Document 1

MINISTRY OF HEALTH
MANATŪ HAUORA

# Briefing

## Decision to Use: Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine (bivalent vaccine) winter dose

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|---|---|---|---|
| **Date due to MO:** | 14 February 2023 | **Action required by:** | 14 February 2023 |
| **Security level:** | IN CONFIDENCE | **Health Report number:** | H2023019738 |
| **To:** | Hon Dr Ayesha Verrall, Minister of Health | | |
| **Copy to:** | Rt Hon Chris Hipkins, Prime Minister<br>Hon Grant Robertson, Minister of Finance<br>Hon Peeni Henare, Associate Minister of Health (Māori Health)<br>Hon Barbara Edmonds, Associate Minister of Health (Pacific Health)<br>Hon Willow-Jean Prime, Associate Minister of Health | | |

## Contact for telephone discussion

| Name | Position | Telephone |
|---|---|---|
| **Alison Cossar** | Manager, Public Health Policy and Regulation | s 9(2)(a) [redacted] |
| **Dr Andrew Old** | Deputy Director-General, Public Health Agency | s 9(2)(a) [redacted] |

## Minister's office to complete:

| | | |
|---|---|---|
| ☐ Approved | ☐ Decline | ☐ Noted |
| ☐ Needs change | ☐ Seen | ☐ Overtaken by events |
| ☐ See Minister's Notes | ☐ Withdrawn | |

Comment:

MINISTRY OF HEALTH
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# Decision to Use: Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine (bivalent vaccine) winter dose

| | | | |
|---|---|---|---|
| **Security level:** | IN CONFIDENCE | **Date:** | xxx |
| **To:** | Hon Dr Ayesha Verrall, Minister of Health | | |



## Purpose of report

1. This briefing seeks your agreement to the use of Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine ("BA.4/5 bivalent vaccine") in the National Immunisation Programme (the Programme) from 1 April 2023 as a winter dose for:
    - anyone in the currently defined high-risk group eligible for a second booster dose who has completed a primary course [1], and regardless of the number of prior booster doses received, but who has not had a dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months, and
    - anyone aged 30 or over who has completed a primary course or received any number of booster doses but who has not had a booster dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months

## Key points

2. Medsafe granted provisional approval for the BA1 and BA4/5 bivalent vaccines on 20 December 2022.
3. On 1 February 2023, you agreed to use the BA.4/5 bivalent vaccine in place of the original Pfizer vaccine for people who are currently eligible for a booster dose as the first part of the winter wellness campaign from 1 March 2023 [H2023019642 refers].
4. On 2 February 2023, the COVID-19 Vaccine Technical Advisory Group (CV TAG) met and reiterated their recommendation that the COVID-19 Immunisation Programme switch to bivalent vaccines, and that a second booster continue to be actively encouraged for adults who are currently eligible for free influenza vaccine in New Zealand.
5. CV TAG also recommended that all other people aged 30 years and over should be eligible to receive a second booster dose. These second booster doses should be administered from 6 months after the previous dose of a COVID-19 vaccine, and from 6 months after a SARS-CoV-

[1] People aged 65 years and over, Māori and Pacific peoples aged 50 years and over, residents of aged residential care and disability care facilities, severely immunocompromised people , people aged 16 years and over who have a medical condition that increases the risk of severe breakthrough COVID-19 illness and, people aged 16 years and over who live with a disability with significant or complex health needs or multiple comorbidities.

2 infection, with flexibility for the dose to be given from 3 months after a SARS-CoV-2 infection

6. In line with the Appendix of the CV TAG memo, 'Guiding Principles for future decisions around additional doses', Manatū Hauora is proposing to use the BA.4/5 bivalent vaccine in the Programme as an additional dose for both high-risk groups and all individuals aged 30 and over who have completed a primary course, regardless of the number of prior booster doses received.

7. Pharmac has confirmed the delivery of the initial 357,000 doses of BA.4/5 bivalent vaccine, with a similar number to follow by 31 March. A total of 1.7m doses will be available by 30 June 2023.

8. As noted above, bivalent vaccines will be available as boosters for those currently eligible from 1 March. Should you agree, we will implement the proposal for expanded eligibility from 1 April 2023 in alignment with the influenza vaccination programme and other winter wellness initiatives.

