MINISTRY OF HEALTH
MANATŪ HAUORA

New Zealand Government

2020 National Immunisation Schedule Changes Guide

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Feedback

Comments on this book and suggestions for future editions are invited, to enhance the usefulness of future editions. These should be sent to the Manager Immunisation, Ministry of Health, at the address below.

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Introduction

This 2020 immunisation schedule changes guide is intended to be a reference to the 2020 schedule changes for use by immunisation providers who will be most affected by these changes. Please refer to the online Immunisation Handbook 2020 versions for more detail about these changes and other chapter updates.

On 1 July 2020 there was a dose change to the pneumococcal primary course and some brand changes.

Pneumococcal dose change for primary course

From I July 2020, PCV10 (Synflorix®) has been moved to a 2 +1 schedule. This means that PCV10 is no longer scheduled at the 3-month immunisation event.

The pneumococcal (PCV10) primary course will be given at 6 weeks and 5 months. The third dose will be given in the 2nd year of life.

Branding changes

Table 1: Branding changes

Vaccine Change	From Brand	→	New Brand
Tetanus diphtheria booster (ADT)	ADT Booster To be delisted 1 Oct 2020 or when existing stock is used	→	Tetanus, diphtheria and pertussis (Tdap)
Hepatitis B	HBvaxPRO (MSD)	→	Energix-B (GSK)
Varicella	Varilrix (GSK)	→	Varivax (MSD) for those aged 12 months and older
	Varilrix (GSK)	→	For infants aged between 9 to 12 months at high risk.

1 October 2020 changes

Table 2: National immunisation Schedule 2020

2020 National Immunisation Programme Changes_1 Oct 2020												
Antigen(s)	**DTaP-IPV_ HepB/Hib**	**PCV10**	**RV1**	**MMR-dose 1**	**MMR–dose 2**	**Hib-PRP-T**	**VV**	**DTaP-IPV**	**Tdap**	**HPV9**	**Influenza**	**ZV**
Brand Name	**Infranriz-hexa**	**Synflorix**	**Rotarix**	**Priorix**	**Priorix**	**Hiberix**	**Varivax**	**Infanrix-IPV**	**Boostrix**	**Gardasil 9**	**Afluria Quad**	**Zostavax**
Pregnancy									●[a]		●	
6 weeks	●	●	●									
3 months	●		●									
5 months	●	●										
12 months (new event)		●		●								
15 months					●	●	●[b]					
4 years								●				
11 or 12 years									●	●[c] (2 doses)		
45 years									●[d]			
65 years									●		● (annually)	●[e] (one dose only)

a. Tdap is for women during every pregnancy, from 16 weeks' gestation, preferably in the second trimester.

b. VV is funded for children born on or after 1 April 2016.

c. HPV is funded for individuals aged 26 years and under: 2 doses are recommended for individuals who receive the first dose before their 15th birthday, even if they are 15 years or older at the time of the second dose; 3 doses are recommended for those aged 9–26 years with certain medical conditions, plus an additional dose post-chemotherapy.

d. Funded only for adults who have not received 4 previous doses of tetanus vaccine

e. One dose of ZV is funded for anyone age 65 years on or after 1 April 2018.

Key changes to the National immunisation Schedule from 1 October 2020 are:

- New 12 month vaccination event for PCV10 (booster) and MMR dose 1 (MMR1). Both were previously given at 15 months.
- MMR dose 2 (MMR2) given at 15months event (brings MMR dose 2 forward from age 4 years) alongside the Hib-PRP-T and VV
- Tdap is funded for individuals aged 45 years who have not previously had four doses of a tetanus containing vaccine.
- Tdap also replaces the ADT at 65 years
- DTaP-IPV will continue to be given at age 4 years.

NB: PCV 13 for high risk individuals will remain as a 3 + 1 schedule (ie. at ages 6 weeks, 3 months, 5 months and 12 months)

New 12 month visit

The addition of the 12 month event will enable the PCV10 booster dose to be given at age 12 months and will also enable both doses of MMR to be offered in the second year of life with MMR1 given at 12 months and MMR2 at given 15months (instead of at the current 4 year event). As a result of this change all primary immunisation courses are now completed by age 2 years providing protection against measles at the earliest possible time.

