~~[IN-CONFIDENCE]~~

DEPARTMENT OF THE
PRIME MINISTER AND **CABINET**
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Briefing: Action in response to the Waitangi Tribunal's Haumaru COVID-19 Priority Report

Date:	29/04/2022	**Report No:**	DPMC-2021/22-1545
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		Priority level	[Priority]

	Action sought	**Deadline**
Hon Kelvin Davis **Minister for Māori Crown Relations: Te Arawhiti** Hon Chris Hipkins **Minister for COVID-19 Response** Hon Peeni Henare **Associate Minister of Health**	**agree/disagree** to recs	6 May 2022

Name	**Position**	**Telephone**
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Minister's Office

Status:

☐ Signed ☐ Withdrawn

Comment for agency

Attachments: Yes/No

Briefing

Action in response to the Waitangi Tribunal's Haumaru COVID-19 Priority Report

To:
Hon Kelvin Davis, Minister for Māori Crown Relations: Te Arawhiti
Hon Chris Hipkins, Minister for COVID-19 Response
Hon Peeni Henare Associate Minister of Health

Date	29/04/2022	**Security Level**	[IN-CONFIDENCE]

Purpose

1. This briefing outlines the changes and progress made towards addressing the findings and recommendations in the Waitangi Tribunal's report *Haumaru: The COVID-19 Priority Report.*

Recommendations

We recommend you:

1. **Note** the Waitangi Tribunal determined that the Crown breached Te Tiriti o Waitangi principles, including the principles of active protection, equity, options, tino rangatiratanga, and partnership, in its COVID-19 pandemic response, and that the Crown would remain in active breach of Te Tiriti o Waitangi until their recommendations were addressed;

2. **Note** that the government's approach to responding to Waitangi Tribunal Kaupapa inquiries is based on the Crown making meaningful changes to policy and practice as part of a commitment to meeting its obligations under Te Tiriti, which differs from the approach to historical Te Tiriti o Waitangi claims of negotiating historical, cultural, and financial redress contained in full and final settlements;

3. **Note** that many of the Tribunal's findings on the government's COVID-19 response relate to known disparities in health and other social outcomes for Māori, and that in several instances the recommendations relate to significant longer-term work already underway across government, including:

   3.1 Improving the monitoring of Māori health outcomes, including by the establishment of the Māori Health Authority;

   3.2 Strengthening the collection and use of health-related ethnicity and disability data, which will provide the fundamental data building blocks necessary to address the Tribunal recommendations; and

3.3 Strengthening the Ministry of Health's data sharing capability and capacity, which includes being able to share more data on COVID-19 vaccination uptake with Māori providers.

4. **Note** that shorter-term changes have also been made to the government's pandemic response that address or relate to the recommendations in the Haumaru Report, including:

4.1 Providing additional funding of $140m for Māori and Pacific community services to support with the Omicron response – this funding is being delivered through health providers, Whānau Ora, and iwi organisations, and complements significant funding being invested into the general Care in the Community framework;

4.2 Providing funding to support the New Zealand Māori Council to establish Ngā Mana Whakahāere a COVID-19 Rōpū, in order for this group to provide advice and monitoring on the COVID-19 pandemic response for Māori;

4.3 Providing targeted support to maximise paediatric and booster vaccination uptake for Māori, including working closely with Māori providers, schools, and community groups; and

4.4 Implementing a strengthened engagement regime with Māori groups to enable clearer and earlier input into policy and decision-making processes relating to COVID-19.

5. s9(2)(g)(i)

s9(2)(g)(i)

6. **Agree** to discuss the government's work relevant to the Tribunal's findings and recommendations at one of the regular meetings with the New Zealand Māori Council and other Māori groups led by the Minister for Māori Crown Relations: Te Arawhiti; and

YES/NO

7. **Agree** to proactively release this briefing, subject to any redactions, as appropriate.

YES/NO

Ruth Fairhall **Head of Strategy and Policy** **COVID-19 Group, DPMC**	Hon Kelvin Davis **Minister for Māori Crown Relations: Te Arawhiti**
29/4/2022	...../...../2022

Hon Chris Hipkins **Minister for COVID-19 Response**	Hon Peeni Henare **Associate Minister of Health**
07/05/2022	...../...../2022

Please forward a copy of this report to Hon Little and Hon Whaitiri.

I'm keen to engage more with Maori leaders on the COVID-19 response. I've found the hui that we have held so far to be very useful. Can we regularise that?

CH

Background

2. From 6-10 December 2021, the Waitangi Tribunal (the Tribunal) held a priority hearing to inquire into the Crown's response to the COVID-19 pandemic based on claims brought by the New Zealand Māori Council (NZMC). The Tribunal identified the following specific issues for its inquiry:

   a) Whether the Crown's vaccination strategy and COVID-19 Protection Framework was consistent with Te Tiriti o Waitangi and its principles; and

   b) Whether there are changes required to ensure the Crown's vaccination strategy and COVID-19 Protection Framework are Tiriti compliant.

