
**IN THE HIGH COURT OF NEW ZEALAND
WELLINGTON REGISTRY**

**I TE KŌTI MATUA O AOTEAROA
TE WHANGANUI-A-TARA ROHE**

CIV-2021-485-13

UNDER THE

Judicial Review Procedure Act 2016

IN THE MATTER OF

**an application for judicial review of a
decision made under the Medicines Act
1981**

BETWEEN

██████████ D ██████████ and others

Applicants

AND

MINISTER OF HEALTH

First Respondent

AND

**GROUP MANAGER OF THE NEW ZEALAND
MEDICAL DEVICES SAFETY AUTHORITY
(MEDSAFE)**

Second Respondent

AND

MINISTER FOR COVID-19 RESPONSE

Third Respondent

**AFFIDAVIT OF DR ASHLEY ROBIN BLOOMFIELD FOR THE RESPONDENTS IN
OPPOSITION TO THE APPLICATION FOR INTERIM RELIEF**

AFFIRMED 25 JANUARY 2022

**CROWN LAW
TE TARI TURE O TE KARAUNA
PO Box 2858
Wellington 6140
Tel: 04 472 1719**

Contact Person:

Kate Wevers / Katie Anderson

Kate.Wevers@crownlaw.govt.nz / Katie.Anderson@crownlaw.govt.nz

I, Dr Ashley Robin Bloomfield, of Wellington, Director-General of Health and Chief Executive of the Ministry of Health, solemnly and sincerely affirm:

Introduction

1. My full name is Ashley Robin Bloomfield.
2. I am the Director-General of Health and the Chief Executive of the Ministry of Health.
3. I hold a Bachelor of Medicine and Bachelor of Surgery from the University of Auckland. I specialised in public health medicine gaining a Master of Public Health from the University of Auckland in 1997. I am a Fellow of the New Zealand College of Public Health Medicine.
4. I have been in my current role since 11 June 2018. Prior to this I was for six months the Acting Chief Executive of the Capital & Coast District Health Board (DHB), and from 2015-2017 I was the Chief Executive of the Hutt Valley DHB. For the three years before that I was Director of Service Integration and Development, and General Manager Population Health at Capital & Coast, Hutt and Wairarapa DHBs.
5. I have held a number of senior leadership roles within the Ministry, including in 2010 and 2012 acting in the role of Deputy Director-General, Sector Capability and Implementation. In 2010 I was Partnerships Adviser, in the Non-communicable Diseases and Mental Health Cluster at the World Health Organization, Geneva.
6. In this evidence I give an overview of New Zealand's COVID-19 immunisation programme and the potential repercussions for the Crown and for the New Zealand public, as well as for Pacific countries reliant on New Zealand donations of vaccines, if the rollout of the COVID-19 vaccine to 5 to 11-year-olds had to stop pending the outcome of these proceedings. In preparing this evidence I have relied on Ministry of Health staff to collate information and data.
7. I understand that other witnesses are providing the following evidence, so I do not cover those areas in my evidence.

- 7.1 Christopher James, Group Manager of Medsafe, has given evidence about the process Medsafe undertook before Mr James made a decision giving provisional consent to Pfizer New Zealand Ltd's COVID-19 vaccine, Comirnaty (Paediatric Vaccine) for use in 5 to 11 year olds.
- 7.2 Dr Ian Town, Chief Science Advisor at the Ministry of Health has given expert evidence on the effects of COVID-19, and the Paediatric Vaccine, on 5 to 11-year-olds.

Limiting rollout to children who are not immunocompromised

8. I have just been made aware that (as of 24 January 2022) the applicants are now asking for a different declaration – one that would only seek to stop the rollout of the Paediatric Vaccine for “healthy children aged 5 to 11 who are not immunocompromised”. In the time available, it is not possible for me to give detailed evidence on this suggestion. However, I have significant concerns with it. While it is correct that children with underlying conditions are at greater risk of severe COVID-19, children who are healthy can and have also suffered from severe COVID-19. It is not clear what the applicants mean by “immunocompromised”, or how the scope of “immunocompromised” children would be determined. And there are children who face an increased risk from COVID-19 for reasons other than being immunocompromised. I also foresee significant – most likely insurmountable – practical difficulties with what the applicants are seeking, which I discuss below at paragraph [66].

My role as Director-General of Health

9. The Public Service Act 2020 requires each department and departmental agency to have a chief executive as its administrative head. Under the New Zealand Public Health and Disability Act 2000 and the Health Act 1956 the chief executive of the Ministry of Health is referred to as the Director-General of Health.
10. As the departmental chief executive I have a responsibility to give effect to the collective interests of the Government and to be an effective steward of the resources of my agency and, indirectly, the wider health and disability

- system to achieve health portfolio responsibilities.
11. Over the past two years, the overwhelming focus of the Ministry's work, and of my own role, has been on New Zealand's response to the COVID-19 global pandemic. As Director-General I have overall responsibility for the provision of public health advice to Cabinet regarding the Government's response to COVID-19.
 12. As part of my responsibilities, I chair the COVID-19 Vaccine and Immunisation Programme Steering Group, which includes Deputy Directors-General from teams closely involved in the immunisation programme, the Director of Public Health, the Ministry's Chief Science Advisor, DHB Chief Executives and senior leaders, and other key advisors. The core function of the Steering Group is to provide senior-level decision-making for the immunisation programme. This Group considers proposals and plans developed by the Ministry and is informed by a number of external advisory groups including the COVID-19 Vaccine Science and Technical Advisory Group (CV-TAG), and the Immunisation Implementation Advisory Group.

