NGĀTI HINE HEALTH TRUST

MEASLES PROVIDER PLAYBOOK

Based on Delivery and Learnings from the September 2025 Te Tai Tokerau Measles Response

Contents

Introduction

This Playbook provides ourselves and other health providers with practical guidance to manage a safe, whānau-centric and effective measles outbreak response, grounded in our learnings from Ngāti Hine Health Trust's response to the September 2025 measles outbreak.

Kaupapa

This Playbook documents the approach and tools that Ngāti Hine Health Trust (NHHT) adopted in response to the September 2025 measles outbreak, as well as the lessons learned from the response. It is intended to act as both our response plan for future events and also help to inform other health providers to rapidly respond with a whānau-centred, clinically safe, and effective response in their own contexts should they need to.

The Playbook complements (not replaces) national standards, clinical guidance, and emergency management arrangements. Providers should align with current Health New Zealand | Te Whatu Ora and National Public Health Service (NPHS) guidance.

While providing an overview of NHHT's measles response, the Playbook is designed to be adapted to local organisational, workforce, and community realities. The intent is through our own experience strengthen preparedness, increase speed to action, and support close coordination between ourselves, Māori and non-Māori providers and their public health and social sector partners.

Finally, this Playbook is not intended to be an end-to-end guidance or replace public health advice. It is intended as a record of what we tried, what worked, and what we would change next time, to ensure that we capture these learnings ourselves and following extensive requests from other providers written in a form to support them should they find themselves in the same position.

Through a series of wānanga, we have reflected on our mahi and gathered kōrero from the whānau we supported. Their voices have been central - guiding our learning, shaping this document, and ensuring our response upheld manaakitanga and placed whānau at the heart of everything we did. This approach reflects our values of whanaungatanga connection and collective strength and kotahitanga working together with one purpose to protect and uplift our people.

Ngā Mātāpono | Our Values

NHHT's response was underpinned by tikanga and our mātāpono: Manaakitanga, Whanaungatanga, Kotahitanga, Pukepuke Rau, Mana Motuhake, and Te Reo o Ngāti Hine. These values shaped how we made decisions at pace, how we welcomed and supported whānau, and how we worked alongside partners. The brief descriptions below show how each mātāpono came to life in this response, for others to adapt to their own context.

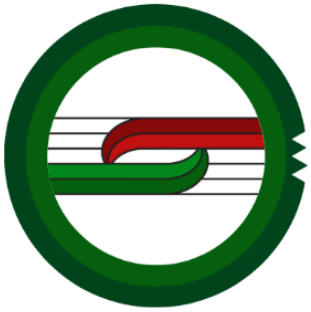
MANAAKITANGA
EMPOWERING WHĀNAU VOICE

WHANAUNGATANGA
KINSHIP & RELATIONSHIPS

KOTAHITANGA
UNITY OF PURPOSE

Taking the time to engage with whānau and using every interaction as an opportunity to show care	Using relationships to support the response, and the response to strengthen relationships	Coordinating with Te Whatu Ora, MSD and partner agencies and the community to achieve shared success

PUKEPUKE RAU
DIVERSE LEADERSHIP



MANA MOTUHAKE
INTER-DEPENDENT WHĀNAU

TE REO O NGĀTI HINE
OUR LANGUAGE, OUR VOICE

Recognising and leveraging the flexibility, commitment, and diverse skills of all our kaimahi	Enabling households to lead care, with us alongside to provide comfort and confidence	Familiar faces, speaking in our own voice, across a range of media channels and kanohi-ki-te-kanohi

Context

Measles is a highly contagious and potentially life-threating viral illness spread through airborne droplets. Without timely isolation and high immunisation rates, it can move swiftly through whānau and hapori, causing harm and placing significant pressure on the health system.

Our Rohe and the wider Te Tai Tokerau region has the lowest MMR (Measles, Mumps, Rubella) immunisation rates in the country, and past experience has shown that Māori and Pacific communities are disproportionately impacted by measles outbreaks[1]. This means that the consequences of a measles outbreak in Te Tai Tokerau could be significant

The National Public Health Service (NPHS) which is part of Te Whatu Ora | Health New Zealand is the lead agency responsible for managing measles cases and outbreaks. Measles is a notifiable disease. They undertake case investigation and confirmation, contact tracing, isolation guidance, and exposure notifications.

As a hauora provider, Ngāti Hine Health Trust holds a range of contracts to deliver primary care services, community health services, and immunisations. Our contribution to the measles response, alongside other providers in our rohe, included:

- delivering vaccinations
- providing clinical care and manaaki to affected whānau
- community connection and intelligence
- Public communications by working closely with NPHS to ensure consistent public health messaging
- delivering local messaging through trusted community channels including iwi radio, social media, and word-of-mouth networks to keep our kōrero aligned while ensuring it was heard in a voice our community recognises and trusts.

When measles cases were confirmed in the Bay of Islands in September 2025, NHHT was well placed to support the response. In addition to strong and trusted relationships within the impacted communities, NHHT services include fixed primary care clinics in Whangārei, Kawakawa, and Moerewa, a mobile Van GP backed service, a range of existing mobile/outreach services to the community, and an affiliated radio station (Ngāti Hine FM), all of which were used to support the measles response.

The first case within the region was confirmed on 25 September, with an Incident Management Team (IMT) activated by Te Whatu Ora the following day. By 27 September, weekend vaccination clinics had been stood up, including at fixed sites operated by

[1] Te Whatu Ora: https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/communicable-disease-control-manual/measles

NHHT. These were shortly followed by mobile and outreach vaccination clinics delivered by a range of health providers, with NHHT also taking a lead role in providing in-home clinical care to confirmed measles cases within its rohe.

At the time of writing the outbreak in Te Tai Tokerau has been contained, with the national IMT stood down on 15 October. In total, there were 12 confirmed cases within the region. Five of these cases (including one paediatric case) received direct clinical case management from NHHT. Throughout the three-week response period, NHHT administered a total of 185 MMR vaccines, contributing to a 239% increase in MMR uptake across Te Tai Tokerau compared to previous weeks.