Waitangi Tribunal findings

3. The Tribunal found breaches of the Te Tiriti o Waitangi principles, that is, the principles of active protection, equity, options, tino rangatiratanga, and partnership[1]. The Tribunal concluded that the Crown breached these principles in the following areas:

   a) **Vaccination roll-out** – The Tribunal found that the Crown did not collect sufficient data to inform the rollout of the vaccine accurately and equitably for Māori, particularly tāngata whaikaha Māori (Māori disabled people) and therefore breached the principles of active protection and equity. The Tribunal also found that Cabinet's decision to reject advice from officials to adopt an age adjustment for Māori 50-64 years old in the age-based vaccination rollout breached the principles of active protection and equity.

   b) **Shift to the COVID-19 Protection Framework** – The Tribunal found that Cabinet's decision to transition to the Protection Framework, without meeting the original District Health Board (DHB) vaccination threshold:

      i. put Māori at disproportionate risk of Delta infection, in breach of the principles of active protection and equity;

      ii. put Māori health and Whānau Ora providers under extreme pressure and undermined their ability to provide equitable care for Māori, in breach of the principles of tino rangatiratanga and options; and

      iii. was made despite the strong opposition of the Māori health leaders and iwi leaders it consulted, in breach of the principle of partnership.

   c) **Engagement with Māori** – The Tribunal found that the Crown's failure to jointly design the vaccination sequencing framework breached the Te Tiriti o Waitangi guarantee of tino rangatiratanga, and the principle of partnership. Further, it found that the Crown did not consistently engage with Māori, to the fullest extent practicable, on key decisions in its pandemic response. In addition, the nature of its engagement was often one-sided. These omissions were found to be in breach of the principle of partnership.

4. The Tribunal was clear that the Crown's pandemic response needed to be revised to better work with and for Māori, and the Tribunal's view was that the Crown would be in ongoing breach of the principles of Te Tiriti until it had done so. It also provided a spotlight on systematic and structural issues that stand in the way of effective Māori-Crown partnership, particularly in times of crisis.

[1] These are the Te Tiriti o Waitangi principles established in *Hauora: Report on Stage One of the Health Service and Outcomes Kaupapa Inquiry*.

Waitangi Tribunal recommendations

5. In response to the findings, the Tribunal made several specific recommendations to the Crown to address the breaches highlighted by the report, which included:
   a) Providing further funding, resourcing, data, and other support to Māori service providers and communities to support their pandemic response;
   b) Improving collection of and reporting on data relating to ethnicity and on disabled people;
   c) Strengthening the monitoring of the pandemic response to ensure accountability to Māori;
   d) Ensuring the paediatric vaccine and booster vaccine rollout is equitable; and
   e) Empowering Māori to coordinate the Māori pandemic response, including strengthening engagement between Māori and the Crown.
6. On 22 December the Minister for COVID-19 Response received an initial high-level outline of work underway across government relating to the findings and recommendations in the Tribunal's Haumaru Report.

Strategic context for the urgent Waitangi Tribunal hearing

7. The Waitangi Tribunal's priority hearing into the government's COVID-19 response took place in the context of the urgent and time-critical work underway as part of the pandemic response, including the booster and paediatric vaccine roll out, and the bedding in of the COVID-19 Protection Framework (the Framework). The Tribunal report provided a point-in-time illustration of the COVID-19 response work underway.
8. Many of the Tribunal's findings on the government's COVID-19 response relate to known disparities in health and other social outcomes for Māori, when compared to the wider population. In several instances, the findings and recommendations in the Tribunal report relate to significant longer-term work already underway across government, for example work to strengthen the collection and reporting of disability and ethnicity data.
9. In other instances, the findings and recommendations relate to shorter-term adjustments that have been and continue to be made to the government's pandemic response, with specific changes being made by the government outlined below in the briefing.
10. Ultimately, the government is making progress and will continue to work towards ensuring that the pandemic response is equitable, particularly for Māori, in line with its Te Tiriti obligations.

Ongoing improvement of COVID-19 health outcomes for Māori

11. Efforts to improve vaccination coverage for Māori have continued to evolve as the nature of the COVID-19 outbreak has changed (dominated first by the Delta and then the Omicron variant).
12. The Tribunal noted that as at 23 November 2021, 70.4 percent of the total New Zealand population had received two doses of the Pfizer COVID-19 vaccine compared with 47.9 percent of the total Māori population. Over the last five months to 26 April 2022 this coverage has increased significantly with 95 percent of the total New Zealand population aged over 12 having received two doses of the Pfizer COVID-19 vaccine compared with 88 percent of the total Māori population aged over 12. Three doses is now considered to provide the best protection against the Omicron variant. As at 26 April, booster rates for Māori are at 55 percent of those eligible aged 18 years and over compared to 71 percent for the general population.
13. The Tribunal also noted that as of 23 November, during the Delta outbreak (which began in August), Māori had represented 43 percent of COVID-19 cases, 32 percent of all hospitalised

cases, and 43 percent of all deaths. As at 26 April, Māori represented 20 percent of all COVID-19 cases, 24 percent of hospitalisations, and 17 percent of all deaths.

14. Policy approaches also continue to evolve in the broader immunisation context with free influenza vaccination being extended to Māori aged 55-64 (for the first time) in 2022.

Work underway across government to address the recommendations in the Tribunal's Haumaru Report

15. The section below outlines the recommendations made by the Tribunal and specific work that has either been completed, or is underway across government, related to those recommendations.

