# Evaluation of the Care in the Community Welfare Response

Report on findings from the survey workstream of the outcomes-focused evaluation

*22 January 2025*

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## Acknowledgements

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# List of abbreviations

| Acronym | Definition |
|---|---|
| CiC | Care in the Community |
| CPF | COVID-19 Protection Framework |
| DPMC | Department of Prime Minister and Cabinet |
| KEQ | Key Evaluation Question |
| MSD | Ministry of Social Development |
| NGO | Non-Governmental Organisation |
| RLG | Regional Leadership Group |
| RPSC | Regional Public Service Commissioner |

# Executive summary

## The Care in the Community welfare response model

### MSD implemented a novel model to meet isolating households' welfare needs during the COVID-19 pandemic

The Care in the Community (CiC) welfare response was established in November 2021 to help manage the COVID-19 Omicron outbreak in Aotearoa New Zealand. The 'locally-led, regionally-enabled and nationally supported' response aimed to ensure that COVID-19 positive people and households could safely self-isolate. While elements of the response were already under consideration, the response represented a new way of working for the Ministry of Social Development (MSD).

MSD was responsible for coordinating the CiC welfare response. The response was delivered through Regional Public Service Commissioners (RPSCs) and Regional Leadership Groups (RLGs) working in partnership with community providers, Iwi, Māori, Pacific peoples, ethnic communities, the disability sector, local government, and government agencies.[1,2,3] MSD funded the provision of critical food support which was delivered via community providers. MSD also funded Community Connectors, who were a key mechanism for identifying households in need and providing them with a broad range of welfare support.

## Survey workstream evaluation activities

### This report presents findings based on the experience of those who designed, co-ordinated, delivered, and received the CiC welfare response

MSD conducted an outcomes-focused evaluation of the CiC welfare response. This report presents the results of the survey workstream conducted as part of the wider evaluation.[4]

Four surveys were designed and completed by 53 RLG respondents, 75 community providers, 107 Community Connectors, and 255 households. While there were common elements across the surveys, different questions were used to explore different aspects of implementation and outcomes for each respondent group.

Interviews were held with 16 people who worked in government agencies at the national level. The interviews explored the context of the CiC welfare response, the operation of the

[1] https://www.publicservice.govt.nz/system/regions/

[2] RLGs were responsible for overseeing planning, alignment, and delivery of CiC welfare support through existing partnerships with iwi, local government, community partners, and government agencies.

[3] The term 'community provider' includes social service providers, health services, marae, Whānau Ora, churches, rūnanga, charity organisations, and Civil Defence Emergency Management groups.

[4] A literature scan was also completed which documented how a range of countries' government and non-government organisations responded to and managed welfare support in times of emergency.

response, how agencies and others worked together, successes, challenges, and lessons learned for future ways of working.

The purpose of the survey workstream evaluation activities was to answer questions about implementation of the response, including enablers and barriers; accessibility and reach; complementarity with other responses; intended and unintended outcomes; and learning and improvements.

# Implementation findings

## Households' experience of the CiC welfare response

### Food parcels were considered the most helpful and important form of support by households

Households, along with Community Connectors and community providers, reported that food support was the most used, helpful and important service provided as part of the response, during and post isolation. The majority of household survey respondents reported that the food support was timely, sufficient, and nutritious.

Support with general household items, urgent expenses, medical needs, and information about community supports were ranked as the next most helpful and important services. Four of the top five highest-ranked supports were expense-related. While some types of support were used more than others, the complete range of supports available were used by surveyed households.

### Community Connectors' understanding, timeliness, and respectful engagement with households supported the effective delivery of the response

Household survey respondents were overwhelmingly positive about the support they received from Community Connectors. For most households the Community Connectors were the 'face' of the welfare response; three-quarters of the household survey respondents reported they were supported by a Community Connector. Over 80% of household survey respondents said their Community Connector understood and met their wellbeing and cultural needs, was respectful, timely, easy to talk to, helped them to access support, and built a relationship of trust.

Households across ethnic groups reported some variation in their experiences with a Community Connector. Households with Māori or Asian family members resident were less positive and households with a Pacific family member were more positive about their experiences with a Community Connector.

## Households' access to, and reach of, the CiC welfare response

### Trusted community providers enhanced access to the response

Delivering the response through providers that were already known in the community, or were easily relatable for community members, was important in ensuring household access to

support. Almost two-thirds of households reported that it was easy to access support while isolating due to the positive, helpful, trusting and friendly relationships that they already had or subsequently built with providers.

The findings did not provide insights about why the remaining households found support difficult to access. The difficulties accessing support may be related to digital, non-relational means of contact. Some household respondents identified having limited trust in government which national stakeholder participants also identified as a barrier for some communities.

### Multiple referral pathways were an important mechanism for enhancing access

Coordinated by MSD, multiple avenues were set up by agencies participating in the CiC welfare response so people could self-refer, e.g., via the 0800 number, contacting providers directly, or on-line. Most referrals were self-referrals, referrals from community providers, and referrals from MSD. Households said that the support was easy to access via phone, email and through Community Connectors. Community providers considered phone calls and in-person discussions to be the most effective methods to communicate with isolating households.

### Regional leadership and local delivery increased the reach of the welfare response into communities that government commonly finds it difficult to engage with

RLG, community provider and Community Connector survey respondents indicated that they had increased reach into Māori, Pacific and socio-economically disadvantaged communities.[5] However, the results indicated less confidence that reach into ethnic communities and older populations had increased, and limited confidence regarding reach to disabled people. Efforts were made to improve reach as the response was rolled out, including the introduction of a dedicated disability fund that provided additional support to disabled peoples and their families/whānau significantly impacted by COVID-19.[6]

While RLG, community provider and Community Connector survey respondents expressed confidence that the CiC welfare response increased reach for some communities, they felt that several groups experienced barriers to accessing CiC support. Access barriers were considered to exist for Māori and priority population households, particularly for older people, disabled people, and socio-economically disadvantaged communities.

## Implementation at the local level

National stakeholder participants reported that community providers and Community Connectors were pivotal to the success of the CiC welfare response.

[5] Reach describes the ability of an organisation or individual to engage with diverse populations and communities, while access is the ease with which individuals or households can enter, use, or receive needed services.

[6] https://www.msd.govt.nz/about-msd-and-our-work/covid-19/care-in-the-community-welfare-response/care-in-the-community-disability-welfare-fund.html

### Local knowledge and relationships were key to the success of the response

Community providers and Community Connectors reported that the Community Connector role worked because the Connectors understood their communities and had existing networks; the role was flexible; and because Connectors knew what community and government support was available. The majority of community provider survey respondents agreed that Community Connectors were important for building relationships with all priority populations.[7] In addition, national stakeholder participants felt that community trust in the providers and Connectors was a key element in the success of the model.

Community providers and Community Connectors also considered that local CiC hubs supported delivery of the response. The hubs acted as a source of referrals, a centre of information, and as a mechanism to support collaboration between agencies and providers.

### Funding certainty and operational flexibility were critical to enabling locally-led delivery of welfare support

The certainty of funding and flexibility built into the CiC welfare response contracting model were highlighted by community providers and Community Connectors as critical to the successful implementation of the response at the community level. Community providers agreed that the contracting model used for CiC enabled them to meet people's needs more effectively than traditional contracting models. Contractual flexibility gave community providers the ability to better tailor their response to community needs and to complement other services and products delivered to those communities. Although community providers said the funding was adequate and flexible for delivering the response, many providers faced challenges with staffing, including staff retention.

## Implementation at the regional level

### The regional component of the CiC welfare response model supported locally-led delivery, co-ordination, and prioritisation of funding in the regions

The majority of RLG survey respondents agreed that the RLGs functioned effectively. For example, there were high levels of agreement that the relevant organisations were represented, meeting frequency was about right, members collaborated effectively, and MSD supported RLGs to enable the welfare response . The RLGs were highly regarded by community provider and RLG survey respondents. Community provider survey respondents agreed that they were supported by their RLG. Most agreed that their RLG was critical in ensuring the CiC welfare response was well coordinated and supported funding to be effectively prioritised in their region.

[7] Pacific peoples, ethnic communities, older people, disabled people, and low income households.

### Representation on RLGs enabled better delivery of support to Māori and priority groups

Iwi were well-represented within the RLGs. RLG survey respondents reported that RLGs enabled tailored responses for Māori, socio-economically disadvantaged and Pacific communities, but less so for ethnic communities and disabled people. The latter appeared to be related to limited representation of ethnic communities and disabled people on the RLGs. Pacific representation and input were also reported to be low in most RLGs. Where there was Pacific representation, RLG respondents believed this led to a better understanding of the welfare and support needs of Pacific peoples and better outcomes for Pacific communities.

### RLGs helped to facilitate the development or strengthening of public sector and community networks

A majority of RLG survey respondents reported that their RLG was able to build positive relationships with government agencies and with iwi. Most RLG survey respondents reported their group was able to build positive relationships with community organisations generally, with community providers, and with CiC hubs. National-level government agency representatives reported that the RLGs enabled better coordination between their agencies' regional offices, which in turn delivered better services to communities. However, some survey respondents and national stakeholders felt that decisions about the response were still largely made at the national level.

## Implementation at the national level

### Government agencies have the ability to adopt locally-led, higher trust ways of working

National-level interview participants highlighted that MSD's and other government agencies' ability and willingness to implement a 'high-trust' model, which prioritised local knowledge, was a key enabler to delivering a locally-led, regionally-enabled and nationally supported response. Agile and consistent communication flowing in multiple directions was also important. Information flowed from MSD and other central government agencies through to RLGs, regional offices, and community providers, with insights shared back from communities to the MSD national office.

### Relationships and collaboration were key to national support of the response

Strong existing relationships between government agencies, along with a willingness to work together, were identified as important to the success of the model. Some national-level government interview participants, particularly from population-based agencies, reported that they had limited ability to contribute to the design of the CiC welfare response in the initial stages. However, they also reported experiencing a shift from 'consultation' to more of a 'collaborative' approach over time. MSD staff spoke about their evolving and maturing relationships with other agencies, resulting in more streamlined funding for COVID-19 supports.

### The rapid development and delivery of the CiC welfare response presented some challenges for coordinating activity across agencies

The key challenge to providing coordinated inter-agency responses was different ministerial drivers, priorities and delivery responsibilities which were driven by agencies separate funding votes. This challenge was primarily addressed through cross-agency collaboration and communication. The cross-agency senior management arrangements were regarded as well set up and working effectively which enabled frequent information sharing and quick decisions to address identified issues. Managers and staff prioritised time to either work together or, at a minimum, ensure they were informed about what each organisation was doing to ensure they were not duplicating each other's activities.

Non-aligned operational models and technology systems between MSD and the Ministry of Health presented specific challenges to the speed with which referral processes could be set up, information and reporting shared, and responses to demand could be actioned. The lack of compatibility resulted in significant time and resource spent on identifying and developing solutions.

### Accountability requirements were complex and time consuming

Accountability requirements to justify spending created extra pressure on already strained national staff. Multiple government agencies working together and providing contributory rather than full funding created reporting complexity, and clashed with ministerial pressure to ensure their allocated funding was used only for items within their portfolios. Responses to questions about whether funding duplication occurred were mixed. Some stakeholders reported duplication of funding from different agencies, while others were less concerned about possible duplication; they reported that community providers made use of the funding regardless of where it came from without delivering duplicate services.

# Outcomes

## Household outcomes

### The CiC welfare response met households' needs, reduced stress, and enabled households to isolate

There were high levels of agreement among household, community provider and Community Connector survey respondents that the welfare support met households' immediate needs while isolating, and that the response was effective in supporting households to isolate for the required period. Support was effective in enabling isolation across all population groups.

A key enabler for households to isolate was the provision of food. Households reported feeling supported and that the support they received reduced their experience of financial and mental stress. Their responses also illustrated that people's dignity and mana was maintained. Community provider, Community Connector and household survey respondents agreed that support met households' cultural, wellbeing and religious needs.

### The CiC welfare response likely contributed to minimising the spread of COVID-19

Findings suggest that the spread of COVID-19 was likely minimised by households who accessed support to isolate. However, the potential to minimise COVID-19 spread may not have been maximised due to barriers to accessing welfare support. As described earlier, RLG members, community providers and Community Connectors reported access issues for Māori and all priority groups during the CiC welfare response, in particular for older populations, disabled people and socio-economically disadvantaged communities.

## Local outcomes

### Community providers had sufficient capacity, but their operations often relied on volunteers which may have impacted their resilience

Community providers had sufficient resources to deliver the CiC welfare response. However, funding was inadequate for hiring and retaining staff and nearly three-quarters of providers relied on volunteers. This suggests that sustaining the welfare response over a long period of time would have been difficult without additional resourcing to support locally-led delivery.

### The CiC welfare response strengthened provider relationships and networks

Most community provider and Community Connector survey respondents agreed that the CiC welfare response facilitated the development of new networks, strengthened existing networks, and meant that providers were better able to respond to community priorities. Moreover, most community providers and Community Connectors reported that they were able to build positive relationships with MSD, other CiC providers, and other social, health and wellbeing services. It is important to note that many community organisations were already well-networked, especially locally.

## Regional outcomes

### Regional leadership structures were largely inclusive, collaborative, and enabled a locally-led and coordinated response

The RLGs provided a valued alignment and coordination role in the delivery of the response. Community providers felt well-supported by their RLG, the RLGs were effective in building positive relationships with different groups, and regional cohesion led to more collaborative ways of working. RLGs appeared to facilitate inclusive decision-making through the involvement of government agencies, iwi, and community providers. The inclusion of Pacific peoples and ethnic communities in regional leadership was less apparent. Despite the positive outcomes of the regional leadership structures, findings indicate that these were constrained by centralised decision-making and siloing within central government agencies constrained the effectiveness of the regional leadership model.

## National outcomes

### The welfare response enabled MSD to work in new ways with the community sector

The national level outcomes for the CiC welfare response were ambitious, encompassing new ways of working with iwi, Pacific peoples, and communities, including authentic partnerships with iwi. Flexibility in contracts and a high-trust model were key enablers to the CiC welfare response, resulting in more relational ways of working with providers and communities. While progress related to new ways of working is promising, the findings also indicate that a high-trust approach was not always apparent and there was a feeling amongst some providers and communities that they were not always listened to.

### There was reduced siloing and increased complementarity across government but challenges remain

The CiC welfare response was expected to deliver new ways of working across the public sector and, in the medium to long-term, to contribute to a unified public service organised flexibly around the needs of New Zealanders. On one hand, there is evidence that open communication between participating agencies, strong relationships, and developing trust helped to reduce agency silos and enhance complementarity of support. On the other hand, some government agencies (or teams within agencies) continued to work in silos which may have contributed to duplication of support at the regional and community level.

# Implications

This section considers the strategic implications of the survey workstream findings for future locally-led, regionally-enabled, and nationally supported welfare responses.

### Relational and flexible practices need to be further embedded into commissioning practices

The CiC welfare response used a flexible approach to contracting and reporting which enabled adaptation to changing circumstances and tailoring of support to community needs. The resultant high-trust model, built on existing relationships, was a key enabler to the effective implementation of the welfare response. There is an opportunity to strengthen this approach through further developing and implementing the principles of the Social Sector Commissioning work programme and building genuine two-way trust with community providers. The shared goal of minimising the impact of COVID-19 on vulnerable populations was a driver for doing something different. There is a risk that commissioning will revert to more traditional, business as usual approaches, which do not enable genuine community-led efforts to turn around the inequities experienced by Māori and other priority communities.

### Flexibility and responsiveness need to be balanced with learning and accountability

Flexibility and responsiveness within the CiC welfare response model were highly valued in responding to household needs during an evolving crisis. There was a level of efficiency which was critical to providing timely support, although there was also some lag time in getting funding to the frontline. The flexible approach to data collection and reporting was a welcome relief and reduced the burden on over-busy, under-staffed community providers focused on delivery. This flexibility needs to be balanced with collecting meaningful data, in real time, that enables learning to guide adaptations, and provides for accountability. Data collection and reporting need to be sufficiently resourced.

### Government agencies need to strengthen collaboration to enable community-led approaches

Government agencies were able to breakdown some silos and work in a more joined-up and complementary way. However, there were still challenges, and collaboration and coherence often occurred *"in spite of the system; not because of it"* (national stakeholder). There is a need to strengthen collaborations across government, including with population-based agencies that often have a strong understanding of community-led approaches, and to reduce fragmentation in funding and reporting across funding agencies. Reducing agency silos requires constant communication and relationship-building.

### The workforce across the system needs to be adequately resourced

While the CiC welfare response was adequately resourced, there were workforce challenges across the system. At the community level, many providers relied, overwhelmingly, on the goodwill of volunteer staff and paid staff putting in substantive voluntary hours. At the regional level, organisations needed resourcing to sustain participation in regional forums that were key to effective coordination. At the national level, the development and implementation of the response placed significant burden on staff. Adequate workforce resourcing is critical to building a resilient system, particularly for ensuring community providers are well-placed to plan for and respond to current and future community needs.

### There is a need to effectively partner and work with Māori and priority populations

Māori and population government agencies were involved in the design and implementation of the welfare response, but to varying degrees. The approach to partnering with community providers trusted by Māori and priority populations, and providing the flexibility to use funding as providers saw fit, proved to be a successful way of extending access to services and has strong potential to increase service reach into these communities. There needs to be an ongoing focus on how best to effectively partner with such population groups in locally-led responses, recognising the value that involvement brings, that participation in decision-making may require dedicated resourcing, and that approaches need to be tailored to different priority populations.

### There is a need to address food resilience and other expense-related issues for households

Support with food was the most common, helpful and important form of support provided by the CiC welfare response. Other highly valued forms of support were also expense-related such as general household items, urgent expenses, and medical needs. This suggests that work needs to continue to build the food resilience of communities and that income adequacy needs to be addressed for those households struggling to meet basic needs.