Key Resources

This Playbook is not intended to be an exhaustive or authoritative guide to measles management. Providers should refer to the latest national standards, clinical guidance, and other official sources for the most up-to-date information when responding to an outbreak. Some of the key resources we found useful are listed below:

- Immunisation Handbook (Ch. 12)
  https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/immunisation-handbook/12-measles

- Communicable Disease Control Manual
  https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/communicable-disease-control-manual/measles

- HealthEd Public Health Resources
  https://healthed.govt.nz/collections/topic-measles

- IMAC Measles Resources
  https://www.immune.org.nz/factsheets/measles-resources-quick-access

- Healthify | He Puna Waiora Resources
  https://healthify.nz/health-a-z/m/measles

How this Playbook is Organised

Five response domains

This Playbook is structured around five domains:

- **Public Health Risk Mitigation**: Alignment and coordination with NPHS and other key stakeholders to support the public health response, this could include supporting contract tracing or providing local community intelligence.
- **Vaccination Response**: Rapid scale-up of vaccination capacity across a range of service models and demand generation activities.
- **Measles Case Management**: Clinical assessment and in-home care model, including daily monitoring and escalation/hospital liaison.
- **Wraparound Support for positive Cases**: Whānau-centred welfare via consistent contact points, cross-agency partnership and practical care packs.
- **Health Promotion & Communications**: Coordinated public campaign, featuring culturally resonant messaging, across multiple media channels.

Within each domain we have identified key messages, provided an overview of how to respond incorporating our learnings, and developed a checklist of actions to consider and adapt for future responses.

Phased actions in every domain

Checklists have been developed with actions identified across four successive phases.

1. **Preparation**: Baseline activities to complete **before** an outbreak (readiness, relationships, templates, training).
2. **Immediate Response (First 48 hours)**: Activate governance, stand up minimum safe services, communicate your offering early.
3. **Scale-Up (Day 3-5)**: Build capacity and reach (workforce, sites, outreach cadence, operational rhythms) while protecting BAU.
4. **Stabilise & Optimise (Day 6+)**: Sustain safe operations, tighten quality, target gaps, and transition to steady-state monitoring.

While these phases outline an indicative order of priorities, in practice they may overlap and will need to be adapted to the specific context of each response. This playbook is based on the assumption of a short, contained outbreak; however, we believe the model is scalable and can be sustained or expanded should case numbers increase or the response need to continue over a longer period.

Domain 1: Public Health Risk Mitigation

Key Messages

- Early, regular, and transparent communication with NPHS and other partners supports speed and reduces risk of service duplication.
- Provider-led, clinically framed collaboration with public health moves faster than waiting to be tasked; name your model and capacity early.
- Timely and precise data is a key enabler to enable culturally-responsive support to impacted whānau, and targeted vaccination in high-risk areas.
- Move fast, but deliberately: right-size rosters and avoid slipping into "COVID autopilot" that risks unnecessary staff fatigue.

Early, regular, and transparent communication for speed and efficiency

Outbreaks are networked problems. In our experience, getting public health, the local Te Whatu Ora team and key local providers on the same page early helped land decisions faster and clarified roles. Public Health also shared with us daily a short update on what was happening – this enabled us to correct information that was circulating in the community. Daily provider meetings led by Te Whatu Ora kept everyone aligned on "what is happening" and "who is where, doing what". Additionally, a simple group chat with the key internal leads (clinical leads, operational leads, management etc) was created early to triangulate information and intel as we received it. Maintaining direct contact channels between individuals to share information, alongside official updates, helped keep things moving at pace.

Clear communication also facilitated vaccine stock and workforce sharing, while pre-existing or rapidly strengthened relationships with local agencies and iwi networks made referrals for kai, rent or utilities far smoother when households needed it. While we know the importance of regular communication with Te Whatu Ora, a key lesson for us was the importance of clear and timely communications between providers and our own internal team.

Provider-led, clinically framed collaboration moves faster

In the early days of the outbreak, NPHS was juggling a range of urgent and competing priorities. Our recommendation would be for providers to front-foot the relationship with public health, naming your immediate capacity and the support you are able to offer. This could include an in-home clinical model, supporting escalation pathways, and/or social

supports. This approach may help shift the dynamic from “awaiting instructions” to “here’s what we can do to care for our people now.”

We suggest that this relationship is really helpful clinician to clinician - our relationship between our treating clinician and the Medical Officer of Health was critical.

Timely, granular data is a key enabler

As an iwi provider, we know the importance of Māori data sovereignty and that sharing identifiable information is sensitive and context-dependent. In our experience, data served two distinct purposes during the response. The first of these was to enable us to reach whānau who needed clinical support.

Our in-home care model addressed a clinical gap between NPHS case monitoring and primary care providers that weren’t set up for home visits or when patients needed a higher level of care. The confirmed cases weren’t our enrolled patients, and there was a delay in getting clinical care into the home environment. In future responses, the proactive approach to outlining capacity (described in the previous paragraph) may help accelerate this timeline, which would allow support to reach whānau earlier. Clear handover notes, including current symptoms, relevant history/co-morbidities, supports already offered, and any identified welfare needs, can also facilitate continuity of care and are more respectful for whānau.

The second distinct purpose of data within the response was to enable targeted vaccination. The NPHS Immunisation dashboard provided useful SA2-level signals for planning, and we complemented this with more granular SA1/meshblock-level data provided by Te Kāhui Raraunga (see Case Study below) to identify the highest-risk areas for outreach activities. In addition, during the early phase of the outbreak, Te Whatu Ora’s public comms updates (e.g. exposure notices) were being published regularly and were a timely information source alongside direct communication channels.

Move fast, but deliberately. Avoid “COVID autopilot”

Speed matters with measles. When an outbreak is declared, there are some things that we needed to do quickly to reduce transmission and take advantage of the communities immediate desire to access vaccination. For example, we called an NHHT multi-disciplinary team (MDT) meeting immediately upon notification of a confirmed case, to align leadership, assess our response capacity, and agree actions. We stood up telephone triage to screen patients for measles symptoms prior to scheduled appointments (see *Appendix 1* for an example tele-triage script*)* across our services and

agreed a dedicated referral pathway so any possible cases who needed care could enter our clinical space safely without exposing others.

At the same time, we learned not to go "all out" on day one. The health system's COVID muscle memory gave us useful tools and rhythms, but it also risked over-scaling. While the success of our response was due to the commitment and flexibility that our kaimahi demonstrated, right-sizing rosters, determining appropriate medical capacity and response, protecting BAU to the fullest extent possible, and naming the exact roles each setting needed, was also required. This was an act of care for both staff and whānau, as early on it is not possible to predict how long an outbreak may last and how sustained an effort may be required.

Case Study: Data-guided activities

Early in the outbreak, NHHT was contacted by Te Kāhui Raraunga offering access to granular immunisation data to support the outbreak response. As the operational arm of the Data Iwi Leaders Group, Te Kāhui Raraunga has a data-sharing agreement with Te Whatu Ora that enables it to access regularly updated, aggregated health data. It has turned this data into an easy-to-use data platform providing SA2-level immunisation data to the public, and meshblock-level data to iwi that have been onboarded to its system. The data enabled NHHT to identify areas in our community with low MMR immunisation rates and target outreach activities to high-risk areas.

