INDEPENDENT EVALUATION

MĀORI COMMUNITIES COVID-19 FUND

POUTŪ-TE-RANGI 2023

GLOSSARY

AOTEAROA-NEW ZEALAND	NEW ZEALAND
KAIMAHI	(NOUN) WORKER, EMPLOYEE AND STAFF. IN THIS CONTEXT, A TE PUNI KŌKIRI OFFICIAL WORKING IN THE REGIONS.
KAITONO	(NOUN) APPLICANTS. IN THIS CONTEXT, SUCCESSFUL APPLICANTS TO THE MCCF WHO THEN DELIVERED MCCF ACTIVITIES.
MANAAKITANGA	(NOUN) A PROCESS OF SHOWING RESPECT, GENEROSITY AND CARE FOR OTHERS.
MANATŪ HAUORA	MINISTRY OF HEALTH
PAE ORA	PAE ORA IS THE GOVERNMENT'S POLICY FOR HEALTH. SEE ALSO PAE ORA (HEALTHY FUTURES) ACT 2022 AND THE RELATED DEFINITIONS.
TANGATA	(VERB) TO BE A PERSON, TO BE HUMAN.
TĀNGATA WHAIKAHA	(NOUN) DISABLED PEOPLE
TE ARAWHITI	THE OFFICE FOR MĀORI CROWN RELATIONS
TE PUNI KŌKIRI	MINISTRY OF MĀORI DEVELOPMENT
TE WHATU ORA	HEALTH NEW ZEALAND

ABBREVIATIONS

MCCF	MĀORI COMMUNITIES COVID-19 FUND
DHB	DISTRICT HEALTH BOARD
MIQ	MANAGED ISOLATION AND QUARANTINE

PREFACE

Kia whakatōmuri te haere whakamua.

I walk backwards into the future with my eyes fixed on my past.

This whakataukī speaks to the point of view in which this independent research was undertaken. This research has been conducted in the spirit of manaakitanga and learning – as the past is central to and shapes both the present and future.

The whakataukī also embraces the idea that complexity seems to have reached extraordinary proportions, with simplification and reductionism seemingly attractive but not often assisting us with uncertainty.

The whakataukī also reminds us that the conditions and consequences of action are sometimes unacknowledged and unknowable – even ex-post – even with the best evidence base.

This is why through the course of this evaluation, we have paid particular attention to the context and background in order to answer the questions about whether the Māori Communities COVID-19 Fund (MCCF) helped lift vaccination rates, how whānau were supported at home and in their communities, as well as how effective the cross-agency collaboration was.

This report offers the results of our evaluation, with six key findings and two recommendations.

In section one, we describe the MCCF and detail the timeline of events in which the MCCF was established.

In section two we offer insight into why the health system was under pressure, such that the MCCF was necessary. It has been written to enable an understanding – or reminder – of the health reforms and the decision-making culture leading up to the establishment of the MCCF.

Section three describes the methodology. This evaluation used a mixed method approach: from quantitative to content analysis, to Q-method interviews with Āta. It has given us a unique insight into what worked.

In section four, we offer our main findings. It begins with an answer to the question of whether the MCCF assisted in removing access inequity in COVID-19 vaccination services between October 2021 and June 2022. The answer is yes. We draw on vaccination data from Te Whatu Ora. We then discuss the specific ways in which the MCCF assisted in improving vaccine uptake and building community resiliency through the use of seven statistically robust narratives. These narratives enable a rich and precise understanding of what went well and what might be improved next time.

At the outset of our work, it was evident that not every investment could be audited or examined during our evaluation. Auditing, reviewing, and hearing about every investment would have taken many years. Choices had to be made.

We are grateful to the experts who guided us on how to use and understand the limitations of the vaccination data. We are especially thankful to the officials at Manatū Hauora, who assisted us with the up-to-date vaccination data and guided us to the health system reform literature.

We mihi to the iwi/Māori providers who worked tirelessly to close vaccination inequities and further build resilience across their communities. Their names are set out in Appendix One. We are deeply grateful to them for all they did willingly, diligently, and skilfully on behalf of their communities.

E hara taku toa i toa takitahi, he toa takitini.

Tēnā rawa atu koutou e toka te moana i tō mahi.

Nāu i ora ai ngā kawa o Te Tiriti o Waitangi.

Ngā manaakitanga

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THE EVALUATION QUESTIONS

Te Puni Kōkiri asked the research team to answer three questions:

- First, did MCCF assist in improving vaccination uptake between October 2021 and June 2022?
- Second, whether and how MCCF helped improve vaccine uptake and build community resiliency in the context of introducing the COVID-19 protection framework?
- Finally, what are the lessons in collaboration between the three institutions: Te Puni Kōkiri, Te Arawhiti and Manatū Hauora?

EXECUTIVE SUMMARY

This evaluation used a mixed method approach: including quantitative, content analysis, Q-method interviews and Āta. The quantitative data established the baseline lift in vaccination rates between October 2021 and June 2022. The content analysis of the programme level documentation informed the Q-method interviews[1]. Q-method transparently quantifies the viewpoints of participants, and through mathematical analysis reduces them to the few narratives on which most participants agree. Unlike research methods that involve qualitative interviews that are then content analysed, Q-method takes a quantified snapshot of a person's viewpoint and compares it to every other participant's viewpoint. That is people are the variable in Q-method, not as in normal statistical analysis, their traits. Q-method, therefore, takes into account a person as a whole. Āta provided a way of building trust necessary for participants to feel safe to share their views. That is because Āta is a way of engaging that is shaped by respectfulness in relationships in such a way as to create well-being. Like Q-method it is entirely people-centred. This unique approach offers powerful and precise insights into what worked by capturing and honouring the wisdom of those involved in MCCF.

On the basis of those insights there are seven findings and two recommendations:

- First and foremost, there is no question that the Māori Communities COVID-19 Fund (MCCF) successfully mobilised support for rapid vaccination activities. And in doing so, it helped communities build resilience by mitigating the impact of COVID-19.

[1] Programme level means MCCF.

- Second, while this evaluation has some limitations, primarily due to the quality of the programme-level impact data, it is evident that the MCCF improved access equity by offering additional vaccination services in areas with high-priority populations and low access to vaccines. This improved equity in vaccination uptake and protected priority populations.
- Third, in addressing access inequity, the MCCF also improved equity in outcomes by funding services that practically reduced the administrative burden on whānau living rural and remotely, tamariki and rangatahi, those whānau who needed to hear from a "trusted messenger" on the efficacy of vaccines, and tāngata whaikaha, so they could access vaccine information and vaccination services. The reduced burden includes a combination of the following:
    - Reduced learning costs (such as finding out who in the whānau was eligible for vaccination and when and where to get information or a vaccine).
    - Reduced psychological costs (such as reducing the stress and stigma involved in interacting with people often unknown to the whānau).
    - Reduced compliance costs (such as streamlining application processes and reporting).
- Fourth, this independent evaluation also finds that some MCCF investments overcame some of the weaknesses in the mainstream vaccination delivery programme by ensuring information and services were targeted at whānau, whanui and hapori and those with the greatest need.
- Fifth, it also finds that some investment benefits have been shared in a way that has built resiliency and bolstered some underserved communities. Vignettes are used to illustrate this point. The building of resiliency, however, must be seen in the context of how vaccination – in and of itself – was one of the most effective ways to maintain and protect Māori and Pasifika communities who were at higher risk of death from COVID-19.
- Sixth, the evaluation also finds that the leadership from Te Puni Kōkiri and the cooperation it enabled between the three institutions (Te Puni Kōkiri, Te Arawhiti and Manatū Hauora) was crucial to the success of MCCF. Senior leaders worked hard to simplify a complex operating environment and manage competing demands. It is also apparent that the shared purpose and goal drove the priorities of each agency and motivated their staff daily.

- Finally, this evaluation also finds critical to the success of the MCCF were Te Puni Kōkiri's kaimahi at all levels, including those based in the regions, and their deep understanding of the Māori and Crown relationship. The approach of these kaimahi was integral in proactively scanning the environment, working across organisational and institutional boundaries, generating and smoothing information flow, and balancing the needs of the authorising environment and the communities they work in. This was consistent with Te Puni Kōkiri's nationally enabled and locally-led approach.

The recommendations are for Te Puni Kōkiri. Te Puni Kōkiri needs to improve the quality of the programme-level impact data. While the research team created a methodology that mitigated the absence of programme-level data, better and more precise mapping between investment costs, impacts and benefits will make for faster evaluation and real-time adjustments. Secondly, in the future, more thought needs to go into including more iwi/Māori voices at the decision-making table, irrespective of the speed and pace of the programme delivery schedule. While officials were aware of this, it might have mitigated the difficulties towards the end of the MCCF as the funding window closed.

SECTION ONE: BACKGROUND

This section describes MCCF and the official timeline that led to its establishment. This section ensures the reader understands the authorising environment and the speed at which MCCF investments were made.

Māori Communities COVID-19 Fund (MCCF)

In 2021 it became clear that there were weaknesses in the health system and shortcomings in the design of the vaccination delivery programme in serving vulnerable and indigenous people in New Zealand. So, Cabinet turned to Te Puni Kōkiri, supported by Te Arawhiti and Manatū Hauora to establish and deliver the Māori Communities COVID-19 Fund (MCCF) which was announced by Ministers Davis, Henare and Jackson on 21 October 2021. The MCCF was established to accelerate Māori vaccination rates and support communities in preparing for the COVID-19 Protection Framework. The first stage was designed to directly fund iwi/Māori to deliver local vaccination activities targeted at whānau.

In describing the MCCF, the Minister for Māori Crown Relations: Te Arawhiti, Hon Kelvin Davis, said, “We have heard calls from across Māori society that they need extra support to help get to their people. This funding provides us an opportunity to partner with and support iwi and Māori as we continue through our COVID-19 recovery.” (Cabinet, 2021).

The Associate Minister for Health (Māori Health), Hon Peeni Henare, said, “From hāngi and vouchers, walk-in clinics and vax buses, partnerships with iwi, local communities and businesses, communities going door-to-door, vaccinations on sports fields and at kura and many more initiatives - we’ve seen what works, and this fund will support more of it” (Cabinet, 2021).

Minister for Māori Development, Hon Willie Jackson, said that iwi/Māori providers and other groups with deep connections and networks in their communities would be funded to reach whānau that other government response efforts have failed to reach (Cabinet, 2021).

Te Puni Kōkiri took on a leadership role and worked with Te Arawhiti and Manatū Hauora to develop the programme and deliver the resourcing set out in the MCCF to communities across the motu. The policy process leading up to the announcement shows that Ministers and officials were meeting regularly with iwi/Māori leaders. The discussion appears to have orientated around the urgent need for the government to more effectively target its resources towards local initiatives, to increase vaccination uptake. The discussion also seems to have covered the disproportionate impact of the regional lockdowns on more vulnerable communities, and the need for the Government to mitigate the negative impact on those communities.

Informed by those discussions, the MCCF was designed to work in three phases:

- Phase one: A focus on direct financial support to iwi/Māori community providers to accelerate vaccination uptake. The investments began a week after announcements and were designed to complement – not duplicate – the mainstream vaccination roll-out effort.
    - From the reports the research team had access to, phase one appears to have focussed on areas where Māori had relatively high populations with low access to vaccination services, including Counties Manukau, Lakes District, Taranaki and Tairāwhiti, Northland and Bay of Plenty District Health Board (DHB) areas. Specific attention was paid to creating access for rangatahi, tāngata whaikaha, and whānau in remote and rural communities, as well as mitigating the impact of the regional lockdowns, especially on Waikato and Te Tara-O-Te-Ika-A-Māui.
- Phase two: A focus on financial support to iwi/Māori community providers who were best placed to deliver community-designed preparedness initiatives. The investments were designed to build and adapt community social infrastructure to mitigate the impact of the COVID-19 Protection Framework.

- From the reports, the research team had access to examples of investments, including activities focussed on community outreach and mobilisation of resources to support rapid responses to local outbreaks; ensuring marae and iwi properties were fit-for-the-purpose of supporting a community response; upskilling community members to become vaccinators; mobile vaccinations; vaccination events; developing material to target high-need groups including specific age groups; support for diagnosis; support for home isolation; ongoing support for returning to school and work.

- Phase three: These investments focussed on enabling communities to mobilise community-based approaches to support at-risk whānau to access available health and welfare, working alongside other government approaches.
    - From the reports, the research team had access to the funding primarily focussed on supporting organisations that were not health providers and not part of the coverage of Whānau Ora Commissioning agencies network to provide navigation-type services to ensure whānau could access mainstream support and resources.

The MCCF totalled $128,980,000 and was invested between October 2021 and 30 June 2022.

In Phase One, $70,546,000 supported rapid vaccination activities.

Phase Two saw $38,049,000 help build the resilience of vulnerable Māori communities. In Phase Three, $20,385,000 built on Phase Two to help hapori Māori to manage the impact of Omicron.

Investment decisions were prepared by officials from Te Puni Kōkiri, with support from Te Arawhiti and Manatū Hauora. Te Puni Kōkiri officials, including those based in the regions worked as the bridge between agencies and fund applicants. This was part of Te Puni Kōkiri's model of practice that provides for nationally enabled and locally-led

approaches. To support Te Puni Kōkiri, Manatū Hauora ensured that MCCF complemented the mainstream vaccination roll-out. It also contributed resources, including data, modelling, intelligence, and advice. Te Arawhiti contributed its networks and guidance.

A Ministerial Oversight Group made up of the Minister of Finance, Minister for Māori Crown Relations: Te Arawhiti, Associate Minister of Health (Māori Health), Te Minita mō Whānau Ora, and Te Minita Whanaketanga Māori, oversaw investments and delivery, particularly through Phase 1 of the programme.

At the initial stages of the roll-out, there was daily reporting. Daily reporting covered vaccination uptake by DHB region, together with actions each of the agencies were taking. This was reduced to weekly reporting as vaccination uptake started to improve.

As vaccination uptake improved, some decision rights were delegated closer to where the work was being done.

166 providers across Aotearoa-New Zealand were funded for 253 projects. Several providers collaborated on proposals. As part of the contracting arrangement, each provider completed either a milestone or an investment report.

Timeline of events leading up to and including the MCCF

The following timeline is drawn from the Crown's evidence to the Waitangi Tribunal and detailed in the Haumaru: The COVID-19 Priority Report (2021).

Early outbreak

28 February 2020: First COVID-19 case reported in Aotearoa-New Zealand.

14 March 2020: Government announces anyone entering the country must self-isolate for 14 days (except for those arriving from the Pacific).

19 March 2020: All indoor gatherings of more than 100 people are to be cancelled. Borders close to everyone except for citizens and residents.

21 March 2020: Government introduces a 4-tiered Alert Level system, and Aotearoa-New Zealand is announced to be at Alert Level 2.

First nationwide lockdown

23 March 2020: The country moves to Alert Level 3 at 1:30pm.

25 March 2020: The country moves to Alert Level 4 at 11:59pm. A State of National Emergency is declared at 12.21pm.

31 March 2020: The State of National Emergency is extended. It will be extended a further six times between April and May 2020.

9 April 2020: Director-General of Health issues an order requiring all people entering Aotearoa-New Zealand by air to enter managed isolation and quarantine.

16 April 2020: Manatū Hauora publishes Initial COVID-19 Māori Response Action Plan.

27 April 2020: Aotearoa-New Zealand moves to Alert Level 3 at 11:59pm.

13 May 2020: The country moves to Alert Level 2 at 11:59pm. The State of National Emergency expires at 12.21pm.

8 June 2020: The country moves to Alert Level 1 at 11:59pm.

First nationwide lockdown ends

9 July 2020: Manatū Hauora publishes the Updated COVID-19 Māori Response Action Plan.

First Auckland lockdown begins

12 August 2020: The Auckland region moves to Alert Level 3 at 12 noon, and the rest of Aotearoa-New Zealand moves to Alert Level 2 after four COVID-19 cases are recorded in the community on 11 August 2020.

30 August 2020: Auckland moves to Alert Level 2 at 11:59pm, with extra restrictions on travel and gatherings. The rest of Aotearoa-New Zealand remains at Alert Level 2.

September 2020: Weekly testing for Managed Isolation and Quarantine (MIQ) staff in quarantine facilities, and fortnightly in managed isolation facilities instituted.

21 September 2020: All regions outside of Auckland move to Alert Level 1 at 11:59pm.

23 September 2020: Additional restrictions on travel and gatherings are removed for Auckland at Alert Level 2.

5 October 2020: The Managed Isolation Allocation System goes live. From 3 November 2020 travellers were legally required to have a MIQ voucher before flying if they were arriving in Aotearoa-New Zealand.

7 October 2020: Auckland moves to Alert Level 1 at 11:59pm.

First Auckland lockdown ends

12 October 2020: New Zealand Government signs an agreement with Pfizer to buy 1.5 million doses of the Pfizer–BioNTech COVID-19 vaccine.

7 December 2020: Cabinet approves the proposed sequencing framework in principle (subject to updating to reflect new and emerging evidence).

9 February 2021: Cabinet notes Pfizer COVID-19 vaccine has been granted provisional consent by Medsafe and is available for use in Aotearoa-New Zealand.

Second Auckland lockdown begins

14 February 2021: Auckland moves to Alert Level 3 at 11:59pm after three COVID-19 community cases are recorded. The rest of the country moves to Alert Level 2.

17 February 2021: Auckland moves to Alert Level 2 at 11:59pm. The rest of the country moves to Alert Level 1.

Vaccine rollout begins

19 February 2021: The first COVID-19 vaccinations are administered.

Second Auckland lockdown ends

22 February 2021: Auckland moves to Alert Level 1 at 11:59pm.

Third Auckland lockdown begins

28 February 2021: Auckland moves to Alert Level 3 at 6am. The rest of the country moves to Alert Level 2.

7 March 2021: Auckland moves to Alert Level 2 at 6am. The rest of the country moves to Alert Level 1.

8 March 2021: Cabinet agrees to allocate 40,000 courses of vaccine to Māori and Pacific providers to distribute to older people living in whānau environments in hard-to-reach places, and their households. Cabinet noted that Manatū Hauora would partner with Māori and Pacific providers to deliver vaccinations in their communities, who will be provided with ongoing vaccine allocations from Tier 2(b) onwards.

10 March 2021: COVID-19 Response Minister Chris Hipkins announces COVID-19 rollout plan using the Pfizer–BioNTech COVID-19 vaccine with 4 vaccine rollout groups.

12 March 2021: Auckland moves to Alert Level 1 at midday.

Third Auckland lockdown ends

26 March 2021: Manatū Hauora publishes the COVID-19 Māori Vaccine and Immunisation Plan: Supplementary to the Updated COVID-19 Māori Health Response Plan.

19 April 2021: Quarantine-free travel between Aotearoa-New Zealand and Australia starts.

23 June 2021: Wellington moves to Alert Level 2 at 11:59pm.

29 June 2021: Wellington moves to Alert Level 1 at 11:59pm.

23 July 2021: Quarantine-free travel from Australia suspended.

Vaccine rollout for the general population begins

28 July 2021: Rollout to the general population begins with invitations to book a vaccination sent to all New Zealanders aged 60–64 years.

6 August 2021: Invitations to book a vaccination sent to all New Zealanders aged 55 years and over. It is clear not all invitations arrived.

7 August 2021: Delta arrives.

11 August 2021: Invitations to book a vaccination sent to all New Zealanders aged 50–54. Again, it is clear that not all invitations arrived.

12 August 2021: Announcement that all people of an eligible age would be able to book vaccination by 1 September 2021.

Second nationwide lockdown begins

17 August 2021: All of Aotearoa-New Zealand moves to Alert Level 4 at 11:59pm. Vaccinations are suspended for 48 hours.

18 August 2021: Invitations to book a vaccination sent to all New Zealanders aged 40–49. Again, it is clear that not all invitations arrived.