### The CiC welfare response highlights the value of locally-led, regionally-enabled and nationally supported ways of working

The experiences of households and the outcomes achieved for households through the CiC welfare response demonstrates how locally-led, regionally-enabled, nationally supported government operating models can make a significant difference to addressing disparities and difficulties experienced by some households. Key to the success of the model was change at the national level – the adaptation of government mechanisms and resourcing which freed up and enabled community efforts that were often already in place. Households valued services that were easy to access, varied and able to be tailored to their needs, delivered by trusted, empathetic staff and organisations from their community.

# Part A: Background

# 1 Introduction

This report is structured in three parts:

- **Part A: Background** describes the CiC welfare response, identifies stakeholders, providers an intervention logic model for the response, and presents the methods used as part of the survey workstream
- **Part B: Findings** presents the survey workstream's findings, organised in two sections:
  - findings on the locally-led, regionally-enabled, and nationally supported model
  - findings related to the support received by households
- **Part C: Improvements and lessons** presents findings on how the response could have been better implemented.

**Appendices 1, 2 and 3** include further details on the methodology and data collection tools.

**Appendix 4** includes additional supporting tables of survey results.

## 1.1 The CiC welfare response

This section describes the policy intent and core components of the CiC welfare response.

### 1.1.1 Policy intent

**The CiC welfare response was an integral part of a whole-of-system approach**

The CiC welfare response emerged as an initiative to address the multifaceted challenges caused by the COVID-19 pandemic. The overarching policy aim of the CiC welfare response was to "*support people to stay safe at home for the duration of their self-isolation period, thereby limiting the potential of further transmission and the increased pressure this would place on the health response*".[8]

The CiC welfare response was developed as a key component within the broader approach of the COVID-19 Protection Framework (CPF), a strategic framework endorsed by Cabinet in October 2021. The CPF aimed to promote synergy between health, housing, and welfare responses to mitigate the spread of COVID-19. The response adopted a "*no wrong door approach*" to support the CPF's objectives to "*minimise and protect*" by providing essential welfare support to individuals and households in self-isolation.[9]

[8] A whole of system welfare approach under the COVID-19 Protection Framework. Cabinet Social Wellbeing Committee COVID-19, 24 November 2021, p.3-4.

[9] Ibid.

### The CiC welfare response was locally-led, regionally-enabled, and nationally supported

The CiC welfare response was designed and delivered based on a model that included three key components: locally-led delivery; regionally-enabled through strong leadership and a coordinated assessment and referral function; and nationally supported oversight.[10]

The CiC welfare response leveraged local expertise and community strengths in recognition of the efficacy of local providers and community groups who were already responding to welfare needs. The response sought to empower hapori Māori and other community entities to tailor interventions according to the specific needs of their communities.

The CiC welfare response was also designed to foster collaboration among regional stakeholders through RLGs which included public service leaders, iwi/Māori representatives, and local government officials. The response aimed to ensure coherence and prevent duplication of services by building on existing regional structures and facilitating cross-sector coordination. By strengthening regional leadership, the response sought to align efforts, adapt to local variations, and optimise resource allocation to address evolving needs.

At the national level, the CiC welfare response involved government agencies and stakeholders providing strategic oversight, system-level monitoring, and reporting. MSD and RPSCs were mandated with leadership and coordination roles at their respective national and regional levels.

### The CiC welfare response was driven by equity and Te Tiriti o Waitangi principles

The CiC welfare response prioritised the needs of Māori and priority population groups, including Pacific communities, ethnic communities, disabled people, older people, and socio-economically disadvantaged communities. The response was designed to recognise that there would be differential impacts of COVID-19, and isolation requirements, on households. As such, it sought to ensure equitable access to support services to bolster community resilience and social cohesion.

## 1.1.2 Core components

This section briefly describes the intended core components of the CiC welfare response.

### A wide range of community groups were involved in delivering the welfare response, with the flexibility to respond to the needs of communities

The backbone of the CiC welfare response were local providers – referred to collectively as ‘community providers’. These included social service providers, health services, marae, Whānau Ora providers, churches, rūnanga, charity organisations, and Civil Defence

[10] Welfare Response to Omicron. Cabinet Social Well-being Committee Care in the Community, 22 February 2022, p.4.

Emergency Management groups. Providers included those with and without existing contracts with MSD.

Contracts with MSD for the provision of the CiC welfare response were non-prescriptive and flexible to ensure providers could respond appropriately to local needs. Examples of the types of support and services offered included:

*Provision*

- food parcels
- general household items (such as clothing, blankets, bedding)
- support with education (such as activity packs).

*Information*

- information about other supports available in the community.

*Connection*

- support with social connection, wellbeing or pastoral care
- connection with employment support and opportunities
- connection to MSD financial support via Work and Income.

*Referral*

- referral to other health or social services.

*Advocacy*

- advocacy to government agencies (such as Work and Income)
- advocacy to other organisations or situations (such as tenancy disputes).

*Financial*

- support with medical needs (such as doctors' bills and prescription costs)
- support with urgent expenses (utilities, rent arrears)
- transport costs (such as warrant of fitness, petrol).[11]

## Community food provision was a core component of the CiC welfare response[12]

MSD supported access to food from the beginning of the pandemic through the Food Secure Communities programme. The Food Secure Committees programme was established in June

[11] Given the contracts with MSD for the provision of the CiC welfare response were non-prescriptive and flexible, this list in non-exhaustive. Examples of other support and services provided are included in Part B: Findings.

[12] The information in this section is from the Report to Hon Carmel Sepuloni, Minister for Social Development and Employment, MSD's enduring role in strengthening food security, 5 October 2022.

2020 to support community food providers to meet the increasing food demand resulting from COVID-19 restrictions.[13]

The Food Secure Communities programme had a wider brief than providing food support to isolating households. The programme involved supporting existing and new community food providers, investing in community food distribution infrastructure, the development of community food security plans, and piloting initiatives to increase vulnerable communities' access to food.

## Community Connectors were key actors in the CiC welfare response

MSD funded providers to host the Community Connection Service. The service comprised 'Community Connector' positions to identify households in need and provide them with CiC welfare support. The service was set up in the first half of 2020, then expanded in December 2021. The November 2021 Cabinet paper described:

> *The initial aim of the Community Connection Service was to offer flexible support to individuals and whānau in need, particularly with psycho-social needs. Community Connectors act as a conduit for individuals and whānau to government services that they may not access, such as through Work and Income. Providers have a 'no wrong door approach' and whānau and individuals in need of the Community Connection Service can be assisted through any service line.*[14]

While most Community Connectors were hosted by community providers contracted by MSD, sometimes the Community Connector was employed by an organisation that had undertaken wellbeing, welfare, and/or health work but was not contracted by MSD, such as Whānau Ora providers.

Community Connectors supported whānau and communities to isolate by working with providers and government agencies. Community Connectors could access a small discretionary fund to meet unexpected, immediate material hardship needs of the people they worked with. They also had a direct line into MSD to ensure expedited support to access MSD products and services.

## Aligned referral mechanisms and pathways were developed regionally

The 'no wrong door approach' to accessing CiC welfare support was implemented through the development of a regionally coordinated assessment and referral function that built on existing systems and integrated welfare, health, and housing responses. The November 2021 Cabinet paper described that health providers were responsible for undertaking an initial health, welfare, and housing needs assessment when a person was identified as COVID-19 positive.

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[13] Food providers are non-government organisations that provide food for people in need, for example via foodbanks, food parcels, or pataka kai.

[14] A whole of system welfare approach under the COVID-19 Protection Framework. Cabinet Social Wellbeing Committee COVID-19, 24 November 2021, p.11-12.

This information was to be passed to an appropriate provider to deliver welfare and housing services, as needed, in a timely manner. The idea was to develop a technology solution that captured health and welfare information at key engagement points with households.[15]

## CiC hubs supported delivery of services at the regional level

CiC hubs were regionally supported confederations of organisations dedicated to delivering and supporting health and welfare services through the COVID-19 pandemic. The hubs comprised a range of organisations including hapori Māori, local offices of government agencies, community groups, and health services. They were often led by the then District Health Boards.[16] The November 2021 Cabinet paper noted that:

> *Some regions are already operating similar functions. In Tāmaki Makaurau, the Auckland Emergency Management (AEM), Auckland MSD and Auckland DHB established a Welfare Triage Centre to identify unmet needs and provide a referral pathway to ensure the most appropriate agency is meeting this need in a coordinated manner. AEM and other agencies have provided increased staffing and are making outbound calls to people referred by MSD or the DHB as self-isolating and having welfare needs.*[17]

## Regional leadership worked with community partners to tailor the response to local needs

The CiC welfare response was delivered through RLGs and RPSCs working in partnership with community providers, community leaders, iwi, Māori, Pacific, ethnic communities, the disability sector, local government, and central government agencies. Partnerships between regional leadership structures and communities allowed for the welfare response to be delivered in a way that was tailored to local needs.

## MSD was responsible for coordinating and supporting the CiC welfare response

MSD was responsible for setting up teams of experienced people in each region, establishing COVID-19 welfare support helpline teams, and conducting a real-time evaluation to produce rapid insights during implementation to inform decision-making. MSD coordinated data sharing, information flows, guidance materials, and communications across agencies (upwards to Ministers, and outwards to regions and providers). MSD also provided strategic oversight, system-level monitoring, reporting, and prepared Ministerial briefings and Cabinet papers. In terms of reporting, this occurred initially through MSD's weekly pulse surveys, then

[15] Ibid, p.14.

[16] A list of DHB CiC hubs as at 31 May 2022:
https://nzregion.communityhealthpathways.org/files./resources/covidcareinthecommunityhubs.pdf

[17] A whole of system welfare approach under the COVID-19 Protection Framework. Cabinet Social Wellbeing Committee COVID-19, 24 November 2021, p.14.

via an online tool (referred to as SORT). The SORT tool captured quantitative data on both Community Connector and food distribution activities.

### Funding of the CiC welfare response involved investment in infrastructure as well as the provision of services

Government funding of $204.1 million was initially approved in November 2021 to deliver the CiC welfare response. The funding was provided to bolster existing community resources, ensure effective delivery of the response, develop and strengthen the components of the CiC welfare response infrastructure, and deliver support and services.[18] The funding was used to:

- establish and resource a co-ordinated **assessment and referral function** to integrate with the health responses in regions
- resource existing **cross-sector RLGs**, including support for iwi to partner and participate, and RPSCs
- strengthen **provider capability**
- resource **Community Connectors**
- supply **personal protective equipment** (PPE) for at-risk communities and for providers delivering services.

Approval was obtained in February 2022 for an additional $203.8 million to respond to the Omicron outbreak and subsequent increase in positive cases.

### MSD provided funding certainty and relaxed contracting mechanisms

MSD developed a *COVID-19 Provider Funding Framework* to "*identify in principle decisions for providers to use to engage with their funders*".[19] The framework outlined principles regarding certainty of funding for 'business as usual' services impacted by COVID-19 and the CiC welfare response funding. The framework contained a commitment to "*working smartly*" with providers by joining up funding agency communications. It also outlined ways in which contractual requirements could be relaxed to support "*NGOs to be flexible to the differing needs of their communities*".

## 1.2 Stakeholder mapping and intervention logic model

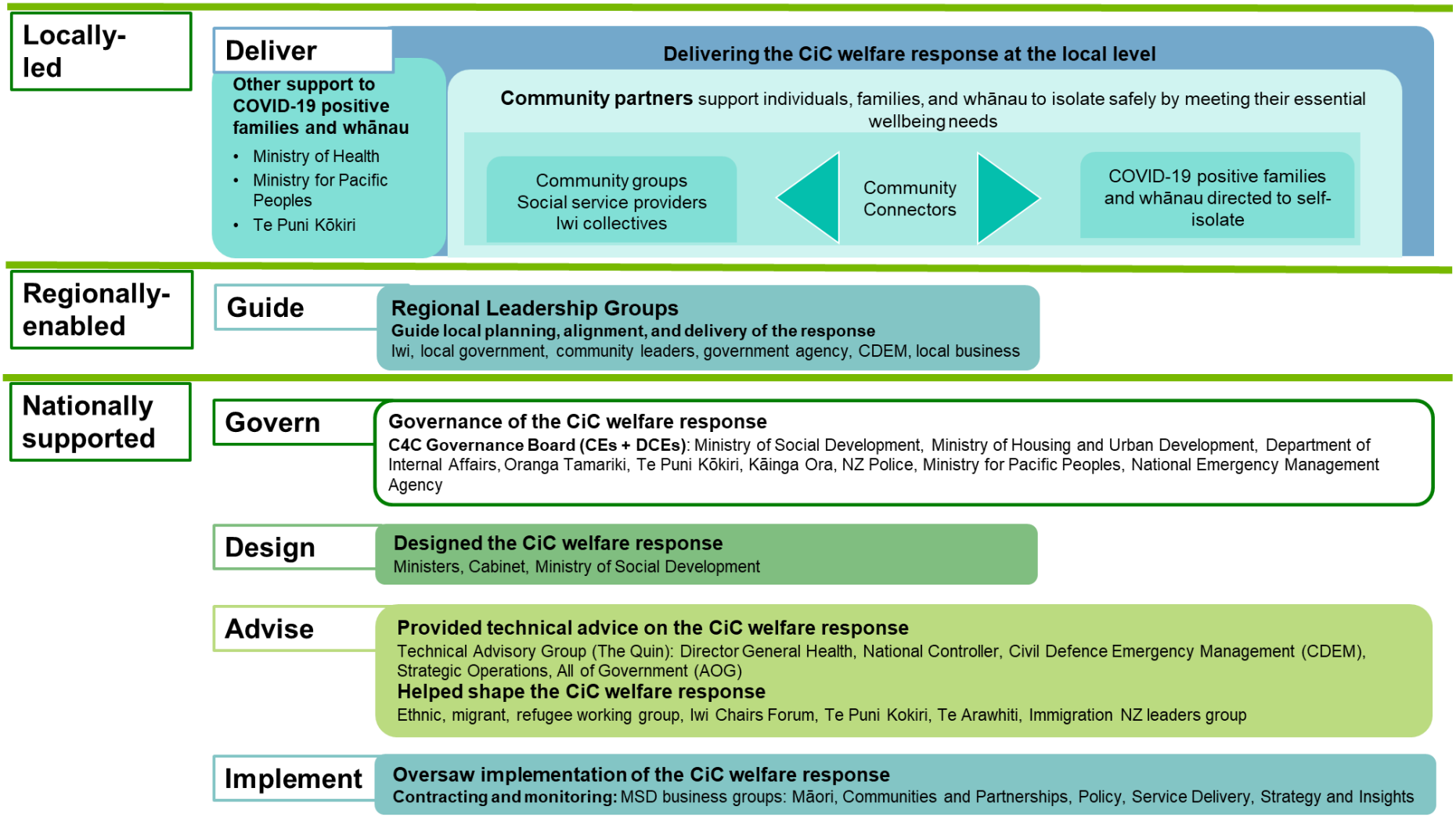
The CiC welfare response was complex, involving a range of stakeholders at the national, regional, and local level. The stakeholder map (Figure 1) aims to provide an 'at a glance' picture of the key groups and organisations that were involved at each level.

[18] https://www.msd.govt.nz/about-msd-and-our-work/covid-19/care-in-the-community-welfare-response/funding-care-community/index.html#Wherethefundingisbeingspent3

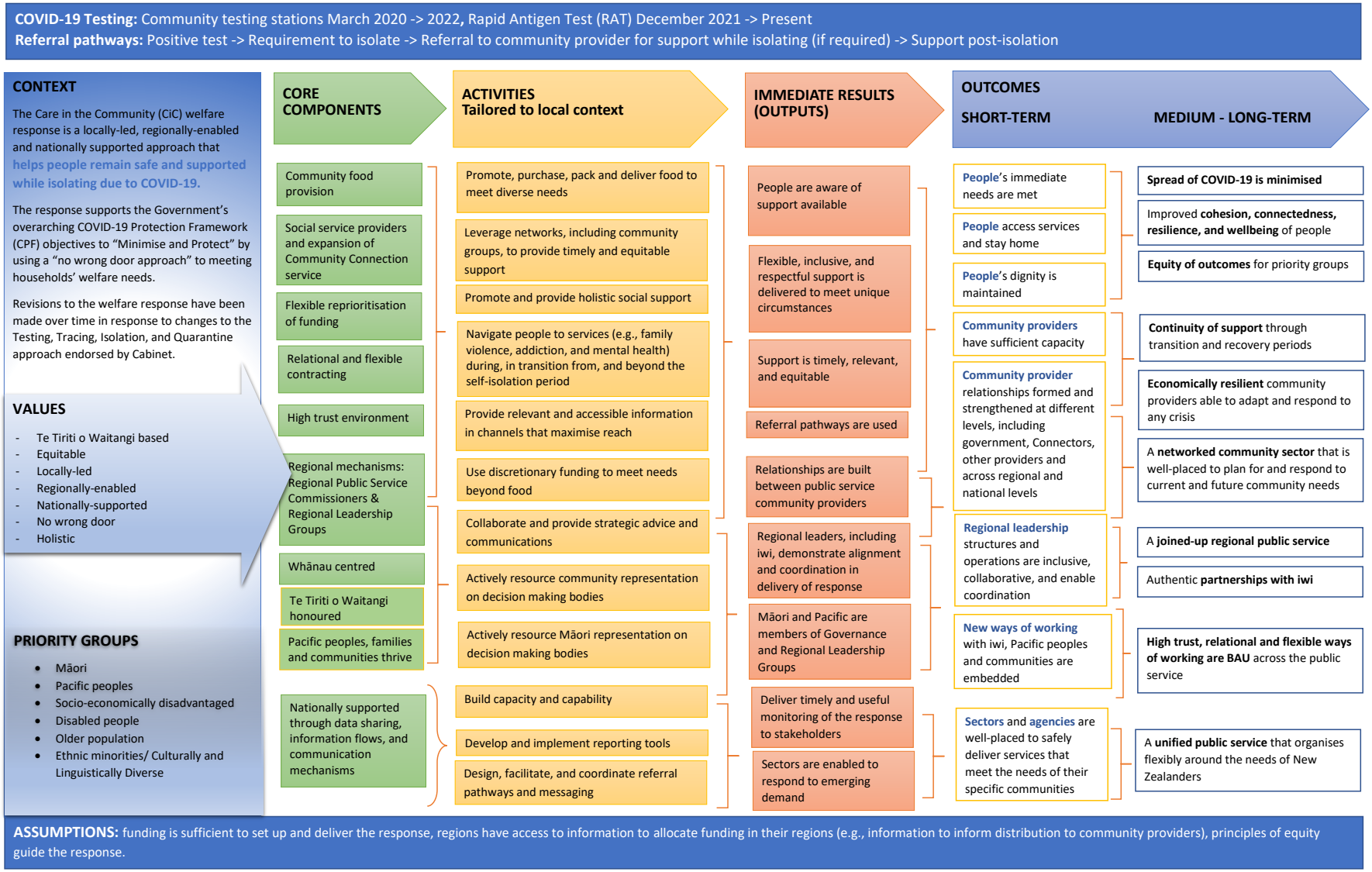
[19] Downloaded from: https://www.mcguinnessinstitute.org/wp-content/uploads/2023/04/covid-19-provider-funding-framework-a3.pdf

An initial intervention logic model for the CiC welfare response was developed by MSD. This was refined throughout the evaluation process for the survey workstream. The intervention logic model (Figure 2) provides a visual description of the 'logic chain' of the response, describing the context of the welfare response, its components, activities, and outputs, as well as the anticipated short-, medium- and longer-term outcomes.