See *Appendix 2* for an example of Te Kāhui Raraunga's publicly available dashboard.

Note: For iwi-affiliated providers, the steps required to access Te Kāhui Raraunga's Hauora Hub with meshblock-level immunisation data are:

1) Contact your Iwi Chair or CEO to confirm if your iwi has already been onboarded to Te Kāhui Raraunga platform.
2) Have your Iwi Chair (or CEO) send a letter to Te Kāhui Raraunga requesting you are given access to the Hauora Hub.
3) Prior to utilisation, agree to the Terms & Conditions ensuring respect for and appropriate use of data.

Checklist: Public Health Risk Mitigation

Phase	Action
Preparation	Draft a one-page Capacity Note summarising the support you could offer in an outbreak for your clinical lead to send to Te Whatu Ora at first notification.
	Build a network and contact list for key stakeholders in the event of an outbreak (NPHS, ED, other Providers)
	Gain access to Te Kāhui Raraunga Hauora Hub for meshblock-level MMR immunisation data (via steps outlined in case study above) *Note: Applicable to iwi-affiliated organisations only*
Immediate Response ***(First 48 hours)***	Call an MDT meeting of key leaders and clinicians across organisation.
	Assess available capacity to support.
	Clinical Lead to contact Medical Officer of Health to advise on support available.
	Share key measles information, precautions and additional processes with all staff.
	Establish regular (daily) meeting cadence to share updates and reminders with staff.
	Adjust rosters as required to support immediate surge activities, while protecting BAU operations and scheduled leave as much as possible.
	Prioritise attendance at IMT meetings to gather latest available information.
	Implement a pre-appointment telephone triage system for primary care clinics.
Scale-Up ***(Day 3-5)***	Establish a routine data feed with NPHS to share your immunisation efforts and case information.
	Build a simple operations board, mapping locations of interest vs. planned presence and review at each MDT meeting.
Stabilise & Optimise ***(Day 6+)***	Plan the handover to steady-state monitoring: reduce meeting cadence, hold the line on right-sizing and adjust staffing mix in line with activities.

Domain 2: Vaccination Response

Key Messages

- "All imms, always": blend fixed, mobile, school/events, and home visits.
- Respectful, low-pressure messaging, from trusted faces can shift hesitancy.
- Workforce is a system asset: pool across providers and consider where commissioning flexibility may unlock reach.
- Plan for the post-early-adopter dip: demand generation becomes the work once capacity is built.

"All imms, always" - blend fixed/mobile sites, and school/home visits

In our experience, a responsive vaccination model wasn't "either/or" it was "and/and". Immediately after measles cases were confirmed, we added weekend hours at our fixed clinics to capitalise on the first awareness wave, and clinic staff called 120 patients who were overdue for measles boosters to raise awareness. In parallel, we extended our mobile and outreach work to kura and into towns with locations of interest. We also maintained a home-visit pathway where this was required (including pēpi/under-3s, whānau with transport limitations etc). When combined with a range of vaccinating sites and options made available by other health providers, this mix helped us meet people where they were while also protecting BAU services.

A key takeaway for us is to maintain "all imms, always" stance beyond the outbreak, with the intention of making all vaccines available wherever we're seeing whānau at all times, so we can sustain the momentum built during the outbreak. This will require a sustained investment in portable cold chain infrastructure.

Respectful, low-pressure engagement from trusted faces. We continue to notice a residual distrust after the COVID-19 vaccine rollout. However, during the early stages of the outbreak of measles we saw some whanau who had been resistant in recent years to vaccination come forward with their whanau to get immunised. It is important that you use the opportunity of measles to have a different conversation with communities and ensure that a non-judgemental approach is undertaken.

The majority of people did not know their MMR vaccination status and therefore messaging about finding out and checking in is important as well.

This meant that some whānau needed time and space before engaging. What seemed to help was kanohi-ki-te-kanohi interaction: door-knocking by health promoters, familiar

kaimahi at clinics and community sites, and mana-enhancing language (often talking about “immunisation” rather than “vaccination”). It is also important to recognise that our patients are often our most influential ambassadors.

We did not offer incentives - instead, we offered clear information, answered pātai, and treated every interaction without judgement, including when whānau chose not to be vaccinated that day. The tone was, “your choice is respected; we’re here whenever you’re ready.” We would combine this with practical approaches people could use to protect themselves so they would still leave the interaction feeling seen and supported.

Workforce is a shared asset

The size of the health workforce is limited everywhere, so considering how to maximise the impact of the local workforce can deliver benefits. In our response, where relationships were strong, partners supported each other within existing arrangements. For example, Plunket provided short-term nursing cover at our Kawakawa clinic so NHHT vaccinators who were well known in the community could focus on mobile and outreach activities.

On the ground, simple things made a difference. The enthusiasm shown by external staff supporting NHHT, and the manaaki our staff showed them, meant teams were collaborating effectively from the start. Additionally, sharing stock and site intel between teams had immediate practical benefits and supported cross-pollination of ideas to carry forward. The takeaway for us is to plan early for practical cross-cover options and open a path to explore temporary arrangements when appropriate.

Plan for the post-early-adopter dip

Following an initial wave of “early adopters”, we saw demand decrease while clinic and outreach capacity remained high. From that point, the job shifted from “stand up services” to generating demand. We shifted from using pre-prepared assets in the early days to more polished content featuring community leaders and used our reach through iwi radio to try to pull the next wave through. Despite these efforts, there were cohorts that remained harder to reach (e.g. 19–24-year-olds) and we saw a steady decrease in demand throughout the outbreak.

Note: Refer to Domain 5 for more information regarding Health Promotion and Communication.

Case Study: Battle of the Aunties

The importance of trusted relationships and familiar faces in encouraging uptake was highlighted by an informal "auntie-to-auntie" competition between three women within NHHT to see who could attract the most MMR recipients over a two hour period. Taking advantage of their respected positions within the local community, they were able to encourage almost 50 vaccinations, which exceeded the total number of MMR vaccines administered per week prior to the outbreak, while also boosting the morale of kaimahi and whānau during the stressful early phases of the response.