Table 3: 2020 childhood schedule for those < 5 years old

Age	Vaccine							
	DTaP-IPV-HepB/Hib,	Rotavirus	PCV10	MMR1	MMR2	Hib-PRP-T	Varicella	DTaP-IPV
6 weeks	•	•	•					
3 months	•	•						
5 months	•	•	•					
12 months			•	•				
15 months					•	•	•	
4 years								•

All children aged under 5 years are now scheduled PCV at 12 months and MMR at 12 and 15 months.

To prevent missed doses, practices are advised to initially recall their 12 to 14 month age group to receive their 12 month vaccinations before these children turn 15months where possible, followed by recalling 16 to 23 month olds and then 2 to 4 year olds.

NB: Children aged under 5 years who have not yet had their MMR dose 2 will now have this showing in the PMS schedule as an overdue MMR-12M event. For children who have already had their MMR-15M dose vaccinators enter their second MMR dose against the overdue MMR-12M event.

All children under the age of 5 years who have yet to complete PCV10-15M and MMR-4Y doses will now have these scheduled at 12months. Practices are advised to initially recall their 12-14month children to receive their 12M vaccinations before they turn 15 months if possible. Followed by recalling those aged 16months -23 months before proceeding onto recalling those aged 2–3 years.

Table 4: Transition process for PCV10 and MMR from 1 October

Age at presentation	Previous vaccines given	DTaP-IPV-HepB/Hib	PCV10	MMR dose 1	MMR dose 2	Hib-PRP-T	VV	DTaP-IPV
12M	Had 6W, 3M, 5M vaccinations		✓	✓				
13M	Had 6W, 3M, 5M vaccinations		✓	✓				
14M	Had 6W, 3M, 5M vaccinations		✓	✓				
15M	Had 6W, 3M, 5M vaccinations		✓	✓		✓	✓	
	Reschedule MMR-12M dose – due 4 weeks after 15M event given				Rescheduled MMR2 to be given at 4 weeks after dose 1 & enter as MMR-12M			
15M	Had 6W, 3M, 5M & 12M vaccinations*				✓	✓	✓	
16 months to 2Y (i.e. 24 months)	Had 6W, 3M, 5M &15M (i.e. PCV10, MMR1, Hib and VV) vaccinations				✓ (recall, give MMR dose 2 & enter against MMR-12M)[a]			
2Y to under 4Y	Had 6W, 3M, 5M &15M (i.e. PCV10, MMR1, Hib and VV) vaccinations				✓ (recall, give MMR dose 2 & enter against MMR-12M)			
4 year	Had 6W, 3M, 5M &15M (i.e. PCV10, MMR1, Hib and VV) vaccinations				✓ (if not previously given)[b]			✓

*had MMR dose 1 at least 4 weeks prior

a. Suggest recall in batches starting at 16 months to 23 months. Recalling the under 2 years olds is important so they can be protected as early as possible. Then recall 2 to 3 year olds.

b. Continue to also recall those reaching milestone age of 4 years for their scheduled DTaP-IPV and MMR dose 2 (if not already had this).

NB: NR and PMS systems will have rescheduled all those aged under 5 years with the new 12 months event (i.e. PCV and MMR). This will show as due/overdue in their schedules until it is given. For these infants the 4 year MMR dose will not show in their schedule.

Pneumococcal disease

Key information

Mode of transmission	Contact with respiratory droplets.
Incubation period	Asymptomatic nasopharyngeal carriage is common. The incubation period is variable and may be as short as 1–3 days.
Incidence and burden of disease	Highest at extremes of age (<2 years and >75 years), Māori and Pacific people, those with multiple comorbidities and with immunocompromise.
Funded vaccines	All children aged under 5 years: PCV10 (Synflorix). Children and adults with eligible conditions: • PCV13 (Prevenar 13) • 23PPV (Pneumovax 23).
Dose, presentation and route	All vaccines: • 0.5 mL per dose • pre-filled syringe • intramuscular injection.
Funded vaccine indications and schedule	PCV10 at ages 6 weeks, 5 months and 12 months, and age-appropriate catch-up for children <5 years; or, PCV13 and 23PPV: • vaccination or re-vaccination at any age with eligible conditions • testing for primary immune deficiencies.
Vaccine efficacy	For pneumococcal conjugate vaccines: reductions in pneumococcal disease and carriage of vaccine serotypes in vaccinated populations, plus herd immunity effects reducing pneumococcal disease in other age groups; some increases in disease caused by non-vaccine serotypes.
Precautions and special considerations	Concomitant PCV13 and influenza vaccine may increase risk of fever and febrile convulsions in children aged 6 months to <5 years. 23PPV should not be given to children aged under 2 years due to the reduced immune response associated with polysaccharide vaccines.