**Figure 1: Care in the Community stakeholder map**



## Figure 2: Care in the Community intervention logic model



# 2 The evaluation

This section describes the purpose of MSD's wider evaluation; the contribution of the activities and findings described in this report to MSD's wider evaluation; the overall key evaluation questions; and the methodology and limitations of the survey workstream.

## 2.1 Purpose of the wider evaluation

MSD conducted an outcomes-focused evaluation of the CiC welfare response. The following lists the purpose of the evaluation:

- to build on the learnings from MSD's real-time evaluation of the CiC welfare response completed in 2022, the real-time evaluation was needed to produce rapid insights during implementation and inform decision-making as the response was unfolding
- to assess the implementation of the CiC welfare response, including the extent to which the response was culturally and contextually appropriate and was delivered in a timely and coordinated manner
- to identify the extent to which the intended outcomes were achieved for individuals, whānau, and communities
- to identify lessons for future work involving locally-led, regionally-enabled, and nationally supported delivery of services.

*Allen + Clarke* was contracted to deliver the survey workstream to support MSD's outcomes-focused evaluation. *Allen + Clarke* also developed a stakeholder map, revised the intervention logic model, reviewed contextual documents, and undertook a literature scan. The literature scan was shared with MSD as a separate document. Key informant interviews were conducted with 16 stakeholders from national government agencies. Four different surveys (online and physical formats) were sent to key groups involved in the CiC welfare response – RLGs, community providers, Community Connectors, and households.

*Allen + Clarke*'s survey workstream of evaluation activities complements a case study workstream conducted by Kaipuke Ltd. which explores the regional mechanisms of the CiC welfare response model. A synthesis of all findings (including the real-time evaluation, the survey workstream and the case study workstream) has been completed by MSD.

## 2.2 Key evaluation questions

The evaluation questions were developed by MSD in consultation with members of a MSD Working Group and a cross-agency Reference Group. The key evaluation questions (KEQs) listed in Table 1 focus on how well the CiC welfare response supported individuals, families and whānau to isolate themselves safely and stay well during their isolation period. The KEQs also cover factors that enabled or hindered the ability of the organisations and groups involved (including MSD and other national government agencies, RPSCs and RLG members, community providers, and Community Connectors) to achieve the desired outcomes.

*Table 1: KEQs*

| Implementation KEQs[20] |
|---|
| KEQ 1.1 How well was the welfare response implemented? |
| KEQ 1.2 What were the conditions and levers that enabled implementation of the response? What were the barriers to implementation and how were these addressed? |
| KEQ 1.3 How accessible was welfare support? What was the reach of the response? |
| KEQ 1.4 How did the implementation of the welfare response enable and embody MSD's organisational strategies? |
| KEQ 1.5 How and in what ways did the welfare response complement support from the Ministry for Pacific Peoples and Te Puni Kōkiri? |
| KEQ 1.6 How could the response have been better? What could have been done differently? |

| Outcome KEQs |
|---|
| KEQ 2.1 To what extent did the welfare response achieve its intended immediate results and short-term outcomes? |
| KEQ 2.2 What progress is being made to achieve medium to longer-term outcomes of the welfare response? |
| KEQ 2.3 What were the unintended outcomes of the welfare response? |
| KEQ 2.4 To what extent did the welfare response help to create, maintain, and/or improve relationships between national, regional, and community partners in the response? |

## 2.3 Survey workstream methodology

A detailed description of the methodology used to undertake the review of contextual documents, literature scan, key informant interviews, and four surveys is provided in Appendix 1.[21]

### 2.3.1 Approach

In brief, the survey workstream employed a utilisation-focussed approach to provide information on what worked well, what was less effective, and to inform future welfare response delivery. These were guided by:

- principles of utility, credibility, ethics, and professionalism

[20] The associated sub-questions are listed in Appendix 1, along with the indicators developed to guide the development of the survey questions and interview schedules. The KEQs indicators articulate what good may 'look like' for each KEQ.

[21] The literature scan is provided in a separate document.

- mana-enhancing practice
- ethics approval from MSD's Research and Evaluation Ethics Panel. A separate Privacy Assessment was also conducted.

### 2.3.2 Data collection

The evaluation team undertook the following data gathering activities from February to September 2023:

- a review of contextual documents
- a literature scan
- 16 key informant interviews with MSD and other national-level government agencies who designed and operationalised the response
- surveys with the three key delivery groups in regions and communities:
  - RLGs (including RPSCs), 78 respondents with valid data
  - community providers, 95 respondents with valid data
  - Community Connectors, 139 respondents with valid data
- a survey of recipients of the CiC welfare response – isolating households who received support from community providers (including from Community Connectors and/or food parcels) – which had 255 respondents with valid data.

### 2.3.3 Analyses

#### Quantitative analysis

The evaluation team used the industry standard analytical language R (using jamovi as the user interface) to conduct the analyses.[22,23] Descriptive statistics including raw counts, means, and percentages were calculated. Chi-square tests were used to test for significant differences in key variables between subgroups.

#### Qualitative analysis

The evaluation team undertook a thematic analysis of qualitative data from the key informant interviews. The data was coded, and a deductive approach was used to identify themes that were relevant to the key evaluation questions. The analysis also explored the experiences of the different groups involved in the CiC welfare response, including those at the local, regional, and national levels. This process involved identifying commonalities of experiences and what elements may be specific to different stakeholder groups. As part of the analytical process,

[22] R Core Team (2022). R: A Language and environment for statistical computing. (Version 4.1) [Computer software]. Retrieved from **https://cran.r-project.org**. (R packages retrieved from CRAN snapshot 2023-04-07).

[23] The jamovi project (2023). *jamovi*. (Version 2.4) [Computer Software]. Retrieved from **https://www.jamovi.org**;

the team identified lessons learned about how the response was implemented, and about the delivery of services in ways that worked for Māori and Pacific peoples.

### Sense checking

The *Allen + Clarke* team presented the emerging findings from the survey workstream at two sessions: firstly, with key MSD personnel, and secondly with the MSD CiC Governance Group. In these sessions the team presented the initial findings and sought feedback from attendees regarding whether the findings appeared relevant, useful, and accurate. These insights further shaped the analysis and write-up of the final report.

## 2.4 Limitations

The survey workstream focuses on the perceptions of national stakeholders, community providers, Community Connectors, and households who needed to isolate due to a positive COVID-19 test and who received support from a community provider (including from Community Connectors and/or food provision).

*Methodological limitations*

It was not possible to collect data about the prevalence of unmet needs for those having to isolate or for those who sought support from other avenues. This was because it was not possible to access data on households who reported a household member having tested positive for COVID-19. Therefore, no data was able to be gathered from households:

- who needed support but were not aware there was support available
- who knew of the support available but chose not to use it
- who may have sought support but did not receive it
- who were supported in other ways.

The survey workstream cannot provide information on outcomes for all households required to isolate and does not allow for a comparison of CiC-specific supports with other health or welfare supports for isolating households, such as Whānau Ora or family and friend networks. There is also no available counterfactual against which to compare the outcomes of the CiC welfare response.

*Limitations related to the surveys*

There are a range of limitations related to the collection of the survey data. For the household surveys, there was no data available regarding the total population of households supported by the CiC welfare response. As there was no estimate available of the total population size, it is not possible to determine the extent to which the household sample is representative of the characteristics of the full population of households that received support through.

The evaluation team relied on community providers to distribute the surveys to households they had supported. This introduced the potential of selection biases in the household survey, including the following:

- only one-third of community providers were able to distribute surveys (24 out of the 74 randomly selected providers distributed the surveys)
- it was not possible to distribute surveys to households directly supported by MSD, despite direct contact with MSD being a key avenue to access support
- a large proportion of community providers preferred to distribute paper-based versions of the survey, leading to missing data as respondents did not answer some questions or gave invalid responses (e.g., multiple answers in a question requiring a single response)
- there was the possibility that households with very positive or negative experiences of support were more likely to have responded
- very few questions were compulsory (an ethical requirement) so there was missing data in the survey responses.

There were relatively good response rates for the community provider (95 valid responses from 221 emails sent) and Community Connector (139 valid responses from 189 emails) surveys. While we do not know the total number of RLG members and households whose participation in the surveys was sought, the number of responses for these groups was low; the RLG survey had 53 valid responses and the household survey had 255 valid responses. Those responding to the household survey are a very small subset of the total number of people supported by the CiC welfare response. The findings should therefore be interpreted with caution.

The small sample size for all surveys meant that it was not possible to breakdown findings by region as initially intended.

*Limitations of the national stakeholder interviews*

The stakeholder interviews were conducted with key individuals involved in the CiC welfare response at the national level, with the focus being on the implementation of the response and inter-agency relationships and communications. Implementation of the response at the regional and local levels was not part of this workstream.

The findings from the qualitative interviews provide data only on the perspectives of national stakeholders that participated in the evaluation. The individuals selected for the interviews represent a range of central government departments involved in the CiC welfare response. This strengthens the relevance of the findings, but nonetheless those engaged are only a small portion of those who were involved in the response at the national level. The findings are therefore not necessarily representative of the views of all national stakeholders involved in the CiC welfare response.

Those involved in the CiC welfare response at the national level are likely to have an interest in presenting their role in the response in a positive way. Whilst this perspective is valuable and critical for the evaluation, it is not neutral. An unbiased perspective is difficult to capture from stakeholder engagement almost by definition. To mitigate this, perspectives from those involved at the regional and local levels were also captured, via the surveys.

While the number of national stakeholder interviews was small, they were held with people who had been highly involved in the CiC welfare response at the senior leadership level and had insights available to them that few other individuals would have. Many of the interviewees also had networks and working relationships with staff in regional offices and community providers. Accordingly, appropriate weight was given to their voice, including reporting on issues raised by one or two interviewees, to ensure that the perspectives from smaller, often population-based, government agencies were included.

# Part B: Findings

# 3 The locally-led, regionally-enabled, nationally supported model

This section reports on findings from the survey workstream regarding how well the CiC welfare response model was implemented and the outcomes it achieved. This includes assessing how well the model operated at three levels – locally, regionally, and nationally – with a focus on the system architecture across these levels and the relational conditions that enabled implementation. This section also assesses how well the implementation of the CiC welfare response involved Māori and priority populations.

The findings in this section contribute to addressing the following KEQs:

*Implementation*

- KEQ 1.1 How well was the welfare response implemented?
- KEQ 1.2 What were the conditions and levers that enabled implementation of the response? What were the barriers to implementation and how were these addressed?
- KEQ 1.5 How and in what ways did the welfare response complement support from the Ministry for Pacific Peoples and Te Puni Kokiri?

*Outcomes*

- KEQs 2.1 To what extent did the welfare response achieve its intended immediate results and short-term outcomes?
- KEQ 2.2 What progress is being made to achieve medium to longer-term outcomes of the welfare response?
- KEQ 2.3 What were the unintended outcomes of the welfare response?
- KEQ 2.4 To what extent did the welfare response help to create, maintain, and/or improve relationships between national, regional, and community partners in the response?

The findings are primarily informed by the responses to three of the four surveys – the RLG survey, the Community Connector survey, and the community provider survey – along with national stakeholder perspectives. The household survey contributed limited findings to this section and is reported on in detail in Section 4.

In considering the findings, it is important to remember the rapidly evolving context in which CiC policy development and operational delivery occurred. Interview participants described the COVID-19 pandemic as a time of flux and uncertainty.

> *I often use that analogy - building the plane while you fly it, but this was building the plane while you're building the airport that you're going to land in.* (National stakeholder)

# 3.1 National support

This section focuses on the support implemented at the national level, including enablers for the welfare support such as policy, funding, contracting, and government systems and processes. Findings related to the involvement of priority populations in the CiC welfare response are reported in Section 3.4.

## 3.1.1 The contracting and funding model

### Certainty of funding and flexibility of contracts were highly valued

The CiC welfare response contracting model had several features that the surveys highlighted as critical to enabling the successful delivery of the response. Community providers reported that certainty of funding was the most valuable aspect of the contracting model, followed by contract flexibility (Table 2). The direct sourcing procurement model ranked third.

> *Having the financial means to make decisions based on what was needed without having to look for funding took one variable out of the equation. It meant less stress for our organisation to be able to respond adequately.* (Community provider)

*Table 2: Most valued aspects of the contracting model (community provider survey)*

| Valued aspects of the contracting model | Rank | Mean | n |
|---|---|---|---|
| Certainty of funding | 1 | 1.47 | 53 |
| The flexibility that was built into contracts | 2 | 1.98 | 53 |
| The direct sourcing procurement model | 3 | 2.64 | 53 |
| Other aspects included ease of reporting, that all aspects were equally valued, support from MSD staff, communication and being included | 4 | 3.91 | 53 |

The flexibility built into the CiC welfare contracting model was rated as the second most valuable aspect by the community provider survey respondents. Eighty-two percent of respondents agreed that the contracts were sufficiently flexible to enable their organisation to tailor their support to community needs (Table 3). A slightly higher percentage (85%) agreed the contracts were sufficiently flexible to enable their organisation to respond to changing circumstances. The open text comments showed that providers valued that the contracting model was flexible enough to enable to them to meets their clients' needs, along with the trust that was given to them to use funding as they saw fit.

> *We could tailor make what was needed and respond immediately via our current work with people we worked with or with others that became known to us, as we had the financial ability to do so.* (Community provider)

> *Targeted assistance for those in desperate need along with flexibility and adaptability of the response was very effective to meet the evolving needs of households during the pandemic, recognising that support circumstances were changing rapidly.* (Community provider)

> *We were able to serve our whānau to a great breadth and depth… this was empowered by the funding and support of MSD, and the fact that a government department let us take a leading role, by allowing flexibility in the way we utilised the funds that were allocated.* (Community provider)

*Table 3: Feedback on the contracting model (community provider survey)*

| Statements about the CiC welfare response contracting model | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Contracts were sufficiently flexible to enable your organisation to tailor support to community needs | 65 | 81.5 % | 12.3 % | 6.2 % |
| Contracts were sufficiently flexible to enable your organisation to respond to changing circumstances | 66 | 84.8 % | 7.6 % | 7.6 % |

The majority (86%) of community provider survey respondents reported that they had received adequate information regarding the contracting arrangements. A majority (80%) also stated that the contracts enabled them to build capacity to meet the needs of their communities, and 79% said the contracting model enabled their organisation to meet people's needs more effectively than traditional models.

An interview participant from a government agency (not MSD) reflected on their organisation's more flexible commissioning and contracting approach to funding, relaxing targets, and creating an understanding that the funding could be used for *"whatever [communities] needed in that community to be supportive."*

> *Funding an advance in anticipation of things that might come through. Having access to stocks, especially for food that could go out quite quickly. So just trying to be as proactive as possible.* (National stakeholder)

### The reporting tool was easy to use but did not always capture the right information

Three-quarters (75%) of community provider and Community Connector survey respondents agreed that the SORT reporting tool was easy to use, with 77% of community providers and 69% of Community Connectors agreeing that the time required to complete the SORT tool was about right. A total of 61% of community providers and around half (53%) of the Community Connectors agreed that the SORT tool captured the right information.

> *The initial contracting process and funding worked well. The regular SORT surveys enabled us to report on what we were doing without fuss.* (Community provider)

Suggestions from Community Connector respondents for other information to capture included collecting the story of the whānau or the households' context, religion, first language, and number of times the individual or household had been supported. Community provider respondents suggested the SORT tool needed to supply further information around food distribution channels (e.g., for food providers), non-COVID food support, and support categories that included *"families with school aged children, seasonal workers, older people".*

## A 'high-trust' model was a key enabler to the CiC welfare response, but it was not always evident

More flexible approaches to allocating funding for community responses was highly regarded by community provider survey respondents and reported as very helpful to enabling appropriate adaptation to the rapidly changing situation on the ground. Community providers also received more financial support for back-end functions and processes.

Providing joined-up and cohesive national support for the CiC welfare response model required significant changes and different ways of working within MSD and with other government agencies. Interview participants highlighted the shift to a 'high-trust model' where local leadership was trusted to know what is needed and supported to deliver the welfare response. This included:

> *Trusting people on the ground who knew what was needed and able to develop the thing that was needed in changing circumstances.* (National stakeholder)

> *Trusting community providers to support communities in ways that made sense and acknowledging our [government] limitations. The community model [is about] trusted faces and trusted places.* (National stakeholder)

Despite this shift, a national stakeholder identified the existence of *"unbalanced trust".* While the insights from people on the ground about what was going on were very important, sometimes people on the ground were not listened to or trusted as sources of information that could help determine what resources were needed.

> *We trust them to deliver certain aspects and do the good work they were doing, but when they fed back to us on what they were doing and what they could see, they were treated as though they were not credible.* (National stakeholder)

Other interview participants spoke about local intelligence being *"diluted"* by the subsequent response from government agencies.