## Recommendations

We recommend that you:

a) **Note** that on 1 February 2023, you agreed to use the BA.4/5 bivalent vaccine in place of the original Pfizer vaccine for people who are currently eligible for a booster dose as the first part of the winter wellness campaign from 1 March 2023 [H2023019642 refers].

b) **Note** that the COVID-19 Vaccine Technical Advisory Group (CV TAG) have met and discussed the use of Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine ("BA.4/5 bivalent vaccine") as a booster.

c) **Note** the 2 February 2023 CV TAG recommendations are that:

   a. Improving first booster coverage should be the top priority of the National Immunisation Programme

   b. In a winter vaccination programme, the groups recommended (i.e., actively encouraged) to receive a second booster dose should be expanded to include those eligible for free influenza vaccine in Aotearoa New Zealand. This is with the exception of the childhood age groups and pregnant people under the age of 30 that are part of free influenza vaccine eligibility.

   c. All people aged 30 years and over should be eligible to receive a second booster dose (i.e., can consider based on an individual risk benefit discussion with their immunisation provider). This expansion could be aligned with a winter campaign.

   d. These second booster doses should be administered from 6 months after the previous dose of COVID-19 vaccine,

and/or from 6 months after a SARS-CoV-2 infection, with flexibility for the dose to be given from 3 months after a SARS-CoV-2 infection (both criteria need to be fulfilled). Clinical discretion can be applied when considering vaccination prior to three months after infection for high-risk individuals.

e. The benefits of a second booster dose for people under the age of 30 years, who are otherwise healthy, is less certain. People in this group are encouraged to discuss their health needs and risks (e.g., risk of myocarditis or pericarditis) and benefits of a second booster dose with their health care provider.

f. The intervals between doses for Pfizer and Novavax COVID-19 vaccines (including BA.4/5 bivalent vaccines) should be interchangeable and consistent across vaccine schedules to simplify vaccination regimes.

d) **Note** that on 21 December 2022, Medsafe provisionally approved the BA.1 and BA.4/5 bivalent vaccines for use as a booster dose in individuals aged 12 years and over who have previously received a primary course of the original Pfizer vaccine, and for individuals aged 18 years and over who have completed a primary course with another COVID-19 vaccine, at least 5 months after the primary course and as early as 4 months after the last booster dose.

e) **Note** that Pharmac has confirmed the delivery of the initial 357,000 doses with the remaining Quarter 1 supply to be delivered by 31 March 2023 and another 1,042,000 doses to be delivered by 30 June 2023 (a total of 1.7 million doses of BA.4/5 bivalent vaccines in New Zealand).

f) **Note** That based on current modelling, there are no financial implications of purchasing the BA.4/5 bivalent vaccine until June 2023 as funding was previously drawn down to pay for the bivalent supply of 1.7 million doses.

g) **Agree** to the use of Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine ("BA.4/5 bivalent vaccine") in the National Immunisation Programme (the Programme) from 1 April 2023 as a winter dose for: **Yes/No**

- (recommended) anyone in the currently defined high-risk group eligible for a second booster dose, and regardless of the number of prior booster doses received, but who has not had a dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months, and

- (available) anyone aged 30 or over who has completed a primary course or received any number of booster doses but who has not had a booster dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months.

h) **Agree** to the proposed implementation plan provided in this briefing. Yes/No

Dr Diana Sarfati

**Director-General of Health**

Date: 13 February 2023

Hon Dr Ayesha Verrall

**Minister of Health**

Date: 19/2/23

Dr Andrew Old

**Deputy Director-General**

**Public Health Agency**

Date: 13 February 2023

# Decision to Use: Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine (bivalent vaccine) winter dose

## Background

9. Currently in New Zealand, first boosters (3rd dose) of original Pfizer COVID-19 vaccines are available for anyone aged 16 and over, and second boosters (4th dose) for anyone aged 50 or over, Māori and Pacific people aged 40 and over, healthcare workers aged 30 and over, and people aged 16 and over with serious medical conditions or disabilities. Eligibility is subject to time since last dose or infection. Novavax vaccines are available under similar circumstances, but a minimum age of 18 years.

10. On 21 December 2022, Medsafe provisionally approved the BA.4/5 bivalent vaccine for use as a booster dose in individuals aged 12 years and over who have previously received a primary course of the original Pfizer vaccine, and for individuals aged 18 years and over who have completed a primary course with another COVID-19 vaccine, at least 5 months after the primary course and as early as 4 months after the last booster dose.