Recommended immunisation schedule

PCV10 for children aged under 5 years

PCV10 (Synflorix) vaccine is funded for all children aged under 5 years. Two doses of PCV10 are given as the primary course, with a booster at age 12 months (Table 5).

Table 5: Usual childhood PCV10 (Synflorix) schedule

Age	Vaccine	Comment
6 weeks	PCV10	Primary series
5 months	PCV10	Primary series
12 months	PCV10	Booster

Extended pneumococcal immunisation for high risk groups

As part of the extended immunisation programme for high-risk groups, PCV13 and 23PPV are funded for eligible individuals, as shown in Table 6. Because the recommended schedule depends on the age of the individual at diagnosis, the tables have been organised into age groups (under 5 years, 5–18 years and 18 years and older).

The PCV13 and 23PPV funding restrictions are as follows. See Table 6 for the eligible conditions and dosing requirements.

PCV13

All high-risk infants are recommended to receive at least three doses of a PCV vaccine, with at least one dose after 12 months of age. Change from PCV10 to PCV13 as soon as the infant is diagnosed as being at high risk.

- Two doses of PCV13 are funded for high-risk children aged from 12 months and under 18 years who have previously received two or three doses of PCV10.
- Up to four doses of PCV13 are funded for vaccination or re-vaccination of high-risk children aged under 5 years.
- Up to four doses of PCV13 are funded for vaccination or re-vaccination of eligible individuals aged 5 years and older.

23PPV

- Up to three doses of 23PPV are funded for individuals with eligible conditions.
- Up to two doses of 23PPV are funded for high-risk children aged under 18 years.

> See also section 15.5.3 '(Re)vaccination'. See sections 4.2 and 4.3 of the immunisation Handbook 2020 for more information about immunocompromised infants, children and adults, including additional vaccine recommendations and schedule tables for certain conditions.

Table 6: Extended pneumococcal immunisation for children aged under 5 years – funded PCV13 and 23PPV indications and schedules

See the Pharmaceutical Schedule (**www.pharmac.govt.nz**) for any changes to funding decisions.

PCV13 (Prevenar 13) and 23PPV (Pneumovax 23) are funded for children aged under 5 years:

- prior to planned immunosuppressive therapy or radiotherapy, including prior to solid organ transplantation
- on immunosuppressive therapy or radiotherapy (vaccinate when there is expected to be a sufficient immune response)
- with primary immune deficiencies
- with HIV infection
- with renal failure or nephrotic syndrome
- who are immunosuppressed following organ transplantation (including HSCT)
- with cochlear implants or intracranial shunts
- with cerebrospinal fluid leaks
- who are receiving corticosteroid therapy for more than 2 weeks, and who are on an equivalent daily dosage of prednisone of 2 mg/kg per day or greater, or children who weigh more than 10 kg on a total daily dosage of 20 mg or greater
- with chronic pulmonary disease (including asthma treated with high-dose corticosteroid therapy)
- who were preterm infants, born before 28 weeks' gestation
- with cardiac disease, with cyanosis or failure
- with diabetes
- with Down syndrome
- who are pre-or post-splenectomy, or with functional asplenia.

Age at diagnosis	Vaccine	Recommended vaccine schedule
<12 months	PCV13	PCV13[a] at ages 6 weeks, 3, 5[b] and 12 months or an age-appropriate catch-up schedule. For those who have not been immunised at age 7–11 months – give 2 doses of PCV13 (8 weeks apart) and a further dose 8 weeks later, from age 12 months. For children aged 7–11 months who have completed a 2-dose primary course with PCV10, give 1 dose of PCV13 as soon as possible and another dose (of PCV13) 8 weeks later, from age 12 months.
	23PPV	Following the completion of the PCV course, give 1 dose of 23PPV at age ≥2 years. There must be at least 8 weeks between the last PCV dose and the 23PPV dose. If risk persists, revaccinate once with 23PPV, 5 years after the first 23PPV.
12 months to <5 years	PCV13	For children who have not yet received any PCV13, give 2 doses of PCV13 at least 8 weeks apart.[c,d]
	23PPV	Give 1 dose at least 8 weeks after the last PCV13 dose, from age 2 years. If risk persists, revaccinate once with 23PPV, 5 years after the first 23PPV.