> *We're giving all this intel, this evidence, and we're pushing it up. And what's actually coming back through, for instance, through the likes of DPMC and MSD is a very what I would like to call a diluted sense of what our […] communities actually need … [including] disseminating funds or support to our communities.* (National stakeholder)

### Prior groundwork enabled MSD to quickly establish the locally-led, regionally-enabled and nationally supported model

MSD interview participants highlighted that one of the enablers that contributed to the successful implementation of the locally-led, regionally-enabled, and nationally supported CiC welfare response was MSD's prior groundwork with community providers. Discussions about enabling national responses to be locally adapted and focused on local need had been occurring since 2020 as part of the Social Sector Commissioning work programme and with a Chief Executives' group. Immediately prior to the start of the COVID-19 pandemic, MSD had convened a major hui with providers, iwi, and community organisations to explore *"a fundamental transition in how we commission alongside and with the community sector to achieve better social outcomes"* (national stakeholder). A series of commissioning principles to guide different ways of working were evolving and put *"straight into play"* as part of MSD's COVID-19 welfare response. These principles had both MSD and community providers agree to:

- act honestly and in good faith
- communicate openly and in a timely manner
- work in a collaborative and constructive manner
- recognise each other's responsibilities
- encourage quality and innovation to achieve positive outcomes. [24]

### The CiC welfare response raised expectations about collaboration

Interview participants reported that the CiC welfare response model raised community provider and national agency staff expectations of collaboration and community-led change. The locally-led, regionally-enabled, and nationally supported model has subsequently been further tested and used in response to two climate events.

> *I think the CiC model definitely raises the expectations for collaboration amongst the amongst government agencies from the sector and also from community, because they're like well, if you [government] did it in CiC then my expectation is that you should continue to do it.* (National stakeholder)

### Uncertainty in the demand for funding and accountability requirements created work for MSD staff

There were tensions created by the uncertainty of determining funding demand. MSD interview participants spoke about the unrealistic level of precision required for funding when demand was uncertain. Part of the uncertainty was due to a lack of information from providers who were, as reported by an MSD interview participant, *"working around the clock"* to support communities. Funding was allocated in *"short bursts"* where *"we had to go and seek funding from Cabinet a lot"* (national stakeholder). This was described as not being operationally

[24] MSD. (2022). Community Connection Service - Service Guidelines.

sustainable. Repeatedly seeking and being allocated short-term funding created slower responses and higher compliance costs for MSD staff. Interview participants spoke about the need for more trust and ways of allocating funding that were more responsive, with an appropriate level of scrutiny, for example, a contingency fund that could be drawn down as needed.

> *At the height of situations we were going back every two to three weeks seeking more funding, which is not sustainable and puts a lot of uncertainty around your operating model, from a business continuity and safety perspective.* (National stakeholder)

Importantly, funding and contract certainty was needed for providers' business and workforce continuity and safety. Balanced against the extraordinary pressures and workloads within MSD was the need to pause and evaluate the model to ensure it was delivering the right services to the right populations once sufficient data had been gathered.

> *We felt they didn't do so well on the costing cause it was sort of a model like how many people are we gonna serve here? How much are we gonna need? It was a real punt at the beginning, but then a few months into it, they [MSD] had 3 months of actuals, it was almost like they didn't reforecast*. (National stakeholder)

Accountability requirements also created additional work. Interview participants said the level of funding oversight was an *"unnecessary distraction because inevitably we're all trying to do the same thing."* An interview participant spoke about receiving hourly emails from Ministers to *"justify and validate and confirm that our funding was only being used for this and that and this."* Government agencies working together and providing contributory rather than full funding also led to the complexity of reporting how funding was used.

> *And so our ability to respond to peak demand was hugely inhibited and the amount of work arounds that operational teams had to come up with was just significant and probably unnecessarily so if we had started from a design place of interoperability a bit more.* (National stakeholder)

### 3.1.2 MSD systems and processes

#### MSD's internal systems and processes were well set up to support the welfare response

MSD interview participants reported that their internal agency arrangements were well set up across the organisation; in particular, these arrangements enabled collaboration between the Food Secure Communities programme, Community Connection Service, Māori Communities and Partnerships team, Policy, and Service Delivery teams. These teams included staff with regional and community relationships who had *"an ear for what communities were saying"* (national stakeholder). There were clear roles at each level, the arrangements worked effectively, and were described by an interview participant as *"not overly bureaucratic"*. This

enabled MSD to understand *"what was happening on the ground"*, identify new policy work, and immediately feed into Cabinet advice. Needs and issues could be quickly escalated to the appropriate level.

### MSD successfully managed communication in multiple directions

MSD successfully managed communication in multiple directions – upwards from community to government, outwards from national to regional and community levels, and across government agencies. Of these, information sharing from national to regional organisations was the only one that was considered less effective by national stakeholders. Success factors in communications included efforts made to ensure agility and consistency.

### Staff passion and effort were key enablers to the implementation of the welfare response

Interview participants highlighted that people within MSD and other government agencies had the passion and drive to work collaboratively to provide coherent, coordinated policy and operational responses that supported the CiC welfare response model to work on the ground. It was evident from the interviews that designing and operationalising the welfare response in a rapidly changing environment took a huge staff effort. Staff were reported to be highly committed to doing their best to have everything prepared as quickly as possible and be available to answer any questions from local providers. An interview participant spoke about using scenario planning while waiting for policy decisions to ensure communications and resources were ready as soon as possible after a decision.

> *We worked a lot of overtime in order to write policy advice and do all the engagement and ensure everyone was on the same page. I don't think we were all adequately resourced*. (National stakeholder)

MSD interview participants spoke about being pro-active – anticipating, planning, and preparing both communications and funding for community providers in advance. They highlighted that this was important to support community providers who were often asked to action government decisions at very short notice. They also spoke about the importance of being *"authentic partners"*, tailoring some procurement processes to reflect working in partnership with community providers. This aligns with more relational approaches to commissioning reflected in the Social Sector Commissioning principles (Section 3.2.1).

> *We tried to do things proactively, we had the mechanics ready …. So being able to front foot funding alleviated some of the [community provider] anxiety… we'd say make that change and we'll give you money in two weeks' time.* (National stakeholder)

> *… sometimes the comms is retrospective, but at least they see the actions have been proactive. [Also] relaxing some of our procurement processes, not to create any risk for the organisation, but actually to do it in the context of partnership.* (National stakeholder)

### Some policy decisions created operational challenges

Some policy decisions and ongoing changes in government settings resulted in community providers needing to pivot or transition without support, in very short timeframes, along with needing to continue providing their business-as-usual services in some instances.

> *Government expected providers to change settings and it would be from midnight to midnight and it could be fundamentally changing the way providers were having to think about their work and do their work. And there wasn't ever the [time] lag for that.* (National stakeholder)

> *For a community organisation who still is being asked to deliver a family violence training or give our food out to those that need it, how do you make that happen within 24 hours.* (National stakeholder)

Interview participants identified that very regular (weekly if not daily) communication between MSD, community providers, and RLGs and 'front-footing' such decisions through scenario planning and pre-preparing communications and funding was important in addressing these challenges. However, some community providers struggled to keep up with the volume of communications coming out with, at times, evolving advice from multiple government agencies.

## 3.1.3 Complementarity and duplication of support

### Views on how well the CiC welfare response complemented support from other government agencies were mixed

RLG survey respondents reported some duplication between CiC welfare response support and the Ministry for Pacific Peoples and Te Puni Kōkiri funding at the regional level. Over half of respondents (61%) reported that there was duplication of MSD's CiC welfare response support with that of other agencies. However, four of the five RLG iwi member respondents reported no duplication.

Reasons for duplication given by RLG survey respondents included too many or complicated funding pathways, overlapping funding from different funding sources, and funding flowing through both local and national contracts.

> *Funding was sometimes overlapped and there was a lot of different funding streams going to different agencies for similar things*. (RLG member)

> *Cross over from local delivery and 'national' level delivery through contracts organised at a national level with national groups.* (RLG member)

RLG respondents also reported there was insufficient communication around related welfare support.

> *TPK [Te Puni Kōkiri] provided funding that was similar to MSD, and we didn't always know about it ahead of time due to the speed things were being done at.* (RLG member)

National stakeholder interview participants were less concerned about duplication of funding streams. Where duplication existed, national stakeholder interview participants reported that community providers made the various funding streams from different agencies work in practice, using the funding to respond to needs on the ground without delivering duplicate services. Moreover, they reported that the flexibility of CiC funding enabled this to occur.

> *I think the problem of duplication was mostly mitigated at their [community providers] end because they knew who they were serving and who was doing what. And I don't think there's any reasonable argument that anyone was duplicating. They might have had some similar contracts for similar things from different agencies, but we know they would have been delivering those to different people.* (National stakeholder)

MSD interview participants spoke about the CiC funding processes *"maturing"* and being a *"learning curve"* as they progressed. Key to this process was having consistent, trusted relationships with the right people in the conversation. This eventually enabled conversations about, for example, who was best placed to apply to Cabinet for funding and inputting into other agencies' Cabinet papers. They described forming panels of agencies to work together for each funding approach such as community grants and service provision funding.

> *So you know … it's all a learning curve and then so you know through the first papers we started to have conversations ... Who can you work with, and we did it more in terms of what we called panels. So, we had panels formed for each funding approach.* (National stakeholder)

### The CiC welfare response complemented and utilised support from Māori wardens which was scaled up

An interview participant described that in some regions, Māori wardens were significant contributors to the CiC welfare response. There was *"quite high demand for [their involvement in the] care in community kaupapa"* (national stakeholder). Te Puni Kōkiri connected Māori wardens to community providers and the RLGs. Te Puni Kōkiri was able to scale-up the services and support delivered by Māori wardens through the Māori Communities COVID-19 Fund.

> *Māori wardens are different [with] their care and organisation. It is about their knowledge and presence with relationships with people. [They] talk to people about how they were coping in their homes, [at a] individual one-to-one level with*

> *whānau, which was gold. Māori wardens are so well connected to Police and social service providers. … Their general presence around the pandemic was in high demand*. (National stakeholder)

### The co-existence of the Community Connector model and Whānau Ora created opportunities and challenges for Māori providers

The Community Connector role was explicitly designed to be supplementary to existing navigator roles. However, a national stakeholder queried the need for the creation of the Community Connector model, given there were already Whānau Ora Navigators working with Māori communities. They expressed a preference for the Whānau Ora Navigator workforce to have *"powered up"* to accelerate support to whānau. Concern was also expressed about the perceived lack of flexibility in the Community Connector model compared with the Whānau Ora Navigators.

Conversely, in support of the co-existence of both models, another interview participant spoke about the need to reach Māori communities who did not *"work within the Whānau Ora framework"* (national stakeholder). A national stakeholder reported that the creation of parallel models provided a choice for Māori providers regarding whether they sought resources from being part of Whānau Ora, or via CiC funding.

> *What the establishment of Community Connectors and broader Care in the Community funding for Māori providers created was an opportunity whereby [Māori providers] no longer had to be part of Whānau Ora to get similar sort of resources.* (National stakeholder)

However, it was reported that for some providers that were already receiving Whānau Ora funding and subsequently received CiC funding, Whānau Ora discontinued their funding so it could redistribute the funding to where Whānau Ora saw the need.

> *Those providers that received funds from MSD… were cut by Whānau Ora as a response… it was also like you're getting resources from MSD now to do effectively the same thing, you don't need our resources anymore, and we can redistribute them to the areas that most need it, and it just kind of pulled providers apart.* (National stakeholder)

Some providers who already had Whānau Ora Navigators used the CiC funding to continue this approach, weaving the funding into their programmes to ensure they were fit for purpose.

> *They ensured they satisfied the MSD reporting requirements and delivery requirements. But in actual fact, what they were doing was they were equipping those FTEs with the skills that they would expect of any other Whānau Ora Navigator. So, in a sense, you could see the FTEs was not perfectly fit for purpose, but the provider made it more suitable for the community in which it operated.* (National stakeholder)

### 3.1.4 Collaboration between central government agencies

**Efforts to 'work across' government silos mostly worked well**

Providing joined-up and cohesive national support for the CiC welfare response model required significant changes and different ways of working within MSD and with other government agencies. Interview participants regarded cross-agency senior management arrangements as well set up and working effectively.

Staff working on the CiC welfare response tried to reduce agency silos by ensuring they kept communications open between participating agencies and knew who was responding to differing requirements of the welfare response such as policy development, Māori and priority population insights and engagement, contracting, and service delivery. Strong existing relationships between government agencies across different levels were a key success factor in the CiC welfare response, and national office MSD staff described a willingness to work together amongst their counterparts in other agencies. Interview participants also spoke of the evolving trust and rapport that occurred at different levels of government – among senior management, those in working groups, and between government agencies responsible for funding the delivery of the CiC welfare response. This sentiment was echoed by other interview participants who commented on how well individuals and agencies worked together with the shared goal of supporting New Zealand through the pandemic. However, there was some concern that this level of collaboration and community involvement was being lost *"as the rubber band of government slips back from crisis to BAU"* (national stakeholder).

Other national stakeholder interview participants noted that *"government is good doing things in their own lane"*. They commented that working across agencies to provide coordinated inter-agency responses was difficult due to different ministerial drivers, priorities, and delivery responsibilities driven by separate funding votes. Another national stakeholder reported that collaboration and coherence tended to occur *"in spite of the system; not because of it"*. Another interview participant spoke about addressing these barriers through government managers and staff prioritising time to either work together or, at a minimum, ensure they were informed about what each organisation was doing and not duplicating each other's activities.

> *Everybody has priorities and a Minister they are responding to, separate votes and different things they are responsible for delivering. Those are things you can recognise and work through. … We found ways to make time to meet to discuss and make time for work that was coming from the CEs. We knew what one another were doing. We weren't setting something up another Ministry was doing.* (National stakeholder)

A lack of shared understanding by decision-makers across government agencies of the realities of a community-led approach also impacted the coherency of the delivery of the CiC welfare response. Population-based agencies were crucial in relaying community insights to government agencies, although representatives of these agencies considered that those insights were not always taken on board.

Other interview participants described non-aligned operational models and information technology (IT) systems presenting challenges regarding referral processes, sharing information, and reporting. There was a lack of compatibility between MSD's and the Ministry of Health's IT systems which inhibited MSD's ability to operationalise the CiC welfare response quickly and respond to demand, especially peak demand. The lack of compatibility resulted in the need to create workarounds that required a significant amount of work.

> *A significant challenge to our [MSD's and Ministry of Health's] ability to work with one another was our two systems not being able to talk to one another. There was a major technological capability problem between our two ministries that meant that we couldn't quickly operationalise something. It took them literally months to come up with solutions, which by that point, you know, we were well past peak periods*. (National stakeholder)

The importance of *"everything being aligned from the top to bottom"* to enable ongoing cross-agency collaboration was raised by a national stakeholder, given the need to support recovery from climate and other crisis events. Another said that:

> *To achieve joined-up work on the ground requires overcoming many obstacles. Ministry operating models require a complete overhaul. Technological, governance and people systems are not set up for collaboration. If government does really believe in holistic service and wellbeing provision, we need to do things differently within government to make that a reality*. (National stakeholder)

### A lack of clarity around roles and responsibilities, and lack of clear definitions of health and welfare were barriers to implementing a join-up approach

National stakeholder participants noted a lack of clarity about how roles and responsibilities were shared between agencies. Participants spoke about the need for greater policy-operational alignment, specifically ensuring both policy and operational staff are *"in the same conversation"*. One interview participant spoke about the direction needing to reverse – *"operations need to lead the policy"*.

> *What makes sense from a policy perspective was extremely difficult from a practical perspective.* (National stakeholder)

There were differences in understanding between those working in health and welfare, particularly in how different responses were delivered by separate agencies despite the significant overlap in the household needs being addressed.

> *So you had the welfare system which was not a COVID response and then you had COVID welfare responses and then your healthcare in the community.* (National stakeholder)

MSD interview participants spoke about challenges arising due to primary health practitioners not seeing the need for a separate MSD welfare response as some considered 'welfare' to already be an integral part of a primary health response.

> *The definition of welfare itself became an incredibly important challenge that we had to overcome and was really difficult to start with because we didn't realise that that we were talking across one another.* (National stakeholder)

This was overcome by MSD staff talking with primary health Chief Medical Officers about the specific assistance that MSD could provide.

> *We're talking across each other, so let's just talk about what that actually means from an activity perspective like, 'So what are we doing versus what are you doing?' … Once we started talking on those real terms rather than these vague terms like welfare, people could see. 'Oh yes, I see you plug that bit. We do this bit.'* (National stakeholder)

### Te Puni Kōkiri, the Ministry for Pacific Peoples, and other agencies had limited opportunity to co-design the CiC welfare response in the beginning, but this improved over time

MSD interview participants reported that cross-agency working groups were set up to coordinate with Te Puni Kōkiri and the Ministry for Pacific Peoples who were already *"doing a lot of work".* MSD participants noted that this supported an all of government view and ensured policy advice and its operationalisation with community providers was coherent and consistent.

Other interview participants, particularly those from population-based agencies, raised concerns about their limited ability to co-design the CiC welfare response. This appeared to be a particular concern in the initial stages of the response where participants from a range of government agencies experienced a consultative rather than a collaborative design process. However, most interview participants noted that the process improved as the response was implemented, including more collaboration with population-based agencies.

> *…a structure was pretty much put on in front of us by MSD and some of the larger agencies on a Monday and we had to find some responses by Tuesday.* (National stakeholder)

> *I will say Māori, Pacific and ethnic communities don't feel like they were necessarily at the table. They were being brought in as and when required, at least in the first few weeks. But very quickly after that … the Ministry started to be involved in a coordinated central government response.* (National stakeholder)

Interview participants acknowledged that *"there wasn't that much time to go through a robust design process"* (national stakeholder) and that this potentially meant that some assumptions

underpinning the design were not able to be tested by all population-based agencies with their communities.

> *I'm not saying that it was wrong to do things the way it was. I will say, though, it necessitated some assumptions that were not necessarily robust for other agencies. I know for us, we could talk confidently about what our communities' needs were, we can speak and point to responses from our communities that they are messaging*. (National stakeholder)

Interview participants reported experiencing a shift over time from 'consultation' to more of a 'collaborative' approach as there was more deliberate involvement of the population-based agencies. This may have reflected reduced urgency following the design and initial implementation of the CiC welfare response.