COVID-19

13. COVID-19 is a viral infectious disease that can cause severe acute respiratory syndrome, and death. The World Health Organisation (WHO) declared a pandemic on 11 March 2020 and this continues today. I understand from the WHO Coronavirus (COVID-19) Dashboard that, as of 24 January 2022 there have been 349,641,119 confirmed cases of COVID-19 worldwide, with more than 5,592,266 deaths, making it one of the deadliest pandemics in history.¹ COVID-19 has also had profound economic and social impacts in New Zealand and around the world. The health risk of COVID-19 is less severe for children and for most children it is a mild illness – but for some children its effects are severe and require hospitalisation and it has caused fatalities.²

¹ <https://covid19.who.int/>

² <https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html> (data as at 16 September 2021).

W
AB

14. As a result of decisions made in the early days of the pandemic, and the hard work and commitment of everyone in New Zealand, we have been able to avoid the widespread community transmission that other countries have experienced. But I cannot emphasise enough that New Zealand is still facing a significant public health threat, particularly now that community transmission of the more transmissible Omicron variant has been detected in both the North and South Islands. On Sunday 23 January 2022, following the detection of community cases of the Omicron variant, New Zealand moved into the red traffic light under the COVID-19 Protection Framework.
15. Our response to COVID-19 has continued to evolve during the course of the pandemic. As the virus has evolved, with new variants emerging, and with high uptake of vaccinations we have moved away from an elimination strategy to a minimisation and protection strategy. This strategy aims to protect those most at risk of severe disease/outcomes and to ensure our health system can continue to function. As part of this, New Zealand has border restrictions in place to minimise the risk of further COVID-19 cases entering the community, including cases of new variants of concern, in order to prevent further outbreaks being seeded. This includes compulsory quarantine for 10 days in a government-run facility for most arrivals. We have a number of other measures in place to reduce the risk of community outbreaks, including regular testing of frontline workers, widespread testing of symptomatic people, a comprehensive contact tracing system, supported isolation of infectious people and close contacts, a requirement to wear masks on public transport, as well as general public health advice such as not going out if you are unwell, physical distancing, and washing our hands. Vaccinating as many people as possible remains one of the most important interventions to reduce the risk of severe illness and death from COVID-19 and to reduce transmission of the virus in the community. Our experience with the current community outbreak of the highly infectious Delta variant of the virus shows just how effective high levels of vaccination are in achieving this minimisation and protection strategy when combined with other public health measures.

LB AB

16. It is also clear to date both in New Zealand and globally that the burden of illness and death from COVID-19 falls most heavily on vulnerable and disadvantaged groups including older people, disabled people, people with pre-existing medical conditions, Pacific people and Māori. So there is a very significant equity imperative in our COVID-19 response, including our vaccination programme and specific Te Tiriti o Waitangi/Treaty of Waitangi responsibilities to protect Māori.
17. On 3 December 2021 New Zealand moved to the COVID-19 Protection Framework. The system is based on the premise that there will be cases of COVID-19 in the community at any given time, but we will predominantly be managing this with a highly vaccinated population and ongoing public health measures. As COVID-19 vaccines are a critical tool in protecting people from the risks of COVID-19, maximising uptake is a key focus of the Government to keep everyone in New Zealand safe. We aim to continue to build population-level protection over the course of 2022, notably through the timely rollout of our booster programme to people who are fully vaccinated, and by offering vaccination to our 5 to 11-year-old population.
18. New Zealand continues to roll out the predominantly Pfizer-based COVID-19 Immunisation Programme (the Immunisation Programme) for those aged 12 years and older, and those aged 18 years and older can access a booster dose at least four months after their second dose. The AstraZeneca vaccine is also now available for those aged 18 and over as an alternative to the Pfizer vaccine.
19. On 16 December 2021, Christopher James, the Group Manager of Medsafe gave provisional consent under the Medicines Act to Pfizer's Paediatric Vaccine, for use in children aged 5 to 11 years' old. Mr James's role was to make a decision under the Medicines Act about whether or not to give provisional consent, i.e. he decides whether Pfizer has legal approval to supply the Paediatric Vaccine in New Zealand. It is for the Government to decide whether or not to fund and make available the Paediatric Vaccine in New Zealand and include it in the Immunisation Programme. In making that decision, Cabinet took advice from the Ministry of Health, and our advice

was in turn informed by that of CV-TAG, as Dr Town has outlined.

20. I accepted and agree with the CV-TAG recommendations; and those recommendations were also noted by Cabinet:

20.1 The Paediatric Vaccine can be offered to all children aged 5 to 11 years, to be given as two doses eight weeks apart, or at least three weeks apart where there is good reason for a shorter dose interval.

20.2 Mandates, vaccine certificates or vaccine targets must not be used for this age group; and children should not be denied access to locations or events or be excluded based on their vaccination status.

20.3 Focus is to be given to the immunisation of Māori and Pacific children, children with high-risk pre-existing conditions, and children living with vulnerable people.

20.4 Focus is also to be given to improving access and uptake of COVID-19 vaccination and boosters in adults, other childhood immunisation in children, and strengthening public health measures in schools and other education settings.