Recommendation 1: Providing further funding, resourcing, data, and other support to Māori service providers and communities to support their pandemic response

16. The Tribunal highlighted that if Māori health and Whānau Ora providers are to be effective, the Crown must adequately resource them to carry out their job, which includes providing them with relevant data that would assist their efforts. They recommended that further funding, resourcing, data, and other support should be urgently provided to assist Māori service providers and communities (**Recommendation 1**). This included assisting with:

    a) The continuing, urgent vaccination effort – including for the paediatric vaccine and booster vaccine – especially in rural areas and in communities living in areas with lower socio-economic decile ratings;

    b) Targeted support for whānau hauā and tāngata whaikaha;

    c) Testing and contact tracing;

    d) Caring for Māori with COVID-19; and

    e) Self-isolation and managed isolation programmes.

Funding and support provided by the Ministry of Health to Māori providers, to support the COVID-19 response

17. Significant funding has been provided by the Ministry of Health and DHBs to Māori providers for a range of services including the delivery of vaccinations, case investigations and testing.

18. A total of $39m was delivered to Māori providers throughout 2021[2] from the COVID-19 Vaccination and Immunisation fund (administered by the Ministry of Health). An additional $36m funding was announced in October to support the Māori response to the COVID-19 Delta outbreak and enable providers to prepare for future outbreaks.

19. This funding has provided an opportunity for Māori health providers to respond to COVID-19, beyond vaccinations and healthcare. This includes social supports such as kai and hygiene packs for whānau, to providing capital and operating support to providers to deliver services directly to whānau. This funding has also helped to provide over 718,000 COVID-19 vaccinations, 185,000 general practice consults, 57,000 mental health services, and 14,000 Rongoā services so far.

20. The National Immunisation Programme and the Māori Health commissioning team at the Ministry of Health have strong relationships with Māori health providers and have a good

[2] This funding was for Māori vaccination preparedness, Māori vaccination coordinators and navigators, local Māori vaccine champions, Māori workforce development and targeted local and regional vaccination communications.

understanding of their funding and resourcing needs, and may provide additional targeted support to providers as needed during an outbreak.

Funding and support provided through Te Puni Kōkiri

21. In October 2021, $120m funding was provided to Te Puni Kōkiri (TPK) to administer the Māori Communities COVID-19 Fund (MCCF) in conjunction with Te Arawhiti and the Ministry of Health. The purpose of the MCCF was to accelerate Māori vaccinations and build community resilience to COVID-19. As of 22 April, $110m had been allocated through 132 contracts. This funding does not include direct funding to providers to deliver COVID-19 services (eg. testing, case investigation and vaccinations).

22. In February 2022, further funding of $140m was announced as part of the *COVID-19 Response: Further Support for Māori and Pacific Community* package in response to Omicron. The four funding pathways that make up the $140 million are:

    a) Close to $40m to Māori and Pacific health providers to enable them to scale up their services;

    b) $40.6m to Whānau Ora Commissioning Agencies to enable wraparound and holistic support for whānau to ensure they have a plan for Omicron, can get tested and know how to access Care in the Community support if needed;

    c) $40.05m to build on the Māori Communities COVID-19 Fund (MCCF), administered by Te Puni Kōkiri with Te Arawhiti, to enable communities (particularly iwi) to mobilise their own approaches and build resilience;

    d) $1.75m for the Karawhiua Māori vaccination campaign informing Māori communities about COVID-19, launched by Te Puni Kōkiri, and supported by the Ministry of Health and DPMC;

    e) $18m funding for Pacific Aotearoa Community Outreach Initiative, led by the Ministry for Pacific Peoples, to support Pacific communities to prepare, respond and recover from the social and health impacts from Omicron.

23. With the move to Phase Three of the Omicron approach, the main levers for supporting Māori outcomes in the pandemic are community led. Efforts have been made to ensure this funding can be deployed efficiently to those working on the frontline, and to prioritise funding increases towards regions with the greatest need.

24. For example, of the $40.6m allocated to Whānau Ora, all the funding was distributed to Whānau Ora Commissioning Agencies within the three days of funding decisions being finalised. This funding has gone out to their extensive networks of over 180 partners and providers, nationwide. It has been spent on providing Omicron related support to whānau in need, to provide complementary support alongside other pathways offered to New Zealanders seeking support to respond to COVID-19.

25. The nature of this support varies as Whānau Ora is a holistic approach responding to the needs and aspirations of whānau on a case by case basis. Examples of support include:

    a) Establishing, operating and supporting testing and vaccination centres

    b) Food and hygiene packages (including RATs, PPE gear and oximeters)

    c) Utilities, medication, rent and fuel payments

    d) Access to key services such as transport, online learning for tamariki and students

    e) Support for families in isolation; and

    f) Mental health consultations.

Welfare related funding and support provided to iwi Māori to support with the COVID-19 response

26. Additionally, the Care in the Community welfare approach has also prioritised Māori community providers in the allocation of funding. For example:
    a) 55 percent of the total $155m in Care in the Community funding committed has been allocated to Māori community organisations;
    b) Over 130 of the 292 food providers identify as Māori, and over 50 of these providers identify as Māori and deliver Whānau Ora services nationally; and
    c) Over 280 of the 500 Community Connectors in place identify as Māori, and over 120 of these Community Connectors identify as Māori and deliver Whānau Ora services[3].
27. The Care in the Community welfare approach actively ensures that partnership obligations under Te Tiriti are recognised by providing resourcing for iwi representation in decision-making through the Regional Leadership groups. Iwi and iwi collectives have played a vital role in connecting with vulnerable whānau and supporting iwi partnerships into the future is a priority.