19 August 2021: Prime Minister announces that Cabinet had approved the vaccine for 12–15-year-olds.

22 August 2021: Announcement that mandatory record keeping was being introduced for many businesses and events.

25 August 2021: From this day, those aged 30 and over were able to book a vaccine.

31 August 2021: All of the country south of Auckland moves to Alert Level 3 at 11:59pm.

1 September 2021: Everyone aged 12 years and over is eligible to be vaccinated. The Minister for Māori Crown Relations: Te Arawhiti announces a $1 million targeted funding pool to support iwi-led response planning, communications outreach, and support for vaccine uptake.

2 September 2021: Northland moves to Alert Level 3 at 11:59pm.

Restrictions ease outside of Auckland

7 September 2021: The country outside Auckland moves to Alert Level 2 at 11:59pm.

8 September 2021: Beehive press release states that the Government has reprioritised up to $5 million to provide immediate relief to vulnerable whānau Māori and communities during the current COVID-19 outbreak.

21 September 2021: Auckland and Upper Hauraki move to Alert Level 3 at 11:59pm. Government announces increased funding of $38 million to support Māori health providers in the COVID-19 response.

25 September 2021: Upper Hauraki moves to Alert Level 2 at 11:59pm.

27 September 2021: Government releases A Strategy for a Highly Vaccinated New Zealand which outlines a high-level approach to the proposed next stage of COVID-19 response in Aotearoa-New Zealand.

3 October 2021: Raglan, Te Kauwhata, Huntly, Ngāruawāhia, Hamilton City, and some surrounding areas move to Alert Level 3 at 11:59pm.

4 October 2021: Prime Minister announces roadmap out of lockdown for Auckland.

Restrictions ease for Auckland

5 October 2021: Alert Level 3 restrictions in Auckland are eased from 11:59pm to Step 1 of Alert Level 3. Cabinet agrees to the use of vaccine certificates in Aotearoa-New Zealand.

7 October 2021: Waikato Alert Level 3 boundary is extended from 11:59pm to include Waitomo District, Te Kūiti, Waipa District and Ōtorohanga District.

8 October 2021: Northland moves to Alert Level 3 at 11:59pm.

11 October 2021: Government announces that health and disability workers would have to be fully vaccinated by 1 December 2021 with a first dose by 30 October 2021, and all teachers and early childhood workers would have to be fully vaccinated by 1 January 2022 with a first dose by 15 November 2021.

16 October 2021: National Day of Action, 'Super Saturday' vaccine drive – 130,000 people vaccinated nationwide.

19 October 2021: Northland moves to Alert Level 2 at 11:59pm.

COVID-19 Protection Framework and MCCF announced

22 October 2021: Announcement that Auckland will move into the new COVID-19 Protection Framework when 90 per cent of the eligible population in each of the three district health boards are fully vaccinated.

A target of 90 per cent fully vaccinated is set across each district health board region before the rest of the country moves into the new system.

The Government announced the MCCF to support Māori communities to fast-track vaccination efforts and prepare for the COVID-19 Protection Framework.

27 October 2021: The parts of Waikato at Alert Level 3 move to Step 1 of Alert Level 3.

2 November 2021: Upper Northland moves to Alert Level 3. The parts of Waikato at Alert Level 3 Step 1 move to Alert Level 3 Step 2 from 11:59pm. The Government announced it has approved $23.5 million for iwi/ Māori organisations to boost Māori vaccination rates through the MCCF.

9 November 2021: Auckland moves to Alert Level 3 Step 2 at 11:59pm.

11 November 2021: Upper Northland moves to Alert Level 2.

15 November 2021: Within three weeks of the MCCF commencing, Ministers approved $48 million of initiatives across 60 contracted providers. Initial targeting was done to those communities with the highest need and low access to vaccination services, and those areas most impacted by the regional lockdowns.

16 November 2021: Parts of Waikato move to Alert Level 2. Vaccine passes are launched.

17 November 2021: Prime Minister announces the approach to transitioning to the Protection Framework.

18 November 2021: Beehive press release says MCCF investments total $46.75 million and 26 contracts signed.

22 November 2021: The Prime Minister announced that the country would move into the traffic light system on 3 December 2021.

23 November 2021: Waitangi Tribunal agrees to hold an urgent inquiry into the Government's COVID-19 Protection Framework, including the vaccine delivery programme.

24 November 2021: Beehive press release states fully vaccinated New Zealanders and other eligible travellers could travel to Aotearoa-New Zealand, from Australia, without staying in MIQ from 16 January 2022, and can travel from all other countries from 13 February 2022.

25 November 2021: Te Pou Matakana and the Crown are heard in the High Court. Te Pou Matakana was still seeking urgent access to Māori health data to help improve vaccination rates for Māori. The Crown released the requested information shortly after the release of the second judgment.

29 November 2021: Prime Minister announces which setting each region will enter the COVID-19 Protection Framework on.

2 December 2021: The Alert System is retired, and the primary mitigation becomes the COVID-19 Protection Framework, also known as the traffic lights, at 11:59pm. On the same day, numerous iwi/Māori leaders, including clinical leaders, draw attention to the lack of any specific priority within the new framework to ensure a 90% total vaccination rate for Māori.

3 December 2021: Aotearoa-New Zealand moves to the COVID-19 Protection Framework.

6 December 2021: Waitangi Tribunal begins its inquiry.

10 December 2021: Omicron arrives. It comes through Auckland from Germany via Dubai and is discovered at MIQ in Christchurch.

16 December 2021: Aotearoa-New Zealand hits its 90 % fully vaccinated target.

16 December 2021: Omicron arrives in Aotearoa-New Zealand.

17 December 2021: The High Court directs the release of information.

21 December 2021: The Waitangi Tribunal finds the Crown's response to COVID-19 is actively breaching the Treaty, particularly that Māori are being put at a disproportionate risk of being infected by Delta than other groups. The Tribunal also recommends additional funding, resourcing, data, and other support to iwi/Māori providers and communities, as well as strengthened engagement and calls to "expressly prioritise Māori" in all vaccination and booster rollout (Waitangi Tribunal, 2021).

13 January 2022: Capital Coast DHB announced 90% of Māori in their catchment are fully vaccinated.

26 January 2022: Auckland DHB announced 90% of Māori in their catchment are fully vaccinated.

27 January 2022: Canterbury DHB announced 90% of Māori in their catchment are fully vaccinated.

4 February 2022: The Government announces 90% of Māori received their first dose of the COVID-19 vaccine.

In summary, when Cabinet turned to Te Puni Kōkiri, Te Arawhiti and Manatū Hauora to design and deliver the MCCF, officials were moving at speed to urgently lift vaccination rates and enable communities to prepare for the new COVID-19 Protection Framework.

SECTION TWO: LITERATURE REVIEW

The literature review covers the weakness in the health system that partly resulted in the need for the MCCF. It also offers commentary on what appears to be a combination of a principled and pragmatic approach to decision-making. For transparency, Cabinet agreed that these were the weaknesses in the health system, which is why the system was reformed in 2021 and through the introduction of the Pae Ora (Healthy Futures) Act 2022. This section enables a fair and appropriate judgement of the MCCF given the context in which it was commissioned.

A 2021 Health System under pressure

Aotearoa-New Zealand's experience of and response to COVID-19 was different and more successful in its early stages than in most other countries (Baker et al., 2020; James, et al., 2020; Mazey & Richardson, 2020; Health Quality & Safety Commission New Zealand, 2021; 2022).The initial early success enabled the Government to keep COVID-19 out of communities long enough to establish a nationwide vaccination delivery programme (Baker et al. 2020; Summers et al., 2020; Parker, 2021; Whitehead et al., 2021a; 2021b; Grout et al., 2023). However, this meant the vaccination delivery programme would always be critically important to reducing morbidity and mortality, and to prevent contributing further to health inequity (Steyn et al., 2020; Thaker, 2021; Thaker & Ganchoudhuri, 2021; Baker et al., 2021; Mulgan et al., 2022; Health Quality & Safety Commission New Zealand, 2021; 2022).

When Delta arrived in early August 2021, and Omicron landed in mid-December 2021, both variants quickly exposed the enduring and deep-seated weaknesses in the health system that health researchers had been calling successive administrations attention to (Reid & Robson, 2000; Curtis et al., 2010; Came et al., 2016; Reid et al., 2017; Reid et al., 2018; Lilley et al., 2019; Ministry of Health, 2020; Came et al., 2021; Clark et al., 2021; Reid, 2021; Health Quality & Safety Commission New Zealand, 2021; 2022; Reid et al., 2022).

Both variants also exposed the shortcomings in the design of the vaccination delivery programme (Baker et al., 2021; Whitehead et al. 2021a; 2021b; Anglemyer et al., 2022; Prickett et al., 2021; Health Quality & Safety Commission New Zealand, 2021; 2022; White & Grimm, 2022).

The first weaknesses Delta and Omicron exposed were the widespread inequity of outcomes and the number of underserved priority populations. The sitting Cabinet had already accepted this weakness (Department of the Prime Minister and Cabinet, 2021k, 2021q, 2021r & 2021s; Henare, 2021 & 2022; Little, 2021 & 2022), and subsequent decisions noted that Māori had persistently poorer outcomes, as did Pasifika (Department of the Prime Minister and Cabinet, 2021a, 2021b, 2021d, 2021e, 2021i, 2021j, 2021k, 2021m, 2021r & 2021s). That is, when Cabinet signed off on the mainstream vaccine delivery programme, it already deeply understood the embedded inequity in the health system and was ready to act.

While the vaccine's arrival gave rise to hope and optimism, the mainstream vaccination delivery programme was heavily focused on age-based prioritisation. In addition, it did not have a clearly articulated and funded plan to build partnerships with and prioritise underserved priority populations to ensure equitable allocation of COVID-19 vaccines. See Whitehead et al. (2021a; 2021b), Waitangi Tribunal (2021); Anglemyer et al. (2022), Sharma et al. (2021), White and Grimm (2022) for a deeper explanation of the impact of those design decisions.

It was also true, however, that an age-focussed approach reduced the complexity of prioritisation and had the potential to increase the pace of the rollout. While it is clear many iwi/Māori leaders pointed out that the design of the roll-out was at odds with the Government's own Te Tiriti obligations as well as its reform programme, it is also clear from the reports the research team had access to that iwi/Māori leaders were in active discussions and debate with Ministers and had a decisive role in shaping the design of the MCCF. Alongside Te Puni Kōkiri and iwi/Māori leaders, hauora leaders were pointing out the vaccination delivery programme was at odds with international best practice, which was to vaccinate the most vulnerable first and ensure indigenous

peoples have access to the resources to tailor health care to their needs (Te Rōpū Whakakaupapa Urutā, 2021a; 2021b; 2021c; 2021d; 2021e). These leaders asked the Waitangi Tribunal to intervene (Waitangi Tribunal, 2021).

The second weakness the two variants exposed was a mismatch between the demand for health services and the ability to meet that demand. Said differently, the system had failed – for many years – to keep up with consumer needs and preferences (Department of the Prime Minister and Cabinet, 2021a; 2021d; 2021e; 2021). This variation in services and outcomes depending on where someone lived, together with the variance in the type of care they needed, had long been evident in health research (Jansen et al., 2011; Came et al., 2016; Reid et al., 2017; Reid, Cormack & Paine, 2018; Lilley et al., 2019; Curtis et al., 2010; Jones et al., 2020; Marek et al., 2020).

Alongside iwi/Māori and Hauora leaders, the various hauora researchers, on-the-ground providers and public health researchers pointed out that the vaccination delivery programme could potentially reproduce inequity for tāngata whaikaha, rural communities, children and tamariki in care, as well as Māori and Pasifika people (Jones et al., 2020; Steyn et al., 2020; Boulton & Te Kawa, 2020; Sharma et al., 2021; Whitehead et al., 2021a; 2021b; Te Rōpū Whakakaupapa Urutā, 2020e; 2021a; 2021b; 2021c; 2021d; 2021e; Ngā Pae o te Māramatanga, 2022).

The third weakness in the health system, which had already been accepted by the Government when the two new variants arrived, was how complicated and fragmented the health system had become (Ministry of Health, 2020; Simpson & Roche, 2020; Came et al., 2021; Department of the Prime Minister and Cabinet, 2021a). In deciding to reform the health system, the Government accepted that health structures had become convoluted with variable levels of governance, leadership, and management capability (Department of the Prime Minister and Cabinet, 2021b; 2021). Indeed, in establishing Te Whatu Ora, the Government was seeking consistent decision-making and an institutional arrangement that would align authority, incentives, and accountability (Department

of the Prime Minister and Cabinet, 2021g; 2021h; 2021k; Ahuriri-Driscoll et al., 2022). The Government also hoped that if the institutional arrangements were smoother at a macro level, practitioners could work at the top of their professional scope of practice, unimpeded by the managerialism that had come to dominate the District Health Boards (Department of the Prime Minister and Cabinet, 2021l; 2021m; 2021n). In a demonstration of the issues with the DHB system, a combination of hauora clinical leaders, hauora kaimahi and health researchers called attention to the variation in how each DHB was implementing the vaccination delivery programme and the early inequity that produced, with patients neither able book appointments online because they lived in low cell-phone coverage areas, nor able to take a day off to travel to services that were primarily located in the cities (Whitehead et al., 2021a; 2021b; Te Rōpū Whakakaupapa Urutā, 2020e; 2021a; 2021b; 2021c; 2021d; 2021e).

The last weakness the emergence of the new variants rapidly exposed was the financial pressures in the health system and how those pressures impacted sustainability (Ministry of Health, 2020). Officials advised Cabinet that review after review had found that healthcare costs were rising faster than funding, leading to shortfalls and trade-offs, which had forced almost every DHB into financial deficits (Ministry of Health, 2020). This last weakness may not seem material, however, it was a significant factor in the decision to establish the MCCF. That is because the mismatch between demand and supply had left an overly unhelpful focus on efficiency – finding different ways to do more for less (Ministry of Health, 2020; Department of Prime Minister and Cabinet, 2021a; 2021d; Health Quality & Safety Commission New Zealand, 2021; 2022). This meant – in the case of the nationwide vaccination delivery programme – the preference was for a fast rollout, as opposed to one that might also have been effective for those communities not living near, or enrolled with, a vaccination service provider, or those whānau who wanted to hear more about the efficacy of the vaccine. To illustrate this point more precisely, Whitehead et al. (2021a; 2021b) identified that the week after Delta arrived, a total of 447 vaccination services were operational, of which 212 were GP clinics (47%), 91 (20%) were pharmacies, 50 (11%) were DHB-run vaccination centres, and only 28, or six per cent, were iwi/Māori and Pasifika led.

In addition, most of those clinics were based in cities, which left smaller towns and large parts of rural Aotearoa-New Zealand with poor access to vaccination services. Indeed, of the major centres, at the start of December 2021, Ōtautahi appeared to have the worst access, while Te Whanganui-a-Tara and Ōtepoti had good levels of access to vaccination clinics (Whitehead, Scott, Atatoa-Carr & Lawrenson, 2021a; 2021b).

But to be fair, it is possible, from the publicly available information, that Cabinet, in making the vaccine delivery programme decision, was trying to balance the logistical constraints of distributing and administering a time-sensitive vaccine while also attempting to minimise the barriers for those who wish to receive it, and trying to achieve some equity in vaccination, albeit with a system that the evidence confirmed was weak at delivering equity (Cabinet, 2021).

That said, it was also clear that Cabinet understood that one of the successes of the first lockdown was that some responses looked and felt Māori to Māori and looked and felt Pacific to Pasifika people (McMeeking, et al., 2020; Pihama & Lipsham, 2020); Health Quality & Safety Commission New Zealand, 2021; 2022). For example:

- The use of Māori oral tradition and intergenerational storytelling to remind whānau of the potentially devastating impacts of previous pandemics (McMeeking & Savage, 2020; Aoake, 2022; Boulton, et al., 2022).
- Iwi Checkpoints, in which a number of iwi and hapū took it upon themselves to protect local communities by establishing monitored entry and exits from their communities (Severinsen, et al., 2021; Te One & Clifford, 2021; Stanley & Bradley, 2021; Cassim & Keelan, 2022).
- Institutions in Te Ao Māori took a more cautious approach to the level step down. For example, many marae, kura and kohanga remained closed during level three (McMeeking, Leahy & Savage, 2020; Te One & Clifford, 2021).

- Manaaki packages were one of the key ways iwi/Māori organisations could protect their members. While priority was given to vulnerable members, such as the kaumatua, low-income earners, and those with pre-existing health conditions, it is possible that this was the most extensive distribution of resources by and for iwi/Māori in recent history (McMeeking et al., 2020; Cram, 2021).

From the publicly available data, we can see that as Delta spread through vulnerable communities in the main cities, it became apparent that it was hitting hardest those people with a history of alcohol and drug dependencies, mental health problems, long-term poverty, and overcrowded and transitional living conditions. These are, of course, the communities in which Māori and Pasifika are overrepresented.

As with the first lockdown, it also hit those who could not work from home and had no choice but to go to work. Several hauora researchers pointed out that social distancing and self-isolation were much easier for those with easy access to vaccinations, long-running trust in authorities, and secure employment (McMeeking, et al., 2020; Prickett & Chapple, 2021). This last point is particularly true for those communities who went through the regional lockdowns (Sense, 2021a; 2021b; Health Quality & Safety Commission New Zealand, 2021;2022).

Approach to key decisions

It goes without saying that COVID-19 presented governments everywhere with major decision-making challenges (Mulgan, et al., 2022). In Aotearoa-New Zealand Cabinet was expected to contain the virus, with limited information, while managing the different views about risk, having accepted the deep and enduring weakness in the health system (Health Quality & Safety Commission New Zealand, 2021; 2022).

When evaluating the implementation of a policy, it is important to lean into the public management literature, especially the research that reminds us that governance in post-industrial societies is extraordinarily complex. As Dr Bill Ryan (2002a) has said of public management in Westminster arrangements:

"Something happening here connects with other things happening there and everywhere else, and it all seems to happen simultaneously. Everything seems fractal in its intricacy, and the density, simultaneity and connectedness confounds and confuses."

On top of that complexity, the public policy literature reminds us that society or communities within society are no longer homogeneous (Sabatier, 1987; Rose, 1989; Ryan, 2002a; 2002b; 2002c; 2006). Differentiation across multiple social axes has accelerated, with identities constantly forming, reforming, and intertwining. This means policy options that are effective in one context might not be successful in another context (Ryan, 2002a). It becomes important for officials to actively learn about the impact of their intervention and adjust accordingly.

Together with complexity and contextuality, the forces of pluralisation and participation are gaining strength (Rhodes & Marsh, 1992; Sabatier, 1996). The Executive is being increasingly forced to work in the open, engage in genuine partnerships and be open-minded. Co-production is in demand.

Turning to the key decisions leading up to the decision to establish the MCCF, suffice to say, uncertainty ran deep: uncertainty about the science, for example, whether successful recovery would lead to immunity from reinfection; uncertainty, in the early days, about how the virus would mutate; uncertainty about how simple ideas such as ‘go hard and early’ would play out and how long the Government could maintain the social license for some of the more intrusive restrictions.

One way to deal with uncertainty is to base all decisions on a core set of principles. Ansell and Bartenberger (2019) call this the ‘principled approach’. Worldwide we can see two types of principle-based approaches. The first approach prioritised the principle of protecting as many people as possible from the virus. The second prioritised the principle of protecting the economy (Mulgan, et al., 2022).

According to the literature, the principled approach embraces a meaningful cultural value while removing all complexities and vagaries in delivery. This approach means public service delivery models do not need to consider multiple interests and tend to reward an implicit set of undefined values. But the principled approach has some disadvantages. For example, it can be a little binary. The research also suggests the principled approach implies a certain degree of inflexibility, which cannot be sustained in a long-running crisis (Boin & Lodge, 2021).

Another way to deal with uncertainty is to use a learning approach. The learning approach accepts that reality cannot be known by collecting more and more information or analysing more data. The learning approach emphasises learning by action (Boin & Lodge, 2021). It is called 'enacted practice' in the public management literature (Ryan, 2002a; 2002b; 2002c; 2006). Enacted practice allows front-line professionals to take the lead and urges them to perform at the pinnacle of their respective professions (Maynard-Moody & Musheno, 2012). The other advantage of enacted practice (over the principled approach) is that uncertainty and risk in decision-making are mitigated through daily interaction with reality (O'Flynn, 2007).