20.5 Careful safety monitoring be undertaken, with recommendations reviewed as data emerges from the United States and Canadian immunisation programmes for children.

21. In developing its advice, the Ministry of Health also completed a child wellbeing impact assessment of immunisation for children aged 5 to 11 years (the Wellbeing Impact Assessment), which is attached as Exhibit **ARB-1**. This was to inform Cabinet's decision and guide implementation to enhance the wellbeing of children in New Zealand, while not jeopardising the rights or wellbeing of any group in the population. While COVID-19 is rarely serious or fatal for children, the pandemic has had and will continue to have significant impacts on children's health, education, relationships, development, and lives. The findings of the Wellbeing Impact Assessment were consistent with the CV TAG advice, including that:

- 21.1 Immunisation of the wider population is important to protect children and promote their wellbeing.
 - 21.2 Immunisation of children adds protection and promotes children's development with or without high levels of population immunisation.
 - 21.3 Immunisation of tamariki Māori requires high and urgent focus – Māori have suffered high pandemic impacts, remain at high risk, and have a younger child population; 25.9% of the Māori population is aged 5 to 11 compared with 15.8% of the non-Māori population (using data from the 2018 census).³
 - 21.4 Immunisation of children should be voluntary, with no associated restrictions for any children, so that their vaccination status does not outweigh the benefits to their development of full access and participation in education, development, recreation and community activities and public places.
 - 21.5 Immunisation of children should, where possible, promote whanāu wellbeing.
22. Cabinet agreed that to promote children's wellbeing:
- 22.1 High priority be given to engagement with and resourcing for Māori to promote COVID-19 immunisation uptake for children and adults, together with access and uptake of other health and social measures that promote whānau wellbeing and the wellbeing of tamariki Māori;
 - 22.2 High priority be given to the promotion of immunisation for children who are, like tamariki Māori, at higher risk of exposure to and impacts from COVID-19, including Pacific children, children with disabilities and health conditions, and children in the care of Oranga Tamariki.

³ <https://www.waitangitribunal.govt.nz/assets/Documents/Publications/Covid-Priority-W.pdf> pp 9 and 112.

W
AB

23. Cabinet made the decision to rollout the Paediatric Vaccine to 5 to 11-year-olds on 20 December 2021 and this was announced publicly on 21 December 2021.
24. Children under 12 years are at lower risk from direct health impacts of COVID-19 than older age groups. However, COVID-19 can have serious health consequences for some children and in Omicron-related outbreaks overseas we are seeing higher rates of hospitalisation than in earlier outbreaks due to the very high numbers of cases.⁴ Children living with pre-existing health conditions or comorbidities have a greater risk of severe disease from COVID-19.⁵ Māori and Pacific children are more likely to live in multigenerational families housed in overcrowded conditions, increasing the risk of transmission from other household members. There is also risk of other household members being infected by unvaccinated children, noting the evidence on this with respect to the Omicron variant is still emerging.
25. The Paediatric Vaccine has the potential to keep children aged 5 to 11 years safe from COVID-19 and may reduce the risk of transmission of COVID-19 especially in multigenerational and overcrowded households.
26. The Paediatric Vaccine has the same active ingredient as the Parent Product, which is currently given to New Zealanders aged 12 and over, although there are differences between the two medicines. In particular, the Paediatric Vaccine has a lower concentration (one-third) of the active ingredient.
27. There is strong evidence demonstrating that both the Parent Product and Paediatric Vaccine have high rates of effectiveness at preventing severe COVID-19.⁶

New Zealand's immunisation programme

28. Vaccination is one of the most significant public health tools we have to

⁴ <https://www.theguardian.com/us-news/2022/jan/20/us-children-covid-vaccinations-cases-hospitalizations>

⁵ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>.

⁶ <https://khub.net/documents/135939561/338928724/Effectiveness+of+3+doses+of+COVID-19+vaccines+against+symptomatic+COVID-19+and+hospitalisation+in+adults+aged+65+years+and+older.pdf/ab8f3558-1e16-465c-4b92-56334b6a832a> (in relation to Omicron). <https://www.nejm.org/doi/full/10.1056/NEJMoa2116298> (in relation to 5 to 11-year-olds).

fight the COVID-19 pandemic. The rare side effects of the vaccinations need to be weighed up against the risk of a person contracting the virus and becoming seriously unwell or dying from the acute infection as well as the evidence about the effects of long Covid, which can affect around one-third of people.⁷

29. I stress that the decision to vaccinate 5 to 11 year old children remains one for their parents and guardians. Our role has been to carefully and systematically assess the evidence, provide advice to support the Government's decision, and put in place all the elements required to ensure equitable and easy access to the vaccine. This includes clear and balanced information for parents and guardians to support their decision regarding vaccinating their tamariki. The Ministry of Health website,⁸ and the Unite Against COVID-19 website,⁹ contain information for parents and caregivers regarding COVID-19 vaccination of 5 to 11-year-olds, including information about side effects.
30. The core principles of New Zealand's immunisation programme are to:
- 30.1 put safety first with all COVID-19 vaccines;
 - 30.2 secure enough safe and effective vaccines to protect Aotearoa and the Pacific;
 - 30.3 protect Māori, Pacific peoples, and other groups at greater risk of COVID-19;
 - 30.4 make it easy for people to get vaccinated;
 - 30.5 ensure we are prepared for future outbreaks; and
 - 30.6 support New Zealand's contribution to global wellbeing.
31. As the Court will be aware, New Zealand's approach to COVID-19 vaccination