11. The first shipment of bivalent vaccines arrived on 30 January 2023, with delivery schedule for Q1 (total 705,600 doses), with a further 1 million doses requested to be delivered early Q2.

12. On 1 February 2023, you agreed to use the BA.4/5 bivalent vaccine in place of the original Pfizer vaccine for people who are currently eligible for a booster dose as the first part of the winter wellness campaign from 1 March 2023 [H2023019642 refers].

*International recommendations and experiences*

13. The Australian Technical Advisory Group on Immunisation (ATAGI) released updated advice on boosters for 2023 on 8 February 2023. They **recommended** boosters for adults aged 65 and over, or adults aged 18 to 64 with medical comorbidities or disability with significant or complex health needs. Other adults aged 18 to 64 and children aged 5 to 17 with medical comorbidities or disability with significant or complex health needs should **consider** a booster dose.

14. The above advice applies to those whose last dose or infection occurred at least 6 months ago, regardless of the number of previous boosters.

15. Australia's approach is broader than our proposed approach as it includes young healthy adults aged 18 to 29. CV TAG considers that the benefits of a second booster for people aged under 30 are less certain, and people in that age group should discuss their health needs and risks (including the risks of myocarditis and pericarditis) with their health care provider.

16. The United Kingdom's Joint Committee on Vaccination and Immunisation is scaling back its booster programme for the time being, and from 12 February 2023, healthy adults aged 18 to 49 will not be eligible for an additional booster. They recommend another autumn

vaccination campaign in the second half of 2023[2], as well as a spring campaign for those most vulnerable.

17. While this is the opposite of our proposed approach, it reflects a different stage in the northern hemisphere seasonal cycle and population immunity following their booster campaign in late 2022.

18. Australia's advice recommends that autumn boosters be administered before June 2023, and it remains open to southern hemisphere countries to pause booster eligibility for healthy adults or revise the time period since last dose later this year.

19. Internationally, health officials have raised concerns about vaccine wastage and the need to make more carefully informed vaccine purchases as vaccine hesitancy continues to reduce uptake. Canada's introduction of BA.4/5 vaccines only 8 weeks after BA.1 vaccines has raised issues about vaccine redundancy, and in the United States, only 15.4% of people aged 5 years or older have received a BA.4/5 bivalent vaccine as of January 2023.

## Eligibility for a winter bivalent COVID-19 vaccine

20. While New Zealand is experiencing decreasing COVID-19 infections at the current time, there remain over 170 people currently in hospital from COVID-19 associated conditions (13 February 2023).

21. Evolving strains of the COVID-19 virus raise the risk that existing vaccines will become less effective against infection or severe illness over time. The effectiveness of vaccines also reduces over time through waning immune response. However, with a large proportion of the New Zealand population having been infected over the last twelve months, a degree of hybrid immunity is reducing the size and impact of surges in COVID-19 infection rates.

22. Emerging variants such as CH.1.1, XBB.1.5 and BQ.1.1, which have been suggested as having more immune-evasive properties than previous Omicron variants, are more closely related to BA.5 than to BA.1. Therefore theoretically, this may suggest that BA.5-containing vaccines could confer greater protection against emerging variants for New Zealand.

### Current CV TAG Review

23. CV TAG met on 2 February and made the following recommendations (Appendix 1):

    a. Improving first booster coverage should be the top priority of the National Immunisation Programme. In particular, the programme should prioritise those who are most at risk of severe disease and severe outcomes (including Māori and Pacific peoples with low first booster uptake).

    b. In a winter vaccination programme, the groups **recommended** (i.e., actively encouraged) to receive a second booster dose should be expanded to include those eligible for free influenza vaccine in Aotearoa New Zealand. This is with the exception of the childhood age

[2] Residents in a care home for older adults and staff working in care homes for older adults; frontline health and social care workers; all adults aged 50 years and over; persons aged 5 to 49 years in a clinical risk group, persons aged 12 to 49 years who are household contacts of people with immunosuppression; and persons aged 16 to 49 years who are carers.

groups and pregnant people under the age of 30 that are part of free influenza vaccine eligibility. See Appendix 3 for more information.

c. All people aged 30 years and over **should be eligible to receive** a second booster dose (i.e., can consider based on an individual risk benefit discussion with their immunisation provider). This expansion could be aligned with a winter campaign.

