65+ as other vulnerable groups are not captured within NIR. However, there is data from providers that indicates they worked with other eligible cohorts.

216. The total number of providers who participated in MIVP is approximately 58. The total number of providers funded directly by the Ministry is 18. There were at least 40 providers included in DHB applications. All except one DHB provided this information for the evaluation, hence the approximation.

Appendix 2 – Additional Data, Tables and Graphs

Ways MIVP has enabled relational approaches between different parties

Table 14 outlines the relationships within MIVP, how they have enabled the process, and the resulting impacts. Significantly, but not surprisingly, where relationships are positive, robust, and working well, communication, collaboration, and sharing of resources and knowledge is fair and equitable.

Table 14. Ways MIVP has enabled relational approaches between the different parties

Relationships	How MIVP has enabled a relational approach?	Impacts of relationships
DHB[25] – Provider (DHB funded)	• Where relationships are developed and working well, DHBs worked together with providers to develop collaborative approaches to administer flu vaccination. • Providers helped to lead the DHB in terms of supports and resources they needed to deliver services to their Māori communities. • DHB approaches aligned with their wider strategic plans and supported new connection by involving a range of providers, including PHOs, GPs, and Māori providers • DHBs supported providers to deliver services. This could be in the form of hands-on assistance, tracking vaccine supply, training and education, recording and sharing vaccine data, and information sharing, including information packs for whānau about other health services. • DHB funded providers, both Māori and non-Māori, connected over a common goal and purpose • Where relationships are less established or functional, DHBs continued to have conversations with providers. Relationships between DHB and providers at times had a whakapapa of tension and disappointment, and it takes time to rebuild trust • DHB-Provider conversations are ongoing, and progress made this	• Improved access to the flu vaccine • Provider kaimahi trained as vaccinators • Strengthened relationships between DHB GM Māori, DHB Māori health units, and providers • Improved connection for DHBs with Māori communities, and what's happening on the ground • Healthy conversations between DHB funded providers (Māori and mainstream) on ways to work together • Less success engaging with providers and implementing MIVP when is low trust and relationships are strained. • DHBs still hold the funds, which Providers must apply and negotiate for

[25] DHB refers to General Manager Māori, Planning and Funding, Immunisation Corrdinators, unless specified.

	year should materialise into collaborations to vaccinate, in 2021.	• Potentially only the providers with good working and less contentious relationships with DHBs will be part of discussions.
DHB – Provider (direct funded)	• DHBs were involved in the planning but then handed over power/control to providers to implement • GM Māori Directorate advocated for providers and showed levels of trust and respect by deciding that the funding would go directly to them • DHBs supported collaborative responses of providers, informing them of the funding available and bringing them together to plan and strategize.	• Providers who were doing well continued to do so with DHB support (when and if required) • Providers were affirmed as the best health response to work with their Māori communities • Providers came to the table with power and mana, in their own right as professional health providers, and are part of the decision-making process.
Provider - Provider	• Māori Providers developed a strategy and planned approach to implementing MIVP that compliments each provider context and community • Shared data on whānau who have not been vaccinated and discussed ways to reach them • Worked together did not only occur between Māori health providers; collaboration and interactions extended to community programmes, marae, pharmacies and GPs.	• Services were delivered respectfully within iwi, hapū boundaries • Less duplication of services occurred • Whānau were not confused by approaches from multiple services • Flu vaccine promotions across several communities • Breadth and depth of access to Māori • Helped to break down the competitive / siloed funding model typically experienced by providers.

Internal DHB	• Within DHBs, "courageous conversations" occurred about the best ways to connect with Māori communities, to improve vaccination rates and to determine how DHB units could work with each other to improve equity for Māori and improved health outcomes • DHB Māori Health Directorates, Planning and Funding, and Immunisation Coordinators worked together to align MIVP and other vaccination approaches • MIVP was a lever for GM Māori to continue the conversations with mainstream DHB services about equitable health outcomes for Māori.	Supported a continuous learning environment within DHBs Provider received funding directly rather than through the DHB DHB mainstream services saw the value in Māori providers DHB services accessed and engaged with Māori communities.
DHB - DHB	• DHBs shared information about what was successful in engaging and accessing Māori to improve vaccination rates • DHBs are contacted other DHBs with excellent vaccination rates to find out how they implemented their approaches. This included learning about how relationships worked between DHB and the providers • DHBs learned and adapted from each other and through implementing their approaches • In one case, three DHBs cam together and developed a strategy to implement MIVP	• DHBs modelled their approaches on what they knew worked, adapting it to reflect their communities' context • A less competitive and more collaborative environment developed. •