⁷ <https://www.npr.org/sections/coronavirus-live-updates/2021/09/29/1041501387/coronavirus-long-covid-study-plos-medicine>

⁸ <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-vaccines/covid-19-vaccine-health-advice/covid-19-vaccine-and-children-information-parents-and-caregivers>

⁹ <https://covid19.govt.nz/covid-19-vaccines/get-the-facts-about-covid-19-vaccination/covid-19-vaccination-and-children/>

VS AB

has involved rolling out the immunisation programme in stages. We started by protecting those most at risk of being exposed to COVID-19; then offered it to those most at risk of getting seriously sick or dying if they get the virus. The general public was then offered the vaccine, with all eligible people aged 12 and over able to access vaccination from 1 September 2021. The booster programme commenced on 29 November 2021 even as we continue to increase our overall coverage of the 12-plus population on a daily basis. The Paediatric Vaccine rollout commenced on 17 January 2022, and in the first week over 80,000 children have already received their first dose (approximately 16% of 5 to 11-year-olds in New Zealand).¹⁰

32. New Zealand has secured access to 1.25 million doses of the Paediatric Vaccine. That is sufficient volume for children aged 5 to 11 years in New Zealand (477,000), and in the six Pacific countries New Zealand has committed to support (Cook Islands, Niue, Tokelau, Samoa, Tonga, Tuvalu), to receive a full two-dose course of the Paediatric Vaccine. As at 19 January 2022, 696,000 doses of the Paediatric Vaccine have arrived in New Zealand, with expiration dates being either the end of March or April 2022. Further doses will continue to arrive weekly throughout the first half of 2022.

Population implications

33. Vaccinating 5 to 11-year-olds first and foremost provides those children with a high level of protection from COVID-19.
34. Tamariki Māori are at higher risk of severe disease and hospitalisation due to COVID-19. Vaccinating children reduces the overall risk for tamariki Māori, and risks to their whānau, and provides an opportunity to utilise whānau-based approaches to engage with whanau on vaccination (including boosters) and other COVID-19 pandemic support.
35. The table below shows the estimate of tamariki Māori, compared to the estimated resident population aged 5 to 11 years.¹¹

¹⁰ Daily rates of vaccination uptake is reported as total vaccinations 5 to 11 and total vaccinations: <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-vaccine-data#age>

¹¹ Source: <http://infoshare.stats.govt.nz/ViewTable.aspx?pxID=91f65d01-17f8-45e3-b908-ee7f7dccc098>

LS AB

	5 years	6 years	7 years	8 years	9 years	10 years	11 years
Māori	17050	17110	17660	17930	18200	18550	18310
Total resident	63910	64090	66140	66820	67470	68070	67420
%	26.7%	26.7%	26.7%	26.8%	26.9%	27.2%	27.1%

36. Pacific children are also at higher risk of severe disease and hospitalisation due to COVID-19. Vaccinating children reduces the overall risk in this population and provides opportunity to engage with aiga on vaccination (including boosters) and other COVID-19 pandemic support.
37. Individuals with disabilities are at higher risk of severe disease due to COVID-19. Families with disabilities also have unique needs from public health services and associated messaging. Allowing the parents of children with disabilities to decide to vaccinate their children reduces the higher level of risk those children bear from COVID-19.
38. More generally, vaccinating 5 to 11-year-olds also increases the proportion of the whole population who have a level of protection from COVID-19, reducing the potential harm COVID-19 could cause in our communities. Again, we know from experience to date, that this harm falls disproportionately on vulnerable and disadvantaged individuals, whānau and communities.

Consistency with World Health Organization guidance

39. WHO issued an Interim statement on COVID-19 vaccination for children and adolescents (updated 29 November 2021).¹² It states that:

39.1 Countries should consider the individual and population benefits of immunising children in their specific epidemiological and social context.

39.2 Benefits go beyond direct health benefits – minimising disruptions

¹² <https://www.who.int/news/item/24-11-2021-interim-statement-on-covid-19-vaccination-for-children-and-adolescents>

to education and maintenance of overall well-being, health and safety are important including to their life prospects.

- 39.3 Attaining high coverage of high-risk groups such as older people, those with chronic health conditions and health workers, including booster doses, should be prioritised before children and adolescents.
- 39.4 Global sharing of vaccines through the COVAX facility should be prioritised before vaccination of children and adolescents who are at low risk for severe disease.
40. The approach New Zealand has adopted with its immunisation programme, including the Paediatric Vaccine rollout, is consistent with the WHO guidance. As discussed further below, acquiring and sharing the Paediatric Vaccine with Pacific countries supports their child immunisation plans.

Repercussions if Paediatric Vaccine rollout stopped pending determination of the proceedings

41. I understand from Crown Law that the timeframe for substantive determination of the judicial review proceeding is not yet known.
42. In order to assist the Court to understand the repercussions of any declaration that the Government should stop the rollout of the Paediatric Vaccine pending the outcome of these proceedings, I have considered the impacts for the Crown and, more importantly, for the New Zealand public in the scenario of a suspension of the programme for anywhere between one and three months.
43. Particularly with the inevitability of the Omicron variant becoming established in the community, I consider that any length of suspension of the rollout of the Paediatric Vaccine that is now underway would have significant negative repercussions. I have outlined the nature of these repercussions below.