> *So, while at the beginning it might have been a little rough. It feels now that we've worked into this. We've come to this agreement that we all need to be at the table, and we respect each other's views*. (National stakeholder)

Some interview participants suggested that the flexibility and high-trust demonstrated in the CiC contracting model with community providers needed to be extended to MSD's relationships with smaller population-based agencies. They noted that the population-based agencies were *"a lot more limber as an individual agency than the system to respond to communities"* (national stakeholder) and were seen by both government and communities as an important conduit in times of need.

### There were concerns about the sufficiency of national-level resources required to deliver the welfare response

National stakeholder interview participants raised concerns that resourcing of the CiC welfare response also needed to consider national-level staffing of the response, as well as the adequacy of resourcing to deliver the response at the community level. Participants described their COVID-19 response work as considerable and in addition to their business-as-usual work. They spoke about staff working hard (*"we had massive TOIL numbers"*) to ensure no communities were left behind. Participants from MSD and the Ministry for Pacific Peoples spoke about being concerned for the welfare of their staff, *"as was every other agency"* (national stakeholder). Some interview participants reported that the infrastructure, including human resources, needed to respond to major events is not yet sustainable.

### 3.1.5 Outcomes

At the national level, the CiC welfare response was expected to deliver the following outcomes:

| **Short-term outcomes** |
| --- |
| • new ways of working with iwi, Pacific peoples, and communities<br>• new ways of working across public service developing<br>• sectors and agencies well-placed to safely deliver services that meet the needs of their specific communities. |
| **Medium-term and long-term outcomes** |
| • a joined-up regional public service<br>• authentic partnerships with iwi<br>• new ways of working embedded in principles, practice, and policy<br>• a unified public service that organises flexibly around the needs of New Zealanders. |

The findings discussed across Section 3.1 indicate the following:

- government systems contributed to the successful implementation of the CiC welfare response, building on prior groundwork with providers in the community sector that enabled MSD to pivot to a locally-led, regionally-enabled, and nationally supported model
- more flexible approaches to allocating funding for community resources helped to respond to the rapidly changing situation
- strong existing relationships between organisations were a key success factor in the welfare response, and staff were highly rated for their attitude and willingness to work hard together
- MSD successfully managed communication in multiple directions – upwards from community to government, outwards from national to regional and community levels, and across government agencies
- there was a reduction in government agencies working in silos in the delivery of the welfare response, although there was not always strong collaboration, particularly with the population-based agencies
- collaboration occurred at the regional, national-regional, and national levels.

The findings suggest a need to look critically at the benefits and risks of a devolved high-trust model and to distinguish this from a crisis support model. This includes asking whether this is the best approach as the *"long-term benefits [of] investment and the programme are unproven"* (national stakeholder). The CiC welfare response model was focused on addressing immediate need, rather than the core reasons why many in the community needed support in the first place, such as income inadequacy.

> *I think what we've learned from experience is to be asking some of the questions earlier and being firmer about moving to a devolved model of delivering government services or support through partners. We're not going to have the same accountability because it's not delivered by a government agency. So, accepting all of that. This made a difference for us because we learned a lot through the Care in the Community model… I think a lot about partnership and who's around the table*. (National stakeholder)

## 3.2 Regional enablers

This section focuses on support implemented at the regional level, particularly through regional leadership structures (RLGs and RPSCs). In line with expected outcomes outlined in the CiC intervention logic model, this section considers the extent to which regional leadership structures and operations were inclusive, collaborative, and enabled coordination.

Findings related to the involvement of priority populations in the CiC welfare response are reported in Section 3.4.

### 3.2.1 RLG functioning

#### There was broad agreement that RLGs functioned effectively

A majority of RLG survey respondents agreed that all the relevant organisations were represented on their RLG (89%),[25] that the meeting frequency was about right (89%), that members collaborated effectively with each other (87%), and that MSD supported the RLGs to enable the CiC welfare response (87%). There was lower agreement (62%) that the RLGs had created effective sub-structures like working groups (Table 4). Given the high-level regional focus of the RLGs this is not unexpected.

*Table 4: Effectiveness of the functioning of the RLGs (RLG survey)*

| Statements about how RLGs functioned | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| All relevant organisations were represented in my RLG | 47 | 89% | 8.5% | 2.1% |
| The frequency of meetings was about right | 47 | 89% | 11% | 0% |
| The members of my RLG collaborated effectively with each other | 47 | 87% | 11% | 2.1% |
| My RLG was supported by the MSD national office to enable the CiC welfare response | 46 | 87% | 13% | 0% |
| My RLG created effective sub-structures (such as working groups) | 47 | 62% | 30% | 8.5% |

[25] There is an unavoidable bias in that those who were not part of a RLG had no opportunity to comment about representativeness on RLGs in these findings.

## RLGs enabled a locally-led, coordinated, and effectively funded regional response

There was strong agreement (91%) from RLG survey respondents that their RLG enabled community providers to lead the CiC welfare response in their regions (Table 5). Almost three-quarters (74%) agreed that their RLG was critical in ensuring the CiC welfare response was well coordinated. Over two-thirds (70%) agreed that their RLG supported funding to be prioritised effectively in their region.

*Table 5. RLG support for the CiC welfare response (RLG survey)*

| Statements about how RLGs supported the welfare response | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| My RLG enabled community providers to lead the CiC welfare response in my region | 46 | 91% | 4.3% | 4.3% |
| My RLG was critical in ensuring the CiC welfare response was well coordinated in my region | 46 | 74% | 20% | 6.5% |
| My RLG supported funding to be prioritised effectively in my region | 46 | 70% | 22% | 8.7% |

These findings indicate that RLGs were fulfilling their intended function of 'enabling' the community to lead the response.

> *The best thing the RLG did was stay in their lanes and let the operational folks get on with it. We were there to remove barriers if they arose and keep everyone above operational level connected.* (RLG member)

## Community providers reported being supported by RLGs, CiC hubs, and MSD

The majority of respondents to the community provider survey (86%) reported that they were supported by the local RLG (Table 6). A majority (84%) also indicated that they were supported by the local CiC hub (84%), while a lower proportion of community provider survey respondents (63%) reported being supported by the RPSC. This needs to be interpreted carefully as the RPSC may not have had the capacity or need to directly engage with all providers in their area.

Additionally, a majority of community provider survey respondents (80%) indicated that they were supported by the MSD national office. On the other hand, one-in-five (20%) survey respondents reported that they were not well supported by the MSD national office.

*Table 6: Extent community providers felt supported to deliver the CiC welfare response (community provider survey)*

| Agency or group providing support | n | Felt supported |
|---|---|---|
| RLG | 62 | 86% |
| CiC hub | 61 | 84% |
| MSD national office | 60 | 80% |
| RPSC | 57 | 63% |

### There was strong stakeholder involvement in decision-making

At the regional level, there were some barriers to collaborative decision-making in the early stages of the welfare response. In particular, there were different ideas about RLGs' common purpose and ways of working, and different levels of connection in different regions. Comments in the survey imply that these issues resolved over time. RLG survey respondents reported high agreement that stakeholder groups were involved in decision-making (Table 7), particularly for government and iwi stakeholder groups. Involvement of iwi, Pacific peoples, and ethnic communities in RLGs is reported in Section 3.4.

*Table 7: Extent to which groups reported being involved in RLG decision making (RLG survey)*

| Group involved in RLG decision making | n | Involved in decision-making |
|---|---|---|
| Iwi | 46 | 98% |
| Central government public service agencies | 46 | 100% |
| Community organisations | 46 | 83% |
| Community leaders | 46 | 87% |
| Local government | 46 | 100% |
| Other community stakeholders | 23 | 67% |

### RLGs enabled tailored responses for Māori and socio-economically disadvantaged communities, but this was not always the case for ethnic communities and disabled people

In terms of the regional leadership model enabling tailored responses for Māori and priority groups, the majority of those responding to the RLG survey (Table 8) agreed that the RLG enabled a tailored response for Māori (88%). Four of the five (80%) iwi representative respondents also agreed. Most (71%) agreed that the RLG enabled a tailored response for Pacific peoples, while fewer than half (45%) agreed that it enabled a tailored response for ethnic communities.

The majority of RLG survey respondents agreed that the RLG enabled a tailored response to socio-economically disadvantaged communities (81%). This dropped to 62% agreement for the older population. Only 41% agreed that their RLG enabled a tailored response to disabled people. Homeless people and young people were reported in the comments as other groups that were not well served by the CiC welfare response.

This difference in support between different populations and communities was also found in the community provider and Community Connector surveys and is discussed further in Section 4.3.

*Table 8: Extent RLGs enabled a tailored response to community needs (RLG survey)*

| Priority community | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Māori | 42 | 88% | 7.1% | 4.8% |
| Socio-economically disadvantaged | 41 | 81% | 15% | 5% |
| Māori (iwi responses only) | 5 | 80% | - | 20% |
| Pacific peoples | 42 | 71% | 24% | 5% |
| Older population | 42 | 62% | 29% | 9.5% |
| Ethnic communities | 44 | 45% | 43% | 12% |
| Disabled people | 42 | 41% | 48% | 12% |
| Others | 8 | 38% | 13% | 50% |

It is worth noting that two government agencies dedicated to supporting priority groups did not exist when RLGs were first established (Whaikaha was established mid-2022 and the Ministry for Ethnic Communities was established mid-2021).

There was acknowledgement amongst national stakeholder interview participants that engagement with the disability sector had been limited during the initial stages of the CiC welfare response, but responsiveness to issues raised by disability communities improved over time. This included the establishment of a dedicated $8 million disability fund, for which 54% of the applications were successful (204 of 378 applications).[26] However, RLGs still appear to have struggled to achieve representation from disabled peoples at the regional level. Interview participants spoke about the need for future regional, place-based mechanisms to involve representation from Māori, Pacific, ethnic, and disability communities from the start of the initiative design to ensure further inequities are not embedded.

## Regional cohesion led to more collaborative and effective ways of working

Interview participants from central government agencies reported that the regional model enabled coordination to be strengthened between agencies, facilitating improved delivery of local services. One participant said that *"through the COVID stuff, we've seen the value and other agencies have seen the value of how we can join up at a regional level".*

Interview participants reported that the regionally-enabled model worked well because:

- the RPSCs were already in place and had strong existing networks
- there had already been national discussions regarding a shift to regionalisation and regionally-enabled support for the delivery of services on the ground
- there were deliberate efforts to ensure the *"right people"* were involved in the RLGs.

[26] https://www.msd.govt.nz/about-msd-and-our-work/covid-19/care-in-the-community-welfare-response/care-in-the-community-disability-welfare-fund.html

### The regional leadership model was constrained by centralised decision-making and agency silos

Interview participants and RLG survey respondents identified several challenges that acted as barriers to the effectiveness of the regionally-enabled response, including centralised decision-making and government agencies operating in silos.

Several interview participants and survey respondents noted that 'big picture' decision-making regarding programme design and funding occurred at the national level. Participants queried whether Wellington-based policy makers had all the knowledge that was needed to make design and implementation decisions that would work for the regions.

> *What I found most frustrating is the establishment of groups in Wellington to sit around the table and interrogate regional investment decision-making. Because actually the people here [in Wellington] don't know.* (National stakeholder)

> *I don't think the RLG influenced the CiC in any way that benefitted our communities as the decisions were made centrally and presented to the RLG as a done deal.* (RLG member)

Interview participants saw the regional response as having *"the potential to break down the silos of government".* However, siloing ultimately needed to change at a national level, along with delegating decisions about how funding was used, in order achieve the desired regional and community outcomes.

> *You might have a housing thing, and you might have an Oranga Tamariki thing, and you might have some MSD and some health things. The regions are constrained in what they can do with it because the parameters of what those funds are for and who they are there to support have already been determined.* (National stakeholder)

## 3.2.2 Regional relationships and networks

### RLGs were largely effective in building positive relationships with a broad range of stakeholder groups

The majority of RLG survey respondents agreed that their RLG was able to build positive relationships with government agencies (Table 9). Over half (58%) agreed that their RLG had formed positive relationships with the Department of Prime Minister and Cabinet (DPMC) Response Group.

At the regional level, 83% of the respondents agreed that the RLG had built positive relationships with iwi, while five of the seven iwi respondents (71%) agreed and one (14%) disagreed.

RLG survey respondents' views on their RLGs relationships at the community level were generally less positive than for government agencies, though still ranging from 69-76%. Around three-quarters agreed that their RLG was able to build positive relationships with community providers (74%) and with other community organisations (76%). The challenges in building collaboration and relationships are reflected in one RLG survey respondent's comment that their *"RPSC was spread very thin"* and that the RLGs were implemented differently across the regions.

> *The RLG does not meet consistently in this region and I cannot see any real advantages to meeting apart from strengthening existing relationships that I already have despite RLG. (RLG member)*

*Table 9: Ability of RLGs to build positive relationships with different stakeholders (RLG survey)*

| Stakeholder group | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| MSD | 44 | 93% | 7 % | - |
| Iwi | 46 | 83% | 15% | 2.2% |
| *Iwi (iwi respondents only)* | *7* | *71%* | *14%* | *14%* |
| Ministry of Health | 34 | 82% | 15% | 2.9% |
| Other national-level government agencies | 45 | 80% | 13% | 6.7% |
| Other community organisations | 46 | 76% | 17% | 6.5% |
| Community providers | 46 | 74% | 20% | 6.5% |
| CiC hubs | 45 | 69% | 27% | 4.4% |
| DPMC Response Group | 45 | 58% | 36% | 6.7% |

Note: Italicised text refers to a sub-group.

## All aspects of the CiC welfare response model were important to building positive relationships

All aspects of the CiC welfare response model that were put forward in the RLG survey were reported as being important to building relationships (Table 10). There was unanimous agreement on the significance of existing RPSC networks and relationships. Additionally, an overwhelming 98% considered the RLG's structure important, while 96% emphasised the significance of ad hoc meetings with key stakeholder groups. Moreover, 94% believed that formal meetings played a vital role in relationship-building, and 91% highlighted the importance of RLG funding.

*Table 10: Importance of aspects of the CiC welfare response model to building relationships (RLG survey)*

| Aspects of the welfare response model | n | Important | Not important |
|---|---|---|---|
| Existing RPSC networks and relationships | 46 | 100% | - |
| The structure of the RLGs | 45 | 98% | 2.2% |
| Ad hoc meetings with key stakeholder groups | 46 | 96% | 4.3% |
| Formal meetings with key stakeholder groups | 46 | 94% | 6.5% |
| The funding of the RLGs | 46 | 91% | 8.7% |

### RLGs facilitated networking across the community sector and between public agencies but were constrained by siloing within central government

RLG survey responses indicate that the RLGs helped to facilitate the development and strengthening of networks in the community sector. The majority of survey respondents (90%) agreed that their RLG had strengthened existing networks within the community sector. Moreover, around three-quarters (74%) agreed that their RLG had facilitated the development of new networks within the community sector. Open text comments indicate that the legacy of networks and relationships that the RLG helped to facilitate had continued to strengthen community sector support within regions.

> *This is definitely an area of combined and integrated agency supports that we need to explore further and continue to develop. It has led on to further networking opportunities and supports for communities.* (RLG member)

This was reflected in discussions with national stakeholders who reported that the RLG model enabled better coordination between various government agencies at the regional level to deliver better services to the community. However, interview participants noted that this may have been constrained by silos that remained at central government level, despite a willingness to work in a cross-agency way.

### Effective flow of information occurred between RLG members, and between RLGs and community providers

The majority of RLG survey respondents (89%) agreed that there had been an effective flow of information between RLG members. Most respondents (71%) agreed that there had been an effective flow of information between RLGs and central government, while 61% agreed that there had been an effective flow of information between RLGs and the DPMC Response Group.

### RPSCs' existing relationships were important to the success of the response but there were concerns about the sufficiency of their resourcing

Existing RPSC relationships were considered important to the success of the CiC welfare response by 87% of RLG survey respondents. Moreover, national stakeholders considered

that the RLG model worked well because the RPSCs were already in place, had existing networks, and had a social policy focus.

While 70% of RLG survey respondents agreed that RPSCs had sufficient resources to support the CiC response, 11% disagreed. Moreover, some national stakeholders reported concerns that RPSCs may not have been sufficiently funded to support the implementation of the CiC welfare response or other crisis responses. One interview participant commented that RPSCs are not *"funded to the capacity that they should be and if we are truly talking about authentic collaboration in an all-of-government perspective, that really does need to be taken quite seriously."* Further, an interview participant reflected that while RPSCs had *"the power to convene"*, those brought to the table did not *"necessarily have the power to make significant financial decisions on behalf of their organisation."*

### RLGs generally contributed to increasing community responsiveness to community priorities

Most RLG survey respondents (76%) agreed that the community sector in their region had become better able to respond to community priorities because of the RLG. However, five survey respondents (12%) disagreed.

## 3.3 Local leadership

This section focuses on support implemented at the community level, particularly through community providers, Community Connectors, and CiC hubs. Findings related to the involvement of priority populations in the CiC welfare response are reported in Section 3.4.

### 3.3.1 Community providers

### Community providers and Community Connectors were pivotal to the success of the CiC welfare response

Interview participants who were involved in the CiC welfare response at the national level emphasised the central role of community providers and Community Connectors in the success of the response. Interview participants also noted the key role of iwi and hapū, including organisations that were not normally social service providers but who *"reprioritised their mahi to stand up quite significant distribution centres."*

> *The success of CiC response and credit should be with community providers. They were the welfare response. We provided the resource, but they did the work… They are the unsung heroes for the whole response.* (National stakeholder)

Interview participants identified that community trust in community providers and Community Connectors was a key element of success.

> *People who work for NGOs that are there to support them, they have a level of trust with them versus us [government agency].* (National stakeholder)

## Māori organisations, and community providers overall, agreed that funding was adequate to deliver the CiC welfare response

Resourcing for community providers (Table 11) was reported as largely adequate with most (79%) community provider survey respondents agreeing that their organisation was adequately funded to deliver the CiC welfare response. Moreover, 86% of respondents from Māori organisations confirmed that they were satisfied with the adequacy of funding.