In summary it is clear from the literature that when Cabinet turned to Te Puni Kōkiri, which drew on support from Te Arawhiti and Manatū Hauora, to deliver the MCCF, the pre-Pae Ora health system and the mainstream vaccination programme were unable to deliver vaccination services to whānau and whanui at the pace required, especially with the Delta and Omicron incursions. It is also clear that iwi/Māori institutions were well placed to deliver local vaccination activities to support whānau and whanui to engage with, and prepare to decide, whether and where to get vaccinated. Finally, the literature is clear that the providers had to move with speed and energy in order to lift the first dose rates to 90% or thereabouts. The research team also notes the Government appeared to be transitioning its decision-making from a principle-based approach towards a more pragmatic and learning approach.

SECTION THREE: METHODOLOGY

This section describes the methods used in this evaluation, beginning with an overview of our use of the programme level information available to us and the vaccination data we received. Then we discuss our use of Āta to ensure the research method created respectful relationships that supported well-being throughout the process. Finally, we discuss Q-method which we used to combine our deep qualitative findings with the transparency and rigour of quantitative analysis. This section enables a deep understanding of the underlying precision in the findings.

There was no programme-level impact reporting. Officials advised they were using vaccination uptake as a proxy. This is fine, but we recommend Te Puni Kōkiri use impact-level or programme outcomes-level reporting in the future. While this is difficult, it is necessary, especially if Te Puni Kōkiri wants to offer commissioning for outcomes practice to the wider public sector (Ussher & Kibblewhite, 2001). In addition, this is what the Whānau Ora Commissioning agencies do and have done for many years. We believe programme-level outcomes reporting will assist with future evaluation to better align investment and investment impacts. To reduce compliance costs on providers, Te Puni Kōkiri may want to align investments to something already in use, for example, the Whānau Ora Outcomes Framework. Because of the lack of programme-level impact data, we designed a bespoke methodology using a combination of vaccination data, content analysis of the milestone and investment reports, and interviews using Āta and Q-method to answer the research questions.

Programme-level documentation

Programme-level documentation was analysed and reviewed. Documentation typically involved investment settings, proposals, contracts, milestone and investment reports, and monitoring information. Most, if not all, investment level reporting was activity and output level reporting, alongside a mix of case studies and descriptions of events.

Content analysis of the programme-level documentation

There are two types of content analysis: conceptual analysis and relational analysis. Conceptual analysis determines the existence and frequency of concepts in a text. The relational analysis develops the conceptual analysis further by examining the relationships among concepts in a text. From July to August 2022, officials from Te Puni Kōkiri completed a conceptual content analysis of all the milestone and investment reports. We peer-reviewed this content-analysis. The independent research team used the analysis to draft the content for the card sort as part of the Q-method (Watts & Stenner, 2012).

Vaccination data

Vaccination data were downloaded by Te Whatu Ora on 8 March 2023. The data was current on 7 March 2023. For clarity, DHB residence is based on the primary address Te Whatu Ora has for an individual, mapped to the old DHB areas. The Overseas and Undefined category, which includes all those that typically reside overseas and those for whom Te Whatu Ora does not have a residential address on record, is excluded from this particular analysis. The data the researchers used includes the population denominator change recommended by Stats NZ.

Āta

Āta guided the data collection and the interviews. Āta is a way of engaging in inquiry, a scientific reductionist might call it a research method, but within Te Ao Māori it calls into being a respect for relationships in such a way as to create well-being for all involved in the research process (Pohatu, 2013; Lipsham, 2012). Practically speaking, it means focusing on relationships, negotiating boundaries, and creating and holding a safe space. This meant the research moved at the speed and pace of the participants – rather than the needs of the official process (Forsyth & Kung, 2007). Āta obliged the researchers to act in a way that was mindful of people, kaupapa, and context. Practically this meant speaking with clarity, requiring quality preparation from the research team and gathering only what has been offered (Mikahere-Hall, 2020).

Āta also demanded effort in building the quality space of time (wā) and place (wāhi). This meant opening and closing with karakia, focusing on whakawhanaungatanga, and creating moments of shared critical reflection. Āta also encouraged a process in which this report – which is the result of the knowledge of the participants – will be discussed with the communities who participated in, and made possible, its production. Finally, Āta makes it incumbent on the writers to ensure the report is written clearly and simply so that others may access the participants' knowledge to plan and strategise (Pohatu, 2013; Lipsham, 2012).

Q-method

Q was selected because it captures objective data about the stories people and communities tell themselves about subjective phenomena, such as the experience of providers and officials working within the MCCF (Brown, 1980; McKeown & Thomas, 1988). Q-method also aligns well with Māori research methodologies such as Āta (MacDonald & Sheed, 2017) since it enables participants to create the language and kupu to discuss their perspectives, it is interactive and dynamic, and it approaches people on their terms and integrates their priorities and beliefs (Niemeyer, et al., 2013).

Q-method was invented by William Stephenson in the 1930s (Stephenson, 1953) and is growing in use in the social sciences (Zabala & Pascale, 2016). It is known as a particularly important method for helping us understand peoples' subjective views about complex issues. That is, it helps us identify viewpoints, using a systematic and analytical process. The process and structure of a Q-methodological study is well established. It also creates an anonymised data set so that others interested in the research can see how a study's conclusions were drawn and, should they wish, test for replicability. One particular strength of the method for this evaluation is its abductive approach, which makes exploratory and theory-generating possible (Watts & Stenner, 2012).

This approach is very helpful when studying or evaluating public policy (Nederhand & Molenveld, 2020; van Eeten, 2014) because policy hypotheses and intervention logic are shaped by delivery (Ryan, 2022b), given our very human inability to comprehend all the possible outcomes at the start of the intervention. In sum, Q-method enables a precise understanding of how those involved in the design and delivery of the MCCF understood what was happening around them.

Collection

From September 2022 to the end of November 2022, the research team conducted 59 interviews. The participants were a combination of iwi/Māori providers (henceforth kaitono), regionally-based officials (henceforth kaimahi) and Wellington-based officials. Given the sample size and our promise of confidentiality to our participants, we are reluctant to further details about the place or number of the officials, kaimahi, and kaitono we interviewed in case it should make it possible for readers to identify them.

Participants were provided explanatory information (including a participant information sheet) about the research project and signed a consent form. The research was reviewed by the Aotearoa Research Ethics Committee (NZEC 22_35). To ensure data sovereignty principles were upheld, the raw data is secured on Aotearoa-New Zealand servers in an account used solely for this project and managed by the University of Canterbury.

While the research design and ethics approval envisaged interviews in person and online, in the end, all interviews were online. The decision to move online was to save on the cost of travel and accommodation and to make staying free of COVID-19 easier, and at the request of many of the participants who were too time-poor to host the research team on-site.

Interviews began and closed with karakia. Time was set aside for whakawhanaungatanga, tikanga and critical reflection.

Two card sorts were conducted.

The first, the *vaccination uptake and resiliency sort*, focussed on answering the first two questions of the evaluation (did MCCF assist in improving vaccination uptake between October 2021 and June 2022? And, whether and how MCCF helped improve vaccine uptake and build community resiliency, in the context of introducing the COVID-19 protection framework?).

The second, the *collaboration sort* focussed on answering the third question (what are the lessons in collaboration between the three institutions: Te Puni Kōkiri, Te Arawhiti and Manatū Hauora?).

For the vaccination uptake and resilience sort, participants were asked to perform a card-ranking activity using 31 cards. Each of the 31 cards had a statement developed using content analysis of all of the kaitono reports. We followed good Q-method practices by testing the selected statements with experts, and with the participants, to ensure the statements captured the breadth and depth of the participant communities' views about the MCCF. No further statements were requested by participants, and only minor modifications to the language of the statements were made at the participants prompting.

In the case of the collaboration sort, participants were asked to work with 24 cards. The cards were drawn from the public management literature on collaboration in Aotearoa-New Zealand (O'Leary, 2014; Scott & Boyd, 2015; Eppel & O'Leary, 2021). Again, the early interviews tested the veracity and language of the statements. No requests were made to change the statements to better represent the participants' voices.

In both sorts, the participants were then asked to assign a hierarchical position in a forced-choice, quasi-normal distribution according to the extent to which the statement was felt to describe the participant's understanding. While the sorting was done via software online, the figure below is a good indication of the method of sorting the statements in a normal distribution.

In practical terms, the participant is asked to sort the cards from 'most disagree' to 'most agree', and the most negative value (−5) represented the left pole while the most positive value (+5) was located on the right pole.

This procedure is dynamic. It generates a single and holistic configuration of all the cards, consisting of each participant's constant comparison between the cards, with the participant having to physically move their attitudes in relation to one another. Thus, the participant physically orders a dynamic representation of their viewpoint on the subject. This makes it a much stronger representation of their views than typical r-method surveys (such as multi-choice answers, or scales).

When each participant finished the card sort, they were invited to critically reflect on their sort and guide the research team on what to think about it regarding vaccination uptake and resilience in communities, and collaboration between the agencies. The information gathered during critical reflection has been used to substantiate the findings and craft the vignettes. The vignettes were also built using the milestone and investment reports.

Analysis

The data for the 59 participants were statistically analysed using dedicated software, Kade-Q (Banasick, 2019). The software offers a variety of by-person factor-extraction and rotation methods and, as with all q-method software, outputs all manner of data about each factor that is extracted (see Appendix Three). In layman's terms, the analysis in Q-method reduces the sorts to a few composite sorts that represent the views of a group of participants who had similar sorts.

We explored the data via Pearson and Spearman correlations and factor rotations for over a month to produce the factors, or representative or average sorts. It takes time to do such analysis since once you have extracted the factors, there are at least forty pages of data to analyse to create the narratives that make sense of the data while checking that those narratives make sense of the opinions of those interviewed. This is necessarily a process of trial and error. For the record, the researchers chose to finalise their analysis using a Spearman Correlation to generate a matrix and used Principal Component Analysis to generate the best average sorts to explain the various viewpoints that emerged (Alberts & Ankenmann, 2001).

The analysis of each sort produced eight factors that demonstrated theoretical statistical significance, in that factors conceivably represented a coherent story for some participants within the participant group (See Appendix Three). However, for the purpose of brevity in this report, the research team has chosen to highlight four factors in the uptake and resiliency sort and three in the collaboration sort (Stenner & Watts, 2012) that most help us answer the questions posed for this evaluation.

For readers unfamiliar with Q-method, it may be helpful to spell out that the method is not producing how many people agreed with this or that idea. Nor is it providing a representative sample. Rather, Q-method uncovers the plurality of perspectives within a community without reference to demographics or

other typical statistical analyses. In the first instance, Q-method ignores the frequency and distribution of perspectives, where peoples' opinions are the variables to be sorted. Instead, people are the variables around which revolve correlations of their ranked statements. Q-method requires quite a mind shift.

To assist with the shift in mindset, we want to remind readers that the factors used in Q-method create narratives to cohere the data and interviews. We use the term 'factors' when talking about the mathematical solutions in the data, and 'narratives' when we want to emphasise the stories that arose from the analysis of each factors' data.

In summary, this evaluation used a mixed method approach: including quantitative, content analysis, Q-method interviews and Āta. The quantitative data established the baseline lift in vaccination rates between October 2021 and June 2022. The content analysis of the programme-level documentation informed the Q-method interviews[2]. Q-method transparently quantified the viewpoints of participants, and through mathematical analysis reduced them to the few most important narratives on which most participants agree.

Unlike most research methods that involve qualitative interviews that are then content analysed, Q-method takes a quantified snapshot of a person's viewpoint and compares it to every other participant's viewpoint. That means people are the variable in Q-method, not as in normal statistical analysis, their traits. Q-method, therefore, takes into account a person as a whole. Āta complements Q-method by building the trust necessary for participants to feel safe to share their free and frank views. This is especially important in matters where there is a historical or current power imbalance. That is because Āta engages

[2] Programme-level means MCCF.

in a way that is shaped by respectfulness in relationships in such a way as to create well-being. And, like Q-method it is entirely people-centred. This unique approach offers powerful and precise insights into what worked, by capturing and honouring the wisdom of those involved in MCCF.

SECTION FOUR: FINDINGS

This section is divided into three parts. It begins with an answer to the question of whether the MCCF assisted in improving vaccine access between October 2021 and June 2022. This section then answers the question of whether and how the MCCF helped to build community resiliency – if at all. This section finishes with insights into the collaboration between the three institutions.

Did the MCCF assist in improving vaccination uptake between October 2021 and June 2022?

There is no question that MCCF successfully mobilised support for vaccination. By the beginning of May 2021, it was clear that Māori, Pasifika, over 65-year-olds and people living rurally had poor access to vaccination services. Most vaccination services were being run out by mainstream health provision: a system that had already produced racialised inequity in health care provision (Jones, King, Baker & Ingham, 2020; Steyn, Binny, et al, 2020; Boulton & Te Kawa, 2020; Sharma, Walton & Manning, 2021; Whitehead, Scott, Atatoa-Carr & Lawrenson, 2021a; 2021b).

By June 2021, iwi/Māori leaders and Hauora clinical advisors were calling attention to how little work was going into engaging with people and communities who were not registered with GPs or were not active users of the health system or who lived rurally, or whom the system had actively excluded, or who wanted information about the efficacy of vaccination (Te Rōpū Whakakaupapa Urutā, 2020e; 2021a; 2021b; 2021c; 2021d; 2021e; Waitangi Tribunal, 2021).

Te Puni Kōkiri, with support from Te Arawhiti and Manatū Hauora designed the MCCF to address these gaps; specifically, Te Puni Kōkiri designed it to be deployed in communities with significantly lower spatial access to vaccination services and a higher proportion of Māori residents. MCCF was also deployed into communities where the regional lockdowns amplified socioeconomic problems, including isolation and loneliness. Table One borrows heavily from work

by Whitehead (2021a; 2021b) on the embedded structural disadvantage of the vaccination programme for priority populations. That work found that vaccination services – at the start of Delta – were neither equally nor equitably distributed, with priority populations who had the most pressing need and the worst access. It shows how MCCF investments were made in areas and communities where mainstream provision had failed to penetrate and where there were relatively higher percentages of Māori with low access to vaccination services.

Table One also shows MCCF investments in those communities impacted by the regional lockdowns. Two groups were primarily affected by the regional lockdowns. First, workers in transition (for instance, between education and work, or returning from time away for family reasons, including maternity). This affected Māori most intensely, followed by Pasifika and immigrant communities. Their populations are younger, and cohorts entering the workforce are larger.

The second group most affected by the regional lockdowns were either unemployed – especially recently unemployed (as a consequence of the lockdowns) and long term unemployed (Sense, 2021a;2021b). This affects Māori most, followed by Pasifika, as more of the population was already unemployed (on Jobseeker Support, for example) before the COVID-19 pandemic, which rose more after the pandemic hit. Several kaitono reported that young people and some older workers faced the most significant shocks during regional lockdowns (Sense, 2021a;2021b).

It is also clear from interviews with kaitono that more-experienced and qualified workers ended up accepting lower-paid jobs, meaning less-qualified workers were being pushed out of work. While it is possible the impact of these decisions will not show up in the official data for another decade, it makes sense that MCCF investments were made in Waikato, Northland and Tamaki to ease the effects of regional lockdowns and, in some cases, reduce wage scarring (Sense 2021a;2021b).

Table One: Total MCCF Investment, Gini Coefficient, spatial access, % of priority populations living in areas with poor access to vaccination services for each DHB region.

Te Puni Kōkiri Region	DHB Region	MCCF (m)	Gini Coefficient*	Median Spatial Access**	% Māori in low access area	% 65+ in low-access areas	% eligible in low-access areas
Waikato-Waiariki	Lakes	$7.890	0.237	1.880	99.300	99.400	99.500
Te Tai Tokerau	Northland	$21.400	0.478	2.100	88.600	93.000	92.600
Tāmaki Makaurau	Waitemata	$3.563***	0.358	4.000	53.000	31.600	35.100
Ikaroa-Rāwhiti	Wairarapa	$0.710	0.197	4.800	39.500	31.600	35.100
Waikato-Waiariki	Bay of Plenty	$12.210	0.392	5.300	25.300	23.100	26.300
Te Tai Hauāuru	Taranaki	$7.840	0.136	5.800	10.800	7.300	10.100
Te Waipounamu	West Coast	$0.580	0.675	6.900	11.200	10.200	11.700
Te Waipounamu	Canterbury	$4.730	0.247	9.540	3.300	3.300	3.400
Te Tai Hauāuru	Whanganui	$5.210	0.276	10.100	32.400	26.200	29.500
Ikaroa-Rāwhiti	Tairāwhiti	$12.570	0.157	12.300	11.200	6.900	8.700
Te Waipounamu	South Canterbury	$0.360	0.284	13.500	12.000	17.100	17.100
Te Tai Hauāuru	MidCentral	$6.870	0.191	13.600	3.000	3.900	4.100
Tāmaki Makaurau	Counties-Manukau	$3.563***	0.208	14.800	8.800	10.090	8.300
Te Waipounamu	Nelson Marlborough	$1.290	0.233	14.800	4.700	5.000	5.100
Tāmaki Makaurau	Auckland	$3.563***	0.131	14.800	3.200	4.000	2.200
Waikato-Waiariki	Waikato	$18.010	0.298	15.300	21.400	18.400	17.000
Ikaroa-Rāwhiti	Hawkes Bay	$5.050	0.208	15.300	5.800	3.700	4.900
Ikaroa-Rāwhiti	Hutt Valley	$0.610	0.290	18.700	1.200	3.600	3.300
Te Waipounamu	Southern	$2.890	0.287	25.000	3.400	3.200	3.800
Te Tai Hauāuru	Capital & Coast	$1.930	0.089	32.350	0.000	0.000	0.000

* The Gini coefficient measures the inequality among values of a frequency distribution, such as levels of income. A Gini coefficient of 0 reflects perfect equality, where all income or wealth values are the same, while a Gini coefficient of 1 (or 100%) reflects maximal inequality among values.