Health and socio-economic impacts

44. Pausing the Paediatric Vaccine rollout would mean that New Zealand children aged 5 to 11 would be denied the protection that vaccination offers

against the risk of illness from COVID-19, and associated socio-economic impacts, which (as I have explained above) remains a real threat. This would particularly affect children most at risk of getting severe COVID (and dying from COVID), for example children who have an underlying medical condition (including asthma and obesity) and Māori and Pacific children. The Paediatric Vaccine can protect them from the serious complications that can result from catching COVID-19.

45. As at 23 January 2022, 80,545 children aged 5 to 11 years' old (supported by their parents or guardians) have received a first dose of the Paediatric Vaccine.¹³ At the time of writing this affidavit, the National Immunisation Booking System contains bookings for a further 27,882 children aged 5 to 11 to have their first dose; and 32,087 children to become fully vaccinated with a second dose. The booking system may not include those children who have been booked with their own GP, or those who plan to 'walk in' to a vaccination site, so the number of children and their families who have made a choice to be vaccinated will be higher.
46. Furthermore, a Ministry of Health commissioned survey by Horizon Research in the last quarter of 2021 showed that there is strong support for and interest from parents in vaccinating 5 to 11-year-olds. The survey found 72% of parents and caregivers who care for 5 to 11-year-olds would allow their child to receive the Paediatric Vaccine.
47. The WHO's Interim statement on COVID-19 vaccination for children and adolescents highlights that, despite a lower risk of severe disease from COVID-19, children and adolescents have been disproportionately affected by the measures put in place to control COVID-19.¹⁴ The most important indirect effects are related to school closures resulting in disruption to education and increase in emotional distress and mental health problems.
48. The impacts of COVID-19 are felt differently across New Zealand communities, and in particular amongst the Māori and Pacific communities

¹³ <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-data-and-statistics/covid-19-vaccine-data#total-vaccinations>.

¹⁴ <https://www.who.int/news/item/24-11-2021-interim-statement-on-covid-19-vaccination-for-children-and-adolescents>.

and disabled people. The immunisation programme (including the Paediatric Vaccine) is designed to protect the 5 to 11-year-olds and other groups in the community they interact with. Access to vaccines is a way to reduce the inequitable impacts of the pandemic, maintain capacity within the health sector and the wider economy should New Zealand experience another resurgence, and facilitate a faster economic recovery.

49. Rollout of the Paediatric Vaccine has been planned so that existing programme delivery elements (logistics, cold chain, supporting technology platforms, available workforce) can be utilised; and doses delivered to 5 to 11-year-olds alongside whānau receiving booster doses. A suspension of the rollout of the Paediatric Vaccine for even one week could mean that potentially 100,000 5 to 11-year-olds would miss out on receiving their first dose of the vaccine (noting that approximately 80,000 children aged 5 to 11 year olds received a first dose in the first week of the paediatric rollout); with a subsequent delay of receiving a second dose, which is an essential element of the vaccination course and is currently recommended to be given eight weeks later. The sooner children receive a first dose, the sooner they will be fully protected.
50. Health care provider capacity and outreach solutions that have been put in place, and are operational to deliver the immunisation programme, are also relied on to deliver the Paediatric Vaccine rollout. Stopping and restarting the Paediatric Vaccine rollout would cause significant disruption to those arrangements.

Obligations under Te Tiriti o Waitangi/the Treaty of Waitangi

51. The obligations the Crown has under Te Tiriti o Waitangi/the Treaty of Waitangi for the immunisation programme also apply to the Paediatric Vaccine rollout. That has included:
- 51.1 Māori led approaches for tamariki Māori
 - 51.2 Partnership between Māori providers, DHBs and iwi
 - 51.3 Empowering, resourcing and providing training for Māori providers as early as possible

- 51.4 Strong Māori communications to promote equitable paediatric uptake for tamariki Māori
- 51.5 A high and urgent focus on the immunisation of tamariki Māori.
52. In evidence to the Waitangi Tribunal's priority inquiry into the COVID-19 response in December 2021, the Tribunal heard about the significant concerns for tamariki Māori aged under 12 in the event of a COVID-19 community outbreak, particularly given this age group represents 25.9% of the Māori population compared with 15.8% of the total New Zealand population (using data from the 2018 census).¹⁵

Public confidence

53. An important aspect of any successful immunisation programme is public confidence in the vaccine. I am concerned that if the Paediatric Vaccine rollout was required to stop for any length of time as a result of the Court granting interim relief, this could significantly undermine public confidence in the Paediatric Vaccine in the longer term.
54. Delivery of the immunisation programme has involved community leaders and groups making significant efforts to reach vulnerable sections of the population, to support trust and delivery of the vaccine, and counter the effects of misinformation. Disruption to the momentum of the programme could have a material impact on the overall success of the programme.
55. For these reasons I am concerned that a decision by this Court that required the Paediatric Vaccine rollout to stop for any length of time, no matter how short, could have long-term implications for public confidence and our ability to maximise uptake, which could in turn affect the ability of our health system to cope with widespread transmission.