This is underscored by the agreement of 68% of all community provider survey respondents (Table 11) and 85% (n=14) of respondents from Māori organisations that the CiC funding enabled them to meet people's needs more effectively than traditional funding models.

*Table 11: Adequacy of resourcing for all community providers and Māori organisations (community provider survey)*

| Statements about adequacy of funding | Total community providers | | Māori organisations | | |
|---|---|---|---|---|---|
| | n | Agree | n | Agree | $\chi^2$ |
| Your organisation was adequately funded to deliver the CiC welfare response | 66 | 79% | 14 | 86% | 0.66, p=.718 |
| The funding for CiC enabled your organisation to meet people's needs more effectively than traditional funding models | 64 | 68% | 13 | 85% | 2.71, p=.258 |

## While overall funding for delivery of the response was adequate, funding was reported to be inadequate when it came to recruiting and retaining skilled staff

Only slightly more than one-quarter (28%) of all community provider survey respondents and just under one-third (31%) of respondents from Māori organisations agreed that the CiC welfare response funding allowed them to recruit skilled personnel (Table 12). Moreover, only one-third (33%) of all community provider survey respondents and 39% of respondents from Māori organisations agreed that the funding facilitated the retention of skilled staff. This suggests that while the funding was adequate to deliver the response and meet people's needs (Table 11), there were wider barriers to employing staff.

*Table 12: Adequacy of resourcing to hire and retain staff for all community providers and Māori organisations (community provider survey)*

| Statements about adequacy of funding | Total community providers | | Māori organisations | | |
|---|---|---|---|---|---|
| | n | Agree | n | Agree | $\chi^2$ |
| The CiC welfare response funding enabled your organisation to hire skilled staff | 64 | 28% | 13 | 31% | 0.19, p=.909 |
| The CiC welfare response funding enabled your organisation to retain skilled staff | 64 | 33% | 13 | 39% | 0.88, p=.644 |

Reflecting these staffing pressures was the proportion of community providers relying on volunteers, with nearly three-quarters (71%) of community provider survey respondents relying on volunteer workers often or always to deliver the CiC welfare response.

> *We were all volunteering from 2020-2021 until we were able to employ four staff members. Even then, when volunteers were not available it was left to the same people who were working full time and volunteering*. (Community provider)

> *There was a lot of pressure on our organisation to deliver a 24/7 service with the majority of our staff being volunteers.* (Community provider)

### While there are some positive indications, the adequacy of resourcing for Pacific community providers is unknown

Given small numbers, conclusions about whether Pacific community providers were appropriately resourced to deliver the CiC welfare response cannot be drawn.

Interview participants reported positively that the design of the CiC welfare response meant *"a lot of [CiC] money just went straight to Community Connectors that are employed by Pacific providers and other providers across the country"* (national stakeholder). They also reported positively that funding went to both providers who had existing relationships with MSD and other providers that were *"already connected in the community"*.

A community provider survey respondent also commented positively about MSD's engagement with Pacific providers.

> *We are most grateful at the way MSD pivoted and responded to the changing and complex needs of the community. The meetings were very useful in disseminating information needed by families on the support available and how these can be accessed. MSD staff were very professional and efficient in the way that they engage with providers.* (Community provider)

### There was a lag in funding for some community providers

Interview participants reported a mismatch in timing between government processes and community needs, noting that volunteers would have already acted and bought what was needed – *"bureaucracy stops us from being able to respond as quickly as our communities can"* (national stakeholder). Community provider survey respondents also identified a lag in funding.

> *The resourcing was good, however for our organisation it came a little late and would have proved more beneficial earlier in the COVID response.* (Community provider)

Interview participants noted that the lag in funding resulted in some Pacific providers having to deliver services without funding.

> *Our Pacific communities who just actually had nothing, almost had to wait 8 weeks before they could get any funding through to support them. So meanwhile, our Pacific communities, RSE [recognised seasonal employer] workers, just anybody in the community, whoever's running the organisation or the church, that money and that volunteering is coming off their own backs.* (National stakeholder)

> *While we're busy writing these Cabinet papers and putting these systems together, they are already stepping in and filling the gap which government isn't because we're too busy worried about money and bureaucracy, trying to get that through the gate, and who's actually paying for is our Pacific communities. They're stepping and they're going, 'oh man, we need masks, I'll go to the $2 shop and buy as many as I can for the church, and we'll bring that here'.* (National stakeholder)

Interview participants indicated a need for faster devolution of flexible funding to communities, based on a high-trust model which recognises that their reporting capacity may be reduced. Importantly, they noted that the model should recognise that Pacific communities (and ministries supporting these communities) have extensive reach into those communities and know the best channels and forums to reach.

### Information flows between MSD, CiC hubs and community providers were mostly effective

Reflecting the role of the RLGs to act as a bridge between the community level response and the national level response, 70% of community provider survey respondents agreed that there was an effective flow of information between their organisation and the local RLG (Table 13).

The level of agreement dropped to 59% of community provider survey respondents agreeing that there was an effective flow of information between them and the MSD national office, and 58% between them and the CiC hub in their region.

As expected, the RPSC did not consistently engage directly in information exchange with community providers. This is reflected in the result that only 35% of community provider survey

respondents agreed that there was an effective flow of information between them and the RPSC in their region.

The number of community provider survey respondents who disagreed that information flows were effective (e.g., 17% for information flows between providers and MSD), indicates a need for improvement.

*Table 13: Effective information flows regarding the CiC welfare response (community provider survey)*

| Groups from whom community providers received information | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| The RLG in your region | 64 | 70% | 16% | 14% |
| The MSD national office | 64 | 59% | 23% | 17% |
| The CiC hub in your region | 62 | 58% | 31% | 11% |
| The RPSC in your region | 58 | 35% | 38% | 28% |

### 3.3.2 Community Connectors

**Community Connectors were respectful, timely, easy to talk to, met households' cultural needs, and helped people to access support**

Overall, household survey respondents provided a high level of positive feedback (80% or higher) on the knowledge, skills, and support provided by Community Connectors on 8 of the 12 factors explored. These 8 factors were that their Community Connector:

- understood the needs of their household (92%)
- was respectful (90%)
- provided support when the household needed it (87%)
- was easy to talk to (87%)
- provided support that met their wellbeing needs (86%)
- provided support that met their cultural needs (83%)
- helped their household to access support (83%)
- built a relationship of trust with their household (81%).

Fewer households agreed that the Community Connector provided support that met their religious needs (68%); checked in on their household regularly (65%); told them about government support services they did not already know about (48%); or told them about community-based support services they did not already know about (39%).

## There were some differences in experiences of Community Connectors for Māori and priority population households

*There were no significant differences between subgroups in the experiences of household survey respondents regarding their Community Connector being respectful, timely, easy to talk to, meeting the household's cultural needs, and helping them to access support (*

Table 14). Open text comments indicate that Community Connectors made substantial efforts to build trust and tailor the support that they provided to the needs of the households they were working with. A small number of comments highlighted some challenges Community Connectors faced.

> *The only barriers that I had with being a Community Connector would be to gain the whānau trust and educating them on the reasons why we ask for certain details. I think that alone was a trust barrier within the community.* (Community Connector)

*An equity analysis shows Māori and priority population groups had different experiences on 5 of the 12 factors.*

Table 14 summarises the significant differences in experiences for household respondents with at least one resident of Māori, Pacific, or Asian ethnicity, a person with a disability or a health condition, and for households that did not have enough money.

In summary, compared with all households:

- households with at least one resident of Māori ethnicity, despite reporting relatively high rates of agreement, were significantly *less* likely to agree that:
  - support from the Community Connector met their wellbeing needs
  - the Community Connector built a relationship of trust with them.
- households with at least one resident of Pacific ethnicity were significantly *more* likely to agree that:
  - the Community Connector understood the needs of their household
  - the Community Connector checked in on their household regularly
  - the Community Connector told them about government support services they did not already know about.
- households with at least one resident of Asian ethnicity were significantly *less* likely to agree that:
  - the Community Connector checked-in on their household regularly
  - the Community Connector told them about government support services they did not already know about.
- households with at least one resident of Asian ethnicity were significantly *more* likely to agree that the Community Connector told them about community-based support services they did not already know about.

*Table 14: Rating of the support provided by Community Connectors (household survey)*

| Perception of the Community Connector | Overall findings | Significant differences |
|---|---|---|
| Understood needs | 92% of all household survey respondents agreed that the Community Connector understood the needs of their household | Households with at least one resident of Pacific ethnicity were significantly more likely to agree (97% agreed, $\chi^2$=6.77, p<.05) |
| Was respectful | 90% of all household survey respondents agreed that the Community Connector was respectful | None |
| Provided support when you needed it | 87% of all household survey respondents agreed support from the Community Connector arrived when the household needed it | None |
| Was easy to talk to | 87% of all household survey respondents agreed that the Community Connector was easy to talk to | None |
| Provided support that met your wellbeing needs | 86% of all household survey respondents agreed that support from the Community Connector met their wellbeing needs. | Households with at least one resident of Māori ethnicity were significantly less likely to agree (80% agreed, $\chi^2$=7.89, p<.001) |
| Provided support that met your cultural needs | 83% of all household survey respondents agreed support from the Community Connector met their cultural needs | None |
| Helped access support | 83% of all household survey respondents agreed that the Community Connector helped their household to access support | None |
| Built a relationship of trust | 81% of all household survey respondents agreed that the Community Connector built a relationship of trust with their household | Households with at least one resident of Māori ethnicity were significantly less likely to agree (71% agreed, $\chi^2$=11.0, p<.01) |
| Provided support that met your religious needs | 68% of all household survey respondents agreed that support from the Community Connector met their religious needs | Households who reported having 'not enough money to meet their everyday needs' were significantly more likely to agree (80% agreed, $\chi^2$=6.24, p<.05) |

| Perception of the Community Connector | Overall findings | Significant differences |
|---|---|---|
| Regularly checked-in | 65% of all household survey respondents agreed that the Community Connector checked in on their household regularly | Households with at least one resident of Pacific ethnicity were significantly more likely to agree (77% agreed, $\chi^2$=8.42, p<.05).<br>Households with at least one resident of Asian ethnicity were significantly less likely to agree (46% agreed, $\chi^2$=6.54, p<.05) |
| Told you about government support services did not already know about | 48% of all household survey respondents reported that the Community Connector told them about government support services they did not already know about | Households with at least one resident of Pacific ethnicity were significantly more likely to agree (60% said yes, $\chi^2$=7.04, p<.05).<br>Households with at least one resident of Asian ethnicity were significantly less likely to agree (27% said yes, $\chi^2$=7.81, p<.05) |
| Told you about community-based support services did not already know about | 39% of all household survey respondents reported that the Community Connector told them about community-based support services they did not already know | Households with at least one resident of Asian ethnicity were significantly more likely to agree (44% said yes, $\chi^2$=9.81, p<.01) |

### Understanding community need was key to Community Connectors' effectiveness

Both Community Connector and community provider survey respondents ranked understanding of their community as the most important aspect of the Community Connector role in enabling the delivery of support to isolating households (Table 15). This is supported by the high proportion of household survey respondents agreeing that, as discussed in the previous section, the Community Connector understood their household's needs (92%), provided support when it was needed (87%), and that the support from the Community Connector met their wellbeing (86%) and cultural needs (83%).

The next most important aspects identified by both the Community Connector and the community provider survey respondents were the flexibility of the role, the Community Connector having existing networks within the community, and an understanding of both community and government supports. While only a small number of community providers responded to this question, their ranking of the most important aspects of the Community Connector role aligned with Community Connectors' rankings.

*Table 15: Rank of the importance of aspects of the Community Connector role in enabling the delivery of support to households (Community Connector and community provider surveys)*

| Aspect of the Community Connecter role | Community Connectors | | | Community providers[27] | | |
|---|---|---|---|---|---|---|
| | Rank | Mean | n | Rank | Mean | n |
| Understanding of the needs of the community | 1 | 1.99 | 121 | 1 | 1.89 | 9 |
| Flexibility of the Community Connector role | 2 | 3.25 | 121 | 2 | 3.44 | 9 |
| Has existing community networks | 3 | 3.73 | 121 | 3 | 4.00 | 9 |
| Understanding of community supports available | 4 | 3.93 | 121 | 4 | 4.44 | 9 |
| Understanding of government supports available | 5 | 4.58 | 121 | 5 | 4.56 | 9 |
| Relationships with others offering non-government support services for the community | 6 | 5.69 | 121 | Not asked | | |
| Well-developed referral pathways to other support service providers | 7 | 6.47 | 121 | 6 | 4.78 | 9 |
| Relationships with those offering government support services for the community | 8 | 6.55 | 121 | Not asked | | |
| Availability of support services targeting specific cultural and population groups | Not asked | | | 7 | 4.89 | 9 |
| Other | 9 | 8.82 | 121 | 8 | 8.00 | 9 |

## The Community Connector role was important for building positive stakeholder relationships

Out of the community providers with a Community Connector service (n=11), 10 (82%) agreed that having Community Connectors within their organisation was important in building positive relationships with stakeholders in their region with only one (9.1%) disagreeing.

For all community provider survey respondents (Table 16), most also agreed that Community Connectors were important in building relationships across all priority communities (including Māori communities, Pacific communities, socio-economically disadvantaged peoples, ethnic communities, older peoples, and disabled peoples). There were some small differences with the smallest proportion being 76% of respondents agreeing that Community Connectors were able to build positive relationships with Māori communities and the largest proportion being 83% for communities in socio-economically disadvantaged areas.

[27] Of the 15 community providers who indicated that they provided a Community Connector service, 9 went on to rank aspects of the Community Connector model.

> *The network of Connectors in our region was a great resource. MSD facilitated monthly hui and these gave opportunity to come together for support and to share what we were seeing*. (Community Connector)

*Table 16. Importance of Community Connectors in building relationships with priority populations (community provider survey)*

| Population groups | n | Important | Not important |
|---|---|---|---|
| Everyone | 51 | 82% | 18% |
| Māori communities | 45 | 78% | 22% |
| Pacific communities | 45 | 76% | 24% |
| Socio-economically disadvantaged areas | 47 | 83% | 17% |
| Ethnic communities | 45 | 80% | 20% |
| Older peoples | 45 | 78% | 22% |
| Disabled peoples | 44 | 80% | 21 % |
| Other | 15 | 53% | 47% |

The open text field of the community provider survey included several comments from providers that did not have a Community Connector within their workforce but considered it would have been beneficial to have had one.

> *[There was] no Community Connector available in our area to help resource our families with their other needs.* (Community provider)

> *We needed a Connector which would have complemented all that we do.* (Community provider)

## Community Connectors helped to build trust in community-based services

While households appreciated and valued the CiC welfare response, overall households' experience with Community Connectors made little difference to trust in government agencies (Table 17). However, it did make a difference to trust in community-based support services with half (51%) of the household survey respondents stating that they were more likely to trust community services.

*Table 17. Change in trust in organisations following support from Community Connector (household survey)*

| Organisation | n | I trust them less | About the same | I trust them more |
|---|---|---|---|---|
| Work and Income | 194 | 8.8% | 74% | 18% |
| Other government agencies | 194 | 6.7% | 78% | 15% |
| Community-based support services | 204 | 2.9% | 46% | 51% |

Māori household survey respondents were more likely to report that their Community Connector experience made no difference to their trust in Work and Income, with 81% reporting that trust was about the same, compared to 74% for the entire sample, and 11% reporting trusting them more, compared to 18% for the entire sample.

Asian household survey respondents had higher overall trust in Work and Income (35% trusted Work and Income more compared to 18% for the entire sample).

A similar picture was seen for trust in other government agencies. For the majority of Māori household survey respondents, the Community Connector experience was significantly more likely to make no difference to their trust in other government agencies (85% reported trust was about the same compared to 78% for the entire sample), although fewer (7%) reported that they trusted them more compared to 15% for the entire sample. For Asian household survey respondents, half (50%) reported trusting other government agencies the same, with almost half (47%) trusting them more.

There were no significant differences found for Māori and priority populations compared to the total survey sample for whether household survey respondents had changed their trust in community-based support services.

### 3.3.3 CiC hubs

**CiC hubs were important in the delivery of the CiC welfare response**

Over half (57%) of community provider and almost three-quarters (71%) of Community Connector survey respondents agreed that CiC hubs were important in building positive relationships with stakeholders. The qualitative comments indicate that the hubs were important as a source of referrals, a centre of information, and a mechanism to support collaboration between providers.

> *What worked well for my team was communication from the hub in regard to responding to those in need during isolation.* (Community Connector)

> *The hub that was set up meant that usual politics and iwi-led barriers were removed for us and a wider network of social and health agencies engaged and accessed us.* (Community provider)

> *The hub worked real well for our team, information being sent was precise and made our job a lot easier.* (Community Connector)

### 3.3.4 Outcomes

At the community level, the CiC welfare response was expected to deliver the following outcomes:

| Short-term outcomes |
|---|
| • community providers have sufficient capacity<br>• provider relationships formed and/or strengthened at different levels, e.g., government, connectors, other providers, regional level. |
| **Medium to long-term outcomes** |
| • continuity of support through transition and recovery periods<br>• resilient community providers<br>• a networked community sector that is well-placed to plan for and respond to current and future community needs. |

## Community providers had sufficient capacity but relied on volunteers

Community providers had the resources needed to deliver support to households impacted by COVID-19 and to meet their needs. However, funding was inadequate for staffing and there was a strong reliance on volunteers. This is likely to have an impact on the resilience of community providers over the medium to long-term.

## Households continued to access support after isolation

Over half of the household survey respondents (59%) went on to engage with government services that their Community Connector told them about, such as Work and Income entitlements and Kāinga Ora housing support. Moreover, 61% went on to engage with community-based services that their Community Connector told them about, such as budgeting services (Table 18).

After people had completed isolation, they tended to continue seeking community-based support services (61%) rather than government support services (46%). The most common services household survey respondents learned about were support for schooling or education, employment and budgeting, housing, and health and wellbeing support.