** Higher median spatial access scores indicate better access to vaccination services.

*** Unable to disaggregate MCCF across Tāmaki Makaurau so we have spread it equally across the DHB boundaries.

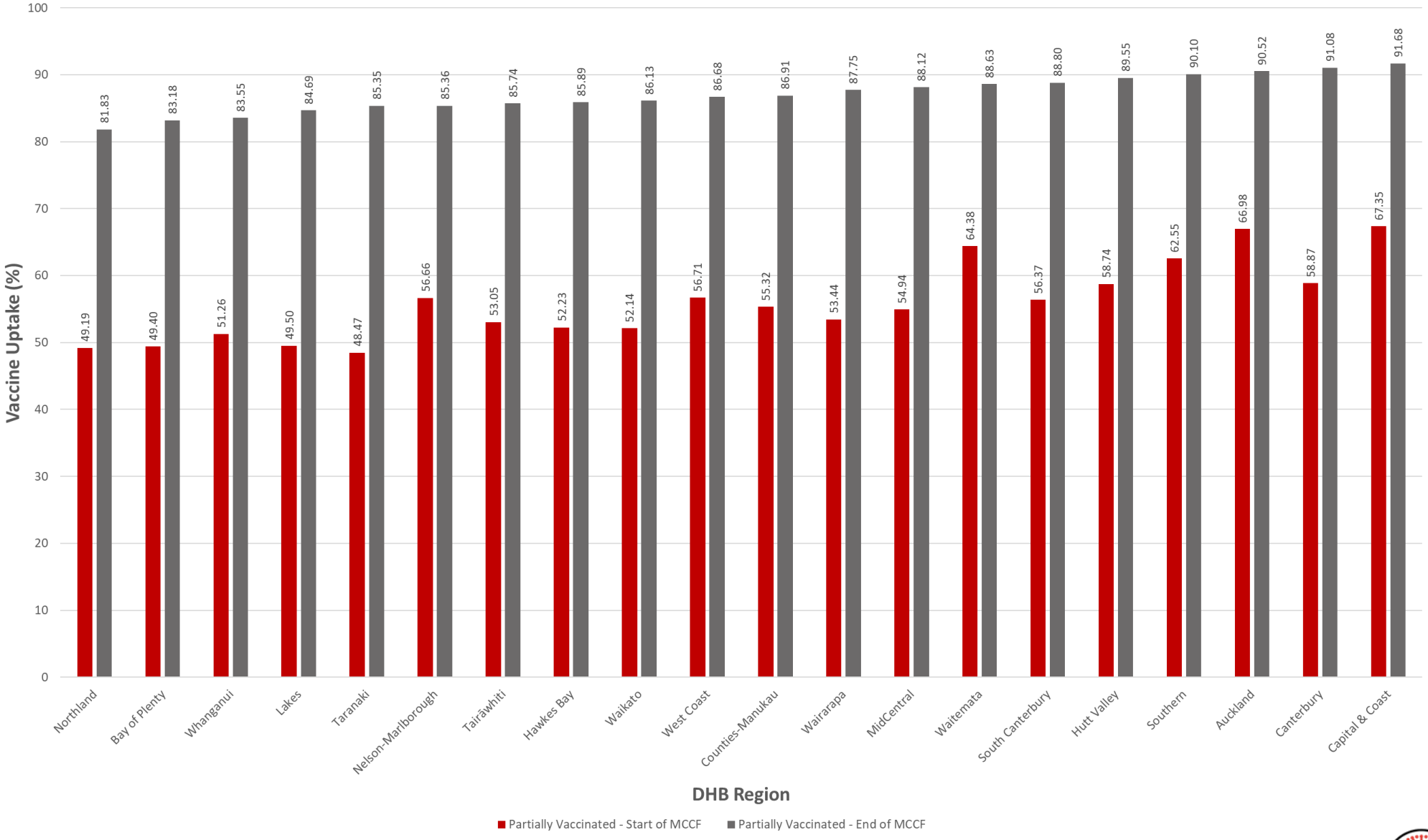
MCCF was also designed to be deployed through institutions that had credibility and a “good ground game”, as one kaimahi put it, and in communities where there was significantly lower spatial access to vaccination services and where there was a higher proportion of Māori residents, as well as residents over 65 years of age. The policy assumption was that barriers to accessing vaccination services, particularly for Māori, would be overcome by ensuring those providing the information, advice and support would be culturally appropriate, available when the community was available, and would be an “acceptable and welcoming face” as one interviewee put it. Appendix One shows the variety of kaitono involved in the provision, especially in provincial and more rural and remote areas.

MCCF was also designed to support communities disproportionately affected by cost and transport as barriers to accessing public services. The policy assumption was that if vaccinations and information about vaccines could be taken to where people live, where their children go to school, or where they spend their free time, equity of access might increase. Table One shows significant investments in remote and rural areas and cities.

As MCCF rolled out, the investment reporting shows the design of the MCCF adapted to focus on smaller, more remote communities, where people with high-risk and very low access to hospitals, let alone any public services, lived. The logic was that if COVID-19 reached these communities, the existing and enduring inequities would be exacerbated.

Towards the programme's end, MCCF mainly focused on supporting whānau who needed to isolate and helping other whānau to isolate. There was a strong focus on ensuring tamariki did not lose contact with kura or their friends at school. Based on our evaluation we can say the MCCF was correctly and carefully targeted for all these reasons.

Graph One: Percentage Māori Partially Vaccinated at Start and End of MCCF



But the next question then becomes, did vaccination rates improve?

The answer is yes. Graph One shows average percentage increases of 31% for first dose and 53% for second dose at the start of MCCF and at its conclusion, across all regions. Every region shows an increase, and many gains are in the order of 30 percentage points. In addition, many of the initial inequities in the mainstream delivery model were mitigated.

While noting that only four DHBs reached the 90% target, Table Two shows that some of the most significant percentage increases occurred in the areas where MCCF was invested, and where there were relatively high numbers of Māori, with low access to vaccination services and low vaccination rates at the start of MCCF.

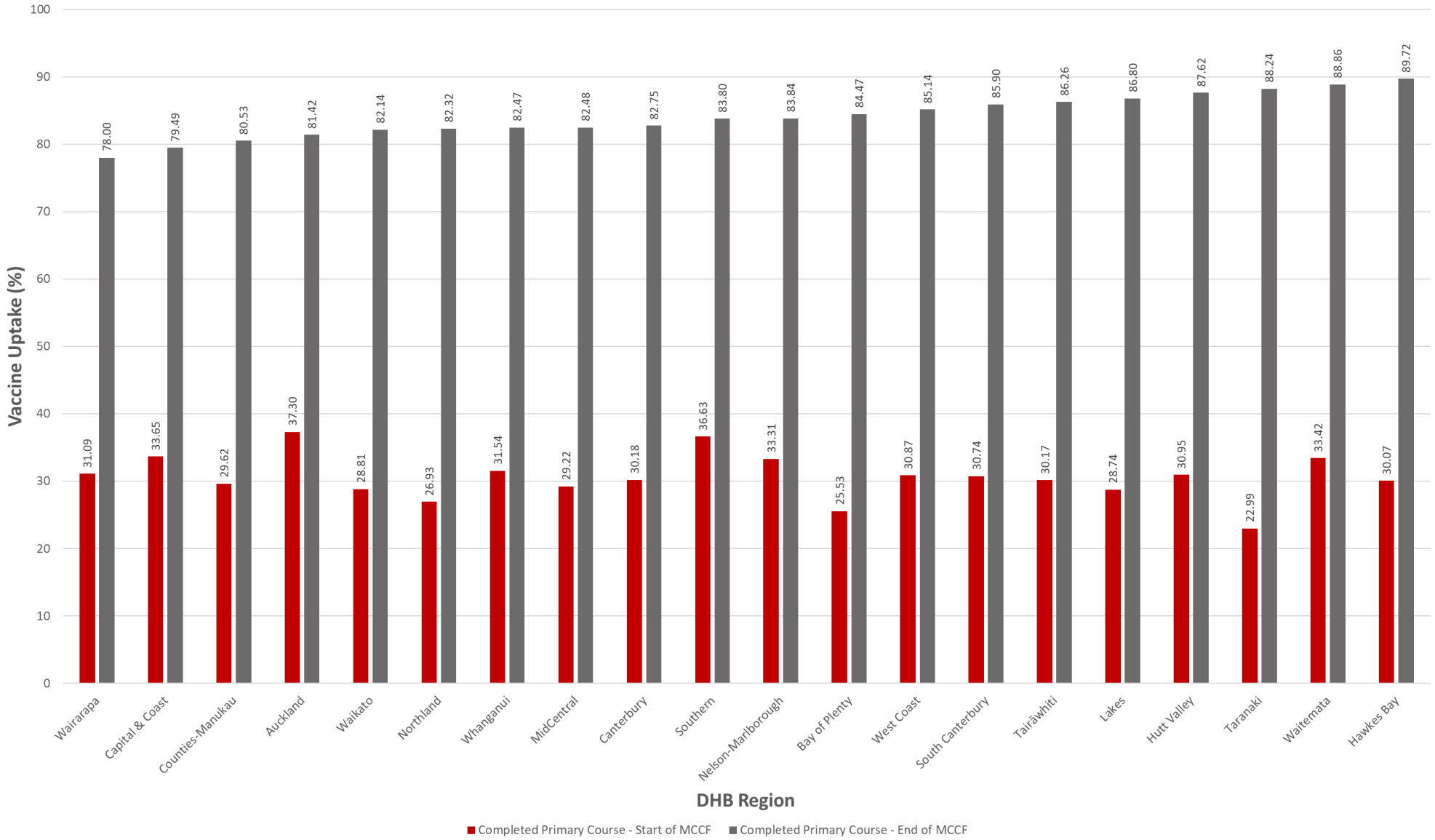
For example, Northland has high levels of inequality, and at the start of MCCF had low median spatial access to vaccination services, with large numbers of Māori living in those areas, but managed to increase vaccination rates by over 30 percentage points by June 2022. Similarly, while Lakes had very low median spatial access to vaccination services, and a high proportion of Māori living in those areas, they managed to lift their vaccination rates for first dose by over 35 percentage points. Bay of Plenty is also illustrative. At the start of MCCF there was low median spatial access, with a large percentage of Māori living in low access areas; nonetheless the vaccination rate rose just over 33 percentage points.

A word of caution though, about the median spatial access in South Canterbury, Tairāwhiti and Southern. It is clear from the reports that iwi/Māori and mainstream providers were already surging to reach whānau and whanui. It is also important to point out that the metros had already deployed their surge resources.

Table Two: DHB regions, Median Spatial Access, % Māori in low access areas with % increases in partial vaccination uptake from start to the end of MCCF

DHB Region	Median Spatial Access	% of Māori in low access area	% points increase (Māori partially vaccinated between start and end of MCCF)
Lakes	1.880	99.300	35.19
Northland	2.100	88.600	32.64
Waitemata	4.000	53.000	24.24
Wairarapa	4.800	39.500	34.31
Whanganui	10.100	32.400	32.29
Bay of Plenty	5.300	25.300	33.77
Waikato	15.300	21.400	33.99
South Canterbury	13.500	12.000	32.43
Tairāwhiti	12.300	11.200	32.69
West Coast	6.900	11.200	29.96
Taranaki	5.800	10.800	36.88
Counties-Manukau	14.800	8.800	31.59
Hawkes Bay	15.300	5.800	33.66
Nelson-Marlborough	14.800	4.700	28.70
Southern	25.000	3.400	27.55
Canterbury	9.540	3.300	32.21
Auckland	14.800	3.200	23.54
MidCentral	13.600	3.000	33.18
Hutt Valley	18.700	1.200	30.80
Capital & Coast	32.350	0.000	24.33

Graph Two: % Māori Completed Primary Course at the Start and End of MCCF



Graph Two shows the percentages of Māori who had completed a primary course of the COVID-19 vaccine at the start and end of MCCF, by region. This also shows that, while the momentum achieved for the first dose continued with significant percentage increases for the second dose, no region reached the 90% target by the end of the MCCF.

Positively, however, Table Three shows that every region shows a significant increase, with many of the gains in the order of 50 percentage points, and all but two regions getting above 80%.

As with the first dose significant percentage increases occurred in the areas where MCCF was invested, and where there were relatively high numbers of Māori, with low access to vaccination services, and low vaccination rates at the start of MCCF.

It is interesting to see the momentum that Hawkes Bay, Waitemata, Taranaki, Hutt Valley, Lakes, South Canterbury, West Coast and Bay of Plenty achieved between the first and second dose. Equally it is fascinating to see that Capital Coast was not able to maintain the momentum it achieved in the first dose. While it is a long bow to draw, this matches the MCCF phase two and three funding patterns.

Table Three: DHB regions, Median Spatial Access, % Māori in low access areas with % increases in completed primary vaccination uptake from start to the end of MCCF

DHB Region	Median Spatial Access	% of Māori in low access area	% points increase (Māori primary course between start and end of MCCF)
Lakes	1.880	99.300	52.68
Northland	2.100	88.600	51.07
Waitemata	4.000	53.000	52.84
Wairarapa	4.800	39.500	53.38
Whanganui	10.100	32.400	49.00
Bay of Plenty	5.300	25.300	53.96
Waikato	15.300	21.400	53.94
South Canterbury	13.500	12.000	55.16
West Coast	6.900	11.200	52.93
Tairāwhiti	12.300	11.200	52.15
Taranaki	5.800	10.800	59.15
Counties-Manukau	14.800	8.800	54.21
Hawkes Bay	15.300	5.800	52.40
Nelson-Marlborough	14.800	4.700	49.17
Southern	25.000	3.400	50.98
Canterbury	9.540	3.300	58.68
Auckland	14.800	3.200	50.94
MidCentral	13.600	3.000	55.93
Hutt Valley	18.700	1.200	55.85
Capital & Coast	32.350	0.000	56.08

In summary, it is clear that MCCF assisted in improving vaccine access between October 2021 and June 2022. There is no question that MCCF mobilised support for vaccination. It is clear that at the start of the MCCF Māori, Pasifika, over 65-year-olds and people living rurally had poor access to vaccination services, and by the end of MCCF both the mainstream providers and MCCF funded activities came to together to address inequities in access to vaccination information and services.

How did MCCF help improve vaccine uptake and build community resiliency?

To answer this question the researchers used a combination of Āta and Q-method to establish how those involved in the design and delivery of the MCCF understood and told their stories about what happened (Brown, 1980; McKeown & Thomas, 1988). As discussed above in the analysis section, the research team determined the top four narratives appropriately represent the most prominent and distinct perspectives on how the MCCF helped whānau and communities build resilience and reduce inequity.

Narrative One: E hara taku toa i te toa takitahi, he toa takitini

The most potent narrative is the one that reminds us that strength comes from the community and not the individual. Two statements were most significant statistically, and in the interviews:

- That MCCF enabled kaitono to support whānau in rural and remote locations to access information about vaccines and then - in time - to get vaccinated; and
- That MCCF enabled kaitono to assist whānau who were either socially isolating or had whānau members who were socially isolating.

Table Five shows the statements as they are ranked in the composite factor that produced this narrative (factor one). Those statements are ranked from most like how this composite group (or viewpoint of the kaitono and kaimahi who sorted in a similar fashion) thought about the MCCF, to the least like how they thought. When examining this data, it is good to keep in mind that, as we suggested in the analysis section, that it is the rankings of one viewpoint created from similar participant sorts. So, it is not a single person, but a single viewpoint or story that is represented by this factor, and the rankings below.

Table Five: Sort One and Narrative One: Statements, Sort Values

Number	Statement	Sort Values
9	The funding helped us to support whānau in rural and remote locations	5
22	The funding enabled whānau to manaaki those who were in isolation	4
1	The funding assisted us in increasing vaccination rates	4
4	The funding assisted whānau with information about where and when they could get vaccinated	3
2	The funding helped us ensure whānau were informed about vaccinations	3
24	The funding enabled whānau to get access to services that they had not been able to access before	2
21	The funding enabled whānau to manaaki one another while in lockdown	2
23	The funding enabled whānau to prepare for COVID-19 coming to their whare door-step	2
3	The funding assisted us in decreasing vaccine hesitancy	2
10	The funding helped us to support whānau with mental health and addictions	1
19	The funding enabled whānau to mitigate the impact of enforced social distancing	1
12	The funding assisted iwi and Māori providers in working together	1
27	The funding assisted whānau to keep participating in their Te Ao Māori obligations despite restrictions	1
11	The funding provided an opportunity for the Crown to better partner with iwi and Māori providers	0
26	The funding assisted whānau to perform their kaitiakitanga obligations in spite of the restrictions	0
31	The reporting was easy to do	0
15	The funding enabled us to do work we would not otherwise have been able to do	0

8	The funding helped us to assist tāngata whaikaha	0
16	The funding enabled whānau to stay in paid work	-1
25	The funding helped keep tamariki and rangatahi in school	-1
30	The expectations of what we would do with the funding were clear	-1
6	The funding helped us innovate and try new things	-1
18	The funding enabled whānau to begin a new business	-2
13	The funding was sufficient for us	-2
28	The funding was easy to apply for	-2
17	The funding enabled whānau to transition to new employment	-2
5	The funding assisted us to maintain our capacity and our capability	-3
20	The funding enabled whānau to mitigate the trauma of domestic violence and family-break ups	-3
14	The funding was flexible enough to deal with changing circumstances	-4
29	The application was easy to fill in	-4
7	The funding helped us to assist whānau without permanent housing	-5

This was a statistically very strong factor (it explained 33% of the variance of the whole sort). We are therefore confident that kaimahi and kaitono involved in MCCF delivery believed MCCF addressed the inequitable vaccine access experienced by whānau – and others living rurally and remotely.

In the critical reflections, kaimahi and kaitono shared the following:

First, MCCF enabled solutions that were community-and-placed-based. Kaimahi and kaitono talked about how the success of MCCF was in the way it helped them create targeted support, in the form of information, manaaki packs or travel vouchers, at a community or collective level and not just at individuals. For example, kaitono talked about how community engagement reduced the individual burden of learning about vaccines and made it a community or collective learning effort that was still paying off at the time of this evaluation. As another example, kaitono talked about how being able to come together as whānau, whanui, and hapori, as well as neighbours, helped reduce the stress and stigma involved in interacting with clinicians who were strangers.

Second, kaitono talked about being able to ignore the DHB boundaries while being encouraged to work along whakapapa and whenua lines. For many kaitono, it was the first time they could work with the Crown in this way without being penalised. For example, kaitono talked about the days spent wasted filling out forms from one DHB, to be then asked to fill out a completely different one from another DHB. Several kaitono explained that because they could fill in only one proposal, they could use that spare capacity to travel to whānau living in remote areas to talk about the efficacy of vaccines, or get down to a vaccination event to provide support. This theme should be seen in the context of the negative value attributed to the difficulty of filling in the application form, and how the funding was not flexible enough to deal with changing circumstances, especially at the end of the financial year. Kaitono advised that community needs did not stop on 30 June 2022 and that the "*bureaucratic assumption that it did was frustrating and naive*".

Third, kaitono talked about how the MCCF enabled them to get a "*foot-in-the-door of some whare*" through the tikanga of manaakitanga. It was explained to us that once trust was built or rebuilt, kaitono were often invited back to talk about vaccines and life. One kaitono offered this example:

"Because we built trust through the practice of manaakitanga, we were invited back to drive that kaumatua to get his vaccination while enrolling him in the GP clinic and connecting him with his local Whānau Ora navigator".

Examples like this were not isolated. Almost every kaitono had a story about how they worked deliberately to reduce the cost to individuals of getting vaccinated, while also working hard to minimise the learning costs and the associated shame and stress that sometimes come with health decisions.

Fourth, kaitono stressed the importance of the manaaki packages, especially for those whānau and communities who were socially isolating or were isolated. For example, almost every kaitono talked about how the packages helped whānau mitigate the impact of enforced social distancing. Many kaitono talked about how packages helped them reduce the impact of loneliness and isolation, especially for remote and more rural whānau, who's own whānau could not visit because of the lockdowns or border controls. In another example, several kaitono talked about how the manaaki packages also assisted those whānau who decided to self-isolate while they considered the safety and efficacy of the vaccine.

Finally, kaitono challenged the research team to consider equity as a quality dimension – not just a matter of access or outcome. That kaitono asked the researchers to ensure equity is understood:

"Not as the uniform provision of services upon which public policies succeed or fail, but rather, for example, the number of delegated or genuinely devolved programmes to communities at a community level for them to design and deliver themselves".

We call the reader's attention to this point. It is clear from this narrative that locally designed and delivered programmes overcome the problem of not knowing "*who-is-who*", especially when it is rural and remote. Thinking about quality as a specific equity enabler is infrequent, and more research can be done in this area. For example, one kaitono called the researchers' attention to equity quality and how manaakitanga institutions already have built-in quality standards based on whenua, whakapapa, whānau and whanui, and that this is why kaupapa and community-led providers are generally more effective, efficient and agile than Crown agents, or large mainstream providers.

Vignette One: Ngāi Tāmanuhiri

Ngāi Tāmanuhiri was part of Toitū Tairāwhiti which received $4.84m in Phase 2. Toitū Tairāwhiti is an iwi collective – the Hinenui Whanui Charitable Trust Board held the contract on behalf of the iwi collective. Ngāi Tāmanuhiri was part of a collective that delivered vaccination activities and support services to those families in isolation because of COVID-19. 1,334 whānau, or 6,119 individuals, were supported with information and access to vaccination services. 91,000 food and welfare packs were delivered to whānau who were isolating for one reason or another. In addition to food and welfare sanitation packs, medical care packs and payment cards for those in need were also provided. Kaitono also checked in on whānau in isolation while manning road closures, coordinating large-scale food and supply deliveries, collecting food shopping for whānau as required and regular "*check-ins*" with rural and more remote living whānau.

Funding was also used to:

- Hold a number of community vaccination events, as well as drive-through vaccination clinics.
- Upskill community members to become vaccinators.
- Update the policies and procedures of over 60 marae to ensure they were compliant with the new COVID-19 Protection Framework.