Checklist: Vaccination Response

Phase	Action
Preparation	Ensure awareness of vaccination capacity within your staff.
	Consider where additional vaccinator support may be able to drawn from in an outbreak, within your organisation and via partners.
Immediate Response ***(First 48 hours)***	Review vaccine stock on hand across sites.
	Stand up a fixed vaccination site as quickly as safely possible, in coordination with NPHS.
	Proactively contact enrolled patients that are overdue for immunisations and use the outbreak as a reason to have a different conversation.
	Review organisation calendar to ensure that you are acting as a responsible ambassador of the public health situation – e.g. not participating in large scale public events.
	Contact partner agencies to consider resource sharing arrangements to cover gaps and protect BAU.
	Agree locations of initial outreach and mobile clinics and publicise this information as quickly as possible.
Scale-Up ***(Day 3-5)***	Launch mobile vaccination sites at known easy to access venues.
	Deploy door-knocking health promoters around mobile vaccination sites.
	Consider adding in-home vaccination options if resourcing permits.

	Publish a rolling outreach schedule and align workforce/admin support against it.
	Add kura/school clinics where invited / use existing relationships. Pre-notify whānau and manage consent
	Actively monitor throughput vs. capacity to optimise resource allocation.
Stabilise & Optimise ***(Day 6+)***	Review site performance. Consider dropping low-yield locations and double-down on approaches where results are strong.
	Review and right-size rosters. Implement a forward schedule to manage fatigue and protect BAU.

Domain 3: Measles Case Management

Key Messages

- Humanise every interaction: whānau feel stigmatised; being seen and cared for reduces anxiety and avoidable hospital admissions.
- In-home clinical models: daily touchpoints, red flags, worsening symptom advice and pre-agreed ED pathways keep people safe.
- Empower household carers, short but frequent check-ins, and a clear contact point are the backbone of safe isolation.
- Early hospitalisation risk is real (~1 in 3): plan escalation with that baseline in mind.

Humanise every interaction

For some, measles is frightening and isolating, and whānau may feel stigmatised or judged. The foundation of the in-home clinical support NHHT provided was showing whānau that we cared and maintaining regular contact in the home was critical for monitoring and building the relationship. From greeting in a way that recognises mana, using plain language (and te reo where appropriate), and taking time to make people feel seen rather than processed. We found that this tone reduced anxiety, supported adherence to isolation, and prevented avoidable ED presentations. To strengthen whanaungatanga, we also kept the clinicians visiting whānau as consistent as possible throughout the course of the illness.

In-home models keep people safe when they're structured

In consultation with Te Whatu Ora, we developed a structured in-home care model:

- brief tele-triage at first contact
- early home assessment
- simple treatment plan
- daily touchpoints
- clearly written red-flag/escalation pathway

Because measles care is largely symptom management (hydration, fever/itch relief, nausea, asthma flares), we found a nurse/extended care paramedic and GP supported service was sufficient to assess and care for cases and their whānau at home. This may look like a Nurse Practitioner, Nurse Prescriber, Registered Nurse working under standing

orders, or an Extended Care Paramedic (ECP) visiting patients, with GP oversight and support and visits as needed. We also dispensed all medication for our patients and undertook swabbing in the home as needed.

We collaborated with Public Health and the assigned Medical Officer of Health to complete the daily household public health calls on their behalf. During our in-person visits, we gathered the required information for Public Health, then shared it with their team and discussed any updates directly with the Medical Officer. This approach reduced the number of contact points for each household and ensured Public Health received valuable context from our in-home observations while their reporting needs were met.

See *Appendix 3* for a list of the medications, equipment, and PPE that was required to support this approach.

Household carers, short but frequent check-ins, and a clear contact point supported safe isolation. Based on our experience, isolation worked best when we named a primary household carer from Day 1 and equipped them with a short, plain-language plan – they could also call our lead clinician if they had questions or wanted more support. We supported immunised whānau to stay and provide care, then kept confidence up with brief daily in person check-ins (noting that twice daily check-ins may be more appropriate for higher-risk households). In addition to the check-ins, we made sure that whānau understood when and how to seek medical help, particularly around warning signs such as difficulty breathing, dehydration, worsening rash, diarrhoea

We also established a dedicated person they could call for support, which appeared to make a noticeable difference. Questions landed in one place, anxiety dropped, and the likelihood of unnecessary hospital trips was reduced.

Early hospitalisation risk is real. Plan with that in mind

Based on previous outbreaks, in our response we planned as for roughly one in three cases might need hospital-level care[2]. Because of this, our case management approach included clear 'red-flag' thresholds (e.g., dehydration, respiratory compromise, infants, pregnancy, immunocompromise), which we needed to act upon in 3 out of the 5 cases that we managed. Where escalation was necessary, having an ED-liaison plan already agreed made a real difference (see Case Study below).

Case Study: Streamlined admission

Early in the outbreak, NHHT worked with Te Whatu Ora to develop a streamlined process for cases requiring hospital admission. Whānau contacted the hospital using a direct line to the charge nurse on-duty before travelling to the hospital by private vehicle. A nurse met whānau and admitted them directly via the ambulance bay to an isolation room. In our rural context this avoided tying up ambulances for IPC downtime, and we provided fuel vouchers when transport costs may have been a barrier. Two of our patients were admitted to hospital via this process, which ensured that they felt supported while also minimising risk of onwards transmission.

Checklist: Measles Case Management

Phase	Action
Preparation	Maintain a stock of medications, PPE and equipment required in an outbreak.
	Establish connection and build relationship with ED.
Immediate Response ***(First 48 hours)***	Seek endorsement from NPHS to provide in-home care.
	Obtain patient information from NPHS, including relevant medical history and information/resources already provided to whānau.
	Confirm ED liaison contacts and a private entry pathway for any deteriorating cases.
	Establish a single contact phone number for whānau to contact outside of daily touchpoints.

[2] https://www.tewhatuora.govt.nz/for-health-professionals/clinical-guidance/diseases-and-conditions/measles/measles-healthcare-providers-healthcare-settings

	Identify a consistent clinical team per household to support continuity.
	Complete initial triage of known cases. Book home assessments in order of priority (i.e. infants, pregnant, immunocompromised, severe symptoms).
	Conduct first patient visit. Assess symptoms, confirm co-morbidities and provide clear advice on medication/equipment provided.
	Identify a primary carer per household (if possible).
	Provide clear case packs to explain symptom course, isolation expectations, warning signs, and when (and how) to seek.
	Assess risk status of patient(s) to determine optimal frequency of check-ins (i.e. once or twice per day).
Scale-Up ***(Day 3-5)***	Maintain daily check-ins and provide clear guidance on post-isolation.
	Refresh case pack content based on whānau feedback.
Stabilise & Optimise ***(Day 6+)***	Monitor progression of outbreak and assess sustainability of model, signalling early if additional support may be required.
	Conduct a quick review on cases upon completion of isolation period to support continuous improvement.