d. These second booster doses should be administered **from 6 months** after the previous dose of COVID-19 vaccine, and **from 6 months** after a **SARS-CoV-2 infection,** with flexibility for the dose to be given from 3 months after a SARS-CoV-2 infection (both criteria need to be fulfilled). Clinical discretion can be applied when considering vaccination prior to three months after infection for high-risk individuals

e. The benefits of a second booster dose for people under the age of 30 years, who are otherwise healthy, is less certain. People in this group are encouraged to discuss their health needs and risks (e.g., risk of myocarditis or pericarditis) and benefits of a second booster dose with their health care provider.

f. The intervals between doses for Pfizer and Novavax COVID-19 vaccines (including BA.4/5 bivalent vaccines) should be interchangeable and consistent across vaccine schedules to simplify vaccination regimes

24. While CV TAG noted they could not provide firm recommendations on additional doses after a second booster dose, they provide guiding principles for subsequent decisions in the section entitled **Future Considerations**.

*Future considerations proposed by CV TAG*

25. CV TAG has proposed the following guiding principles:

a. Improving first booster coverage should be the top priority of the National Immunisation Programme. In particular, the programme needs to prioritise those who are most at risk of severe disease and severe outcomes (including Māori and Pacific peoples with low first booster uptake).

b. Firm recommendations for additional doses beyond the first half of 2023 cannot be made currently due to uncertainty on the future epidemiology of COVID-19 (e.g., seasonality), future variants, and duration of protection against severe disease from hybrid immunity.

c. A flexible approach should be applied to current and future decisions on intervals between additional doses (boosters). This will provide the ability to adapt to changing variant, immunological, and epidemiological landscapes, as well as clinical decisions by an individual's healthcare provider.

d. Terminology should shift from the number of doses/boosters (i.e., first booster, second booster) towards terms such as 'additional doses' or 'autumn/annual vaccine doses', to minimise confusion and account for variations between populations.

e. Based on the likelihood of hybrid immunity providing protection against severe disease for many months, the potential programmatic advantages of aligning the COVID-19 vaccination programme to the winter influenza vaccination programme, as well as a need to mitigate the risk of over-burdening hospitals with winter respiratory illness, the Programme may be heading towards making an annual winter COVID-19 booster recommended (i.e. actively encouraged) for those at higher risk of severe COVID-19, and available (i.e. can be administered on request) to all those aged 30 and over.

f. Additional doses, such as a "third booster", (including more frequent doses for those at higher risk of severe COVID-19, or in high-risk epidemiological situations) could be considered in line with the following:

   i. For the general population, a schedule which has **six months or more** between additional doses should generally be implemented unless epidemiologically indicated (for example, a wave of severe COVID-19 is anticipated), in which case a schedule with as little as three months before a subsequent dose could be used. This includes the preferred interval between completion of the primary course and the first booster dose being six months or more. The previous three-month interval was based on epidemiological considerations at the time, which are no longer applicable to the current Aotearoa New Zealand situation. As above, schedules with longer intervals between additional doses (for example, twelve months after the previous dose) would be supported by this recommendation if the risk of severe COVID-19 remains low in the general population.

   ii. Current and future decisions on intervals between additional doses should also provide schedules for both those at higher risk of severe COVID-19 (e.g., the elderly, those with co-morbidities, and Māori and Pacific Peoples in high-risk age groups) and those at lower risk (e.g., those under 30 years of age). In general, higher risk groups would have a shorter recommended interval than the general population, and lower risk groups would have a longer interval. Some low-risk groups, such as young healthy children, may have no additional doses recommended until they reach a given age (or otherwise enter a group at higher risk of severe-COVID-19 disease)

g. An additional booster dose, if due, should be postponed for **at least three months, and preferably from six months, after SARS-CoV-2 infection.** Clinical discretion can be applied when considering vaccination prior to three months after infection. This may be appropriate for those individuals considered to be at high risk of severe disease from COVID-19 re-infection

## Proposal for a winter dose

26. As a winter dose has been signalled in winter preparedness planning by Te Whatu Ora, consideration of the CV TAG Guiding Principles has been undertaken and the following approach is proposed:

   a. use of Pfizer-BioNTech's Comirnaty Original/Omicron BA.4/5 COVID-19 vaccine ("BA.4/5 bivalent vaccine") in the National Immunisation Programme (the Programme) from 1 April 2023 as a winter dose for:

      i. **(recommended)** anyone in the currently defined high-risk group eligible for a second booster dose, and regardless of the number of prior booster doses received, but who has not had a dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months, and

      ii. **(available)** anyone aged 30 or over who has completed a primary course or received any number of booster doses but who has not had a booster dose in the past 6 months or a confirmed case of COVID-19 in the past 6 months.