Additional data provided to Māori providers to support with the COVID-19 response

28. The Ministry of Health has also strengthened its data sharing capability and capacity, which includes being able to share more data on COVID-19 vaccination uptake with Māori providers.
29. The Ministry of Health monitors both national and regional data to assess whether vaccinations are being rolled out equitably. It has data-sharing agreements in place with DHBs and partner agencies such as TPK which can then share data with providers on the Ministry of Health's behalf. This data informs strategies to increase vaccine uptake, with successful strategies shared between organisations and groups.
30. Data is also shared with service providers, in some cases down to an individual level, as well as released on the Ministry's website down to suburb level. This data supports local community activities to lift vaccine uptake rates. The Ministry currently has 16 data-sharing agreements in place with iwi and Māori organisations to support outreach activities. This includes agreements with the Whānau Ora Commissioning Agency, Data Iwi Leaders Group and National Hauora Coalition, as examples of large organisations with extensive reach.
31. Some data-sharing agreements are for aggregated and anonymised data. Individual and identifiable information is also being made available on request to organisations which may be effective in increasing vaccination rates on the basis that:
    a) There remains a serious threat to public health;
    b) Disclosure of the information is necessary to prevent or lessen the threat; and
    c) It is not practicable to obtain authorisation for disclosure from the individuals concerned.

Recommendations 2 and 3: Improving collection of and reporting on data relating to ethnicity and on people with disabilities

32. The Tribunal was provided with evidence that the data collected by the Crown does not accurately capture information for particular population groups, including Māori. It raised a concern that the undercounting of Māori means that the officially recorded equity gap in vaccination rates may underestimated, and recommended that the Crown improve its

[3] Provider ethnicity is reported using an approach called 'prioritised ethnicity' – this means that people are allocated to a single ethnic group in an order of priority, even if they identify with more than one ethnicity. The priority used by MSD is Māori, Pacific Peoples, NZ European and Other. For example, if a provider identifies as Māori and Tongan, they're reported as Māori only". Data as at 28 March 2022.

collection of quantitative and qualitative ethnicity data and information relevant to Māori health outcomes (**Recommendation 2**).

33. In addition, the Tribunal also noted a practical absence of quality data on disabled people, and recommended the Crown prioritise the work to improve the quality of quantitative and qualitative data on disabled people in partnership with Māori disability care providers and community groups (**Recommendation 3**).

Short-term work to analyse the ethnicity data used in the vaccination roll out

34. The Ministry of Health has been working with Statistics New Zealand (Stats NZ) to further analyse the ethnicity data captured as part of the vaccination roll out. This has involved placing the health datasets used to calculate vaccination coverage into the Integrated Data Infrastructure (IDI[4]), to further assess the ethnicity make-up of vaccination data.

35. This analysis highlighted that people identify with different ethnic groups in different situations. Approximately 10-15 percent of people who completed the 2018 Census and identified as Māori in the Census are not recorded as Māori in health data. Data calculated in this way indicates vaccination coverage for Māori to be a few percentage points higher than the rates publicly reported because some Māori are being vaccinated but not being counted in the Māori vaccination statistics. Therefore, the reported equity gap is likely an overestimation rather than an underestimation.

Longer-term work to improving the collection of and reporting on ethnicity data in the health system

36. Work is underway at the Ministry of Health to improve the quality of ethnicity data used in the health system over the longer term, particularly as individuals interact with the health system. Recent developments include:

    a) Issuing an updated Ethnicity Data Protocol by the Health Information Standards Organisation (HISO) Ethnicity Data Protocols.

    b) Implementing this protocol through key health system development, such as the National Enrolment Service for Primary Health Organisation enrolment.

    c) Updating and reissuing tools to help organisations to assess the quality of their ethnicity data, for example through the Hospital Ethnicity Data Audit Toolkit.

    d) Building the capability for consumers to have better access to and control over their health information, including their ethnicity data as part of the Hira programme (National health information platform).

37. The Ministry of Health has also begun work on the collection of Māori Descent and Iwi Affiliation information. The Ministry is working in partnership with the Data Iwi Leaders Group on this project, working under the framework of the Mana Ōrite agreement between the Leaders Group and the Crown, and drawing on Māori data experts from across government. This will help to imbed the collection of this data across health IT systems, with an ultimate goal of being able to share health statistics with iwi, in accordance with the Treaty principle of active protection.

38. The actions being undertaken are fundamental data building blocks, necessary to be able to meet the recommendations of the report over the longer term. They will have benefits both for the COVID-19 response directly and monitoring health system performance.

Short-term work to analyse the disability data used in the vaccination roll out

[4] The IDI is a large research database that contains information about people and households from government agencies, Stats NZ surveys like the Census, and non-government organisations.

39. The Ministry of Health commissioned the Social Wellbeing Agency in 2021 to create a disability indicator using the IDI and look at vaccination coverage for disabled people. The creation of this disability indicator within the IDI significantly expanded the amount of disability data and insights available to inform the COVID-19 response.