Note: Actions in the above table are a mix of one-off events (e.g. establishing an ED referral pathway) and individual case management activities that will need to be repeated for each new case that in-home support is provided for.

Domain 4: Wraparound Support for Cases in Isolation

Key Messages

- Identify welfare needs early, and ensure coordinated support through trusted clinical and community networks.
- Clinician-guided, whānau-informed support beats generic hampers: electrolytes, soothing kai, and symptom relief matter more than bulk food.
- Trust and continuity outrank the number of services involved: familiar faces, mana-enhancing interactions and front-line coordination make the difference.

Identify welfare needs early, backed by trusted networks

In our experience, the first contact is the right moment to check practical welfare needs. This included gentle, direct pātai about kai, heating/power, medications, sleeping arrangements, rent, caregiving, and whether the household can safely isolate from a psychosocial point of view. We found it helped to explain why we're asking ("so we can line up the right support quickly") and to offer a plain-language guide to what measles usually feels like (typical order and timing of fever, rash, fatigue, cough/ conjunctivitis), when symptoms might improve, and how to recover safely at home.

Where needs were identified, moving early and in a coordinated way was preferable to multiple agencies contacting whānau. The combination of early, respectful welfare checks, clear expectations about the illness, and coordinated support through familiar relationships seemed to keep isolation safer and less stressful for whānau.

For some of our whānau, the length of isolation meant financial strain became a real concern. With support from our local MSD office, we accessed a discretionary grant that we could draw on to meet urgent needs. This covered rent payments (where sick leave had run out and housing stability was at risk), petrol costs so household carers could travel to hospital, and a few outstanding medical bills that pre-dated our involvement. Kai packs were also funded through this grant to keep cupboards stocked during isolation. In cases where rent support was needed, we worked directly with landlords to ensure payments were made promptly and transparently on behalf of whānau.

Clinician-guided, whānau-informed support beats generic hampers

A key takeaway from our response is that measles care packs needed to be different from those provided during COVID. Not only is the isolation period shorter, but patients may also have poor appetite or discomfort swallowing, especially in the rash/fever phases. That made hydration and soothing, easy-to-take kai the priority.

We also found that isolation support lands best when it is clinically led and personalised. We updated subsequent care packs based on whānau feedback, while continuing to prioritise hydration for patients and support for wider whānau. Ultimately, small but timely drops that match the household's reality are worth more than large, late hampers that miss the point.

See *Appendix 4* for a list of the items that we included or identified to be in our whānau support packs.

Trust and continuity outrank the number of services involved

In our experience, whānau trusted familiar faces and consistent voices more than logos. Mana-enhancing interactions such as greetings, te reo where appropriate, and checking what matters to the whānau before launching into tasks was important, while minimising extra agencies at the door or on the phone reduced stress, repetitive questioning and mixed messages. Having a lead clinician for each case that other people then worked behind worked well.

Operationally, we found that while multiple agencies can provide support, one should lead. In the same way, we found it helpful to nominate a lead clinician per household as the central coordination point. Whānau told us the same kaimahi coming back, or the same voice on the phone, made isolation feel manageable. Continuity felt more important than volume , and trust was established quickly.

A small practical detail that mattered: keep extra PPE on hand for any unavoidable additional visitors (e.g., tradespeople or other agencies) and consider leaving a small stock of PPE with the household for this reason.

Case Study: Measles-specific support packages

When initially preparing support packages for isolating whānau, our knee-jerk reaction was to re-build the packages used to support whānau during Covid. Upon further consideration, we realised that the nature of measles meant different patient needs had to be addressed. For a start, measles symptoms mean that managing is hydration is crucial, so our packs included a lot of fluid related items (water, juice, electrolytes). Given many patients will have difficulty swallowing, soft items like porridge and Weetbix were included, as well as fruit and ingredients that could be put into smoothies. Ice blocks were another key ingredient to soothe sore throats and provide additional hydration. These practical items to support patients were complemented by a range of solid foods to support other whānau within the household.

Refer to Appendix 4 for a list of the items that we included in our whānau support packs.

Checklist: Wraparound Support for Cases in Isolation

Phase	Action
Preparation	Establish connections with government agencies and other partner organisations within your region.
Immediate Response *(First 48 hours)*	Define a lead provider for welfare support to be coordinated through.
	Assemble (or contribute to) measles whānau support packs.
	Contact your local MSD team or other funding agencies to identify any support available.
	Discuss practical welfare needs in initial triage meeting with whānau.
	Deliver first care package as soon as possible following initial triage.
Scale-Up *(Day 3-5)*	Offer recovery follow-ups and social supports once isolation ends.
Stabilise & Optimise *(Day 6+)*	Update support pack content based on whānau feedback and usage patterns.

Domain 5: Health Promotion & Communications

Key Messages

- Be campaign-ready, then pivot to demand: Pre-prepared messages to support initial momentum, followed by tailored content to capture the next wave.
- Clarity beats complexity: simple messaging, that aligns with national and local public health messages.
- Local voices and kanohi-ki-te-kanohi carry, particularly when coupled with culturally resonant messaging.

Be campaign-ready, then pivot to demand

At NHHT we are fortunate to have access to an iwi radio station, a social media presence that is well followed in our community, and media-trained spokespeople. Our initial comms approach involved pushing key messages via Ngāti Hine FM and using simple tiles and repurposed templates to announce vaccination site locations on social media. In hindsight, having more pre-built measles-specific content could have made those first posts stronger when interest was particularly high.

In the first wave of the outbreak, moving quickly to contact people who were overdue for vaccination made a noticeable difference. Our teams focused on getting out of the blocks fast – calling and texting whānau directly from our clinic lists and framing the message in the context of the local measles cases. This early, proactive approach saw an uptake in the first few days, as the presence of a confirmed local case prompted many who were overdue to come in promptly. Acting swiftly and personally at that moment of heightened awareness helped build early momentum for vaccination.

As awareness grew, the work shifted from announcing services to generating demand. We pushed comms across multiple media channels, including social media, iwi radio, mainstream media opportunities (including interviews on breakfast TV and RNZ) as well as through personal networks to amplify key messages. In future outbreaks, we would look to increase our use of interactive social media features, for example Facebook live crosses or posting stories from vaccination sites to promote locations and encourage attendance.