Vignette Two: Poutini Waiora

In phase one Poutini Waiora was funded for navigator services. The navigators worked on efforts to increase vaccination rates in priority groups, including Māori and at-risk whānau living remotely and in rural areas. The navigators focussed on Buller and Māwhera, knocking on doors and ensuring whānau stayed well informed. Via these methods, and in 15 vaccine clinics, Poutini Waiora facilitated support for over 1,000 individuals and vaccinations for just under 800 people.

Narrative Two: Waiho i te toipoto kaua i te toiroa

The next most potent narrative is a reminder to keep close together and not far apart. It is made up of the ideas that MCCF:

- Enabled whānau to keep tamariki and rangatahi in school.
- Funding was flexible enough to deal with changing circumstances.
- Enabled whānau to mitigate the impact of enforced social distancing.

Table Six shows the statements as they are ranked in the composite factor that produced this narrative (factor two). Those statements are ranked from most like how this group of participants (kaitono and kaimahi who sorted in a similar fashion) thought about the MCCF, to the least like how they thought. When examining this data, it is good to keep in mind, as we suggested in the analysis section above, that it is the rankings of one viewpoint created from similar participant sorts. So, it is not a single person, but a single viewpoint or story that is represented by the rankings below.

This factor represented 11% of the sorts (the rest of the factors each explain less than 8%). We can confirm from the interviews with the participants represented by this narrative that the kaimahi and kaitono involved in MCCF delivery believed that MCCF assisted in keeping tamariki and rangatahi connected to their school, which mitigated the impact of enforced social distancing. They found they could do that because the funding was flexible enough to deal with changing circumstances.

This narrative is a pleasant surprise, simply because only a small number of investment reports spoke about how MCCF supported kohanga and kura communities to keep tamariki connected to school. But we were please pleased to see this strong narrative because the evidence tells us that school vaccinations offer access to about 99.9% of the total population (Whitehead et al., 2021a;2021b).

Table Six: Sort One and Narrative Two: Statements and Sort Values

Number	Statement	Sort Values
25	The funding helped keep tamariki and rangatahi in school	5
14	The funding was flexible enough to deal with changing circumstances	4
19	The funding enabled whānau to mitigate the impact of enforced social distancing	4
23	The funding enabled whānau to prepare for COVID-19 coming to their whare door-step	3
6	The funding helped us innovate and try new things	3
13	The funding was sufficient for us	2
29	The application was easy to fill in	2
28	The funding was easy to apply for	2
22	The funding enabled whānau to manaaki those who were in isolation	2
21	The funding enabled whānau to manaaki one another while in lockdown	1
5	The funding assisted us to maintain our capacity and our capability	1
15	The funding enabled us to do work we would not otherwise have been able to do	1
24	The funding enabled whānau to get access to services that they had not been able to access before	1
31	The reporting was easy to do	0
9	The funding helped us to support whānau in rural and remote locations	0
27	The funding assisted whānau to keep participating in their Te Ao Māori obligations despite restrictions	0
30	The expectations of what we would do with the funding were clear	0

11	The funding provided an opportunity for the Crown to better partner with iwi and Māori providers	0
20	The funding enabled whānau to mitigate the trauma of domestic violence and family-break ups	-1
16	The funding enabled whānau to stay in paid work	-1
1	The funding assisted us to increase vaccination rates	-1
10	The funding helped us to support whānau with mental health and addictions	-1
26	The funding assisted whānau to perform their kaitiakitanga obligations in spite of the restrictions	-2
12	The funding assisted iwi and Māori providers in working together	-2
18	The funding enabled whānau to begin a new business	-2
17	The funding enabled whānau to transition to new employment	-2
2	The funding helped us ensure whānau were informed about vaccinations	-3
7	The funding helped us to assist whānau without permanent housing	-3
3	The funding assisted us to decrease vaccine hesitancy	-4
8	The funding helped us to assist tāngata whaikaha	-4
4	The funding assisted whānau with information about where and when they could get vaccinated	-5

In the critical reflections kaimahi and kaitono shared the following:

First, in hindsight, it was essential to keep tamariki and rangatahi connected with school and their kura whānau to minimise any widening of the educational gaps that already existed in the pre-pandemic generations, and to reduce the inequalities in learning between children from high and low socioeconomic groups. This has been recognised by the Government in its new plan to get young people back at school and learning.

Second, kaitono asked the research team to consider this specific example in the broader perspective of contracting to achieve outcome equity. For example, one kaitono suggested that the MCCF may not bear fruit for many years to come, but the ease and willingness of tamariki to return to school because of feelings of belonging (as a result of the manaaki packs while whānau were self-isolating) might itself lead to economic and non-economic impacts that this project cannot hope to measure.

Third, kaitono talked about how the manaaki packages kept whānau who did not want to be vaccinated connected to the school community so that when their tamariki returned to school, there was no whakamā in returning but rather a sense of re-joining the whānau.

Fourth, kaitono overwhelmingly shared how MCCF empowered and supported them, unlike funding from other public sector agencies. While every kaitono acknowledged and agreed that the scrutiny of public money is essential, they also called attention to the significant learning and compliance costs attached to other funding (see for scholarly support, Humpage, 2019; Moynihan et al., 2015).

Lastly, several kaitono talked about how the MCCF investment means they have no student absenteeism problems at their school because the funding enabled them to ensure students were "valued, noticed and connected", even as their whānau were isolating because of COVID-19 or were isolating because their whānau declined to be vaccinated.

This particular narrative suggests some of the investment benefits have been shared in a way that has built resiliency and bolstered some underserved communities.

Narrative Three: Mā roto hoki kia ora ka pai te kōrero

The next most substantial narrative reminds us that the korero is always agreeable when we are refreshed by the renewing of relationships. That is, the funding made it possible for “trusted messengers” to have conversations with whānau in ways in which those whānau felt heard and seen. Sometimes this was referred to as “cupofteatanga”. The key statements for the narrative are:

- MCCF helped us ensure that whānau were informed about vaccinations.
- The reporting was easy to do.
- The funding was sufficient for us.

We can confirm, on the basis of this narrative, that kaimahi and kaitono involved in MCCF delivery believe MCCF assisted in addressing vaccine hesitancy and access inequity.

While it is essential to say that there is no evidence that Māori are more prone to believe COVID-19 vaccine conspiracy theories than the rest of the population, it is fair to say that a combination of unequal health outcomes, distrust in health institutions themselves, and the lack of a targeted communications and engagement campaign, meant that many whānau, whanui and hapori wanted a "*gab before a jab*".

Table Seven: Sort One and Narrative Three: Statements and Sort Values

Number	Statement	Sort Values
2	The funding helped us ensure whānau were informed about vaccinations	5
13	The funding was sufficient for us	4
30	The expectations of what we would do with the funding were clear	4
31	The reporting was easy to do	3
14	The funding was flexible enough to deal with changing circumstances	3
1	The funding assisted us to increase vaccination rates	2
5	The funding assisted us to maintain our capacity and our capability	2
3	The funding assisted us to decrease vaccine hesitancy	2
29	The application was easy to fill in	2
6	The funding helped us innovate and try new things	1
11	The funding provided an opportunity for the Crown to better partner with iwi and Māori providers	1
28	The funding was easy to apply for	1
12	The funding assisted iwi and Māori providers in working together	1
15	The funding enabled us to do work we would not otherwise have been able to do	0
22	The funding enabled whānau to manaaki those who were in isolation	0
7	The funding helped us to assist whānau without permanent housing	0
8	The funding helped us to assist tāngata whaikaha	0

24	The funding enabled whānau to get access to services that they had not been able to access before	0
9	The funding helped us to support whānau in rural and remote locations	-1
4	The funding assisted whānau with information about where and when they could get vaccinated	-1
25	The funding helped keep tamariki and rangatahi in school	-1
21	The funding enabled whānau to manaaki one another while in lockdown	-1
16	The funding enabled whānau to stay in paid work	-2
27	The funding assisted whānau to keep participating in their Te Ao Māori obligations despite restrictions	-2
20	The funding enabled whānau to mitigate the trauma of domestic violence and family-break ups	-2
10	The funding helped us to support whānau with mental health and addictions	-2
23	The funding enabled whānau to prepare for COVID-19 coming to their whare door-step	-3
19	The funding enabled whānau to mitigate the impact of enforced social distancing	-3
26	The funding assisted whānau to perform their kaitiakitanga obligations in spite of the restrictions	-4
18	The funding enabled whānau to begin a new business	-4
17	The funding enabled whānau to transition to new employment	-5

In the critical reflections, kaimahi and kaitono shared the following:

First, kaitono were adamant that iwi and hapū-led approaches are much more efficient and effective simply because people get vaccinated when vaccination programmes, especially the provision of information, are community-led, and the "messengers are trusted".

Second, kaitono explained that while hearing from the Prime Minister and Director-General of Health and scientists might meet some people's needs, it did not meet the needs of all communities. For example, kaitono explained that hearing from "trusted messengers" in iwi and hapū contexts were much more successful than ads on television or messages from Wellington.

Thirdly, kaitono talked about how vaccine hesitancy is a complex combination of beliefs, culture, and history. This is why, kaitono explained, community-led vaccination efforts were as much about sharing information in community environments, addressing concerns and answering questions before pointing out where the local vaccination service was.

Fourth, when asked why the MCCF was not focused on employment outcomes, kaitono and kaimahi pointed out they still supported those whānau but did not use MCCF investments.

Finally, kaitono appreciated the opportunity to connect and reconnect with whānau and whanui to hear about their concerns and address them thoughtfully and respectfully without spending days on compliance. Kaitono reported that the application proposals were easy to fill in, they had good support from kaimahi, and the reporting was simple and appropriate. Kaitono appreciated not being caught up in "red tape" and being able to use that time and energy to support whānau.

Vignette Three: Waiariki Whānau Mentoring

Waiariki Whānau Mentoring received funding to provide vaccination activities and support services to Ngāi Tokomatua in the Lakes, Waikato and Bay of Plenty regions. Funding was used to employ Whānau Navigators, who were able to work with Ngāi Tokomatua leaders and their whānau to encourage and coordinate attendance at vaccination locations. Funding was also used to run vaccine information hui, care packages, and deploy emergency testing clinics. Quick work reportedly halted an outbreak in the Bay of Plenty. Over 1,000 Ngāi Tokomatua and their whānau were vaccinated. Rongoa work continues as multiple gang leaders now trust Waiariki Whānau in what they do and the hauora support they offer which means services will reach clients who were previously not accessing hauora services.

Narrative Four: Mā te ngākau aroha koe e ārahi

The next narrative is a vital one, it reminds us to let a loving and compassionate heart guide decision-making, especially in times of change. This narrative focussed on ensuring tāngata whaikaha were assisted, and able to manaaki one another and their whānau. Some disability providers were able to do work they would not otherwise have been able to do. Mathematically, this factor was not highly significant in comparison with the first three (see Humphrey's rule row in Appendix Three), but Q-method asks researchers to look beyond just mathematical analysis and to be aware that even a single participant sort may be extremely relevant if all considerations are taken into account (McKeown and Thomas, 1988). For us, a particular consideration is that tāngata whaikaha and their whānau are some of our most vulnerable citizens, so any story about how a policy process had some success in supporting them should be told and highlighted.

Table eight shows the statements as they are ranked in the composite factor that produced this narrative (factor four). Those statements are ranked from most like how this group of participants (kaitono and kaimahi who sorted in a similar fashion) thought about the MCCF, to the least like how they thought. When examining this data, it is good to keep in mind, as we suggested in the analysis section above, that it is the rankings of one viewpoint created from similar participant sorts. So, it is not a single person, but a single viewpoint or story that is represented by the rankings below.

This factor represents an important story that we heard often – though not always – in the interviews, and represents a reasonable proportion (7%) of the sorts. We can confirm that kaimahi and kaitono involved in MCCF delivery believe the MCCF enabled kaitono to support tāngata whaikaha. At the outset, it is essential to say that this might be because the health reforms had not yet clarified what the new Whaikaha agency would look like. It is possible that MCCF was playing a compensatory role. It might also have been because there was a pressing and urgent need to mitigate the regional lockdowns' harm and the socioeconomic vulnerability and risk of hardship experienced by tāngata whaikaha and their whānau. That said, it is also clear from the investment reporting that a lot of energy went into building a network of kaitono who could support tāngata whaikaha and their whānau and ensure they had access to essential resources to meet their needs, mainly because the regional lockdowns disconnected them from their formal and informal support systems.

Table Eight: Sort One and Narrative Four: Statements and Sort Values

Number	Statement	Sort Values
8	The funding helped us to assist tāngata whaikaha	5
21	The funding enabled whānau to manaaki one another while in lockdown	4
15	The funding enabled us to do work we would not otherwise have been able to do	4
6	The funding helped us innovate and try new things	3
24	The funding enabled whānau to get access to services that they had not been able to access before	3
22	The funding enabled whānau to manaaki those who were in isolation	2
12	The funding assisted iwi and Māori providers in working together	2
14	The funding was flexible enough to deal with changing circumstances	2

23	The funding enabled whānau to prepare for COVID-19 coming to their whare door-step	2
1	The funding assisted us to increase vaccination rates	1
4	The funding assisted whānau with information about where and when they could get vaccinated	1
9	The funding helped us to support whānau in rural and remote locations	1
2	The funding helped us ensure whānau were informed about vaccinations	1
30	The expectations of what we would do with the funding were clear	0
5	The funding assisted us to maintain our capacity and our capability	0
27	The funding assisted whānau to keep participating in their Te Ao Māori obligations despite restrictions	0
11	The funding provided an opportunity for the Crown to better partner with iwi and Māori providers	0
3	The funding assisted us to decrease vaccine hesitancy	0
10	The funding helped us to support whānau with mental health and addictions	-1
19	The funding enabled whānau to mitigate the impact of enforced social distancing	-1
28	The funding was easy to apply for	-1
26	The funding assisted whānau to perform their kaitiakitanga obligations in spite of the restrictions	-1
25	The funding helped keep tamariki and rangatahi in school	-2
17	The funding enabled whānau to transition to new employment	-2
29	The application was easy to fill in	-2
7	The funding helped us to assist whānau without permanent housing	-2
16	The funding enabled whānau to stay in paid work	-3

31	**The reporting was easy to do**	**-3**
13	**The funding was sufficient for us**	**-4**
20	**The funding enabled whānau to mitigate the trauma of domestic violence and family-break ups**	**-4**
18	**The funding enabled whānau to begin a new business**	**-5**

In the critical reflections kaimahi and kaitono shared the following:

First, how MCCF enabled kaitono to develop disability-related advice, support and resources and share those widely across the tāngata whaikaha community and the provider sector.

Second, how the MCCF enabled tāngata whaikaha to play a "trusted messenger" role in and with their communities and whānau. Examples include leading group chats, organising hui and leading webinars on whether and how to get vaccinated.

Third, how the MCCF enabled tāngata whaikaha to coordinate their vaccination events, including reshaping mainstream provision to suit their needs.

Fourth, how the funding enabled tāngata whaikaha to take a leadership role in their whānau. Several kaitono reported that because they were able to ensure equity of access for tāngata whaikaha, that also created equity of access and outcome for the wider whānau. This is a reoccurring sub-theme: the idea that building quality in equity interventions for whānau also produces equity for others. For example, kaupapa-led mobile vaccination services provided first-of-its-kind services to underserved rural and remote areas (thereby building equity for Māori and non-Māori). Likewise building quality in equity for tāngata whaikaha means an increase in equity of access and outcomes for their whānau. It is not something this research can take much further, but it is an area for further inquiry.

Vignette Four: Taikura Trust

Taikura Trust received funding to act as a conduit between iwi and hapū with their disabled whānau. Taikura Trust used the funding to become a voice to raise awareness in response to inequity, and mitigate vaccination discrimination, for disabled people in Tamaki Makaurau.

They funded:

- Disability support for existing community health care and vaccination providers.
- Information and resources tailored to the needs of tāngata whaikaha and whānau on managing in COVID-19 outbreak communities, developed explicitly for whānau with health issues or intellectual disability, hearing, vision, and/or communication disorders.
- Outreach support to stay connected to the community during COVID-19 outbreaks.

Taikura Trust's focus was also on supporting tāngata whaikaha and whānau through crises that arose due to the impact of COVID-19 and the regional lockdowns, including instances of family harm, financial and social hardship, and emotional and mental anxiety.

Are there any insights into the collaboration between the three institutions?

The leadership from Te Puni Kōkiri was fundamental to the positive roll-out of the MCCF. From the perspective of communities, Te Puni Kōkiri was supported by useful coordination between the three institutions (Te Puni Kōkiri, Te Arawhiti and Manatū Hauora) and from the kaitono perspective this was crucial to the successful implementation of MCCF in an integrated fashion. This section is concerned with institutional collaboration from a public management perspective. The literature generally divides collaboration into three separate, albeit complementary, categories: between public institutions, with citizens, and in partnership with groups of people with specific legal rights (Ansell & Gash, 2008;.O'Leary, 2014)

This section is about the first type of collaboration, particularly between Te Puni Kōkiri, Te Arawhiti and Manatū Hauora in ensuring that providers received an integrated approach to MCCF funding. Furthermore, the literature uses a continuum of collaboration, from just cooperation, through to coordination, onto collaboration, and finally complete service integration (Selden, et al., 2002). Readers will note our use of these terms in the statements participants sorted, and even a casual observer will be able to note that neither collaboration nor service integration rose much from the most negative rankings. However, the cooperation and coordination statements did feature as strong positives.

A reminder, to answer this question, the researchers used a combination of the Āta and Q-method to establish how those involved in the design and delivery of the MCCF understood and told stories about what happened (Brown, 1980; McKeown & Thomas, 1988).

Our analysis produced a set of eight mathematically significant narratives (see Appendix Three). Upon analysis and discussion, the research team determined the first three narratives appropriately represent the most prominent and distinct perspectives on collaboration in the MCCF. These three narratives represent almost half the total sort,

and all three each explain more than 10% of the variance in the sort, meaning they are very strong and illustrative. In time, the research team will unbundle the remaining narratives that are of academic interest, but they are not relevant to the evaluation questions asked.

Narrative One: Shared mission and the weavers

The most vital narrative – by some way – is that the officials involved in the collaboration were focused on the shared mission to reduce disproportionately poor access to COVID-19 information and vaccination services for rural and older people, as well as Māori, all of whom are groups who are at risk of severe outcomes from COVID-19 infection.

This factor represents 20% of the variance amongst the sorts of the participants. As such, we are confident that officials and kaimahi involved in MCCF design and delivery believed they had a shared mission that was supported by kaimahi working proactively with kaitono. However, this factor comes with a proviso; officials did not think they spent enough time critically examining one another's work or building a collaboration that was fully integrated for kaitono (see statement 19 at -3).

Table Ten: Collaboration Sort and Narrative One: Statements and Sort Values

Statement Number	Statement	Sort Values
6	We had a shared mission	4
20	We actively sought feedback from providers	3
14	In our own agency, we understood who was accountable, for what and when	3
2	The collaboration in the MCCF was more like coordination	2
1	The collaboration in the MCCF was more like a cooperation	2
22	We actively considered how to build trust with providers	2

23	We harnessed the potential of information technology to assist us	1
16	We actively managed the power imbalances	1
11	The governance arrangements encouraged us to provide free and frank advice	1
12	The clarity of decision-making rights assisted delivery	0
5	We had a shared context	0
17	We had an active flow of information	0
10	The governance arrangements assisted us	0
18	We had a shared view of engagement and communication with providers	0
9	We had the same level of motivation and commitment	-1
13	The right decision-makers were at the table	-1
21	We actively considered how to build trust with one another	-1
15	In our colleague agencies we understood who was accountable, for what and when	-2
4	The collaboration in the MCCF was a true collaboration	-2
7	We understood one another's unique institutional skills, resources, expertise and knowledge	-2
8	We understood one another's tikanga and kawa	-3
19	We created time to listen to one another, brainstorm and ensure we critically examined one another's work	-3
3	The collaboration in the MCCF was more like service integration	-4

This finding is no surprise, as one of the ideas at the heart of the governance arrangements was ensuring senior officials maintained and communicated a clear and shared sense of institutional purpose and mission. For example, it is one of the key findings from the system-level analysis of all the Performance Improvement Framework review

reports between 2010 and 2020; the clearer and more sufficiently distilled and straightforward a vision is, the more likely it is to be both motivating to partners and staff (Te Kawa, 2020).