40. The Social Wellbeing Agency created this indicator by combining several datasets in the IDI[5]. This methodology estimated a disabled population of approximately 1.2 million people, a much larger group than had been established through identifying the people who receive funded supports from the Ministry of Health or ACC.

41. A key insight gained from IDI analysis with information from November 2021 was that disabled people had higher vaccination coverage than non-disabled. This was also true for Māori disabled people. 84 percent of Māori disabled had at least their first dose, compared to 74 percent Māori non-disabled people.

Longer-term work to improve the quality of disability data in the health system

42. While the disability indicator provided population wide insights, many of the issues raised by the Tribunal related to a lack of person-level administrative data to be used to target vaccination efforts. The disability indicator in the IDI does not fill this gap as it may only be used to create anonymised snapshots of outcomes, rather than granular targeting of services or real-time monitoring in line with specific population groups.

43. Work is underway by the Ministry of Health to improve the quality of disability data at a more granular level as part of the Patient Profile and National Health Index Project (PPNHI) in partnership with disabled people. One key aim of PPNHI is to identify disabled people by NHI identifier, including tāngata whaikaha.

44. PPNHI is undergoing a shift to both bolster its tāngata whaikaha participation towards genuine partnership and extend the timeline to enable a greater focus on key equity groups including tāngata whaikaha and disabled rangatahi and tamariki. As a part of this shift, it has included additional tāngata whaikaha voices including input from the claimants.

45. It is expected that the project will significantly improve the quantity, quality and breadth of data available on disabled people and tāngata whaikaha in the health system over the longer-term.

Recommendations 4 and 5: Strengthening the monitoring of the pandemic response to ensure accountability to Māori

46. The Tribunal outlined that while it had some concerns about the quality of the data available to the Crown to monitor its health response for Māori, it indicated that there is sufficient data available to the Crown to be able to identify early whether or not its policies are having the desired effect for Māori.

47. The Tribunal recommended that the Crown strengthen its monitoring regime to enable it to identify, in as close to real time as possible, whether or not its policy settings in relation to Māori are working as expected, so as to enable the Crown to change those settings to achieve the desired and intended results (**Recommendation 4**). The Tribunal also recommended that Crown partner with Māori to determine what elements of the pandemic response should be monitored and how that monitoring should be reported (**Recommendation 5**).

Monitoring of Māori outcomes

48. The Ministry of Health have identified some existing mechanisms for monitoring the impact of the COVID-19 response on Māori. The COVID-19 Māori Monitoring Group (MMG) enables

[5] This included the 2018 Census data, which employed the Washington Group Short Set of Questions on Functioning (WGSS). Other datasets were also used to identify more people with functional impairments in line with the WGSS questions - Walking, Seeing, Hearing, Remembering, Washing, and Communication.

Māori leadership from across different sectors and communities to provide independent insights to the Ministry of Health as part of their ongoing response to COVID-19, with a particular focus on longer-term recovery. The Group acts as an accountability and monitoring mechanism to track the Ministry's progress against Whakamaua: Māori Health Action Plan 2020-2025 and to ensure the Ministry continues to progress and prioritise equity-centred, Tiriti-compliant workstreams. Further information on the MMG's surveillance and monitoring of COVID-19 specific actions is included in Appendix 1.

49. Ngā Mana Whakahāere a COVID-19 Rōpū (NMWC), which includes national Māori stakeholders, has also been established by the New Zealand Māori Council to provide advice on the COVID-19 pandemic. The Ministry of Health has supported this establishment with $132,140 provided to the NZ Māori Council to provide secretariat support for NMWC. Engagement between this newly established group and the Crown started prior to the release of the Haumaru Report.

50. The Ministry of Social Development (MSD) also provides weekly dashboard reporting on the Care in the Community welfare response, including the ethnicity of people requesting welfare support. MSD is currently working on having a fuller breakdown of data to understand the number of Māori who are receiving support through the Care in the Community welfare response, including household breakdowns of support and referrals that have been managed through community providers. Much of this information will be available through the new Reporting tool for Community Connectors and Food Providers which was live from 28 March, with data available in May.

51. The Ministry of Health have also been working to improve the visibility and cohesiveness of work underway specific to the disabled community as part of the COVID-19 response. This has included the implementation of a regular dashboard (the All of Government COVID-19 Disability Response Tracker), requested by the Minister for Disability Issues, that tracks the progress of work relating to disabled communities[6]. A number of the workstreams relate directly to iwi Māori and Māori providers, for example one key workstream relates directly to increasing vaccination rates within these communities. The tracker is one of the tools being used to inform the government's response to the Disability Rights Commissioner's recent inquiry.

52. Each agency, including the Ministry of Health and MSD, collects data on Māori outcomes and Māori-led and targeted programmes. The strengthened engagement approach (outlined in paragraphs 64 to 70 of this briefing) will provide Māori pandemic groups a greater visibility over COVID-19 outcomes for Māori. Having both data and insights provided together in real time will help to facilitate a greater opportunity for these groups to engage more effectively on the COVID-19 response and to advise on changes to the approach if necessary.

53. A strengthened monitoring approach, in partnership with Māori, will ensure we can assess the effectiveness of Māori-led and mainstream initiatives in supporting Māori outcomes.