a. A three-dose primary series plus a booster dose of PCV13 replaces PCV10 on the usual Schedule.
b. Additional dose of PCV13 given at 5 months, differing from PCV10 Schedule.
c. If 23PPV has already been given (prior to any doses of PCV13) to children aged under 5 years, wait at least 8 weeks before administering PCV13 (note: this timing differs in adults, see footnote in Table 15.5 of the Immunisation Handbook).
d. There are no safety concerns, regardless of the interval between the last dose of PCV10 and the first dose of PCV13.

Measles, mumps and rubella (MMR)

Key information

Mode of transmission	By direct contact with infectious droplets or by airborne spread. Measles is one of the most highly communicable of all infectious diseases (R0=12–18).
Incubation period	Measles - About 10 days but may be 7–18 days from exposure to onset of fever. The incubation period may be longer in those given IG after exposure. Mumps - About 16 to 18 days, ranging from 12 to 25 days. Rubella - 14–23 days, usually 16–18 days. Up to 50 percent of rubella infections are subclinical
Period of communicability	Measles -From 5 days before to 5 days after rash onset, counting the day of rash onset as day 1. Mumps - For contact tracing purposes, the recommended period of communicability is from 2 days before to 5 days after the onset of parotitis. The virus is also transmitted by asymptomatic infections Rubella - 7 days before until 7 days after the onset of the rash. Infants with CRS may be infectious for months.
Incidence and burden of disease	New Zealand was declared free of endemic measles in 2017. Outbreaks continue to occur through imported cases, as occurred in 2019. To prevent recurrent outbreaks of measles, 95 percent of the population must be immune. Outbreaks of mumps continue to occur in New Zealand Endemic rubella was verified as eliminated in 2017
Funded vaccine	MMR (Priorix) is a live attenuated vaccine.
Dose, presentation, route	0.5 mL per dose after reconstitution. Pre-filled syringe and glass vial. The vaccine must be reconstituted prior to injection. Intramuscular or subcutaneous injection.

Continued on next page

Funded vaccine indications and schedule	Children at ages 12 months and 15 months. Adults who are susceptible to one or more of measles, mumps and rubella. This includes all adults born in New Zealand from 1 January 1969 without two documented doses of measles-containing vaccine received after age 12 months. For (re)vaccination following immunosuppression (if the individual is immunocompetent enough to safely receive the vaccine).
Recommended	All adults born since January 1969 should be up to date with two doses of MMR or have evidence of immunity to all three vaccine components. It is particularly important for health care workers, individuals who work with children, armed forces personnel, staff of correctional facilities, long-term care facilities and immigration/refugee centres and laboratory staff. All vaccine-eligible travellers, particularly to high risk countries.
Vaccine effectiveness	Measles vaccines are around 95 percent effective after 1 dose and 99 percent effective after two doses.
Duration of protection	Two doses are anticipated to provide lifelong protection. Protection is best achieved through herd immunity from high immunisation coverage.
Contraindications	MMR is contraindicated for immunocompromised individuals and in pregnancy. Priorix is contraindicated for anaphylaxis to neomycin.
Precautions and special considerations	See section 11.6 of Immunisation Handbook 2020 for cautions around receipt of blood products and other live vaccines, and other precautions.
Potential responses to vaccine	MMR is generally well tolerated. Fever and rash 6–12 days after vaccination. Salivary gland swelling and joint pain is possible due to mumps and rubella components.
Public health measures	Notify the local medical officer of health immediately on suspicion of wild-type measles or wild type mumps and for suspected cases of rubella Measles: Prevent measles transmission through exclusion and use of personal protective equipment. Mumps: Exclude cases for 5 days from onset of glandular swelling. Exclude susceptible contacts from 12 days after the first exposure to 25 days after last exposure to the infectious case. Promote immunisation to susceptible individuals.
Post-exposure prophylaxis	Management of contacts of cases should be discussed with the medical officer of health.