In the critical reflections, officials and kaimahi shared the following:

First, how officials, kaimahi and kaitono valued the unmistakable sense of role and purpose, and how the officials used that clarity to make MCCF simple for kaitono to access and simple for kaitono to prioritise competing daily demands.

Second, in discussing the success of MCCF, almost every kaitono called attention to the work of the kaimahi (i.e., the Te Puni Kōkiri staff in the regions) as weavers. The overriding theme from these discussions was just how capable the kaimahi in the regions were in moving information laterally, diagonally, in spirals — while keeping them informed, and that despite the speed, they ensured kaitono had opportunities to shape or input into decisions. In the Māori Crown relationship, this is not unimportant. One rangatira asked the research team to ensure the Te Puni Kōkiri kaimahi based in the regions were acknowledged in this report. She asked that their unique ability to diffuse and reset the distribution of power based on "who knows what" in favour of everyone having the same information was one of the key contributors to the MCCF's success. While the public management literature calls this boundary spanner leadership (Williams, 2013). One kaitono called it te raranga whāriki - the art of weaving threads. In offering the research team this concept, she reminded us that the most important challenge the Crown Māori relationship faces is how interdependent it is – and how it can only be a success if both sides work on the solutions by working collaboratively.

Finally, many officials talked about the success of MCCF collaboration in how the structure, roles and responsibilities evolved as the programme matured. It is clear from the documentation and this narrative that decision-making and delegations were a matter of conscious design instead of by accident. It is also clear that the cascade of responsibilities and accountabilities were tightly linked to vision, risk and pace of delivery.

Narrative Two: Shared Context and Motivation Enabling Free and Frank

The next strongest narrative is that the MCCF collaboration had a shared context underpinned by a shared level of motivation and commitment, enabling free and frank conversations. As with the first narrative, this is qualified with the shared belief of officials and kaimahi that the MCCF did not actively build trust with kaitono or integrate kaitono feedback. Thus, it was more like cooperation between agencies and not a true collaboration.

Table Eleven: Collaboration Sort, Narrative Two: Composite factor statements and sort values ranked

Statement Number	Statement	Sort Values
5	We had a shared context	4
9	We had the same level of motivation and commitment	3
11	The governance arrangements encouraged us to provide free and frank advice	3
18	We had a shared view of engagement and communication with providers	2
8	We understood one another's tikanga and kawa	2
19	We created time to listen to one another, brainstorm and ensure we critically examined one another's work	2
23	We harnessed the potential of information technology to assist us	1
1	The collaboration in the MCCF was more like a cooperation	1
2	The collaboration in the MCCF was more like coordination	1
17	We had an active flow of information	0
6	We had a shared mission	0
16	We actively managed the power imbalances	0

12	The clarity of decision-making rights assisted delivery	0
7	We understood one another's unique institutional skills, resources, expertise and knowledge	0
3	The collaboration in the MCCF was more like service integration	-1
10	The governance arrangements assisted us	-1
21	We actively considered how to build trust with one another	-1
15	In our colleague agencies, we understood who was accountable, for what and when	-2
13	The right decision-makers were at the table	-2
14	In our own agency we understood who was accountable, for what and when	-2
22	We actively considered how to build trust with providers	-3
20	We actively sought feedback from providers	-3
4	The collaboration in the MCCF was a true collaboration	-4

This narrative represents 14% of the variance in the collaboration sort so we are confident that officials and kaimahi involved in MCCF design and delivery believed they had a shared context, supported by the same or similar motivation that enabled free and frank advice, but that the MCCF was not quite a true collaboration.

In the critical reflections, officials and kaimahi shared the following:

First, in discussing what worked well and what could be improved for next time, officials uniformly agreed that in an ideal world, there would have been more iwi/Māori voices at the decision-making table, but due to the speed and pace the programme needed to deploy resources into communities, they did not. However, it is clear from the documentation that senior officials were constantly looking for ways to ensure process fairness in the decision-making while at the same time being aware not to fetter

or infringe on the decision-making rights of institutions in Te Ao Māori. Alongside this awareness was the acknowledgement that kaitono are independent and autonomous entities themselves and are best placed to decide what vaccination activities to undertake, as well as when and where. While in no ways ideal, the documentation also shows the Wellington-based officials reaching out to their weaver kaimahi to try and make the processes as participatory and inclusive as possible.

Second, the research team also notes that discussions and debates about fairness and equitability of decision-making structures and processes resulted in decisions being made closer to where the work went on as the rollout matured and the risk reduced. All up, funding decisions were made in three levels within the Crown and at least two levels by kaitono.

Lastly, the research team thinks it is a good sign that the officials and kaimahi were able to have a free and frank conversation and acknowledge the areas for improvement.

Narrative Three: The Weavers Again

The next strongest narrative centres on the weavers. It is important to note that weavers operated at all levels of the programme, across Te Puni Kōkiri and in the way those staff worked with Te Arawhiti and Manatū Hauora. This narrative emphasises that Te Puni Kōkiri kaimahi in the regionals were central to the success of the MCCF from the perspective of the kaitono we engaged with. It also suggests that officials are increasingly expected to work openly, in public, and to engage genuinely. Partnership is in demand – and kaimahi working in regional roles are comfortable working in Ao Māori and Ao Pakeha. At the same time those officials and kaimahi observed that in the rollout of MCCF more feedback from providers and active management of the power imbalances that arise through contracting, and those officials and kaimahi working within that power imbalance had to manage it (see statement 16 at -3).

Table Twelve: Collaboration Sort, Narrative Three: Composite factor statements and sort values ranked

Statement Number	Statement	Sort Values
6	We had a shared mission	4
8	We understood one another's tikanga and kawa	3
5	We had a shared context	3
7	We understood one another's unique institutional skills, resources, expertise and knowledge	2
14	In our own agency we understood who was accountable, for what and when	2
21	We actively considered how to build trust with one another	2
23	We harnessed the potential of information technology to assist us	1
2	The collaboration in the MCCF was more like coordination	1
11	The governance arrangements encouraged us to provide free and frank advice	1
4	The collaboration in the MCCF was a true collaboration	0
12	The clarity of decision-making rights assisted delivery	0
9	We had the same level of motivation and commitment	0
3	The collaboration in the MCCF was more like service integration	0
22	We actively considered how to build trust with providers	0
19	We created time to listen to one another, brainstorm and ensure we critically examined one another's work	-1
13	The right decision-makers were at the table	-1
18	We had a shared view of engagement and communication with providers	-1

17	**We had an active flow of information**	**-2**
1	**The collaboration in the MCCF was more like a cooperation**	**-2**
10	**The governance arrangements assisted us**	**-2**
20	**We actively sought feedback from providers**	**-3**
16	**We actively managed the power imbalances**	**-3**
15	**In our colleague agencies we understood who was accountable, for what and when**	**-4**

This factor explains 13% of the sort, so we are confident that the kaimahi involved in the delivery of MCCF had a shared mission and context, and valued and placed value on kaitono tikanga and kawa.

In the critical reflections, officials, kaimahi, and kaitono shared the following:

First, iwi/Māori – like other communities - are seeking to participate and engage in public policy debates, especially when the decisions affect them. Like other communities, iwi/Māori are less accepting of expertise and authority, especially that of experts who have nothing to offer other than their disciplinary science and process, particularly if those experts do not like to share space with those communities who bring experience, tacit knowledge and practical reasoning. It appears Te Puni Kōkiri kaimahi are well placed to support and facilitate the process of iwi/Māori more actively participating in public policy processes at all levels including in the regions.

Second, in discussing the importance of the regional officials, kaitono called attention to the practical wisdom of kaimahi and how MCCF would have never been able to be implemented without their involvement in the implementation approach. There was a uniform agreement on the value of the Te Puni Kōkiri kaimahi especially in public policy processes that seek to use local solutions to solve local problems.

Third, kaitono talked about how kaimahi found the right balance between compliance that enabled accountability and compliance that became a burden. Examples of compliance as accountability included streamlining application and reporting processes, guidance on good practice reporting, and keeping kaitono up-to-date on decisions.

Fourth, kaitono also talked about the information facilitation and brokerage role kaitono played throughout the MCCF and how their predominant role became geared towards collective learning. For example, the exercise of facilitative, not authoritative, leadership in standing back to let kaitono take the lead, help to identify and applaud effective practice, provide opportunities to share these lessons and to help others to try those lessons out in their own context, and then creating and recreating the overall strategic purpose wherein particular adaptations could reign.

This last point deserves some additional attention. There is something in the way MCCF willingly innovated, "*mixed-'n-matched*" resources, means and methods and did "*what it took to be effective*". Dare we say, we heard of a "culture of bureaucratic entrepreneurialism" that was answerable and accountable while playing with possibilities, moulding to the means, and working through the necessary methods, all-the-while engaging in learning to be effective. It is something that deserves its own research.

CONCLUSIONS AND RECOMMENDATIONS

Based on the methodology and analysis outlined in this report the following findings are offered. The reader is reminded that Te Puni Kōkiri asked the research team to answer three questions:

- First, did MCCF assist in improving vaccination uptake between October 2021 and June 2022?
- Second, whether and how MCCF helped improve vaccine uptake and build community resiliency, in the context of introducing the COVID-19 protection framework?
- Finally, what are the lessons in collaboration between the three institutions: Te Puni Kōkiri, Te Arawhiti and Manatū Hauora?

In answer to the first question, the MCCF absolutely assisted in improving vaccination uptake between October 2021 and June 2022. While the data we brought together shows extraordinary gains given the proportionally small amount spent against the overall COVID-19 spend. We are also mindful that inequity persisted between Māori and non-Māori vaccination rates.

On the second question, while this evaluation has some limitations, primarily due to the quality of the programme-level impact data, it is evident that the MCCF improved access equity by offering additional vaccination services in areas with high-priority populations and low access to vaccines. This improved equity in vaccination uptake and protected priority populations.

Also, in addressing access inequity, the MCCF improved equity in outcomes by funding services that practically reduced the administrative burden on whānau living rural and remotely, tamariki and rangatahi, those whānau who needed to hear from a “trusted messenger” on the efficacy of vaccines, and tāngata whaikaha, so they could access vaccine information and vaccination services.

The reduced burden included a combination of the following:

- Reduced learning costs (such as finding out who in the whānau was eligible for vaccination and when and where to get information or a vaccine).
- Reduced psychological costs (such as reducing the stress and stigma involved in interacting with people often unknown to the whānau).
- Reduced compliance costs (such as streamlining application processes and reporting).

Further, this independent evaluation also finds that some MCCF investments overcame some of the weaknesses in the mainstream vaccination delivery. We also find that it appears some investment benefits have been shared in a way that has built resiliency by bolstering the self-determination of some underserved communities. This will need to be studied over the long-term to confirm whether the gains remain.

On the third question of the evaluation, "what are the lessons in collaboration between the three institutions", the evaluation also finds that the leadership from Te Puni Kōkiri and the cooperation between the three institutions (Te Puni Kōkiri, Te Arawhiti and Manatū Hauora) was crucial to the success of MCCF. The senior leaders in all three agencies worked hard to simplify a complex operating environment and manage competing demands. It is also apparent that the shared purpose and goal drove the priorities of each agency and motivated their staff.

Finally, we want to put on the record that we found that critical to the success of the MCCF were the regional networks of Te Puni Kōkiri and their deep understanding of the Crown Māori relationship. Alongside senior leaders in the organisation, Te Puni Kōkiri kaimahi based in the regions were proactively scanning the environment, working across organisational and institutional boundaries, generating and smoothing information flow and balancing the needs of the authorising environment and the communities they work in.

This evaluation has two recommendations. It is for Te Puni Kōkiri to improve the quality of the programme impact data, and if necessary, align to the Whānau Ora Pou – if only to reduce the compliance burden on providers. The research team were able to create a methodology that mitigated the absence of programme investment data. Better and more precise mapping between investment costs, impacts and benefits would have made for a much faster evaluation. The second recommendation asks Te Puni Kōkiri to give more thought to including iwi/Māori voices at the decision-making table, irrespective of the speed and pace of the programme delivery schedule. While officials were aware of this, it might have mitigated the difficulties towards the end of the MCCF as the funding window closed.

APPENDICES

APPENDIX ONE: KAITONO PARTICIPATING IN THE MCCF

Adrienne Gulliver
Air Ruatoria
Aotea District Māori Wardens Association
Aranui Community Trust Incorporated
Arataua Limited
Arewa Limited on behalf of Te Tauihu Māori Business Network Incorporated Society
Arowhenua Whānau Services
Ātiawa ki Whakarongotai Charitable Trust Board
Aupouri Ngāti Kahu Te Rarawa Trust
BBM Motivation and Manurewa Marae
BDO Northland Limited (on behalf of Ngā Pai Kitea trading as Te Pai Roa Tika)
BDO Northland Limited (on behalf of Te Pai Roa Tika)
Bros for Change Charitable Trust
Bros for Change Limited
Christchurch Collective for Homeless Charitable Trust
Cobham School
DV Walker Limited on behalf of Te Au Pakihi Māori Business Network
Engage Safety NZ Limited
Gisborne District Council
He Toronga Pakihi ki Taranaki Māori Business Network
He Waka Tapu Limited
HealthWest Limited
Hikoi Koutou Charitable Trust
Hinenui Whanui Charitable Trust Board
Hiruharama Marae
Hoani Waititi Marae Trust
Hokianga Health Enterprise Trust
HR Sageese Limited
HTK Group Limited
Huakina Development Trust
Internal Strength Limited
Kahungunu Exec and Wairoa Taiwhenua
Kaiti School
Kaiwhaiki Pa Trust
Kirikiriroa Family Services Trust
Little Green Man Productions Limited
Ma Te Huruhuru Charitable Trust
Mad Ave Community Trust
Mahitahi Trust
Making Everything Achievable Limited (on behalf of Te Hiku o Te Ika Iwi Development Trust)
Maniapoto Māori Trust Board
Maranga Mai Ngā Wātene Māori
Matakohe Architecture & Urbanism Limited
Mataura & Districts Marae Charitable Trust
Muaūpoko Tribal Authority Incorporated
MultiCultural Whangarei Incorporated (on behalf of Rangatahi Ora)
National Hauora Coalition Trust
New Zealand Māori Council
Ngā Kairauhii
Ngā Kete Mātauranga Pounamu Charitable Trust
Ngā Kete Mātauranga o Te Waipounamu
Ngā Maia Māori Midwives o Kahungunu Trust
Ngā Manga Puripuri Charitable Trust
Ngā Mataapuna Oranga Limited

Ngā Tāngata Tiaki o Whanganui
Ngāhere Communities Limited
Ngāruahine
Ngāti Awa Social and Health Services Trust
Ngāti Haua Iwi Trust
Ngāti Hine Health Trust Board
Ngāti Kahungunu Iwi Inc
Ngāti Kuri Trust Board
Ngāti Manaiapoto Marae Pact Trust
Ngāti Pahauwera Development Trust Ltd
Ngāti Porou Hauora
Ngāti Porou Holding Company Limited
Ngāti Porou Ki Hauraki
Ngāti Pukenga Iwi ki Tauranga Trust
Ngāti Ranginui Fisheries Trust
Ngāti Ruanui Vaccination Plan
Ngāti Tamaterā Settlement Trust
Ngāti Tumutumu
Ngāti Whare
Ngāti Whatua Runanga (Te Hā Oranga)
Ngāti Whatua Runanga on behalf of Ki Te Ao Marama Charitable Trust
Ngatiwai o Aotea Marae
Ngātiwai Trust Board
Ochre Business Solutions Limited
Otago University (on behalf of Māori Indigenous Health Institute)
Otakou Health Limited
Pango Productions
Papakura Kootuitui Trust Board
Papakura Marae Society Incorporated
Parihaka Papakainga Trust
Pehiaweri Māori Church and Marae Incorporated
Porirua Whānau Centre (for Awarua ki Porirua Māori Business Network)
Pou Tāngata Ngāi Tai ki Tāmaki Community Development Trust
Poutini Waiora
Pukearuhe Marae Trust
Raetihi Marae Trust
Rakeiwhenua Trust T/A Tūhoe Hauora
Rangitāne Tamaki Nui a Rua Incorporated
Rangitāne Tu Mai Rā Trust (on behalf of Ko Wairarapa Tēnei COVID-19 Iwi Collective of Wairarapa)
Ratana Ōrakeinui Trust
Raukawa Charitable Trust
Rongomaiwahine Iwi Charitable Trust
Roopu a Iwi Trust
Rugby for Life Charitable Trust
STRIVE Community Trust
Super Grans
Tai Timu, Tai Pari Limited
Tai Tokerau Polynesian Canoe Association Incorporated
Taikura Trust
Tairawhiti Regional Māori Wardens Association
Tairawhiti Technology Trust
Tāmaki ki te Tonga District Māori Wardens Association
Tāmaki Tū Kotahi ira.dot
Taranaki Māori Trust Board
Taumarunui Community Kōkiri Trust
Te Ahi Kaa Training and Social Services Centre Incorporated
Te Aitanga a Hauiti Hauora
Te Ao Hou
Te Arahanga o Ngā Iwi Limited (for Matarau a Māui)
Te Aranga o Taranaki COVID-19 Taranaki Māori Vaccination Tactical Plan (Update)
Te Arawa Lakes Trust

Te Aroha Kanarahi Trust
Te Hāpai Tūhono Charitable Trust
Te Hau Ahwhiowhio o Otangarei Trust
Te Hau Ora Ō Ngapuhi Limited
Te Hauora o Te Hiku O Te Ika Trust
Te Hauora o Turanganui a Kiwa
Te Hiku Iwi Development Trust
Te Hiringa Charitable Trust
Te Hou Ora Ōtepoti Incorporated
Te Ika Whenua Hauora Incorporated
Te Iwi o Ngati Kahu Trust
Te Kaahui o Rauru Custodian Trustee Limited
Te Kohanga Reo National Trust
Te Kōhanga Reo National Trust on behalf of Ngāti Kahungunu Kōhanga Tari-ā-Rōhe
Te Korowai Hauora o Hauraki Incorporated
Te Kotahi o Te Tauihu Charitable Trust
Te Kotahitanga – Māori Music Artists United
Te Kotahitanga e Mahi Kaha Trust
Te Kupenga Hapū
Te Kura Kaupapa Māori o Hoani Waititi
Te Kura Kaupapa Māori o Te Ara Hou
Te Kura Kaupapa Māori o Te Wānanga Whare Tapere o Tamaki
Te Mahurehure Cultural Marae Society Incorporated
Te Manu Ātatū Māori Business Network
Te Manu Tōroa Trust
Te Ora Hou Ōtautahi Incorporated
Te Paatu ki Kauhanga Trust Board
Te Pae Herenga o Tamaki
Te Papanui Enderley Community Centre
Te Piki Oranga
Te Piringa Manatōpū Incorporation
Te Pou Matakana Limited (trading as the Whānau Ora Commissioning Agency)
Te Pou Oranga o Whakatōhea Limited
Te Puna Ora o Mataatua Charitable Trust
Te Puna Oranga o Otaki
Te Pūtahi-Nui-o-Rehua Charitable Trust
Te Pūtahitanga o Te Waipounamu GP Limited
Te Ranga Tupua Collective
Te Roopu Tautoko ki te Tonga Incorporated
Te Rōpū Pakihi Society Incorporated
Te Roroa Development Charitable Trust
Te Runanga o Kaikoura
Te Runanga o Kirikiriroa
Te Rūnanga o Ngā Maata Waka Incorporated
Te Runanga o Ngā Maata Waka Incorporated on behalf of Te Kahui Hauora o Te Waipounamu
Te Runanga o Ngai Takoto Custodian Trustee Limited
Te Runanga o Ngati Awa Limited
Te Rūnanga o Ngāti Hinemanu me Ngāti Paki ki Mokai Patea Incorporated
Te Rūnanga o Rangitāne o Wairau
Te Runanga o Te Whānau
Te Rūnanga o Toa Rangatira Incorporated
Te Runanga o Whaingaroa (on behalf o Te Kahu o Taonui)
Te Rūnanga-ā-Iwi o Ngāti Kahu Trust
Te Rūnanganui o Te Ati Awa ki te Upoko o Te Ika a Maui Incorporated
Te Tai Awa o te Ora Charitable Trust
Te Tairawhiti Māori performing Arts
Te Taki Tu Charitable Trust
Te Tari o Te Ariki o Tūwharetoa
Te Tihi o Ruahine Whānau Ora Alliance Chairtable Trust
Te Uri o Tai Hapū (Pawarenga)