iii.

| | Current eligibility – **second** booster | Proposed eligibility – **additional** booster at least six months following last dose or infection, regardless of number of previous boosters |
|---|---|---|
| **Recommended** | • People aged 65 and over<br>• Māori and Pacific aged 50 and over<br>• Residents of aged care and disability care facilities<br>• Severely immunocompromised people<br>• People aged 16 and over with a medical condition that increases the risk of severe COVID-19<br>• People aged 16 and over who live with a disability with significant or complex health needs | • People aged 65 and over<br>• Māori and Pacific aged 50 and over<br>• Residents of aged care and disability care facilities<br>• Severely immunocompromised people<br>• People aged 16 and over with a medical condition that increases the risk of severe COVID-19<br>• People aged 16 and over who live with a disability with significant or complex health needs |
| **Available** | • People aged 50 and over<br>• Māori and Pacific people aged 40 and over<br>• Healthcare, aged care and disability workers aged 30 and over | • People aged 30 and over |

*Rationale*

27. A winter dose of the new bivalent vaccinations provides additional protection from severe disease and hospitalisation before the winter illness season begins.

28. CV TAG recommendations on the bivalent vaccine and Medsafe approval indicate the safety and efficacy of the bivalent vaccine as an additional dose, and particularly to those eligible who have not received a booster or have only had one booster.

29. While CV TAG is cautious regarding additional doses beyond a second booster, many eligible people are 6 to 12 months since their last dose, and possibly from their COVID infection.

| Age group | Median days since last vaccination |
|---|---|
| 5 to 15 | 183.5 |
| 12 to 15 | 266.5 |
| 16 to 29 | 332 |
| 30 to 39 | 336.5 |
| 40 to 49 | 327 |
| 50 to 59 | 324.5 |
| 60 and over | 330 |

*Median days since last vaccination dose (Source: National Immunisation Programme, 30 November 2022)*

30. This means the majority of the vaccinated population aged 16 and older, are beyond, or are approaching, 12 months since their last vaccination dose for COVID-19.

31. Increasing immunity prior to the challenging winter season provides benefits beyond reducing illness and hospitalisations.

32. These benefits include:

    a. Reducing the potential burden on the health system, especially if COVID illness coincides with other winter respiratory illnesses

    b. Encouraging people to think about receiving other vaccinations, such as influenza.

33. While Australia is rolling out to people aged 18 years and over, CV TAG has suggested eligibility for the non-high-risk group to be 30 years and over. We support this analysis as there is still a risk of myocarditis in the younger age cohort and younger people have good recovery history.

34. CV TAG has recommended the post-infection interval to be at least three months, and preferably from six months, after SARS-CoV-2 infection. The proposal for the winter dose is 6 months post-infection with discretion for an earlier dose. While the impact of hybrid immunity is still emerging, 6 months post-infection is considered to likely provide a satisfactory level of protection.

*Prior doses and moving towards a more routine COVID-19 vaccination programme*

35. The proposed recommendation moves away from the language of booster doses and how many booster doses a person should have. In order to move to a new routine COVID-19 vaccination programme, and with emerging evidence of the safety of repeat doses, this winter dose will be available to people who cover the range of no boosters (but completed the primary course) to those who have had up to three boosters (immunocompromised).

36. It is envisaged that health officials will look to future doses as required, rather than the number of doses.

37. People outside these recommended/available groups can access the vaccine with a prescription from an authorised prescriber, ie. pregnant women under the age of 30 years, people living with disabilities with significant or complex health needs under the age of 16 years.

## Influenza immunisation

38. Pharmac are responsible for setting the eligibility criteria for funded influenza immunisation. Typically, this includes people aged 65 and over, pregnant people, and people with certain serious health conditions. For 2022, they expanded eligibility criteria in response to the COVID-19 pandemic to include all children aged 3-12 years, Māori and Pacific people aged 55 to 64 years, and people with serious mental health and addiction conditions. Te Whatu Ora and the Public Health Agency have written to Pharmac seeking the continuation of these expanded criteria for the 2023 influenza immunisation programme. Pharmac's decision is forthcoming but will need to be made soon in time for this year's programme.