The new Māori Health Authority will also play an ongoing health system monitoring role

54. The creation of the Māori Health Authority within the reformed health system may create opportunities to improve monitoring of the COVID-19 response. If passed, the Pae Ora (Healthy Futures) Bill will establish key system monitoring functions within the Māori Health Authority, including:

    a) Providing accessible and understandable information to Māori on health system performance;

[6] This dashboard is compiled by the Ministry of Health but has input from the Ministry of Social Development, Accident Compensation Corporation, Office for Disability Issues, the Ministry of Education and DPMC.

b) Monitoring the delivery of hauora Māori services by Health New Zealand;

c) Monitoring, in co-operation with the Ministry of Health and Te Puni Kōkiri, the performance of the health system in relation to hauora Māori; and

d) Supporting and engaging with iwi-Māori partnership boards.

55. The Māori Health Authority's monitoring role is expected to focus on health system performance (including public health, primary and community care, and secondary care), the performance of Health New Zealand and other central health agencies, and the wider social, cultural and economic determinants of health.

56. The creation of iwi-Māori partnership boards may create further opportunities to improve monitoring. Iwi-Māori partnership boards will have a statutory function to represent local Māori perspectives on the needs and aspirations of Māori in relation to hauora Māori outcomes, how the health system is performing in relation to those needs and aspirations, and the design and delivery of services and public health interventions within localities. The Māori Health Authority expects to monitor the performance of localities in partnership with iwi-Māori partnership boards.

Recommendation 6: Ensuring the paediatric vaccine and booster vaccine rollout is equitable

57. The Tribunal determined that the vaccine rollout for Māori adults had been inequitable due to the sequencing framework applied, which did not make an age adjustment for Māori and recommended that the Crown partner with Māori to design and implement an equitable paediatric and booster vaccine sequencing framework for Māori (**Recommendation 6**).

58. The sequencing framework applied to the adult roll-out in 2021 which managed initial vaccine scarcity did not prioritise Māori aged 50 years and over. However, this age group did achieve equitable uptake rates with the non-Māori, non-Pacific population. The reasons for this are not yet fully understood but will be partly due to the focus of DHBs and Māori providers on this age group applied early in the campaign.

Progress on the paediatric vaccine and booster roll out

59. Vaccination rates for younger Māori continue to be lower than for other ethnicities, including for booster vaccines. As noted above, at 26 April 55 percent of the Māori population aged over 18 and eligible for a third (booster) dose had received it compared with 71 percent of the total eligible population over 18. However, for the older population, the differences between ethnicities are smaller with 89 percent of the Māori eligible population over 65 having received a booster compared with 92 percent of the non-Māori non-Pacific eligible population over 65 (as at 18 April).

60. Unlike the roll-out of the COVID-19 vaccination programme to the general population in 2021, sequencing of access to vaccinations for 5–11 year-olds was not required due to sufficient vaccine supply and provider capacity available to be able to offer COVID-19 vaccination to all 5-11 year-olds at the same time. However, targeted support will continue to be needed to maximise uptake for tamariki Māori for who, as at 26 April, first dose uptake is 35.2 percent compared to 54.2 percent uptake for all children.

61. There is significant work underway by the Ministry of Health, in conjunction with Māori providers, to maximise the paediatric and booster vaccine roll outs for Māori. For example, the National Immunisation Programme (NIP) staff are working with:

a) Māori health providers to connect them with local kura kaupapa and schools with high Māori populations to support tamariki vaccinations;

b) Māori health providers and DHBs on several local vaccination events such as the recent four-week long sprints campaign;

c) NIP Regional Account Managers, DHBs and hauora providers to engage with local community groups such as sports clubs and/or schools and kura to support whānau who face barriers to attending vaccination clinics during weekday hours; and

d) Ngā Mana Whakahāere on vaccination misinformation and vaccine hesitancy.

62. Many sprint events have resulted in high numbers of Māori vaccinations. Some events yielded only a small number of vaccinations delivered, however these numbers were often significant in the context of the communities they were provided in, for example small rural communities impacted by the Omicron outbreak and with high levels of vaccine hesitancy.

Recommendation 7: Empowering Māori to coordinate the Māori pandemic response, including strengthening engagement between Māori and the Crown

63. The Tribunal identified that one of the key tensions of the COVID-19 response is that, while government agencies provided contestable policy advice and Māori and other groups wield important influence, Cabinet ultimately makes the final policy decisions. It highlighted that only the proper recognition of tino rangatiratanga, as manifested through iwi, hapū, and other Māori collectives, can reflect a true Te Tiriti o Waitangi partnership.

64. The Tribunal recommended that future engagement between Māori and the Crown, should reflect a number of key principles, including that it must give effect to tino rangatiratanga in its constitution and decision-making and must be broadly representative of Māori, iwi, providers, and other national groups (**Recommendation 7**). A full list of these principles is included in Appendix 2.

Strengthened engagement between iwi Māori and the Crown

65. In response to the Tribunal's recommendations, the government strengthened COVID-19 engagement between iwi Māori and the Crown. In January 2022, the Minister for Māori Crown Relations, Te Arawhiti, approved and implemented a revised Crown approach to engaging with iwi Māori on the COVID-19 response which built on and strengthened the previous approach by planning ahead and streamlining government engagement as much as possible.