Te Waipounamu Māori Wardens Association
Te Whakaruruhau 2013 Incorporated Waikato Women's Refuge
Te Whānau a Apanui
Te Whare Awhina o Ngati Tautahi
Te Whare Āwhina o Ngāti Tautahi Incorporated
Te Whare Hauora o Raungaiti
Te Whare Maire o Tapuwae Charitable Trust
Te Wharekura o Manaia
The Ngātiwai Trust Board
Tipu Ake Tonū Limited
Tuhiariki Marae Trust
Turanga FM (Te Reo Irirangi o Turanganui a kiwa)
Turanga Health
Turuki Health Care Charitable Trust
Whitiora Centre Limited
Tuwharetoa ki Kawerau Health, Education and Social Services Trust
Tuwhera Trust
Vision West Community Trust
Waiariki Mentoring Trust
Waiariki Whānau Mentoring Limited
Waikato Tainui
Waikirikiri School Board of Trustees
Waitaha Hauora Charitable Trust
Waitaha Primary Health Trust
Waitangi Cultural Society Incorporated
We are Indigo Limited
Whararikī Trust
Whare Hauora Charitable Trust
Wharekawa Marae Reservation Trust

APPENDIX TWO: VACCINATION UPTAKE TABLE

Te Puni Kōkiri Region	DHB Region	MCCF (m)	Gini Coefficient	Median Spatial Access	% Māori in Low Access Areas	% 65+ in Low Access Areas	% Eligible in Low Access Areas	% Partially Vaccinated - Start of MCCF	Completed Primary Course - Start of MCCF (%)	Partially Vaccinated - End of MCCF (%)	Completed Primary Course - End of MCCF (%)	Partially Vaccinated Increase (percentage points)	Primary Course Increase (percentage points)
Ikaroa-Rāwhiti	Tairāwhiti	$12.570	0.157	12.300	11.200	6.900	8.700	53.05	30.17	85.74	82.32	32.69	52.15
Ikaroa-Rāwhiti	Wairarapa	$0.710	0.197	4.800	39.500	31.600	35.100	53.44	31.09	87.75	84.47	34.31	53.38
Ikaroa-Rāwhiti	Hawkes Bay	$5.050	0.208	15.300	5.800	3.700	4.900	52.23	30.07	85.89	82.47	33.66	52.40
Ikaroa-Rāwhiti	Hutt Valley	$0.610	0.290	18.700	1.200	3.600	3.300	58.74	30.95	89.55	86.80	30.80	55.85
Tāmaki Makaurau	Auckland	$10.690	0.131	14.800	3.200	4.000	2.200	66.98	37.30	90.52	88.24	23.54	50.94
Tāmaki Makaurau	Counties-Manukau	$0.000	0.208	14.800	8.800	10.090	8.300	55.32	29.62	86.91	83.84	31.59	54.21
Tāmaki Makaurau	Waitemata	$0.000	0.358	4.000	53.000	31.600	35.100	64.38	33.42	88.63	86.26	24.24	52.84
Te Tai Hauāuru	Capital Coast	$1.930	0.089	32.350	0.000	0.000	0.000	67.35	33.65	91.68	89.72	24.33	56.08
Te Tai Hauāuru	Taranaki	$7.840	0.136	5.800	10.800	7.300	10.100	48.47	22.99	85.35	82.14	36.88	59.15
Te Tai Hauāuru	Mid Central	$6.870	0.191	13.600	3.000	3.900	4.100	54.94	29.22	88.12	85.14	33.18	55.93
Te Tai Hauāuru	Whanganui	$5.210	0.276	10.100	32.400	26.200	29.500	51.26	31.54	83.55	80.53	32.29	49.00
Te Tai Tokerau	Northland	$21.400	0.478	2.100	88.600	93.000	92.600	49.19	26.93	81.83	78.00	32.64	51.07
Te Waipounamu	Nelson Marlborough	$1.290	0.233	14.800	4.700	5.000	5.100	56.66	33.31	85.36	82.48	28.70	49.17
Te Waipounamu	Canterbury	$4.730	0.247	9.540	3.300	3.300	3.400	58.87	30.18	91.08	88.86	32.21	58.68
Te Waipounamu	South Canterbury	$0.360	0.284	13.500	12.000	17.100	17.100	56.37	30.74	88.80	85.90	32.43	55.16

Te Waipounamu	**Southern**	$2.890	0.287	25.000	3.400	3.200	3.800	62.55	36.63	90.10	87.62	27.55	50.98
Te Waipounamu	**West Coast**	$0.580	0.675	6.900	11.200	10.200	11.700	56.71	30.87	86.68	83.80	29.96	52.93
Waikato-Waiariki	**Lakes**	$7.890	0.237	1.880	99.300	99.400	99.500	49.50	28.74	84.69	81.42	35.19	52.68
Waikato-Waiariki	**Waikato**	$18.010	0.298	15.300	21.400	18.400	17.000	52.14	28.81	86.13	82.75	33.99	53.94
Waikato-Waiariki	**Bay of Plenty**	$12.210	0.392	5.300	25.300	23.100	26.300	49.40	25.53	83.18	79.49	33.77	53.96

APPENDIX THREE: Q-SORT TABLES

Vaccination uptake and resiliency sort

Statements used in the uptake and resiliency sort

Number	Statements
1	The funding assisted us to increase vaccination rates
2	The funding helped us ensure whānau were informed about vaccinations
3	The funding assisted us to decrease vaccine hesitancy
4	The funding assisted whānau with information about where and when they could get vaccinated
5	The funding assisted us to maintain our capacity and our capability
6	The funding helped us innovate and try new things
7	The funding helped us to assist whānau without permanent housing
8	The funding helped us to assist tāngata whaikaha
9	The funding helped us to support whānau in rural and remote locations
10	The funding helped us to support whānau with mental health and addictions
11	The funding provided an opportunity for the Crown to better partner with iwi and Māori providers
12	The funding assisted iwi and Māori providers in working together
13	The funding was sufficient for us
14	The funding was flexible enough to deal with changing circumstances

15	The funding enabled us to do work we would not otherwise have been able to do
16	The funding enabled whānau to stay in paid work
17	The funding enabled whānau to transition to new employment
18	The funding enabled whānau to begin a new business
19	The funding enabled whānau to mitigate the impact of enforced social distancing
20	The funding enabled whānau to mitigate the trauma of domestic violence and family-break ups
21	The funding enabled whānau to manaaki one another while in lockdown
22	The funding enabled whānau to manaaki those who were in isolation
23	The funding enabled whānau to prepare for COVID coming to their whare door-step
24	The funding enabled whānau to get access to services that they had not been able to access before
25	The funding helped keep tamariki and rangatahi in school
26	The funding assisted whānau to perform their kaitiakitanga obligations in spite of the restrictions
27	The funding assisted whānau to keep participating in their Te Ao Māori obligations despite restrictions
28	The funding was easy to apply for
29	The application was easy to fill in
30	The expectations of what we would do with the funding were clear
31	The reporting was easy to do

Eigenvalues, % Explained Variance, Cumulative % Variance, Humphrey's Rule and Standard Error for the eight significant narratives in the uptake and resiliency sort.

	Narrative 1	Narrative 2	Narrative 3	Narrative 4	Narrative 5	Narrative 6	Narrative 7	Narrative 8
Eigenvalues	11.69859	3.77516	2.57323	2.3251	2.19578	1.64225	1.47561	1.37745
% Explained Variance	33	11	7	7	6	5	4	4
Cumulative % Expln Var	33	44	52	58	64	69	73	77
Humphrey's Rule	0.68756	0.3652	0.34957	0.19428	0.29149	0.27389	0.23735	0.2147
Standard Error	0.16903	0.16903	0.16903	0.16903	0.16903	0.16903	0.16903	0.16903

Explanations:

Eigenvalues are a measure of the statistical significance of each factor. Any value over 1 is said to be worth exploring, but that is the start of the interpretation not the end (McKeown & Dan, 1988). Any factor with an eigenvalue less than one actually accounts for less variance than a single sort (Stenner & Watts, 2012).

Explained variance: The percentage of the sorts that each factor explains.

Cumulative explained variance: The cumulative percentage of the sorts that the combined factors to that point explain.

Humphrey's rule: This suggests that in Q-method, factors should be retained only if the cross-product of the two highest factor loadings exceeds twice the standard error. The software that produced this table automatically determines the cross-product of the two highest factor loadings for each factor, which is displayed in the row named Humphrey's Rule. One can see only the first three sorts meet this rule, which is one of the reasons we did not explore all eight.

Standard error: Is one divided by the square root of the number of participants.

Collaboration sort

Statements used in the collaboration sort

Number	Statements
1	The collaboration in the MCCF was more like a cooperation
2	The collaboration in the MCCF was more like coordination
3	The collaboration in the MCCF was more like service integration
4	The collaboration in the MCCF was a true collaboration
5	We had a shared context
6	We had a shared mission
7	We understood one another's unique institutional skills, resources, expertise and knowledge
8	We understood one another's tikanga and kawa
9	We had the same level of motivation and commitment
10	The governance arrangements assisted us
11	The governance arrangements encouraged us to provide free and frank advice
12	The clarity of decision-making rights assisted delivery
13	The right decision-makers were at the table
14	In our own agency, we understood who was accountable, for what and when
15	In our colleague agencies, we understood who was accountable, for what and when
16	We actively managed the power imbalances

17	We had an active flow of information
18	We had a shared view of engagement and communication with providers
19	We created time to listen to one another, brainstorm and ensure we critically examined one another's work
20	We actively sought feedback from providers
21	We actively considered how to build trust with one another
22	We actively considered how to build trust with providers
23	We harnessed the potential of information technology to assist us

Eigenvalues, % Explained Variance, Cumulative % Variance, Humphrey's Rule and Standard Error for the eight significant narratives in the collaboration sort

	Narrative 1	Narrative 2	Narrative 3	Narrative 4	Narrative 5	Narrative 6	Narrative 7	Narrative 8
Eigenvalues	4.8500	3.36035	3.15978	2.25643	1.68934	1.3909	1.16926	1.13531
% Explained Variance	20	14	13	9	7	6	5	5
Cumulative % Expln Var	20	34	47	57	64	70	74	79
Humphrey's Rule	0.53224	0.51663	0.45352	0.42848	0.26269	0.24946	0.21036	0.24959
Standard Error	0.20412	0.20412	0.20412	0.20412	0.20412	0.20412	0.20412	0.20412

Explanations:

Eigenvalues are a measure of the statistical significance of each factor. Any value over 1 is said to be worth exploring, but that is the start of the interpretation not the end (McKeown & Dan, 1988). Any factor with an eigenvalue less than one actually accounts for less variance than a single sort (Stenner & Watts, 2012).

Explained variance: The percentage of the sorts that each factor explains.

Cumulative explained variance: The cumulative percentage of the sorts that the combined factors to that point explain.

Humphrey's rule: This suggests that in Q-method, factors should be retained only if the cross-product of the two highest factor loadings exceeds twice the standard error. The software that produced this table automatically determines the cross-product of the two highest factor loadings for each factor, which is displayed in the row named Humphrey's Rule. One can see only the first three sorts meet this rule, which is one of the reasons we did not explore all eight.

Standard error: Is one divided by the square root of the number of participants.

APPENDIX FOUR: REFERENCES

Ahuriri-Driscoll, A., Lovell, S., Te Kawa, D., & Mathias, K. (2022). The future of Māori health is here – The 2022 Aotearoa New Zealand health reforms. The Lancet Regional Health – Western Pacific, 28.

Alberts, K. S., & Ankenmann, B. (2001). Simulating Pearson's and Spearman's correlations in Q-sorts using Excel: A simulation proof of a widely believed result. Social science computer review, 19(2), 221-226.

Ansell, C., & Bartenberger, M. (2019). Pragmatism and political crisis management: Principle and practical rationality during the financial crisis. Edward Elgar Publishing.

Ansell, C., & Gash, A. (2008). Collaborative governance in theory and practice. Journal of public administration research and theory, 18(4), 543-571.

Anglemyer, A., Grey, C., Tukuitonga, C., Sporle, A., & Sonder, G. J. (2022). Assessment of ethnic inequities and subpopulation estimates in COVID-19 vaccination in New Zealand. JAMA Network Open, 5(6).

Aoake, M. (2022). Extraordinary Conditions, Ordinary Realities and a Squandered Opportunity: Māori Social Imaginaries and COVID-19. In Anthropological Forum (Vol. 32, No. 3, pp. 234-252). Routledge.

Arjen, C., & & Lodge, M. (2021). Responding to the COVID-19 crisis: a principled or pragmatist approach? Journal of European Public Policy, 28:8, 1131-115Baker, M. G., Kvalsvig, A., Crengle, S., Harwood, M., Tukuitonga, C., Betty, B., Bonning, J., & Wilson, N. (2021). The next phase in Aotearoa New Zealand's COVID-19 response: a tight suppression strategy may be the best option. The New Zealand Medical Journal (Online), 134(1546), 8-16.

Baker, M. G., Kvalsvig, A., Verrall, A. J., & Wellington, N. (2020). New Zealand's COVID-19 elimination strategy. Med J Aust, 213(5), 198-200.

Baker, M. G., Wilson, N., & Anglemyer, A. (2020). Successful elimination of COVID-19 transmission in New Zealand. New England journal of medicine, 383(8), e56.

Banasick, S. (2019). KADE: A desktop application for Q methodology. Journal of Open Source Software, 4(36), 1360.

Boulton, A. & Te Kawa, D. (2020). Waka not just yachts, Ten Perspectives: Possible futures for public and community services, pp 12-16. New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi, Wellington, New Zealand.

Boulton, A., Devine, T., McMennamin, K., & Walsh-Tapiata, W. (2022). Te Ranga Tupua: An Iwi (Tribal) Response to COVID-19 in Aotearoa New Zealand. International Journal of Indigenous Health, 17(1).

Brown, S. R. (1980). Political subjectivity: Applications of Q methodology in political science. Yale University Press.

Cabinet. (2021). [21 October Press Release]. New fund to accelerate Māori vaccinations https://www.beehive.govt.nz/release/new-fund-accelerate-m%C4%81ori-vaccinations.

Came, H., Kidd, J., McCreanor, T., Baker, M., & Simpson, T. (2021). The Simpson-led health sector review: A failure to uphold te Tiriti o Waitangi. The New Zealand Medical Journal (Online), 134(1532), 77-6.

Came, H., McCreanor, T., Doole, C., & Rawson, E. (2016). The New Zealand health strategy 2016: whither health equity?. The New Zealand Medical Journal (Online), 129(1447), 72.

Cassim, S., & Keelan, T. J. (2022). A review of localised Māori community responses to COVID-19 lockdowns in Aotearoa New Zealand. AlterNative: An International Journal of Indigenous Peoples, 11771801221124428.

Cassim, S., & Keelan, T. J. (2022). A review of localised Māori community responses to COVID-19 lockdowns in Aotearoa New Zealand. AlterNative: An International Journal of Indigenous Peoples.

Clark, T. C., Best, O., Bourque Bearskin, M. L., Wilson, D., Power, T., Phillips-Beck, W., Graham, N.K., Wilkie, M., Lowe, J., Waipo, C., H., & Brockie, T. (2021). COVID-19 among Indigenous communities: Case studies on Indigenous nursing responses in Australia, Canada, New Zealand, and the United States. Nursing Praxis in Aotearoa New Zealand, 37(3).

Cram, F. (2021). Mahi aroha: Māori work in times of trouble and disaster as an expression of a love for the people. Kōtuitui: New Zealand journal of social sciences online, 16(2), 356-370.

Curtis, E., Harwood, M., Riddell, T., Robson, B., Harris, R., Mills, C., & Reid, P. (2010). Access and society as determinants of ischaemic heart disease in indigenous populations. Heart, Lung and Circulation, 19(5-6), 316-324.

Department of the Prime Minister and Cabinet (2021a) 14 May 2021 DPMC-2020/21-956 Health Reform: Strategy and Approach to Legislation, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021b) 20 May 2021 DPMC-2020/21-986 Health Reforms: Implementation and Transition Cabinet Paper, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021c) 01 Jun 2021 DPMC-2020/21-1046 Health Reforms: Planning and Accountability Framework, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021d) 04 Jun 2021 DPMC-2020/21-1063 Health Reforms: Implementation of a Consumer Voice Framework, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021e) 23 Jun 2021 DPMC-2020/21-1161 Health Reforms: Legislation Cabinet Paper Summary and Talking Points, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021f) 25 Jun 2021 DPMC-2020/21-1173 Health Reform: Legislation and Transition Update, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021g) 29 Jun 2021 DPMC-2020/21-1191 Health Reforms: Legislating for Public Health Structures, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021h) 29 Jul 2021 DPMC-2021/22-60 Health Reforms: Legislating Intervention Powers and Obligations Relating to Health New Zealand, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021i) 13 Aug 2021 DPMC-2021/22-149 Health Reforms: Final Decisions for Legislation, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021j) 16 Aug 2021 DPMC-2021/22-177 Health Reforms: Implementation Cabinet Paper Summary and Talking Points, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021k) 19 Aug 2021 DPMC-2021/22-192 Confirming Hauora Māori System Settings, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021l) 19 Aug 2021 DPMC-2021/22-196 Health Reforms: Employment Relations Settings, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021m) 25 Aug 2021 DPMC-2021/22-223 Further Policy Decisions for the Health Reform Bill: Cabinet Paper Summary and Talking Points, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021n) 27 Aug 2021 DPMC-2021/22-234 Health Reforms: Development of the NZ Health Charter and Associated Legislative Provisions, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021o) 02 Sep 2021 DPMC-2021/22-263 Health Reforms: Independent Alcohol Advice and Research Function and Levy, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021q) 10 Sep 2021 DPMC 2021/22-308 Joint Te Kawa Mataaho/ Health Transition Unit Report: Māori Health Authority – Proposed Application of Crown Entities Act 2004 and Public Service Act 2020, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021r) 21 Sep 2021 DPMC-2021/22-389 Health Reforms: Draft Cabinet Paper to Approve Bill for Introduction and Health System Principles, Wellington, New Zealand.

Department of the Prime Minister and Cabinet (2021s) 15 Oct 2021 DPMC-2021/22-588 Pae Ora (Healthy Futures) Bill: Approval for Introduction at Cabinet, Wellington, New Zealand.

Department of the Prime Minister and Cabinet, (2021p) 10 Sep 2021 DPMC-2021/22-307 Health Reforms: Remaining Transitional and Consequential Provisions for Decision, Wellington, New Zealand.

Eppel, E., & O'Leary, R. (2021). Retrofitting collaboration into the new public management: Evidence from New Zealand. Cambridge University Press.

Forsyth, H., & Kung, N. (2007). Ata: A philosophy for relational teaching. New Zealand Journal of Educational Studies, 42(1/2), 5-15.

Grout, L., Gottfreðsson, M., Kvalsvig, A., Baker, M. G., Wilson, N., & Summers, J. (2023). Comparing COVID-19 pandemic health responses in two high-income island nations: Iceland and New Zealand. Scandinavian Journal of Public Health.

Health Quality & Safety Commission New Zealand. (2021) A window on quality 2021: COVID-19 and impacts on our broader health system – Part 1 | He tirohanga kounga 2021: me ngā pānga ki te pūnaha hauora whānui – Wāhanga 1. Wellington, New Zealand.

Health Quality & Safety Commission New Zealand. (2022) A window on quality 2021: COVID-19 and impacts on our broader health system – Part 2 | He tirohanga kounga 2022: Me ngā pānga ki te pūnaha hauora whānui - Wāhanga 2. Wellington, New Zealand.