39. CV TAG's recommendation for COVID-19 boosters to match adult influenza vaccine eligibility helps simplify communication to encourage uptake, as well as reduce the burden on

healthcare systems. Consequently, more efficient use of resources could be achieved, along with a more effective vaccination campaign.

40. While we can support a significant proportion of people getting influenza vaccine to also get COVID-19 boosters at the same time, a perfect match between the two services would be difficult to achieve. For influenza, universal vaccination is encouraged but funded only for some. For COVID-19, booster vaccination is free for all, but recommended for some, available for others and discouraged for the remainder.

## Equity

41. Equity recognises that different people with various levels of advantage require different approaches and resources to get equitable health outcomes.

42. Overall, Māori, Pacific and whaikaha peoples are impacted more by communicable diseases as well as the social and economic consequences of serious illness. The differential impact is expected to continue or increase as these communities have lower vaccination rates, higher rates of underlying health conditions and disabilities and high-contact living conditions. These communities may face inequitable access to appropriate healthcare services, be disproportionately impacted by COVID-19 and/or be at risk of more severe illness

43. Ongoing access to COVID-19 vaccines is essential to enable maximum protection for our population, particularly in the context of the evolving threat of COVID-19.

44. Māori and Pacific populations have been most affected by COVID-19 in the community to date, making up a disproportionate percentage of cases and age standardised hospitalisations and have a lower uptake of the COVID-19 vaccine.

45. As noted in the CV TAG advice, hospitalisation admissions in the third and fourth Quarter of 2022 were consistently higher among Māori and Pacific peoples aged 20 years and over in all age groups compared to Asian, European and Other ethnicities. Mortality risk for people aged 59 years and younger was 2.0 (95% CI 1.2–3.3) times higher for Māori and 1.8 (95% CI 1.0–3.5) times higher for Pacific people compared to European and Other groups after adjusting for sex, ages, ethnicity, comorbidity and vaccination status.

46. Ensuring there are safe and effective COVID-19 vaccines which are accessible in sufficient volumes enables the Programme to continue without delay and protect the most vulnerable groups at risk of harm from COVID-19.

47. Whānau-based approaches, alongside the provision of accessible vaccination services and communications, will provide an opportunity to improve delivery and uptake of the COVID-19 vaccine among Māori, Pacific and Tāngata whaikaha peoples as well as uptake of the wider National Immunisation Schedule.

48. Achieving equity for Māori, Pacific and whaikaha communities will be a major focus. Early engagement and targeted communications with these communities and the providers that work closely with them are the first steps. Preparing Māori, Pacific and disability providers and their vaccinating workforces will ensure capacity and capability is available to lead implementation in vulnerable communities before 1 April.

49. Ensuring equitable access to the bivalent vaccine for high-risk populations will continue to involve ensuring Māori and Pacific providers in particular are resourced and supported to deliver vaccination services to their communities. Ensuring access to vaccination services also includes addressing other barriers to health care services including cost and transport. Clear communication in appropriate languages and formats will be essential to providing

communities with the resources they need to make informed decisions in support of vaccination.

50. Equity groups in each Region will be established with the remit of monitoring uptake and supporting access to the vaccine for Māori and Pacific communities. Their activities to support implementation will include making data available to providers on the frontlines to guide responses at the community level, workforce development, and providing a communication channel between providers and the Programme. These groups will consist of local and national representatives from Te Whatu Ora, Te Aka Whai Ora, and the The National Immunisation Programme (the Programme).

## Implementation and roll out

51. The Programme) has established a working group who are supporting the implementation planning for the Pfizer Comirnaty bivalent vaccine (the vaccine). Te Aka Whai Ora and Whaikaha are represented on this Working Group.

52. Te Whatu Ora regions have undertaken planning to support the COVID-19 Health System Response up to 30 June 2023. The planning is in accordance with the SWC and Cabinet decisions to secure and retain core COVID-19 services (7 December and 12 December 2022). As part of this planning, regions have identified providers, with a focus on Māori and Pacific providers, that they will contract with to deliver bivalent vaccinations.

53. The regions will utilise these providers to deliver bivalent vaccinations with a focus on equity. The Programme will work with National Public Health service (NPHS) and Te Whatu Ora Regional Directors, district SROs and immunisation leads to ensure demand is met.