Recommended MMR vaccination schedule

Table 7: Immunisation schedule for pertussis-containing vaccines (excluding catch-up)

	Schedule
Usual childhood schedule[a]	2 doses: at ages 12 months and 15 months
Catch-up[b] for children, adolescents and adults	2 doses: at least 4 weeks apart

a. If MMR is given to children aged 6–11 months for outbreak control, 2 further MMR doses are still required at age 12 months (given at least 4 weeks since the previous dose) and 15 months.

b. For those born from 1 January 1969 who do not have documented evidence of two doses of an MMR-containing vaccine given after age 1 year, or who do not have serological evidence of protection for measles, mumps and rubella. See section 11.5.2 of the Immunisation Handbook

Tetanus, diphtheria and pertussis

Key information

Mode of transmission	Tetanus - Environmental exposure to the bacillus, usually through contaminated wounds. The disease is not directly transmitted from person to person. Diphtheria -Contact with respiratory droplets or infected skin of a case or carrier or, more rarely, contaminated objects. Pertussis - By aerosolised droplets.
Incubation period	Tetanus -Between 3 and 21 days, commonly about 10 days; may vary from 1 day to several months. Diphtheria - Usually 2–5 days, occasionally longer Pertussis - 7–10 days (range 5–21 days).
Period of communicability	Tetanus - A person with tetanus is not infectious to others. Diphtheria - Variable; usually 2 weeks or less, seldom more than 4 weeks. Carriers may shed for longer. Effective antimicrobial therapy promptly terminates shedding. Pertussis - For control purposes, in untreated cases the communicable stage lasts from the catarrhal stage to 3 weeks after the onset of paroxysmal cough. For control purposes, in untreated cases the communicable stage lasts from the catarrhal stage to 3 weeks after the onset of paroxysmal cough.
Incidence and burden of disease	Tetanus -Older individuals, usually women, who are less likely to have received a primary series of tetanus vaccine; and in unvaccinated children. Diphtheria – Was common in New Zealand until 1960. Last report case of toxigenic respiratory disease as in 1998. Pertussis - Widespread outbreaks occur every 3–5 years. Infants aged under 12 months are at highest risk from pertussis, particularly those who have received fewer than two doses of vaccine and if the mother did not receive vaccine in pregnancy.
Funded vaccines	DTaP-IPV-HepB/Hib (Infanrix-hexa). DTaP-IPV (Infanrix-IPV). Tdap (Boostrix).
Dose, presentation, route	Intramuscular injection. 0.5 mL per dose.

	DTaP-IPV-HepB/Hib: pre-filled syringe and glass vial. The vaccine must be reconstituted prior to injection. DTaP-IPV, Tdap: pre-filled syringe.	
Funded vaccine indications and schedule	During each pregnancy (recommended from 16 weeks' gestation) for pertussis protection	Tdap
	6 weeks, 3 months and 5 months	DTaP-IPV-HepB/Hib
	4 years	DTaP-IPV
	11 years	Tdap
	45 years (catch-up, if individual has not received 4 previous tetanus doses)	Tdap
	65 years	Tdap
	Parents or primary caregivers of infants admitted to neonatal intensive or specialist baby care units for more than 3 days and whose mothers had not received Tdap at least 14 days prior to birth for pertussis protection	Tdap
	For vaccination of previously unimmunised or partially immunised patients	DTaP-IPV-HepB/Hib, DTaP-IPV or Tdap
	For (re)vaccination of eligible patients	
	For boosting of patients with tetanus-prone wounds	Tdap
Post-exposure prophylaxis	Tetanus - If an injury is tetanus prone *and* there is any doubt about previous tetanus immunisation, the individual must be given tetanus immunoglobulin (TIG) and a 3-dose primary immunisation course. Diphtheria – All cases of diphtheria must be notified immediately on suspicion.	

Recommended immunisation schedule

Table 8: Immunisation schedule for tetanus-containing vaccines (excluding catch-up)

Age	Vaccine	Comment
Pregnant women: recommended from 16 weeks' gestation of every pregnancy, preferably in the second trimester (funded when given any time in second or third trimester)	Tdap	Booster for mother Passive immunity for infant
6 weeks	DTaP-IPV-HepB/Hib	Primary series
3 months	DTaP-IPV-HepB/Hib	Primary series
5 months	DTaP-IPV-HepB/Hib	Primary series
4 years	DTaP-IPV	Booster
11 years	Tdap	Booster
45 years (individuals who have not received 4 tetanus vaccinations in their lifetime)	Tdap	Booster
65 years	Tdap	Booster

Changes for Human Papillomavirus catch-ups

A two-dose schedule of HPV at least 6–12 months apart is recommended for individuals who receive their first dose before their 15th birthday, even if they are 15 years or older at the time of the second dose.