Some Paediatric Vaccines would expire

56. The Paediatric Vaccine is stable for six months at -70 degrees from the date of manufacture. Due to the time taken for finished product quality control and release, and transport, by the time it gets to New Zealand we often have

¹⁵ <https://www.waitangitribunal.govt.nz/assets/Documents/Publications/Covid-Priority-W.pdf> pp 9 and 112.

three months to use it. Once 'defrosted', it may be stored for 10 weeks (within the six month period) in standard cold chain conditions (2 to 8 degrees). As at 19 January, we have approximately 499,000 Paediatric Vaccine doses in storage across New Zealand. If it is not used, all of this supply would expire by the end of March or April 2022 respectively. Pausing the Paediatric Vaccine rollout for almost any length of time would result in some wastage. I am very concerned at the prospect of doses going to waste, particularly when it is critical that as many of the New Zealand population as possible are given the opportunity to be vaccinated.

57. Furthermore, allowing this quantity of vaccine to go to waste when there are so many people around the world in need of a vaccine would run counter to New Zealand's efforts as a responsible global citizen to contribute to a co-ordinated international response to the pandemic. As I explain further below, New Zealand has made particular commitments to assist some of our Pacific neighbours with immunisation programmes. New Zealand has also contributed to wider international efforts to respond to the pandemic, for example by investment and participation in the COVAX Facility, a global initiative to distribute safe and effective COVID-19 vaccines worldwide.

The logistics of the rollout would be severely disrupted at huge cost

58. The COVID-19 immunisation programme is an enormous logistical operation requiring large-scale resource to deliver (including service design, logistics, communications, information technology, a distribution system, cold chain infrastructure, operations, and vaccinators). The Paediatric Vaccine rollout is only part of the overall immunisation programme, it is difficult to predict precisely the flow-on implications of these arrangements if there was an abrupt halt to the rollout of the Paediatric Vaccine. It is also likely to have a negative impact on the local arrangements that have been implemented to maximise the likelihood of being able to reach more vulnerable populations (e.g. community-based centres, marae, churches, drive-throughs and pharmacies).

Effects on public health advice and decision-making

59. A suspension of the Paediatric Vaccine rollout could impact on public health

advice and decision-making on issues including appropriate settings and other public health measures. New Zealand's ability to keep its health systems and its economy operating, and to recover from the COVID-19 pandemic and relax public health controls, relies significantly on the availability of safe and effective vaccines being delivered to as many of the population as possible at the earliest possible time.

60. This also has wider social and economic implications for New Zealand. In particular, the speed at which population protection from COVID-19 can be improved is one of the factors affecting the pace of economic recovery and overall wellbeing.

Public health risk to Pacific neighbours

61. New Zealand has supported access to vaccines for the six Pacific countries with whom we have constitutional relationships and/or strong historical and cultural ties: the Cook Islands, Niue Tokelau, Samoa, Tonga and Tuvalu. New Zealand is also directly supporting access to vaccines in other Pacific countries such as Fiji.
62. Pacific countries have young populations, many of whom are under 12. These countries have a strong interest in vaccinating their 5 to 11-year-olds in order to strengthen protection against COVID-19 in their populations, especially as the region begins looking towards reconnecting (including with New Zealand and Australia) and the risk of COVID-19 entering their borders increases.
63. New Zealand has procured sufficient volumes of the Paediatric Vaccine to fully immunise those aged 5 to 11 years in the Pacific countries we have agreed to support (130,000 doses), although none of these doses have been delivered yet.

64. If the Court declared that the Government should not take steps relying on the provisional approval of the Paediatric Vaccine until these proceedings were substantively determined, New Zealand would not be in a position to export the Paediatric Vaccine to our Pacific neighbours. This means that we would not only be delaying access to the vaccine within our border, but also beyond it, with negative impacts on those countries' populations and economies. In my view, there is a risk that a decision delaying delivery of the Paediatric Vaccine would impact on vaccine confidence in the Pacific as well.
65. A COVID-19 outbreak and rapid spread of the virus in the Pacific would likely have severe health consequences and place great pressure on already fragile health systems. Providing COVID-19 vaccines and support to neighbouring countries supports New Zealand's international reputation as a responsible global citizen, and recognises New Zealand's unique relationships with and obligations to Pacific countries born of close economic, people and socio-cultural linkages.

Limiting the Paediatric Vaccine rollout to immunocompromised children

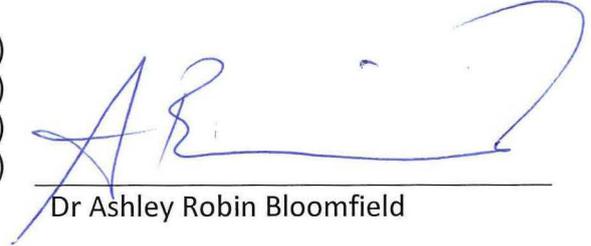
66. As noted above, I have just been made aware that (as of 24 January 2022) the applicants are now asking for a different declaration – one that would only seek to stop the rollout of the Paediatric Vaccine for “healthy children aged 5 to 11 who are not immunocompromised”. In the time available, it is not possible for me to give detailed evidence on this suggestion. However, I foresee significant – and most likely insurmountable – practical difficulties with attempting to restrict the Paediatric Vaccine rollout to children who are immunocompromised. For example:
- 66.1 The Bookmyvaccine website in its current form is not able to identify which children are immunocompromised. It would not be simple or quick to change the booking platform to limit bookings to immunocompromised children (if it is even possible), and then there is the question of what happens to all existing bookings.
- 66.2 Who would decide whether a child is immunocompromised, and how would confirmation of eligibility to be vaccinated work in practice? Would it be possible to have walk-in vaccinations?