Funding awarded to each DHB region

Table 15 presents actual funding awarded to each DHB region (assuming an equal split between regions for collaborative applications and incorporating funding awarded to both DHBs and directly to providers) and the funding awarded per region based on the number of unvaccinated Māori over 65 years as at 8 May 2020, when MIVP application submissions closed – in other words, the amount of funding per intended recipient of MIVP-funded activities. Funding decisions are compared against outcome markers: the cumulative sum of Māori over 65 years who received the flu vaccination before Week 41 2020, the corresponding number of unvaccinated Māori, and the resulting equity gap in that region as at Week 46 2020; and two decision factors: the 2019 flu vaccination rate equity gap and the regional population of Māori over 65 years.

Table 15. Funding allocations, context for funding decisions and outcomes observed by DHB region

DHB	2019 Equity gap	Māori 65+ Population	Funding awarded per unvaccinated as @ 8 May	Total funding awarded	Sum unvaccinated as @ 8 May 2020 (Week 19)	Sum vaccinated as @ 9 Oct 2020 (Week 41)	Sum unvaccinated as @ 9 Oct 2020 (Week 41)	Percentage vaccinated Māori 65+ (2020)	2020 Equity gap (as @ Week 46)
Whanganui	7.00	1290	$780.82	$181,150.00	232	1110	180	86.05	8.38
Hawkes Bay	-4.63	2970	$431.41	$481,457.00	1116	2290	680	78.11	5.16
Lakes	4.73	2680	$230.42	$216,825.00	941	1849	831	68.99	5.35
Bay of Plenty	-7.18	4770	$234.09	$419,951.00	1794	3240	1530	68.01	-7.09
Hutt Valley	-3.86	1430	$232.95	$138,836.00	596	920	510	64.41	-1.97
Nelson Marlborough	-9.70	1170	$156.31	$84,250.00	539	746	424	63.68	-9.34
Waikato	-11.09	6420	$281.88	$867,510.00	2900	3898	2522	60.78	-9.09
Capital and Coast	-6.93	2020	$391.25	$352,904.00	902	1224	796	60.64	-6.13
Wairarapa	-14.80	650	$290.11	$78,329.00	270	388	262	60.00	-16.67
Northland	-7.57	5300	$355.30	$965,000.00	2716	3163	2137	59.70	-4.78
Tairawhiti	-10.86	2410	$78.78	$87,285.00	1108	1421	989	59.00	-10.25
West Coast	-15.58	350	$810.83	$121,625.00	150	199	151	56.57	-18.51
MidCentral	-13.39	2410	$81.24	$94,160.00	1159	1359	1051	56.39	-13.72
Southern	-12.99	2380	$81.71	$110,632.00	1354	1340	1040	56.34	-6.46
Canterbury	-24.18	3720	$37.49	$75,875.00	2024	2017	1703	54.35	-20.93
Counties Manukau	-8.05	5180	$309.97	$936,546.40	2755	2732	2448	52.95	-9.44
Taranaki	-18.66	1760	$197.45	$193,500.00	980	898	862	50.80	-17.11
Waitemata	-11.70	3610	$375.01	$771,386.40	2057	1749	1861	48.53	-12.26
South Canterbury	-14.65	430	$0.00	$0.00	253	191	239	44.42	-13.46
Auckland	-21.07	3300	$401.93	$795,241.40	2184	1312	1988	40.18	-22.15

Māori 65+ who received flu vaccinations 2015 to 2020

Table 16 presents the percentage of Māori over 65 years that received a flu vaccination in each region, as at Week 38 from 2015 to 2020, sorted by 2020 rates. The five highest performing and five lowest performing regions are highlighted.