Individuals who start their HPV schedule from age 15 years and older receive three doses of HPV at 0, 2 and 6 months. If required, a shortened schedule of three doses can be given over a 5-month period, with a minimum of four weeks between any two doses.

Non-residents who were under age 18 years when they commenced HPV vaccination are currently funded to complete the course, even if they are aged 18 years or older when they complete it. See Table 10 for HPV catch-up schedules.

Table 9: Minimum number of antigens required by individuals aged 10 to under 18 years at the time of presentation

10 years to <18 years
4 Tdap[a]
3 IPV[b]
3 HepB for children aged 10 to <18 years; or alternatively 2 HepB doses for children aged 11–15 years[c]
2 MMR
2 HPV[d, e, f] for those aged 11–14 years, or 3 HPV[d, g] for those aged 15 years and older
1 VV[h]

a. If aged 10 years to under 18 years, use Tdap for the primary series and the booster dose, with a minimum interval of 6 months between doses 3 and 4 (the primary series and the booster dose).

b. A minimum of 3 polio doses are required for the primary series (at a minimum of 4-weekly intervals).

c. If aged 10 years to under 18 years, 3 doses of HepB are required. An alternative 2-dose schedule may be used for children aged 11–15 years with the second dose given 4–6 months after the first.

d. Individuals who started with HPV4 may complete their remaining doses with HPV9.

e. For those aged 11–14 years, the second HPV dose is preferably given at least 6 months after the first. If the second dose is given earlier than 5 months after the first, a third HPV dose is recommended and funded — give the third dose at least 5 months after the first dose.

f. A two-dose schedule of HPV at least 6–12 months apart is recommended for individuals who receive the first dose before their 15th birthday, even if they are 15 years or older at the time of the second dose.

g. For those aged 15 years and older, give a 3-dose HPV course at 0, 2 and 6 months. If a shortened schedule is required for these older individuals, the 3 doses can be given over a 5-months period, with a minimum of 4 weeks between any two doses.

h. One dose of varicella vaccine is funded for children born on or after 1 July 2006, who have not previously had varicella vaccination or infection.

Table 10: Primary immunisation requirements for adults

Antigens and number of doses required
3 Tdap[a]
3 polio (IPV)[b]
2 MMR[c]
3 HPV[d,e] (aged 26 years and under)

a. A primary course of 3 doses of Tdap vaccines (at a minimum of 4-weekly intervals) is recommended and funded for unimmunised or partially immunised adults. At age 45 years, the Tdap is recommended for those adults who have not previously received four tetanus containing vaccines in their lifetime, and for all adults at age 65 years.

b. A primary course of 3 polio (IPV) doses (at a minimum of 4-weekly intervals) is recommended and funded for unimmunised or partially immunised adults.

c. Two doses of MMR (given a minimum of 4 weeks apart) are recommended and funded for unimmunised adults who are susceptible to any one of the three diseases. Those born in New Zealand before 1969 are considered immune to measles and those born prior to 1980 are considered to be immune to mumps.

d. HPV9 vaccine is recommended and funded for individuals aged up to 26 years inclusive. Give the 3-dose course at 0, 2 and 6 months. If a shortened schedule is required, the 3 doses can be given over a 5-month period, with a minimum of 4 weeks between any two doses.

e. Those who were under age 27 years when they commenced HPV vaccination are currently funded to complete the 3-dose course, even if they are aged 27 years or older when they complete it. Non-residents who were under age 18 years when they commenced HPV vaccination are currently funded to complete the course, even if they are aged 18 years or older when they complete it.

Links to additional resources

- Ministry of Health, Immunisation Handbook 2020 **https://www.health.govt.nz/publication/immunisation-handbook-2020**

- Ministry of Health, New Zealand Immunisation Scheduled **https://www.health.govt.nz/our-work/preventative-health-wellness/immunisation/new-zealand-immunisation-schedule**

- IMAC webinars **https://www.immune.org.nz/resources/presentations-webinars**

- IMAC **https://www.immune.org.nz/health-professionals**