66.3 Even if it were (in theory) possible to change a nationwide rollout to ensure that only immunocompromised children could receive the vaccine, that type of operational change would take significant time and effort to implement. It would also divert limited public health resource at a time when the country is dealing with a public health crisis.

AFFIRMED

at Wellington this 25 day of
January 2022
before me:



)
)
)
)


Dr Ashley Robin Bloomfield

A Solicitor of the High Court of New Zealand

**Victoria Ellen Squires
Solicitor
WELLINGTON**

"ARB-1"

Child Wellbeing Impact Assessment

COVID-19 immunisation for children 5 to 11 years

20 December 2021

This is the exhibit marked "ARB-1" referred to in the annexed Affidavit of **ASHLEY ROBIN BLOOMFIELD** affirmed at **Wellington** this **25th** day of **January 2022** before me:  **Victoria Ellen Squires**
Solicitor
WELLINGTON
Solicitor of the High Court of New Zealand

Overview

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

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

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

Key points

Immunisation of the population protects children and promotes their wellbeing

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

Immunisation of children adds protection and promotes children's development

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

Immunisation of tamariki Māori requires concerted focus

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

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

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

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

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

Immunisation of children should promote whānau wellbeing

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

Contents

Child Wellbeing.....	1
Impact Assessment.....	1
COVID-19 immunisation for children 5 to 11 years.....	1
DRAFT 15 December 2021	1
Child Wellbeing.....	1
Impact Assessment.....	1
COVID-19 immunisation for children 5 to 11 years.....	1
DRAFT 15 December 2021	1
Child Wellbeing.....	1
Impact Assessment.....	1
COVID-19 immunisation for children 5 to 11 years.....	1
DRAFT 15 December 2021	1
Child Wellbeing.....	1
Impact Assessment.....	1
COVID-19 immunisation for children 5 to 11 years.....	1
DRAFT 15 December 2021	1
Overview	2
Key points	2
Contents.....	4
Section A: Proposal details	6
Summary	6
Context.....	6
Advancing children’s rights and meeting Children’s Convention principles.....	8
Section B: Data, evidence, and stakeholder views	10
Evidence of proposal impacts	10
Direct impacts for children of COVID-19.....	10
Direct impacts for children who are immunised.....	13
Indirect impacts for all children of some children being immunised	14
Indirect impacts for whānau and communities of children being immunised.....	15
Significant impacts on children and young people	15

Impacts on different groups of children and young people.....	16
Implications for Tamariki Māori.....	20
National Distribution of 5 to 11 Age Group.....	21
Views of Children.....	23
Other stakeholder views.....	24
Section C: Summary of Impacts.....	28
Conclusion of impacts on policy proposal.....	28
Recommendations.....	29

Section A: Proposal details

Summary

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

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

Context

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

Pandemic impacts

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

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

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

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

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

Pandemic mitigation and role of immunisation

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

Broader social, ethical and legal issues around immunisation

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

Issues to be examined include:

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

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

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

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

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

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

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

A rights analysis is outlined in Table 1, below.

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

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

Section B: Data, evidence, and stakeholder views

Evidence of proposal impacts

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

Direct impacts for children of COVID-19

Health

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

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

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

Social and emotional

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

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

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

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

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

Cultural

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

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

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

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

Economic

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

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

Educational

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

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

Direct impacts for children who are immunised

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

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

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

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

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

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

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

Indirect impacts for all children of some children being immunised

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

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

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

Indirect impacts for whānau and communities of children being immunised

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

Significant impacts on children and young people

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

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

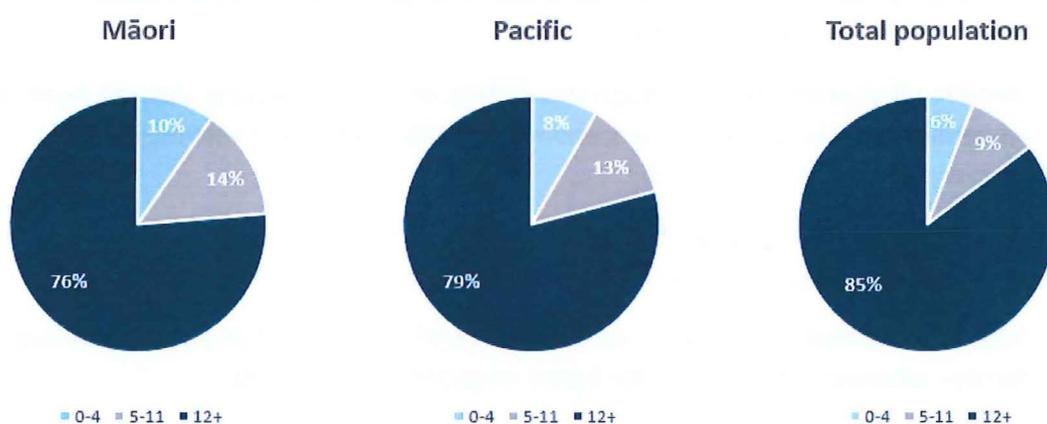
The positive impacts of immunisation are particularly strong for children in communities with:

- higher COVID-19 exposure, risks and impacts

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

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

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



Impacts on different groups of children and young people

Māori

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

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

Pacific

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

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

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

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

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

Disabled children

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

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

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

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

Long-term illness

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

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

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

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

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

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

Children in the care of Oranga Tamariki

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

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

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

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

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

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

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

Children in poverty or deprived communities

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

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

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

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

Children in multiple households

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

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

Implications for Tamariki Māori

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

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

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

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

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

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

National Distribution of 5 to 11 Age Group

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

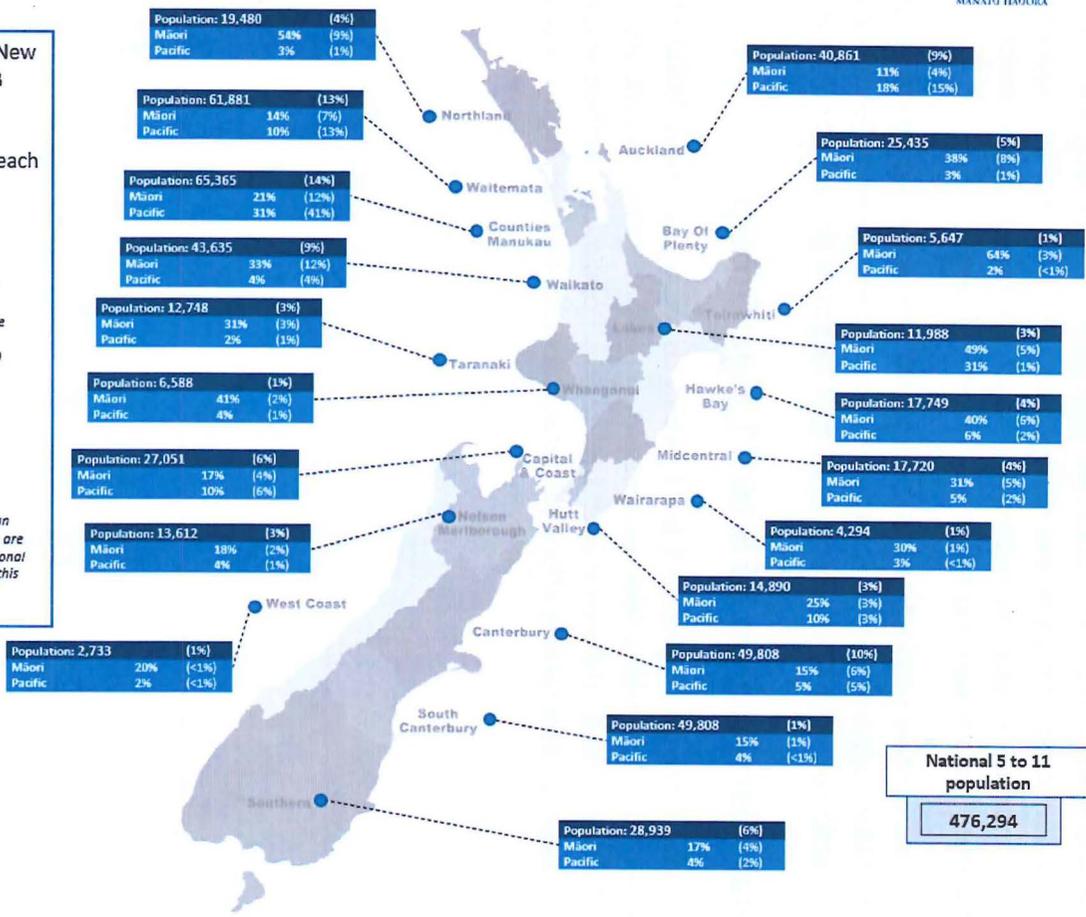
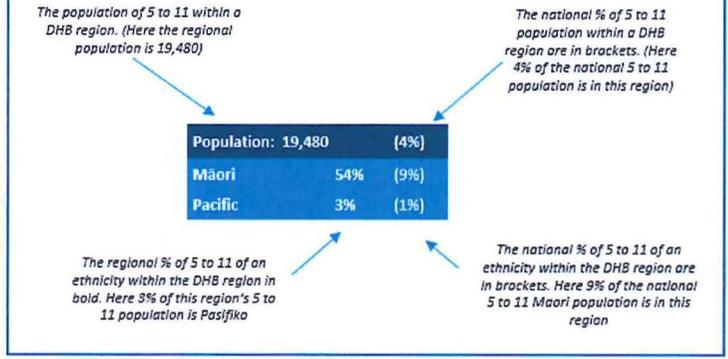
Figure 2: Distribution of 5 to 11 year olds throughout New Zealand



Overview

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

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



National 5 to 11 population
476,294

Views of Children

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

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

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

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

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

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

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

Consent to vaccination

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

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

Other stakeholder views

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

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

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

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

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

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

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

Guidance on promoting child wellbeing during the pandemic

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

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

Ongoing engagement through development and implementation

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

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

High level engagement plan

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

WHO guidance

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

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

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

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

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

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

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

Section C: Summary of Impacts

Conclusion of impacts on policy proposal

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

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

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

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

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

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

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

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

Recommendations

Offering COVID-19 immunisation to children 5 to 11 years

Based on this impact analysis, it is recommended that:

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

Communication

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

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

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

Maximising opportunities for children's wellbeing and development

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