Table 16. Percentage vaccination rate of Māori 65+ by DHB region, as at Week 38 2015-2020

DHB	2015	2016	2017	2018	2019	2020
Whanganui	48.31%	52.30%	53.48%	56.15%	55.60%	85.27%
Hawkes Bay	41.47%	46.76%	43.65%	43.63%	45.32%	77.07%
Lakes	19.67%	23.00%	25.71%	26.40%	42.19%	68.92%
Bay of Plenty	39.39%	41.74%	43.58%	44.21%	48.27%	67.82%
Hutt Valley	33.39%	36.93%	38.42%	42.31%	46.58%	64.34%
Nelson Marlborough	38.67%	42.93%	43.18%	45.35%	44.92%	63.76%
Waikato	37.43%	42.94%	41.01%	45.00%	45.41%	60.67%
Capital and Coast	38.49%	39.65%	40.73%	42.14%	45.05%	60.59%
Wairarapa	49.58%	44.07%	47.59%	51.61%	54.24%	59.69%
Northland	40.13%	40.52%	41.03%	37.57%	36.07%	59.66%
Tairawhiti	33.16%	39.41%	39.78%	40.08%	39.11%	58.92%
West Coast	17.92%	48.75%	48.46%	50.71%	53.70%	56.86%
MidCentral	41.38%	43.50%	40.74%	38.80%	40.33%	56.27%
Southern	31.67%	37.51%	40.47%	45.29%	46.26%	56.18%
Canterbury	21.28%	25.05%	25.46%	26.61%	28.81%	54.11%
Counties Manukau	37.14%	43.22%	36.73%	45.40%	44.16%	52.74%
Taranaki	31.64%	38.18%	37.80%	42.62%	41.32%	51.42%
Waitemata	29.76%	34.54%	30.85%	38.12%	38.15%	48.31%
South Canterbury	36.67%	42.07%	45.48%	43.53%	46.94%	44.42%
Auckland	32.11%	35.70%	33.38%	39.08%	38.99%	39.70%

A significant increase can be seen in 2020 rates, as also shown in Figure 2. The evaluation team has limited knowledge of whether interventions similar to the MIVP have run in previous years, however, overall, data indicates that history typically repeats itself.

- Whanganui has performed noticeably well since 2015, and generally continues to grow year on year.
- Wairarapa, West Coast and South Canterbury have dropped out of the top five regions in 2020, which may be related to limited MIVP funding and activities in these regions.
- Lakes has demonstrated a significant improvement from bottom five regions as recently as 2018 to third highest region in 2020.
- Auckland, Waitematā and Canterbury show a continued trend of comparatively low performance.

References

Health Quality and Safety Commission NZ (2019). He tirohanga ki te ōritenga hauora o te Māori: A view on Māori Health Equity. Wellington: Health Quality and Safety Commission.

Jansen, Peter & Bacal, Kira & Buetow, Stephen. (2011). A comparison of Māori and non-Māori experiences of general practice. The New Zealand medical journal. 124. 24-9.

Jatrana, S. and Crampton, P., 2009. Primary health care in New Zealand: Who has access? Health Policy, 93(1), pp.1-10.

Jeffreys, Mona & Irurzun-Lopez, Maite & Russell, Lynne & Smiler, Kirsten & Ellison-Loschmann, Lis & Thomson, Michael & Cumming, Jackie. (2020). Equity in access to zero-fees and low-cost Primary Health Care in Aotearoa New Zealand: Results from repeated waves of the New Zealand Health Survey, 1996-2016. Health Policy. 124. 10.1016/j.healthpol.2020.08.009.

Lambert, M., Luke, J., Downey, B., Crengle, S., Kelaher, M., Reid, S. and Smylie, J., 2014. Health literacy: health professionals' understandings and their perceptions of barriers that Indigenous patients encounter. BMC Health Services Research, [online] 14(1). Available at: <http://www.biomedcentral.com/1472-6963/14/614>.

Mauri Ora, (2009). He Ritenga Whakaaro: Maori experiences of health services. Auckland: Mauri Ora Associates.

Russell L, Smiler K, Stace H. (2013). Improving Māori Health And Reducing Inequalities between Māori and Non-Māori: Has the Primary Health Care Strategy Worked For Māori? An Evaluation of the Period 2003-2010. Wellington: Health Services Research Centre Victoria University of Wellington.