As we moved through the response, we leaned into community-led moments (e.g., “Aunties” events) and partnered with a Māori media organisation on the *Mahi Poto, Oranga Roa* campaign. This high production value campaign took longer to deliver but involved culturally resonant messaging voiced by a range of prominent local people, and helped sustain momentum once the initial surge tapered. While not every provider has

an iwi station or media-trained spokespeople, relationships and confidence can be built ahead of time. In our experience, identifying a couple of comfortable, consistent voices and giving them simple talking points could be enough inform and provide assurance to the community. Local voices, te reo where appropriate, and consistent messaging was key. We found that the term immunisation resonated better than the use of the word vaccination.

Clarity and consistency create adherence

A key test for any comms that we produced was whether it was clear and concise. We found that these attributes were more important to people than detail and complexity. Wherever possible, we would recommend aligning content with Te Whatu Ora/NPHS messaging, so whānau are hearing the same basics everywhere, as measles rules and eligibility can be confusing even for those involved in the response.

Aligning with Te Whatu Ora allowed pre-existing resources to be capitalised on, rather than recreating everything from scratch. It also enabled a two-way information loop. We shared our plans and activities so Te Whatu Ora could include them in press releases where relevant. In return we drew on their bigger-picture numbers and framing for iwi radio and media interviews. That feedback cycle helped us keep messages simple, current, and trusted.

What seemed to help most was plain, stigma-free language on the essentials: vaccination eligibility, symptoms, and isolation. We kept the tone mana-enhancing, used te reo where appropriate, and avoided anything that felt coercive. Internally, having a single source of truth (a short summary document on measles) reduced confusion for staff and the community.

Local voices and face-to-face interactions carry, particularly when coupled with culturally resonant messaging.

In addition to consistent messages, we found that using local voices speaking in local ways was a recipe for success. Simple, culturally resonant lines, like *"Measles is fast, we need to be faster"* and later *Mahi Poto, Oranga Roa (Immunise, Save Lives)* were used. The intention was to give people a reason to act now without feeling pushed. We kept the tone subtle and mana-enhancing and brought te reo into scripts and visuals where appropriate.

Our experience was that broad communications were important for building awareness and accessing whānau that were not vaccine-hesitant, but kanohi-ki-te-kanohi approaches were the ones that changed minds. Health promoters went door-to-door in the area around our mobile clinics. Offering home visits for pēpi/under-3s was also impactful for whānau who preferred care in their own space or had transportation limitations. The combination of familiar messengers, respectful kōrero and practical options often proved more persuasive than volume alone.

Case Study: Mahi Poto, Oranga Roa

In the first week of the outbreak we partnered with a Māori media organisation to develop a bespoke social media campaign under the tagline *Mahi Poto, Oranga Roa* (Immunise, Save Lives). The campaign involved videos and stills featuring community leaders, rangatahi, and NHHT staff delivering a simple, culturally resonant message. Backed by funding provided by Te Whatu Ora, the campaign was publicly launched within two weeks of the first positive case, and supported NHHT to sustain momentum after the initial media interest and vaccination demand had slowed.

Example collateral from this campaign is available in Appendix 5.

Checklist: Health Promotion and Communications

Phase	Action
Preparation	Build a day-0 kit including key measles messages, FAQ responses, and updateable templates for services.
	Identify key spokesperson(s) within your organisation in the event of an outbreak.
	Identify respected figures in your community and seek their in-principle agreement to lend their support in case of an outbreak.
Immediate Response ***(First 48 hours)***	Push initial content across social media, focusing on what people should know/do, and where/when services will be available.
	Access most up-to-date public resources available via Te Whatu Ora to align messaging.
	Respond to any requests for media coverage, prioritising those that are most likely to resonate with your community.
	Consider engagement approach with anti-vax content posted to social media pages (hide, delete or engage).
	Engage community leaders for rapid event support.
	Consider available budget for boosting social media content and developing tailored comms.
	Discuss availability of, and apply for, any potential funding support via Te Whatu Ora for public comms.
Scale-Up ***(Day 3-5)***	Utilise Facebook Live or Stories to promote vaccination sites.
	Mobilise health promoters around mobile vaccination sites.
	Start to develop more polished and bespoke campaigns to support ongoing demand-generation.
	Provide regular updates on today/tomorrow clinic locations.
	Maintain regular contact with Te Whatu Ora to support bi-directional exchange of information.
Stabilise & Optimise ***(Day 6+)***	Refresh messaging based on recurring questions or concerns.
	Release bespoke campaign content as it becomes available.

Key Enablers

In this section we discuss four key enablers that we consider to be necessary to make every domain in the Playbook possible. These enablers are data and information sharing, funding models, workforce, and coordination of vaccination outreach. While these topics are also referenced throughout the Playbook, we name them here separately to highlight the aspects underpinning these enablers that may merit further consideration for future responses.

Data and information sharing

Data and information were needed in our response for three distinct purposes:

- reaching whānau for targeted vaccination
- getting timely access to patient information for case management, and
- having clear, consistent public health guidance to keep messages straight.

We recognise Māori data sovereignty and that sharing identifiable information is sensitive and context-dependent.

For vaccination targeting, dashboards at SA2 level were a helpful compass for planning, and working with an iwi data partner to view SA1/meshblock signals added further precision to place outreach without compromising privacy. Early on, public exposure notices and comms outputs also acted as a bridging feed while formal flows caught up.

On the guidance side, even experienced spokespeople found eligibility rules and isolation settings easy to mix up in the first days. Having a single, pinned FAQ (aligned to national messaging, in English and te reo) reduced confusion for kaimahi and whānau.

Considerations for future responses:

- Engage a lead in-home clinical provider early and share confirmed case details with a comprehensive handover as soon as possible.
- Consider options to maximise granularity of vaccination data able to be shared with selected providers during an outbreak.
- Maintain a single source of truth for public guidance (vaccine eligibility, isolation requirements etc) aligned to national messaging, with a rapid Comms pathway for providers in case of updates.

Funding models

In our experience, the response worked best when funding could follow the care, especially for in-home support that kept people safely out of hospital and reduced onward transmission. Measles case management isn't a "15-minute visit": it involves, manaakitanga, clinical assessment including PPE donning and cleaning, along with practical and emotional support for the entire home which take time.

NHHT was able to move quickly with existing resources, with confidence that funding would be available given the urgency of containment and our trusted relationships. Where there wasn't a specific mechanism for GP home visits, we based our costs on our local POAC rates, recognising that measles requires a different mix of time, workforce and materials than standard primary care.

Considerations for future responses:

- Clarify POAC or equivalent use for home visits where standard GP funding doesn't apply, with simple claim rules to reduce admin during the acute phase.
- Establish an in-home care funding path for measles and similar outbreaks, recognising longer visit times and essential consumables.