54. In preparation for implementation on 1 April 2023, the Programme is working on the following areas:

    a. **Technical**: Work is underway to simplify Book My Vaccine. Following these changes, consumers will no longer be required to enter the date of their last dose when booking an appointment. The system update will also enable consumers to book for a COVID-19 vaccine and flu vaccine together, which will align with the winter preparedness campaign. The 6-month interval allows for people eligible for the BA.4/5 vaccine to receive it in time for winter, and at the same time as their flu vaccine.

    b. **Communications:** from a communications perspective, the Decision to Use advice allows clear and consistent messaging, as the dose interval is consistent across eligible populations. Current communications planning includes the reintroduction of messaging about staying up to date with COVID-19 vaccination, which will begin from late February. Initial campaigns will focus on Māori and Pacific, whaikaha communities and those in aged care. Following that there will be a wider campaign focusing on the general population.

    c. **Operational quality and safety:** Strong operational process settings are required to protect clinical safety with the introduction of the BA.4/5 vaccine. Considerable coordination is happening prior to the implementation. This includes the training of the vaccinator workforce, updating the Immunisation Handbook, clinical advice, operational guidelines, the informed consent form, and consumer collateral.

    d. **System capacity:** The primary focus is, and will continue to be, on ensuring equitable access to the BA.4/5 COVID-19 vaccine. This is done through engagement with Māori and Pacific health providers, as well as mobile and outreach teams. The Programme is

working with districts to ensure there is sufficient capacity to meet demand and are anticipating that a high proportion of boosters will be delivered through pharmacy and general practice.

e. **Workforce**: In 2022, for COVID-19 first boosters, 46% were delivered by pharmacy and 20% by General Practice. For the influenza vaccinations, 52% were delivered by general practice with 37% by pharmacy. Māori and Pacific providers also played a key role to deliver COVID-19 vaccinations also. It is anticipated primary care and pharmacy will continue to deliver the majority of COVID-19 boosters and influenza vaccinations. However, due to the recent announcement that general practice will no longer be funded for COVID-19 related consultations may impact access to general practice. In 2022, the Vaccinating Health Worker (VHW) role was introduced, where COVID-19 Vaccinators Working Under Supervision could transition to become a VHW and be able to administer a range of vaccines in addition to the COVID-19 vaccine. As of 7 February 2023, there are 100 VHWs who are able to administer COVID-19 and influenza vaccines (for those 12 years and over).

f. The Programme will work with the immunisation sector in the regions, districts and primary care to support the delivery of the winter wellness campaign.

g. **Stock**: If the Decision to Use recommendation is implemented, the total eligible population for the BA.4/5 vaccine is expected to be 2.35 million. Pharmac has confirmed the arrival of the initial supply of 59,520 vials (up to 6 doses in each vial) equivalent to 357,000 doses. Additional supply of 384,000 doses is expected to be received by 31 March 2023 with the Quarter 2 supply of 1.1 million doses to follow by 30 June 2023. The total expected supply of BA.4/5 bivalent vaccines in New Zealand is 1.7 million doses. Of this, 43,000 doses are earmarked for the Pacific Islands.

The table below outlines the volumes based on 40% to 80% uptake:

| | Total eligible population | 40% | 50% | 60% | 70% | 80% |
|---|---|---|---|---|---|---|
| 30y + | 2,355,572 | 842,229 | 1,177,786 | 1,413,343 | 1,648,900 | 1,884,457 |

To date, 73% of the eligible population (18 years +) have received a COVID -19 first booster, and 48% of the eligible population (50+) received a COVID-19 second booster.

Officials expect that bivalent vaccine deliveries will continue regularly throughout Q1 and 2, with exact vaccine delivery dates set four weeks in advance. Pharmac and the National Immunisation Programme will continue to monitor uptake and stock levels. While at this stage it is not expected to be any periods of scarcity, if necessary it may be able to negotiate earlier delivery dates.

## Financial Implications

55. Based on current modelling, we do not expect any financial implications of purchasing the BA.4/5 bivalent vaccine until June 2023 as funding was previously drawn down to pay for the bivalent supply of 1.7 million doses.

## Next steps

56. If you agree to the recommendations in this briefing, officials will progress implementation plans and confirm delivery schedules with Pharmac.

ENDS.

MINISTRY OF HEALTH
MANATŪ HAUORA

# Minister's Notes