*Table 18. Engagement with services and continued use of services post isolation (household survey)*

| Type of service | n | Yes | No |
|---|---|---|---|
| Engagement with government support services that Community Connector told people about | 87 | 59% | 41% |
| Engagement with community-based support services that Community Connector told people about | 74 | 61% | 39% |
| Continued use of government support services post isolation | 81 | 46% | 54% |
| Continued use of community-based support services post isolation | 74 | 61% | 39% |

## Collaborations and relationships were strengthened at all levels

Most Community Connector (88%) and community provider survey respondents (78%) agreed that they were able to build a positive relationship with MSD (Table 19). They were less positive about their ability to build relationships with other government agencies, which likely reflects that many community organisations had no direct relationship or contracting relationship with other government agencies (Table 19). Community Connectors were, overall, more positive than community provider representatives about their ability to build relationships across community groups.

*Table 19: Ability to build positive relationships (community provider and Community Connector surveys)*

| Ability to build positive relationships during the CiC welfare response with… | Community provider | | Community Connector | |
|---|---|---|---|---|
| | n | Agree | N | Agree |
| MSD | 63 | 78% | 123 | 88% |
| Ministry of Health | 60 | 32% | 122 | 59% |
| Other central government agencies | 61 | 39% | 123 | 64% |
| CiC hubs | 62 | 60% | 119 | 82% |
| Other Community Connectors | | | 122 | 83% |
| Other community providers delivering the CiC welfare response | 62 | 74% | 122 | 84% |
| Other social, health and wellbeing services | 61 | 71% | 123 | 81% |
| Māori groups or organisations | 63 | 59% | 123 | 81% |
| Pacific groups or organisations | 62 | 48% | 120 | 67% |
| Ethnic community groups or organisations | 63 | 44% | 120 | 63% |
| Other stakeholders | 21 | 45% | 38 | 50% |

Interview participants were mixed in their opinion about how government agencies' engagement with Māori communities and iwi changed as a result of the CiC welfare funding.

> *I don't think Māori and government engagement with Māori communities has improved very much*. (National stakeholder)

> *Cross sector and cross iwi collaboration [was successful]. I felt we were genuinely treated as equals at the table and our voices heard.* (RLG member – iwi)

## The CiC welfare response strengthened community networks

There were also positive signs, overall, that the CiC welfare response enhanced community sector networks. Most respondents to the community provider and Community Connector surveys agreed that the welfare response facilitated the development of new networks and strengthened existing networks (Table 20).

Furthermore, the majority of Community Connector survey respondents (87%) and around two-thirds of community provider survey respondents (67%) agreed that the community sector had become better able to respond to community priorities because of the CiC welfare response.

*Table 20: The CiC welfare response's impact on community networks (community provider and Community Connector surveys)*

| Impact on network | Community provider | | Community Connector | |
|---|---|---|---|---|
| | n | Agree | n | Agree |
| Facilitated the development of new networks within the community sector in your region | 63 | 68% | 123 | 85% |
| Strengthened existing networks within the community sector in your region | 62 | 71% | 123 | 89% |

Some interview participants believed that community organisations were more networked, while others considered that the CiC response made little difference to how well community organisations were networked, with Māori and Pacific providers already well connected.

> *There are the providers that are very much embedded within their communities, which tend to be your Māori and Pacific providers. Those that aren't quite as closely connected with their communities, I would say it's really patchy as to whether that's changed much at all.* (National stakeholder)

Another interview participant believed that while the public sector had improved its connection to communities, many of these connections were through individuals and, therefore, it is questionable as to whether the system itself had made these connections.

> *The public sector has improved its connection as a whole with communities. I do think individuals within the system have certainly done better…but I don't know if the system's been carried along with it.* (National stakeholder)

## 3.4 Involvement of Māori and priority populations

This section focuses on how the implementation of the CiC welfare response involved Māori and priority populations. This section also identifies barriers and enablers to the involvement of Māori and priority populations.

### 3.4.1 National perspectives

#### There was strong advocacy from Māori and Pacific organisations to ensure community needs were heard

National stakeholder participants reported strong advocacy from the National Iwi Chairs Forum[28], Māori NGOs, and Te Puni Kōkiri – described as *"a quasi-Māori voice albeit an arm of the Crown"* – to ensure that communities, NGOs, iwi, hapū, and whānau views and voices were being heard and informed the CiC welfare response. Involvement of iwi and Māori in decision-making processes was reflected in DPMC's quarterly COVID-19 updates:

> *Māori have several opportunities to feed into the decision-making process. Where iwi are connected into established regional leadership group arrangements, they can provide advice or raise risks or issues directly through RLG into NRG [National Response Group] through the RPSCs. Additionally, iwi can feed information, advice, risks, and issues into Te Arawhiti and TPK [Te Puni Kōkiri] at both the regional and national level as well as through the National Iwi Chairs Forum and other forums convened by Te Arawhiti.*[29]

#### Some communities had insufficient input into the CiC welfare response design and implementation

Despite MSD's willingness to move in the direction of a high-trust model that prioritised local responses, some national stakeholder interview participants considered that communities were not listened to as well as they could have been, with their insights not always treated as credible.

> *It took a long time for the Māori voices to be heard and taken seriously.* (National stakeholder)

> *The conversations were hard, we kind of struggled to find a meeting of minds and as I said earlier they perhaps weren't as receptive to our feedback.* (National stakeholder)

[28] https://iwichairs.org.nz/, https://iwichairs.maori.nz/ko-wai-about-us/

[29] https://www.dpmc.govt.nz/sites/default/files/2023-01/COVID-19-National-Management-Approach-2022-Quarter-2-Update.pdf

## 3.4.2 Involvement in regional leadership

### Iwi were involved as partners in the design and decision-making of the CiC welfare response through RLGs

The majority of RLG survey respondents (91%) confirmed that iwi were members of their RLG, while six of seven iwi members[30] (86%) also agreed that iwi were members of their RLG. It is not possible to determine from the data whether all RLGs had iwi representation. Even where there was iwi membership, there are likely to be instances where iwi did not have representation because of capacity issues (e.g., iwi having membership across multiple regions), where non-represented iwi were content with existing representation (e.g., a nominated pan-iwi representative), or where iwi members had not been included in the RLG discussions (accidentally or deliberately).

Just over half (56%) of the RLG survey respondents identified iwi as being leaders on their RLG. Five of seven (71%) iwi members on the RLGs who responded to the survey identified iwi as leaders on their RLG.[31]

Most of those responding to the RLG survey (71%) agreed that Māori were involved in the design of the CiC welfare response (Table 21), as did four of six iwi member respondents (67%). Moreover, the majority of RLG survey respondents (87%) agreed that iwi were involved in the distribution of communications regarding the CiC welfare response, as did five of the six iwi member respondents (83%).

*Table 21: Iwi involvement in RLGs (RLG survey)*

| Ways iwi were involved in RLGs | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Iwi were involved in the design of the CiC welfare response | 44 | 71% | 23% | 6.8% |
| *Iwi were involved in the design of the CiC welfare response (iwi respondents only)* | 6 | 67% | 17% | 17% |
| Iwi were involved in disseminating communications about the CiC welfare response | 45 | 87% | 8.9% | 4.4% |
| *Iwi were involved in disseminating communications about the CiC welfare response (iwi respondents only)* | 6 | 83% | 16.7% | - |

Note: The sub-samples are italicised.

[30] Of the 54 RLG survey respondents, eight indicated they were representing or belonged to a Māori or iwi organisation covering five regions (Bay of Plenty/Te Moana-a-Toi, Manawatū-Whanganui, Southland/Murihiku, Taranaki-King Country, Waikato). This is a small sample so the figures will be more sensitive to individual experiences, however they do represent a wider Māori regional population and will have a mandate to speak on behalf of their iwi, hapū, or hapori Māori.

[31] The low number of iwi survey respondents means any statistics generated do not necessarily reflect agreement across all RLGs, and caution should be exercised in their interpretation.

### Experiences of iwi leadership were mixed

Five of the six iwi member RLG survey respondents were positive about the leadership opportunities in RLGs. Iwi member RLG representatives reported feeling *"genuinely treated as equals at the table and our voices [were] heard"*. In contrast, only two of six iwi member RLG survey respondents agreed that the RLG enabled the CiC welfare response to meet Te Tiriti o Waitangi obligations. Two respondents disagreed and two neither agreed nor disagreed regarding meeting Te Tiriti o Waitangi obligations.

Comments from other RLG members noted the value of iwi leadership at the regional level.

> *Our response was successful because iwi leaders took the lead and looked after their communities.* (RLG member)

### Pacific peoples were less involved in the design and decision-making of the welfare response through RLGs

Just over half (59%) of RLG survey respondents agreed that Pacific peoples were members of their RLG. Only one-third of respondents (33%) agreed that Pacific organisations were leaders on their RLG.

Just over half of those responding to the RLG survey (52%) agreed that Pacific peoples were involved in the design of the CiC welfare response, while almost two-thirds (66%) agreed that Pacific peoples were involved in the distribution of communications regarding the CiC welfare response (Table 22). This indicates that Pacific peoples were less involved in RLGs and in the design and delivery of the CiC response than iwi.

*Table 22: Pacific peoples' involvement in RLGs (RLG survey)*

| Ways Pacific peoples were involved in RLGs | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Pacific peoples were involved in the design of the CiC welfare response | 41 | 52% | 32% | 16% |
| Pacific peoples were involved in disseminating communications about the CiC welfare response | 44 | 64% | 32% | 4.5% |

Where there was Pacific representation, RLG survey respondents noted that this brought substantial benefit to RLGs in understanding the welfare and support needs of Pacific peoples.

> *From the regional leadership group, there was the Pacific leadership group [that] were the voice of the community and fed information onto the main regional leadership group. This model worked well for our Pacific communities.* (RLG member)

### Ethnic communities were even less involved in the design and decision-making of the welfare response through RLGs

Responses to the RLG survey indicate that ethnic communities had limited involvement in RLGs and in the design and delivery of the CiC welfare response. Less than half of the RLG survey respondents (43%) agreed that ethnic communities were members of their RLG, and only 21% agreed that ethnic communities were leaders on their RLGs.

Only 41% of those responding to the RLG survey agreed that ethnic communities were involved in the design of the CiC welfare response, while only 40% agreed that ethnic communities were involved in the distribution of communications regarding the CiC welfare response (Table 23).

*Table 23: Ethnic communities' involvement in RLGs (RLG survey)*

| Ways ethnic communities were involved in RLGs | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Ethnic communities were involved in the design of the CiC welfare response | 44 | 41% | 32% | 27% |
| Ethnic communities were involved in disseminating communications about the CiC welfare response | 43 | 40% | 19% | 42% |

The representation of ethnic communities on RLGs and their involvement in the design of the CiC welfare response was reported by an interview participant to have improved over time.

## 3.4.3 Barriers and enablers to involvement of Māori and priority populations in the CiC welfare response

### There were various barriers to the involvement of Māori and priority population groups in regional leadership and decision-making

RLG survey respondents identified three main barriers to Māori and priority population groups' involvement in regional leadership structures:

- a lack of understanding of different organisations' roles *"in supporting a collaborative and shared response"*
- funding-related issues, including confusion over the funding scope of different organisations – *"who had what funding"*
- a lack of knowledge of *"opportunities, how to access, who to approach".*

### Dedicated funding is important to iwi participation in RLGs

Dedicated funding was an important factor in enabling iwi participation in RLGs. Of the six iwi respondents to the RLG survey, four (67%) agreed that dedicated funding for iwi was important to enable iwi participation in the RLG.

### Representation of priority population groups on regional bodies needs to occur pre-crisis

Interview participants spoke about the need for future regional, place-based mechanisms to involve representation from Pacific, ethnic, and disability communities to ensure their involvement from the start. A national stakeholder interview participant observed that:

> *If disabled people weren't at the Regional Commissioner table pre-COVID, then they weren't at the RLG table.* (National stakeholder)

### Coming together online removed some barriers for disabled peoples

As with the rest of Aotearoa, the need to come together online removed many physical accessibility barriers for disabled peoples. This also meant that Whaikaha and associated support organisations were able to include more disabled peoples in their support networks, improving insights and advocacy. It is possible that this improved access would only last as long as the need to provide support online lasted (i.e., as long as lockdowns persisted).

### There were various barriers to Māori, Pacific, and ethnic groups accessing welfare support

RLG survey respondents identified five key barriers to enabling Māori, Pacific, and ethnic groups to access welfare support:

- limited representation, community leadership not engaging, or not having the right people on the RLG
- fragmented and centralised systems resulting in a lack of control by local agencies and support networks
- similarly, systems not set up for collaboration – *"Some processes were more complex than others and support in differing contexts were released at differing times, spaces and places. Technology and trust in the system remains an issue"* (RLG member)
- a lack of funding to support situations which sat outside of generic funding guidelines (e.g., homecare support post-surgery)
- rapidly changing communications – *"There was so much communication that seemed to change daily"* (RLG member).

# 4 The support received by households

This section reports on the services received by isolating households and their experience of the CiC welfare response. It covers households' entry process and communication, and the types of services that were delivered to households. Access to and reach of the response is explored for Māori and priority population households, along with enablers and barriers to improving access and reach. This section concludes with an assessment of the extent to which the intended outcomes for households were met.

These findings contribute to addressing the following KEQs:

*Implementation*

- KEQ 1.1 How well was the welfare response implemented?
- KEQ 1.2 What were the conditions and levers that enabled implementation of the response? What were the barriers to implementation and how were these addressed?
- KEQ 1.3 How accessible was welfare support? What was the reach of the response?

*Outcomes*

- KEQs 2.1 To what extent did the welfare response achieve its intended immediate results and short-term outcomes?
- KEQ 2.2 What progress is being made to achieve medium to longer-term outcomes of the welfare response?
- KEQ 2.3 What were the unintended outcomes of the welfare response?

The findings are informed by the responses to the four surveys – the household, Community Connector, community provider, and RLG surveys, along with national stakeholder perspectives.

## 4.1 Entry process and communication

This section describes the findings about how households found out about the available welfare support; the pathways by which they were referred into the CiC welfare response; households' experience of asking for support; and the ways in which community providers and Community Connectors communicated with households.

### 4.1.1 Awareness

**Personal connections and health and social service providers were the main ways people became aware of support**

Households usually found out about available welfare support via family, friends, or a health or social service provider. The most common response given by household survey respondents when asked how they found about the support available (n=214) was from friends

and family (65%) or a health or social service provider (48%).[32] The number of households that found out from MSD or Work and Income, or social media, were 22% and 20% respectively. Only a very small number (3.7%) found out via a radio station or notices in public places.

### 4.1.2 Referral pathways

The surveys explored the pathways through which households were referred into the CiC welfare response. There was an alignment of responses, with community providers, Community Connectors, and households all reporting that referrals came through three main channels:

- self-referral by existing clients of an organisation
- referrals from health or social service providers
- referrals facilitated by MSD.

#### Households were primarily referred by providers

The most common pathways for referral reported by household survey respondents were from a health or social service provider (29%) and self-referral via a community provider they were already a client of (17%). Self-referral via social media were less frequent (13%), as were referrals through government channels. Only 11% of household survey respondents were referred to CiC welfare support by the Ministry of Health, while 9% were directed through an 0800 number, 8% through MSD, and 5% using the MSD website. A small proportion (1.5%) opted for self-referral through MSD service centres or case managers.

The top three referral pathways reported by community provider and Community Connector survey respondents included the top two pathways reported by households. Self-referral, referral from MSD, and referral from a health or social service provider were the top three referral pathways (Table 24).[33] Referral from a CiC hub was ranked fourth, followed by a referral from the Ministry of Health, with self-referrals via social media or 0800 number, and self-referrals from MSD service centres/case managers or the MSD website last.

[32] Respondents could select more than one response, so the total percentage is greater than 100%.

[33] Referral from MSD was not reported as a common referral pathway by household survey respondents, however it is likely that household survey respondents would recall the community provider as being the first point of contact given they would represent the last and most enduring memory of receiving support.

*Table 24: Rank of most common referral channels (community provider and Community Connector survey)*

| Referral channels | Community provider survey (n=68) | | Community Connector survey (n=133) | |
|---|---|---|---|---|
| | Rank | Mean | Rank | Mean |
| Self-referral - Existing client of your organisation | 1 | 3.19 | 3 | 3.77 |
| Referral from MSD | 2 | 3.40 | 1 | 3.08 |
| Referral from a health or social service provider | 3 | 3.54 | 2 | 3.72 |
| Referral from the CiC hubs | 4 | 4.32 | 4 | 4.29 |
| Referral from Ministry of Health | 5 | 5.74 | 5 | 5.32 |
| Self-referrals – Social media | 6 | 5.46 | 7 | 5.95 |
| Self-referrals - 0800 number | 7 | 6.09 | 6 | 5.74 |
| Self-referrals – MSD service centres and case managers | 8 | 6.62 | 8 | 6.30 |
| Self-referrals - MSD website | 9 | 6.65 | 9 | 6.83 |

### Māori households were more likely to be referred by a provider whereas Asian households were more likely to self-refer via social media

The survey analysis revealed some statistically significant differences in referral pathways between groups.[34] Households with at least one resident of Māori ethnicity reported a referral from a health or social service provider as the most common ethnicity (43% compared to 29% for the total sample, $p < .001$). Some Māori providers described drawing on their existing knowledge of their clients to identify people who may benefit from referral to the CiC welfare response, which may explain the higher referrals from this source for Māori households.

> *We had pre-existing processes in place… and a solid grass roots knowledge of who's who in our zoo. We knew where the vulnerability was in our community in terms of our whānau who would be negatively impacted by lock down and physical isolation. I believe… we were able to get to the most vulnerable and prevent undue suffering.* (Community provider)

The survey also found that households with at least one resident of Asian ethnicity (25% compared to 13% for the total sample, $p<.05$) were more likely to self-refer via social media when compared to the responses of the total household survey sample.

[34] The key points are summarised here. Detailed tables are provided in Appendix 4.