Henare, P. (2021, October 21a) Introduction of the Pae Ora (Healthy Futures) Bill — First Reading. https://www.parliament.nz/en/pb/hansard-debates/rhr/combined/HansDeb_20211027_20211027_28.

Henare, P. (2022, June 22b) Pae Ora (Healthy Futures) Bill — Third Reading https://www.parliament.nz/en/pb/hansard-debates/rhr/combined/HansDeb_20220607_20220607_28.

Humpage, L. (2019). Innovation and improved social outcomes?:'Payment for outcomes' in social services in New Zealand. New Zealand Sociology, 34(2), 149-174.

James, A., Hendy, S. C., Plank, M. J., & Steyn, N. (2020). Suppression and mitigation strategies for control of COVID-19 in New Zealand. MedRxiv, 2020-03.

Jansen, P., Bacal, K., & Buetow, S. (2011). A comparison of Māori and non-Māori experiences of general practice. The New Zealand Medical Journal (Online), 124(1330).

Jones, B., King, P. T., Baker, G., & Ingham, T. (2020). COVID-19, intersectionality, and health equity for indigenous peoples with lived experience of disability. American Indian Culture and Research Journal, 44(2), 71-88.

Koziol-McLain, J., Cowley, C., Nayar, S., & Koti, D. (2023). Impact of COVID-19 on the health response to family violence in Aotearoa New Zealand: a qualitative study. INQUIRY: The Journal of Health Care Organization, Provision, and Financing, 60, 00469580221146832.

Lee, P. R., Estes, C. L., & Rodriguez, F. M. (Eds.). (2003). The nation's health. Jones & Bartlett Learning.

Lilley, R., de Graaf, B., Kool, B., Davie, G., Reid, P., Dicker, B., Civil, I., Ameratunga, S., & Branas, C. (2019). Geographical and population disparities in timely access to prehospital and advanced level emergency care in New Zealand: a cross-sectional study. BMJ open, 9(7).

Lipsham, M. J. H. (2012). Ata as an innovative method and practice tool in supervision. Aotearoa New Zealand Social Work, 24(3/4), 31-40.

Little, A. (2021, 21 October). Introduction of the Pae Ora (Healthy Futures) Bill — First Reading. https://www.parliament.nz/en/pb/hansard-debates/rhr/combined/HansDeb_20211027_20211027_28.

Little, A. (2022a, 22 June) Pae Ora (Healthy Futures) Bill — Third Reading https://www.parliament.nz/en/pb/hansard-debates/rhr/combined/HansDeb_20220607_20220607_28.

Little, A. (2022b, 1 July) Health Minister Andrew Little's address to first joint meeting of the boards of Te Whatu Ora - Health New Zealand and Te Aka Whai Ora - the Māori Health Authority, https://www.beehive.govt.nz/speech/health-minister-andrew-littles-address-first-joint-meeting-boards-te-whatu-ora-health-new.

Marek, L., Hobbs, M., McCarthy, J., Wiki, J., Tomintz, M., Campbell, M., & Kingham, S. (2020). Investigating spatial variation and change (2006–2017) in childhood immunisation coverage in New Zealand. Social Science & Medicine, 264, 113292.

Maynard-Moody, S., & Musheno, M. (2012). Social equities and inequities in practice: Street-Level workers as agents and pragmatists. Public administration review, 72(s1), S16-S23.

Mazey, S., & Richardson, J. (2020). Lesson-drawing from New Zealand and COVID-19: The need for anticipatory policy making. The Political Quarterly, 91(3), 561-570.

McKeown, B., & Thomas, D. (1988). Q Methodology, Newburg Park.

McLeod, M., Gurney, J., Harris, R., Cormack, D., & King, P. (2020). COVID-19: we must not forget about Indigenous health and equity. Australian and New Zealand journal of public health, 44(4), 253.

McMeeking, S., & Savage, C. (2020). Māori responses to COVID-19. Policy Quarterly, 16(3).

McMeeking, S., Leahy, H., & Savage, C. (2020). An Indigenous self-determination social movement response to COVID-19. AlterNative: An International Journal of Indigenous Peoples, 16(4), 395-398.)

Mikahere-Hall, A. (2020). Tūhono Māori: a research study of attachment from an indigenous Māori perspective. Ata: Journal of Psychotherapy Aotearoa New Zealand, 23(2), 61-76.

Ministry of Health. (2020). Health and Disability System Review. 2020. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington, New Zealand.

Mulgan, G., Marsh, O., & Henggeler, A. (2022). Navigating the Crisis: How Governments Used Intelligence for Decision Making During the COVID-19 Pandemic. Available at SSRN 4304021.

Nederhand, J., & Molenveld, A. (2020). Q methodology in public administration: State of the art. Oxford Research Encyclopedia of Politics.

Niemeyer, S., Ercan, S. A., & HartzKarp, J. (2013). Understanding deliberative citizens: The application of Q methodology to deliberation on policy issues. Operant Subjectivity, 36(2).

Ngā Pae o te Māramatanga. (2022) [31 August Webinar] Rationing Māori Life and Well-Being - Who Decides and How https://vimeo.com/45550625

O'Flynn, J. (2007). From new public management to public value: Paradigmatic change and managerial implications. Australian journal of public administration, 66(3), 353-366.

O'Leary, R. (2014). Collaborative governance in New Zealand: Important choices ahead. Wellington, New Zealand: Fulbright New Zealand.

Parker, R. W. (2021). Why America's response to the COVID-19 pandemic failed: lessons from New Zealand's success. Adm Law Rev, 73, 77-103.

Pihama, L., & Lipsham, M. (2020). Noho haumaru: reflecting on Māori approaches to staying safe during COVID-19 in Aotearoa (New Zealand). Journal of Indigenous Social Development, 9(3), 92-101.

Pohatu, T. W. (2013). Āta. Ata: Journal of Psychotherapy Aotearoa New Zealand, 17(1), 13-26.

Prickett, K. C., & Chapple, S. (2021). Trust in government and COVID-19 vaccine hesitancy. Policy Quarterly, 17(3).

Reid, M. J., Paine, S. J., Curtis, E., Jones, R., Anderson, A., Willing, E., & Harwood, M. (2017). Achieving health equity in Aotearoa: strengthening responsiveness to Māori in health research.

Reid, P. (2021). Structural reform or a cultural reform? Moving the health and disability sector to be pro-equity, culturally safe, Tiriti compliant and anti-racist. The New Zealand Medical Journal (Online), 134(1535), 7-10.

Reid, P., & Robson, B. (2000). Understanding health inequities. Hauora: Māori Standards of Health IV. A study of the years, 2005, 3-10.

Reid, P., Cormack, D., & Paine, S. J. (2018). Colonial histories, racism and inequity–the experience of Māori in Aotearoa New Zealand. The European Journal of Public Health, 28.

Reid, P., Paine, S. J., Te Ao, B., Willing, E. J., Wyeth, E., Vaithianathan, R., & Loring, B. (2022). Estimating the economic costs of Indigenous health inequities in New Zealand: a retrospective cohort analysis. BMJ open, 12(10).

Rhodes, R. & Marsh, D. (1992). 'New directions in the study of policy networks', European Journal of Political Research, Vol 21, pp. 181-205.

Rose, R. (1989). Ordinary People in Public Policy: A Behavioural Analysis. Sage Publications. London.

Ryan, B. (1991). 'Towards a Model of Public Sector Marketing' in O'Faircheallaigh, C., Graham, P. & Warburton, J. (Eds) Service Delivery and Public Sector Marketing. Macmillan. Melbourne.

Ryan, B. (1992). 'Monitoring Effectiveness in Selected Social Policy Programs' in C. O'Faircheallaigh and B. Ryan (Eds), Program Evaluation and Performance Monitoring: An Australian Perspective. Macmillan. Melbourne.

Ryan, B. (1996) 'Are Non-Positivist Approaches to Evaluation Replacing Positivist Ones?' paper presented to the AIC Conference, Performance-Driven Evaluation in the Public Sector, Sydney, 19-20 February.

Ryan, B. (2001) 'A Missing Link? Effective Public Management and the Idea of Utilisation', in Essays in Implementation and Service Delivery 1990-93, Victoria University of Wellington.

Ryan, B. (2002a). Managing for Outcomes in the 21st Century: A Discussion Paper. School of Government. Wellington, New Zealand.

Ryan, B. (2002b). Essays on Implementation and Service Delivery 1990-93. School of Government, Wellington. New Zealand.

Ryan, B. (2002c) 'Beyond Intervention Logic? A Public Management Heuristic for the 21st Century', paper presented to the Association for Public Policy Analysis and Management 24th Annual Research Conference, Asking "What if…": Assessing the Public Policy and Management Implications of Social Science Research, Dallas, Texas, November 7-9.

Ryan, B. (2006). Beyond Westminster: thinking the Aotearoa/New Zealand way of governing. Policy Quarterly, 2(3).

Sabatier, P. A. (1986). Top-down and bottom-up approaches to implementation research: a critical analysis and suggested synthesis. Journal of public policy, 6(1), 21-48.

Sabatier, P. A. (1987). Knowledge, policy-oriented learning, and policy change: An advocacy coalition framework. Knowledge, 8(4), 649-692.

Scott, R. J., & Boyd, R. (2015). The New Zealand Better Public Service Results: a comparative analysis linking inter-agency collaboration with outcome performance. In Proceedings of the 2015 Australia and New Zealand Academy of Management Conference. Queenstown, New Zealand: ANZAM.

Selak, V., Crengle, S., Harwood, M., Murton, S., & Crampton, P. (2021). Emergency COVID-19 funding to general practices in early 2020: lessons for future allocation to support equity. The New Zealand Medical Journal (Online), 134(1538), 102-7.

Selden, S., Sowa, J., & Sandfort, J. (2002). The impact of non-profit collaboration in early childcare and education on management and program outcomes. Public Administration Review, 66(3), 412-425.

Sense. (2021a) Report One Labour Market Scarring Advice for Government. Unpublished for Te Putahitanga. Ōtautahi, Te Waipounamu, Aotearoa.

Sense. (2021b) Report Two Measuring Māori Labour Market Regional Intervention Needs: Looking Beyond the HLFS. Unpublished for Te Putahitanga. Ōtautahi, Te Waipounamu, Aotearoa.

Severinsen, C., Ware, F., Came, H., & Murray, L. (2021). COVID-19 and Indigenous knowledge and leadership:(Re) centring public health curricula to address inequities. Australian and New Zealand Journal of Public Health, 45(1), 6.

Sharma, S., Walton, M., & Manning, S. (2021). Social determinants of health influencing the New Zealand COVID-19 response and recovery: a scoping review and causal loop diagram. Systems, 9(3), 52.

Sheed, T., & MacDonald, L. T. A. O. T. (2017). The diverse stories of Māori political agency: a Q method study. Political Science, 69(3), 214-226.

Simpson, H., & Roche, B. (2020). Report of Advisory Committee to Oversee the Implementation of the New Zealand COVID-19 Surveillance Plan and Testing Strategy.

Stanley, E., & Bradley, T. (2021). Rethinking policing in Aotearoa New Zealand: decolonising lessons from the COVID-19 pandemic. Current Issues in Criminal Justice, 33(1), 131-137.

Stephenson, W. (1953). The study of behavior; Q-technique and its methodology. University of Chicago Press, Chicago.

Steyn, N., Binny, R. N., Hannah, K., Hendy, S. C., James, A., Lustig, Ridings, K, Plank, M. J., & Sporle, A. (2020). Māori and Pacific People in New Zealand have higher risk of hospitalisation for COVID-19. medRxiv, 2020-12.

Summers, J., Cheng, H. Y., Lin, H. H., Barnard, L. T., Kvalsvig, A., Wilson, N., & Baker, M. G. (2020). Potential lessons from the Taiwan and New Zealand health responses to the COVID-19 pandemic. The Lancet Regional Health-Western Pacific, 4, 100044.

Te Kawa, D.M. (2020) Performance Improvement Framework System Findings [15 March 2020 Webinar IPANZ/VUW] Wellington, New Zealand..

Te Rōpū Whakakaupapa Urutā. (2020a). [30 March Press Release]. Flu Vaccinations: Information for Health Provider. https://www.uruta.maori.nz/flu-vaccinations-information-for-he.

Te Rōpū Whakakaupapa Urutā. (2020b). [13 April Press Release]. Position Statement - Te Rōpū Whakakaupapa Urutā Policy. https://www.uruta.maori.nz/policy.

Te Rōpū Whakakaupapa Urutā. (2020c). [4 June Webinar]. Kōrero with Professor Dr Papaarangi Reid Co-leader, Te Rōpū Whakakaupapa Urutā. https://vimeo.com/425780665.

Te Rōpū Whakakaupapa Urutā. (2020d). [4 June Webinar]. Kōrero with Dr Rawiri Jansen, Co-leader, Te Rōpū Whakakaupapa Urutā. https://vimeo.com/425782931.

Te Rōpū Whakakaupapa Urutā. (2020e). [4 June Webinar]. Kōrero with Professor Dr David Tipene-Leach. https://vimeo.com/425777165.

Te Rōpū Whakakaupapa Urutā. (2021a). [4 June Online Interview]. Dr. Rāwiri McKree Jansen perspective on RSV and its impact on Māori. https://www.facebook.com/watch/?v=916337558953226

Te Rōpū Whakakaupapa Urutā. (2021b). [19 August Press Release]. Unvaccinated Māori and Pasifika must be prioritised to receive their first COVID-19 vaccination. https://www.uruta.maori.nz/unvaccinated-m%C4%81ori-and-pasifika-must-be-prioritised.

Te Rōpū Whakakaupapa Urutā. (2021c). [20 August Online Interview]. Pae Ohu Rata Aotearoa, Te ORA Māori Medical Practitioners Association supports Te Rōpū Whakakaupapa Urutā in prioritising Māori, https://www.facebook.com/watch/live/?ref=watch_permalink&v=527578825137939

Te Rōpū Whakakaupapa Urutā. (2021d). [20 August Online Interview]. Professor Paparangi Reid talks to Claudette Hauiti about priority vaccination of Māori. https://www.facebook.com/watch/live/?ref=watch_permalink&v=523505895414459.

Te Rōpū Whakakaupapa Urutā. (2021e). [20 September Press Release]. Government challenged to walk their equity talk. https://www.uruta.maori.nz/government-to-walk-their-equity-talk.

Thaker, J. (2021). The persistence of vaccine hesitancy: COVID-19 vaccination intention in New Zealand. Journal of Health Communication, 26(2), 104-111.

Thaker, J., & Ganchoudhuri, S. (2021). The role of attitudes, norms, and efficacy on shifting COVID-19 vaccine intentions: a longitudinal study of COVID-19 vaccination intentions in New Zealand. Vaccines, 9(10), 1132.

Tukuitonga, C. (2022). Learning the lessons from COVID-19. Pacific Health Dialog, 21(10).

Ramlo, S. (2022). Mixed Methods Research and Quantum Theory: Q Methodology as an Exemplar for Complementarity. Journal of Mixed Methods Research, 16(2), 226-241

Ussher, C., & Kibblewhite, A. (2001) Outcome-Focused Management in New Zealand: A Background Paper. Treasury Working Paper 01/05. Wellington, New Zealand.

van Eeten, M. J. (2001). Recasting intractable policy issues: the wider implications of the Netherlands civil aviation controversy. Journal of Policy Analysis and Management: The Journal of the Association for Public Policy Analysis and Management, 20(3), 391-414.

Waitangi Tribunal. (2021) Haumaru: The COVID-19 Priority Report, Wellington, New Zealand.

Waitoki, W., & McLachlan, A. (2022). Indigenous Māori responses to COVID-19: He waka eke noa?. International Journal of Psychology, 57(5), 567-576.

Watts, S., & Stenner, P. (2012). Doing Q methodological research. Theory, method and interpretation, 2012.

Williams, P. (2013). We are all boundary spanners now?. International Journal of Public Sector Management, 26(1), 17-32.

Wiki J, Marek L, Hobbs M, Kingham S, Campbell M. Understanding vulnerability to COVID-19 in New Zealand: a nationwide cross-sectional study. Journal of the Royal Society of New Zealand. 2021; 51:S179-S96.

White, N. D., & Grimm, H. (2022). Vaccine Equity: Lessons Learned from the COVID-19 Pandemic. American Journal of Lifestyle Medicine, 16(4), 443-446.

Whitehead, J., Carr, P. A., Scott, N., & Lawrenson, R. (2021b). Spatial inequity in distribution of COVID-19 vaccination services in Aotearoa. medRxiv, 2021-08.

Whitehead, J., Scott, N., Atatoa-Carr, P., & Lawrenson, R. (2021a). Will access to COVID-19 vaccine in Aotearoa be equitable for priority populations? New Zealand Medical Journal, Vol 134 No 1535.

Zabala, A., & Pascual. N. (2016). Bootstrapping Q Methodology to Improve the Understanding of Human Perspectives. PLoS One 11: e0148087

APPENDIX FIVE: RESEARCH TEAM

Deborah Te Kawa (Ngāti Porou, Whānau o Hineatua raua ko Whānau O Haenga)

Bachelor of Arts (Victoria University of Wellington)

Diploma in Gender Mainstreaming Global Institutions (United Nations University, Amman, Jordan)

Post Graduate Diploma – Information Management (Victoria University of Wellington)

Post Graduate Diploma – Systems Thinking (Cornell, Ithaca, New York)

Master of Public Management (Victoria University of Wellington)

Prime Minister's Prize in Public Management (Victoria University of Wellington)

Doctoral Candidate (University of Canterbury)

Deb is an internationally experienced former senior public servant. She brings extensive knowledge and understanding of politics, public management, governance and indigenous public policy to her consultancy with public, private and community organisations and iwi across Ahitereiria and Aotearoa. Her recent work includes advice for a large public service department on the fitness of its appointment and governance support to its various Crown entities, statutory bodies and Crown-owned companies. She also provided machinery of government advice and governance assistance to the reform of the NZ Government's health system, including the establishment of Te Aka Whai Ora and Te Whatu Ora. She is currently working on enabling faster research uptake into public policy practice and assisting the Treasury as a business case reviewer.

Previously, Deb played a crucial role in designing and implementing the Performance Improvement Framework (PIF). As a public policy advisor she is skilled at using complex policy frameworks, including Te Tiriti, gender implications and equity. Her expertise was recognised in 2013 when she was awarded the Prime Minister's Prize in Public Management for post-graduate work examining contemporary governance and integrity issues in the New Zealand public sector.

Deb brings a strong academic foundation to her consultancy. She is a PhD candidate at the University of Canterbury. She works with peers and students on both sides of the Tasman and internationally. She is also an accredited Board and Company Secretary with a number of current board appointments, including the Institute of Public Administration of New Zealand and the Chair of Molesworth Holdings Limited. Deb is also an active member of the American Society for Public Administration and the Governance Institute of Australia. Her other memberships include the International Research Society for Public Management, New Zealand Institute of Directors, and New Zealand Political Studies Association / Te Kāhui Tātai Tōrangapū o Aotearoa.

Dr Lindsey MacDonald (Kai Tahu, Ngāi Tūāhuriri)

Bachelor of Arts (Honours) (University of Canterbury)

Master of Arts (University of Canterbury)

Doctor of Philosophy (University of Canterbury)

Lindsey MacDonald defended his PhD thesis ‘a political philosophy of property rights’ in December 2008 and then joined the Department of Political Science at the University of Canterbury, New Zealand. Lindsey had previously lectured for the indigenous studies programme at Canterbury (2003-2007), and the political science programme at Auckland University (2003). Before returning to University, Lindsey worked at Te Puni Kōkiri (Ministry of Māori Development) 1996-1997, and at the State Services Commission between 1998-2001. He is the registered contact for the Wai 2237 claim on contemporary disparities in Māori Health as part of the WAI 2575 Inquiry. He was chair of the University of Canterbury Human Ethics Committee (2013-2016) and has recently returned to the committee as its Māori co-chair, and is co-chair of the Aotearoa Research Ethics Trust which provides a committee to review ethics applications from those researchers in New Zealand unable to access institutional ethics committees.