66. A key aim of the revised engagement approach was for Māori views to have a stronger and earlier input into policy and decision-making processes relating to COVID-19. In order to achieve this, the revised framework features various streams of engagement, including with:

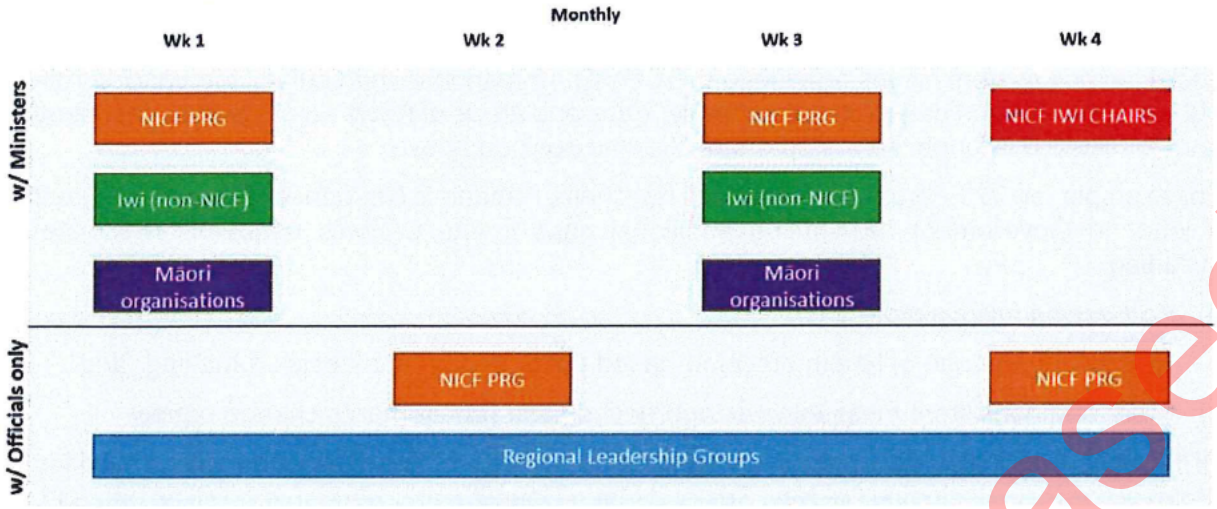
a) The National Iwi Chairs Forum - Pandemic Response Group (NICF-PRG);

b) Other iwi groups not affiliated to the NICF; and

c) National Māori Organisations (including the New Zealand Māori Council and Ngā Ngaru Rautahi o Aotearoa).

67. The diagram below outlines the revised framework for regular COVID-19 engagement between iwi Māori and the Crown:

Māori engagement framework



68. The updated engagement process between the Crown, iwi leaders, and Māori organisations was an important step in addressing the findings in the Waitangi Tribunal's report. However, government agencies were expected to proactively use engagements to inform early policy thinking and delivery for it to be effective. The Department of the Prime Minister and Cabinet (DPMC) has used this process to inform early policy thinking on the COVID-19 post-peak response and Reconnecting New Zealanders, and include feedback from iwi and Māori in advice to Ministers. There are opportunities for agencies to use this engagement framework more consistently and effectively to inform other elements of pandemic response policy.
69. With New Zealand having passed its first Omicron peak and the move to a more steady-state of pandemic management, the frequency of engagement is likely to reduce. However, agencies remain connected to key contacts and are able to continue engaging with them on ongoing policy issues. The formal infrastructure remains in place should the need for future (bespoke or regular) engagement arise.
70. While the scale of this engagement series created some administrative complexities for the Crown, it helped ensure broad and inclusive engagement with iwi Māori representatives on the COVID-19 response. Conversations with some Māori leaders have demonstrated a preference for their relative groups to engage directly with the Crown, rather than as part of broader groupings of leaders based on Māori interests.
71. The framework above provided a balance to ensure broad representation among iwi and Māori. It is noted however, that iwi Māori may remain open to working together on particular kaupapa with a defined purpose (e.g., monitoring), and the nature of engagement across iwi and Māori groups will continue to be kept under review as the COVID-19 response adjusts.

Improving the quality of Te Tiriti o Waitangi analysis in Cabinet papers

72. Te Arawhiti is also working, both in the short and long-term, to improve the quality and visibility of Te Tiriti o Waitangi analysis. Te Arawhiti has allocated resources to support COVID-19 policy development, including assisting lead agencies with Te Tiriti-based analysis of their proposals. They have taken on the Tribunal's advice of preserving the space to include independent Te Arawhiti comment in Cabinet papers as part of their system leadership function.
73. DPMC have developed internal guidance for undertaking Te Tiriti analysis, based on existing government guidance to consider the impacts decisions and options have on Māori, particularly in the context of COVID-19. DPMC is working with Te Arawhiti and Crown Law to refine the guidance.

Continuous improvement of the pandemic response

74. Iwi Māori continue to express concerns about various operational matters and health and social service system issues relating to the COVID-19 response, particularly the vaccine roll-out and the provision of welfare. Note further gaps and areas of focus continue to be identified and considered through the engagement streams outlined above.

75. For example, on 22 February, the National Iwi Chairs Pandemic Response Group (PRG) sent a letter to Government highlighting additional gaps in the Crown's pandemic response, including:

    a) Addressing mis/disinformation;

    b) Reinforcing the use of health outcome-based policy design and decision-making; and

    c) Clear and consistent messaging as approaches and requirements change rapidly.