Workforce

The finite nature of the health workforce made drawing upon the whole local workforce and seeing it as a single workforce an important consideration. Where relationships were strong, partners provided short-term cover at fixed sites (e.g., Kawakawa) so NHHT vaccinators known to the community could focus on mobile/outreach activities. If cases are contained to a highly localised area, there may be opportunities for providers to activate wider networks to draw in support from further afield to reinforce vaccinating workforce without impacting BAU services.

For medical support of positive cases, we recommend having at least an Extended Care Paramedic or Registered Nurse authorised to work under standing orders for all relevant medications to undertake home visits. A GP should also be available for telehealth consultations, particularly where comorbidities or chronic conditions are present.

Considerations for future responses:

- Providers to explore agreements around workforce sharing so that these can be quickly activated in case of an outbreak.
- Maintain a central record of any temporary variations to contract condition so that the applicability of these can be quickly considered in future outbreaks.

Coordinating vaccination outreach efforts

Multiple providers mobilised surge vaccination capacity quickly across Te Tai Tokerau in response to the outbreak. Alongside NHHT's vaccination activities, organisations that stood up additional vaccination clinics included Te Hau Ora O Ngāpuhi, Hauora Hokianga, Te Rūnanga o Whaingaroa and Whānau Āwhina | Plunket, as well as Te Whatu Ora's own public health team.

The range of activities in place meant knowing *who was where, when* became essential to avoid duplication and to redirect whānau to the closest option if they were unable to access our sites. Daily IMT stand-ups were crucial for sharing the days locations, as well as forward plans, to minimise duplication.

For NHHT, we tried to be deliberate about operating in locations where trust and strong connections already existed. While some overlap with other providers was inevitable, and in some cases useful when organisations had reach into different parts of the community, open communication to avoid systematic duplication was important.

Considerations for future responses:

- Share forward plans early and circulate a rolling daily/weekly calendar of outreach sites (who/where/when) across providers and Te Whatu Ora to optimise coverage and reduce duplication.
- Coordinate in real time via a simple cross-provider channel for same-day changes and referrals.

Appendix: Templates & Tools

Appendix 1: Pre-appointment tele-triage script for GP clinics

The script below was provided to administrative staff at NHHT's primary care clinics to support pre-appointment tele-triage.

Kia ora ___ speaking.

How can I help you today?

Are you currently feeling unwell?

Are you aware we currently have a measles outbreak in our area?

We are just taking precautions and asking the following questions just to ensure we keep everyone safe

Do you currently have any of the following symptoms:

- *high fever (over 38°C), cough, runny nose, and sore red / running eyes (conjunctival symptoms)*
- *a rash. This may begin on the face and gradually spread down the body to the arms and legs.*

If patients indicate they have developed any of these symptoms

- Please ask them to phone ahead before visiting the doctors or our hauora provider so precautions can be taken to prevent measles spreading
- Remind them they can also call Healthline free on 0800 611 116 for advice.
- Alternatively, if you are concerned you can put the call through to one of our clinical staff to manage

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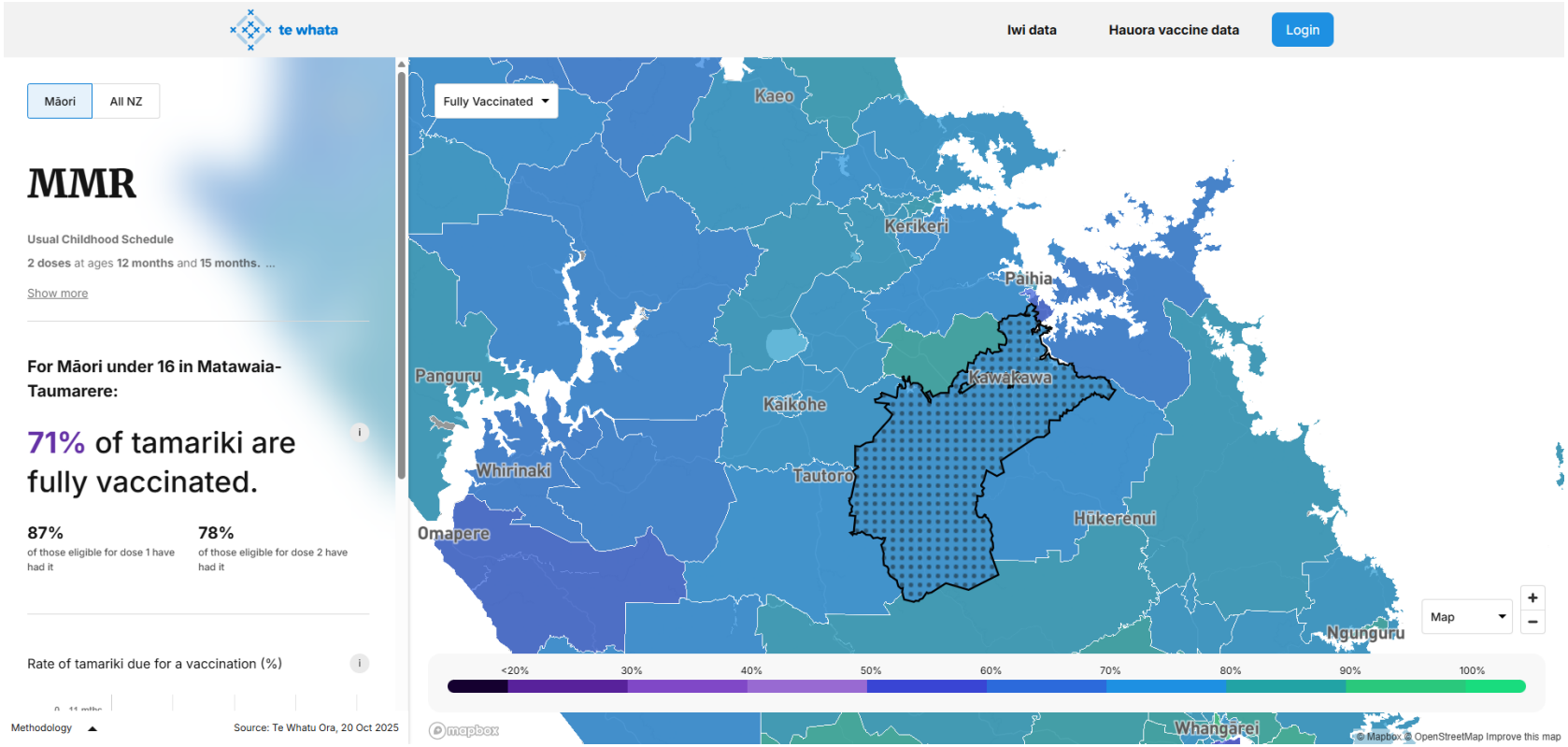
Additional information provided to team to support phone conversations:

- Please advise of vaccination locations if anyone asks.
- For patients enquiring about symptoms or if they feel they may have measles:
    - Ask them to stay home and call Healthline for guidance 0800 611 116.
    - You may also allocate the call to a nurse for a call back
- If there is anything you feel needs to be coordinated or investigated more – put through to our nursing staff to manage
- If someone presents to the counter with any measles symptoms:
    - Ask them to go back to their car and park around our back car park and to stay in their car until someone can see them

- Give them our 0800 number in case they need to communicate to us while waiting

Appendix 2: Te Kāhui Raraunga: Hauora vaccine data example*



**Note:* This screenshot is taken from the publicly accessible version of Te Kāhui Raraunga's Te Whata data platform. Data available to onboarded iwi would include MMR immunisation rates at meshblock-level, as well as counts underlying quoted percentages.

Appendix 3: Medication, Consumables and PPE requirements for in-home case management

Medication

- Paracetemol, 500mg tablets
- Paracetemol, 250mg/5ml
- Paracetemol, 120mg/5ml
- Nurofen, 200mg tablets
- Nurofen, 120mg/5ml
- Vitamin A
- Loperamide
- Ondansetron, 8mg
- Mucosoothe
- Cetirizine, 10mg
- Chloramphenicol eye drops/ointment
- NaCL 0.9% 1000ml

Asthmatic Patients

- Prednisone 20mg
- Salbutemol inhaler
- Symbicort inhaler
- Spacer

Supplies

- Sp02 Pulse Oximeter
- Tympanic Thermometer

Note: These supplies should be left with patient, alongside clear instructions on there use and escalation pathways.

PPE

- N95 Mask
- Level 2 Mask
- Eye protection
- Isolation gown
- Gloves
- Hand Sanitiser
- Clinel Wipes

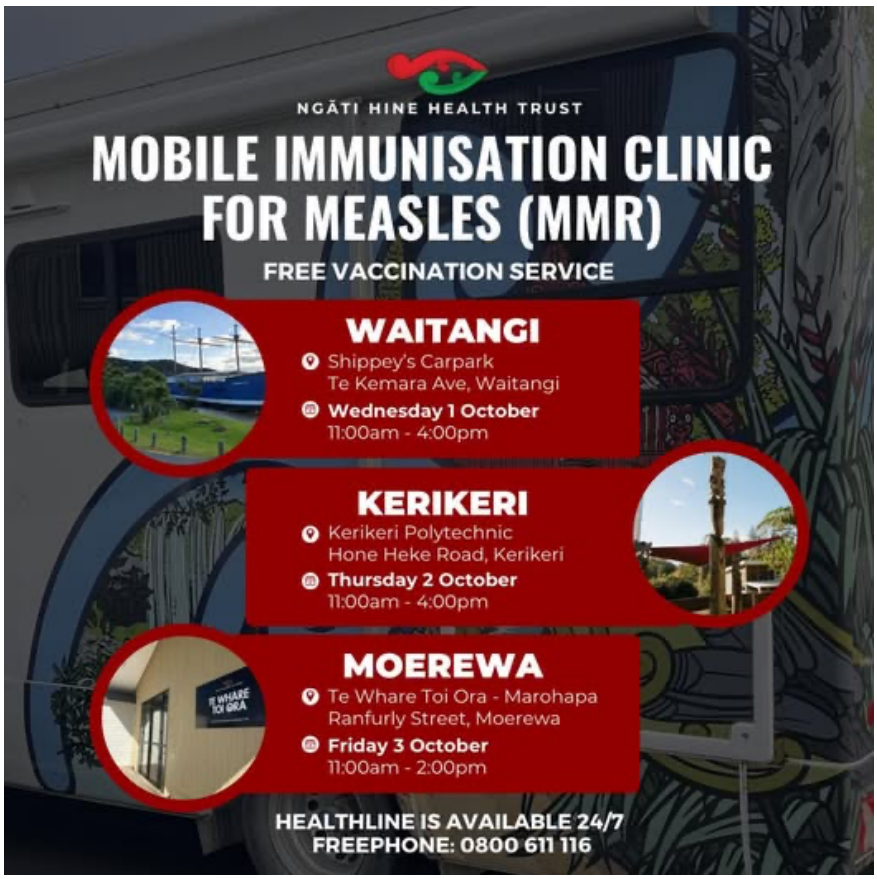
Appendix 4: Contents for whānau support packages

Shopping List (Basic)

- ☐ 2x Bread
- ☐ 2ltr Milk
- ☐ 1ltr UHT Milk
- ☐ 24 x 500ml Water
- ☐ 24 x Electrolytes sachets
- ☐ 2 boxes x Ice blocks
- ☐ 2 x Butter
- ☐ 1 x Margarine
- ☐ 1 x 1kg cheese
- ☐ 500g Flour
- ☐ 250g Rice
- ☐ 250g Sugar
- ☐ 60 bag Tea
- ☐ 200g Coffee
- ☐ 500g Mince
- ☐ 1kg Sausages
- ☐ 2 Kg Chicken
- ☐ 1 x 200g Jam
- ☐ 1 x 200g Peanut Butter
- ☐ 2x Baked Beans
- ☐ 2 x Spaghetti
- ☐ 1 x Corned Beef
- ☐ 2 x Fruit Salad
- ☐ 1 x Salad Mix
- ☐ Tomatoes
- ☐ Bananas
- ☐ Oranges
- ☐ Apples
- ☐ 2Ltr Juice
- ☐ 500g Weetbix
- ☐ 250g Porridge
- ☐ 2 x Crackers
- ☐ 2 x Plain Biscuits
- ☐ Baby Food: (Brand)
- ☐ Baby Milk: (Brand)
- ☐ Baby Nappies: (Brand & size)
- ☐ Baby wipes: (Brand)
- ☐ Feminine products: (Brand & size)
- ☐ 12 pkt Toilet paper
- ☐ 2 x Soaps
- ☐ 2 x Sanitizers
- ☐ 2 x Sanitizer wipe

- ☐ Dog/cat Roll or biscuits

Appendix 5: Example Comms Collateral




MAHI POTO
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ORANGA ROA
SAVE LIVES


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NGĀTI HINE HEALTH TRUST