76. DPMC has had initial discussions on addressing COVID-19 disinformation with a working group of the PRG (including the New Zealand Māori Council), and work on this will be ongoing.

77. DPMC has also published an updated communications approach on addressing disinformation. Key examples of work that has come as a result includes guidance to support schools and communities to respond to misinformation and updates to the Unite Against COVID-19 website that promote official content in plain English and a wide variety of languages including te reo Māori.

78. DPMC, in consultation with Te Arawhiti, has also developed guidance to support how marae can operate within the rules of the COVID-19 Protection Framework. Officials continue to update this guidance, with feedback from iwi representatives, as the COVID-19 response changes.

Māori involvement in the future of the pandemic response

79. Significant work is underway to prepare for the long-term stage of the COVID-19 response. The long-term strategy will consider surveillance, immunisation programme, access to treatment, targeted protection, behaviour and culture change, and institutional settings. This work provides an additional opportunity to consider how the government can further support and include Māori in the management of these factors for their communities. Further engagement on the long-term domestic strategy and variant planning will take place with iwi/Māori groups in May.

80. It is important that the government's long-term strategy to managing the COVID-19 response meets our obligations under Te Tiriti o Waitangi, particularly that equity is a key focus for all agencies and Māori-led approaches are supported. The government will need to consider how we give effect to the strategy to achieve our equity objectives, including pursuing equity in COVID-19 health outcomes for Māori and developing measures to support Māori response to and recovery from COVID-19 in partnership with Māori.

81. The new Māori Health Authority provides an additional opportunity to ensure that protection for Māori is provided in a way that is consistent with Te Tiriti o Waitangi, through more effective monitoring of Māori health outcomes. Māori pandemic response groups should also continue to play a role in ensuring response measures are designed in partnership with Māori.

82. In general, continuing to address the findings and recommendations of the Haumaru Report will help to support a meaningful Tiriti partnership, and health, economic and social outcomes for Māori.

Government response to the Haumaru report

Responding to Kaupapa inquiries

83. s9(2)(f)(iv) [redacted]

84. [redacted]

85. The Crown's response to Wai 2575 to date has been consistent with the developing approach to resolving contemporary Te Tiriti o Waitangi issues, and particularly Kaupapa inquiries, and this could continue for this next part of the inquiry. The government has taken significant action to address a number of these recommendations through the development of legislation, policy and strengthening of services for Māori such as the development of the new Māori Health Authority.

Responding to the Haumaru report

86. There is no established practice on how the Crown should formally respond to Tribunal reports in Kaupapa inquiries, as well as no legislative requirement to respond. Rather, the Crown's responses so far have primarily come through its actions, informed by what it heard in and from the Tribunal.

87. s9(2)(g)(i) [redacted]

88. [redacted]

89. [redacted]

90. [redacted]

91. [redacted]

s9(2)(g)(i)

Next steps

92. s9(2)(g)(i)

93. An agenda item related to the Haumaru and Hauora reports will be added to the agenda for the engagement meetings with the NCIF-PRG, other iwi groups and Māori organisations (including the NZMC) in May.

Appendix 1

Māori Monitoring Group – Advice as part of the COVID-19 response

The Māori Monitoring Group's advice on the COVID-19 response has included;

a) Surveillance and monitoring of COVID-19 specific actions to;
   i. actively protect the health and wellbeing of whānau, hapū, iwi and Māori communities;
   ii. ensure equitable outcomes for Māori and other priority population groups, this includes equity of access, quality and health outcome;
   iii. mobilise resources and services to areas/populations of greatest need.

b) The quality and completeness of the information on the surveillance, pathology transmission and management of COVID-19 for Māori;

c) Best practice solutions to clinical management of risk, clinical quality and patient safety;

d) Technical and scientific (including epidemiological) matters in relation to testing management and contact tracing for Māori communities;

e) Reports, evidence-based research and scientific investigations on the international situation of COVID-19 including infection prevention and control efforts in other countries that are relevant to the Aotearoa context.

Appendix 2

Principles for future Māori – Crown engagement

The Tribunal recommended that future engagement between Māori and the Crown, with the [national collective proposed by the claimants] and with other Māori groups, should reflect the following principles:

a) It must give effect to tino rangatiratanga in its constitution and decision-making processes;

b) It must be broadly representative of Māori iwi, providers, and other national groups including but not limited to all of the interested parties who participated in this priority inquiry;

c) Similarly, it must have access to a broad range of expertise, including from Māori health, Whānau Ora, and disability service providers;

d) It must meet regularly;

e) Māori must influence the agenda;

f) Key Ministers should be actively engaged, which at a minimum should include the COVID-19 Response Minister, the Minister and Associate Ministers of Health, the Minister for Social Development, the Minister for Māori -Crown Relations, and the Minister for Māori Development;

g) Key Crown officials should be actively engaged, which at a minimum should include the chief executives or other senior officials from the COVID-19 All-of Government Response Group, the Ministry of Health, the Ministry for Social Development, Te Arawhiti, and Te Puni Kōkiri; and

h) Any pending Cabinet papers that materially impact on the Māori pandemic response should be tabled, and discussed.