### Self-referral from an existing client and referral from MSD or from a health or social service provider were the easiest to manage

The respondents to both the community provider and Community Connector surveys ranked which referral channels were easiest to manage in the same order (Table 25). Self-referral from an existing client was ranked as being easiest to manage, with a referral from MSD or from a health or social service provider ranked second and third respectively. Referrals from the CIC hubs or Ministry of Health were fourth and fifth, with self-referrals from an 0800 number, social media, or MSD service centres and case managers ranked as harder to manage. Self-referral from the MSD website was ranked as the most difficult to manage.

*Table 25: Rank of easiest to manage referral channels (community provider and Community Connector surveys)*

| Referral channels | Community provider survey (n=63) | | Community Connector survey (n=126) | |
|---|---|---|---|---|
| | Rank | Mean | Rank | Mean |
| Self-referral - Existing client of your organisation | 1 | 2.78 | 1 | 3.14 |
| Referral from MSD | 2 | 3.56 | 2 | 3.46 |
| Referral from a health or social service provider | 3 | 3.60 | 3 | 3.68 |
| Referral from the CiC hubs | 4 | 4.21 | 4 | 4.02 |
| Referral from Ministry of Health | 5 | 4.98 | 5 | 5.28 |
| Self-referrals - 0800 number | 6 | 5.92 | 6 | 5.82 |
| Self-referrals – Social media | 7 | 5.92 | 7 | 6.13 |
| Self-referrals – MSD service centres and case managers | 8 | 6.92 | 8 | 6.52 |
| Self-referrals - MSD website | 9 | 7.11 | 9 | 6.95 |

### There may have been missed opportunities for referrals from those households not connected with providers

While most community providers and Community Connectors found the referral pathways effective, the open text comments identified some community provider concerns that they had received "*limited connection/referrals from sources outside our organisation*" or felt that the number of referrals they had received was not an accurate reflection of need within their community.

> *We didn't get many referrals even though we knew the need was huge.* (Community provider)

This speaks to possible gaps or weaknesses in the awareness of support and subsequent referral process. Other evaluation sources such as the case studies or MSD frontline interviews may provide additional insights into where these households were receiving support from, if they were receiving support at all, and the pathways by which they became aware of, contacted, and were supported by community providers when they had to isolate.

### 4.1.3 Household experience of asking for support

**For households referred for support, the CiC welfare response was relatively straightforward**

Almost two-thirds (65%) of household survey respondents reported that it was easy to ask for support while isolating. From comments made by households in response to an open text question asking what made it easy for them to ask for support, the four most prevalent reasons were:

- positive, helpful, trusting, friendly and consistent relationships that households built or already had with community providers and Community Connectors – "*our Community Hub worker made me feel so welcome and made me really feel at ease", "[cultural organisation] are well known in our church for helping people and being confidential"* (household)
- effectiveness of the support provided, that it met household needs – *"they seemed to know what we needed without telling them"* (household)
- accessibility of the support – "*they didn't make us fill out too much paperwork"* (household), and check-ins by Community Connectors
- the respectful way in which the support was provided, particularly the understanding, and lack of judgement shown.[35]

Requesting support was easier for some groups than others. Households with at least one resident of Māori ethnicity were significantly more likely to find it easy to request support (75% found it easy, $p<.01$ compared to 65% for the total sample). This likely reflects the CiC welfare response's approach of funding community providers with existing links to Māori and priority communities, reflecting how respondents "*trust the people supporting us*" and "*felt as though I could really relate to the person helping myself and my family*" (household).

Households with at least one resident of Asian ethnicity, were also significantly more likely to find it easy to request support (86% found it easy, $p<.001$ compared to 65% for the total sample), with a common response being that they "*responded very quick and [were] very polite*" (household).

[35] This information is from an analysis of open text household responses commissioned by MSD. The total number of households that responded to the question about ease of asking for support was 166 which is 65% of the total number (255) of household survey participants. The most prevalent reasons are those commented on by 20% (33) or more of survey participants who responded to this question. They are listed in descending order of prevalence.

Households with at least one resident aged over 65, had a slightly higher proportion say it was easy to request support (68% found it easy, p<.05 compared to 65% for the total sample), but also had a higher proportion report that it was hard to ask for support (18% found it hard, p<.05 compared to 14% for the entire sample) – "[*We] felt we should have been able to do it ourselves, but we are elderly*" (household).

For the 14% of household survey respondents reporting that it was hard to ask for support, the most common reason given was feeling ashamed or too shy: "*Very unwell & embarrassed for needing help"* (household)

### 4.1.4 Communication methods

#### Phone calls and text messages were the most common methods for communicating with isolating households

The most common methods used for communicating with households, reported by both community provider and Community Connector survey respondents (Table 26), were phone calls and text messages. Other methods included email, in-person discussions, online messaging platforms, and printed materials (e.g., pamphlets). Zoom was reported as an additional communication method.

*Table 26: Methods for communicating with households (community provider and Community Connector surveys)*

| Communication methods | Community provider (n=66) | Community Connector (n=128) |
|---|---|---|
| Phone calls | 82% | 90% |
| Text messages | 56% | 74% |
| Email | 53% | 66% |
| In-person discussions | 47% | 55% |
| Online messaging platforms (e.g., WhatsApp, Facebook Messenger) | 33% | 55% |
| Printed materials such as pamphlets | 21% | 14% |
| Other | 82% | 90% |

*This will total to more than 100% as respondents could tick more than one response.

#### The personal touch via phone and in-person discussions were the most effective methods to communicate with isolating households

An important aspect of the CiC welfare response was ongoing communication and check ins with isolating households. Community provider survey respondents ranked phone calls and in-person discussions as the most effective methods to communicate with isolating households (Table 27). Online messaging platforms were the third most effective, followed by text messaging, and email. Printed materials were ranked as the least effective. Households indicated that they valued the ongoing communication, which made them feel supported.

> *The odd check in phone call to see how we were doing both mentally and physically was a welcomed unexpected surprise and made the process of asking for help in the future much easier.* (Household)

> *Follow ups and whether there were other needs such as walking our dog were valued hugely.* (Household)

*Table 27: Rank of effectiveness of methods for communicating with households (community provider survey)*

| Communication methods | Number using method | Rank | Mean |
|---|---|---|---|
| Phone calls | 43 | 1 | 2.12 |
| In-person discussions | 27 | 2 | 2.30 |
| Online messaging platforms | 27 | 3 | 2.37 |
| Text messages | 42 | 4 | 2.71 |
| Email | 31 | 5 | 3.81 |
| Other | 10 | 6 | 3.90 |
| Printed materials such as pamphlets | 18 | 7 | 4.39 |

### Use of methods reliant on online access created barriers for people in rural areas, older people, and socio-economically disadvantaged households

Community provider survey respondents' open text comments reported digital access issues were a mix of poor internet connectivity in rural areas, insufficient income, not having access to the internet, and a lack of computer skills. This affected people's ability to be in contact with others, access information and online services to request support, and to order food online.

> *Our older community struggled to access information online and processes online to be able to ask for help. Low socio-economically challenged families were unable to order food online as well due to having no funds and having no access to the internet.* (Community provider)

> *I think generally people got assistance they needed; however, I think the most difficult group would be the elderly particularly in South Auckland where they generally don't have internet and have low skills with computers*. (Community provider)

A Community Connector survey respondent also highlighted that the use of phone and online processes was "*a huge barrier*" as some households did not have a phone or internet access. These households needed to rely on their friends to inform the Community Connector they were in isolation.

**Online access worked well in terms of removing physical barriers for engagement with disabled peoples**

Interview participants from Whaikaha reported that, for disabled people, meeting with others online had removed a lot of physical accessibility barriers. As a result of the change in engagement style necessitated by the pandemic, the interview participants could more easily tap into their networks. Whaikaha subsequently used this form of engagement during the 2023 flooding events to hear what was happening on the ground and share information about available supports and how people are solving problems.

> *So, we have networks that we can tap into very quickly now and get people face to face online that we didn't have before.* (National stakeholder)

## 4.2 Types of support received by households

This section describes household use of support services; the support received by Māori and priority population group households; whether the support received met diverse needs; the most helpful and important forms of support; food support; who provided the support to households; timeliness; and post-isolation support.

### 4.2.1 Household use of support services

**Food parcels were the most common form of support**

The majority of households (84%) reported receiving food parcels. Similarly, Community Connectors and community providers reported that food parcels were the most requested form of support. The majority (96%) of Community Connector survey respondents reported delivering food parcels and almost two-thirds (60%) of community provider survey respondents reported providing food support to households.

> *It was good to be able to eat fresh vegetables by providing food parcels.* (Household)

> *My family was so blessed when we received support, especially food and medical supplies, when we got COVID for the first time.* (Household)

Community Connectors and community providers indicated that being able to support their communities through assisting them with food allowed them to meet an immediate community need.

> *Just being able to provide food parcels and living costs to whānau who did not have savings or work leave because they were impacted by COVID.* (Community Connector)

> *Built on the mahi we are doing in the food security space. Recognised that we work in a high deprivation community and therefore have community reach. Enabled us to facilitate access to affordable nutritious kai in a timely manner for whānau experiencing food poverty during self-isolation.* (Community provider)

After food parcels, all three groups of survey respondents – households, community providers, and Community Connectors – reported that information about other support available in the community was the next most used or provided form of support (Table 28).

Households then reported support with medical needs, education, and general household items as the next most used forms of support. Community Connectors reported supporting households with urgent expenses, referral to health and other social services, support with medical needs, and general household items. Community providers reported referral to other health or social service providers, support with social connection, wellbeing, or pastoral care, and general household items.

*Table 28: Types of support used by households and provided by Community Connectors and community providers (household, Community Connector, and community provider surveys)*

| Types of support | Households n | Community Connectors n | Community providers n |
|---|---|---|---|
| Food parcels | 216 | 135 | 65 |
| Information about other supports available in the community | 89 | 116 | 47 |
| Support with medical needs (e.g., doctors bills and prescription costs) | 67 | 113 | 28 |
| Support with education (e.g., activity packs) | 53 | 95 | 22 |
| General household items (e.g., clothing, blankets, bedding) | 50 | 113 | 40 |
| Support with urgent expenses (e.g., utilities, rent arrears) | 41 | 115 | 27 |
| Referral to other health or social services | 39 | 114 | 46 |
| Support with social connection, wellbeing, or pastoral care | 37 | 97 | 43 |
| Connection to MSD financial support via Work and Income | 29 | 90 | 26 |
| Connection with employment support and opportunities | 27 | 78 | 18 |
| Help dealing with / advocacy to government agencies (e.g., Work and Income) | 21 | 96 | 30 |
| Transport costs (e.g., warrant of fitness, petrol) | 15 | 92 | 21 |

| Types of support | Households n | Community Connectors n | Community providers n |
|---|---|---|---|
| Help dealing with / advocacy to other organisations or situations (e.g., tenancy disputes) | 15 | 74 | 8 |

### 4.2.2 Types of support received by Māori and priority group households

**While some types of support were used more than others, the range of support available was used to meet the differing needs of Māori and priority households**

The kinds of support that household survey respondents received while isolating varied between Māori and priority population groups. The differences are reported in the order of the most to least common types of support received while isolating.[36]

*Food packages*

Across those responding to the household survey, 84% received food packages while isolating. Households that had at least one resident of Māori ethnicity and those in rural/remote areas received less food support than other groups (73%, p<.001 and 47%, p<.001 respectively compared to 84% for the total sample). Households with at least one resident of Asian ethnicity and those reporting having not enough money to meet their everyday needs were more likely to report receiving food packages (100%, p<.01 and 97%, p<.001 respectively compared to 84% for the total sample).

*Information about different supports available*

After food support, information about the different supports available was the next most common type of support (47%) received while isolating, with no significant differences for Māori and priority populations.

*Support with medical needs*

Support with medical needs was the next most reported (35%) type of support received while isolating, with those living in rural or remote areas reporting needing these supports more (50%, p<.05 compared to 35% for the total sample).

*Support with education*

Twenty-eight percent of households reported receiving support for education while isolating, with no significant differences found for Māori and priority populations.

[36] A detailed table is provided in Appendix 4.

*General household items*

One quarter (26%) of households reported receiving support for general household items while isolating, with households that had at least one resident of Māori ethnicity and rural/remote households reporting receiving this support more often (33%, p<.05 and 39%, p<.05 respectively compared to 26% for the total sample).

*Support with urgent expenses*

One fifth of households reported receiving support with urgent expenses while isolating (21%) with no significant differences found for Māori and priority populations.

*Referrals to other health or social organisations*

One fifth (20%) of households reported receiving a referral to other health or social services while isolating, with households with at least one resident over the age of 65 reporting receiving referrals significantly more often (32%, p<.05 compared to 20% for the total sample).

*Support for social connection, wellbeing and/or pastoral care and connection to Work and Income financial support*

There were no significant differences for Māori and priority populations in regard to support received while isolating for social connection, wellbeing and/or pastoral care (19%), and connection to Work and Income financial support (15%).

*Connection with employment support and opportunities*

A relatively low proportion of households reported receiving support to connect with employment support and opportunities (14%) while isolating, with households that had at least one resident of Māori ethnicity and rural/remote households reporting receiving this support more often (17%, p<.05 and 24%, p<.05 respectively compared to 14% for the total sample).

*Least common types of support received by households*

The least common supports received by isolating households were help dealing with government agencies (11%), transport costs (8%), and help dealing with other organisations or situations (8%). Those with not enough money to meet their everyday needs reported receiving no support with transport costs (0%, p<.05 compared to 8% for the total sample), while households with at least one resident of Māori ethnicity or aged 65+ reported receiving more help dealing with other organisations or situations (20%, p<.05 and 16%, p<.05 respectively compared to 8% for the total sample).

*In summary*

Māori households and those in rural areas were less likely to receive food support, while Asian households and those with not enough money to meet their everyday needs were more likely to receive food support. Māori households were more likely to receive support for general household items, support with employment, and to help deal with other organisations or situations. Households with at least one resident over the age of 65 were more likely to be referred to other health or social services. Households living in rural or remote areas were more likely to receive support for medical and/or education needs, and employment support.

### 4.2.3 Diverse household needs

This section describes findings in relation to whether the range of services met the needs of diverse isolating households; whether households diverse cultural, wellbeing, and religious needs were met; and the factors that contributed to households having more complex needs.

#### The diverse range of services available mostly met the needs of isolating households

Most Community Connectors thought households had access to the range of services that they needed, with 79% agreeing that there was a diverse range of services available to isolating households (Table 29). Two-thirds (65%) also agreed that services were available to assist people impacted by COVID-19 who were not isolating.

*Table 29: Diversity of services available to households (Community Connector survey)*

| Statements about diversity of services | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| There was a diverse range of services available in my region to support households who were isolating | 128 | 79% | 11% | 10% |
| There was a diverse range of services available in my region to assist individuals significantly impacted by COVID-19 (other than those in isolation) | 128 | 65% | 22% | 13% |

The household survey data indicates that households appreciated the ability to access a range of supports to meet their welfare needs while isolating. Open text comments from some households referred to the tailored nature of the support they received.

> *[The support made a] big difference as my cats needed specific dietary food and the Connector got that sorted for them.* (Household)

> *It allowed our tamariki to access educational options a lot easier.* (Household)

A small number of households stated that there were some types of support that were needed but could not be provided.

> *I think access to the medicines was a bit difficult. Also hard getting support around the children (who did not get unwell unlike us adults) but needs something to do or to distract them.* (Household)

> *During COVID I had a toothache really bad. It was impossible to see anyone.* (Household)

## Overall, the CiC welfare support met households' cultural, wellbeing, and religious needs

Generally, there was concurrence between the survey respondents about how well CiC welfare support met households' cultural, wellbeing, and religious needs.

*Cultural needs*

The majority of respondents agreed that the support met households' cultural needs, with 82% of community providers, 89% of Community Connectors, and 83% of household survey respondents agreeing.

*Wellbeing needs*

Nearly all community providers (94%) and Community Connectors (96%), and the majority of household survey respondents (86%) agreed that the support met households' wellbeing needs. Households with at least one resident of Māori ethnicity were significantly less likely to agree that the support met their wellbeing needs (80% agreed, $p<.001$ compared to 86% for the whole sample).

*Religious needs*

While three-quarters (74%) of Community Connectors and two-thirds (68%) of the household survey respondents agreed that the support met religious needs, there was lower agreement from community providers (52%). Households who reported having not enough money to meet their everyday needs were significantly more likely to agree that the support met their religious needs (80% agreed, $p<.05$ compared to 68% for the whole sample).

## Māori and Pacific households were more likely, and Asian households were less likely, to have complex needs, and having school aged children was the most common complicating factor for households

To describe the household survey respondent characteristics, in particular the complex needs of the households requiring support, the evaluation team created a risk score by totalling five factors that were related to more complex household needs:

- being a rural or remote household
- having school children resident
- having retired individual(s) resident
- having individual(s) with a disability, long-term condition, or mental health condition resident
- not having enough money to meet everyday needs.

Table 30 shows how the majority (87%) of the household survey respondents (i.e., who had received CiC welfare support while isolating) reported having, on average, at least one individual with one to two of these complex needs (mean=1.53).

Households with at least one resident with Māori ethnicity had the largest number of risk factors with only 5% having no risk factors (mean=1.81, p<.001 compared to 1.53 for the total sample). On the other hand, households with at least one resident with Asian ethnicity had the lowest number of risk factors with 25% having no risk factors (mean=1.15, p<.001 compared to 1.53 for the total sample). Across all household survey respondents, having school-aged children resident in the house was the most common risk factor.

*Table 30: Priority population distribution and number of risk factors (household survey)*

| Risk factors (n=277) | Total | Māori | Pacific | Asian |
|---|---|---|---|---|
| Rural/remote household | 22% | 38% | 16% | 7.5% |
| Has school children resident | 72% | 82% | 81% | 58% |
| Has retired individual(s) resident | 34% | 44% | 32% | 20% |
| Individual(s) with a disability, long-term condition, or mental health condition is resident | 29% | 38% | 25% | 17% |
| Not enough money to meet everyday needs | 28% | 27% | 37% | 23% |
| Total number of risk factors | | | | |
| 0 risk factors | 13% | 5% | 8% | 25% |
| 1 risk factor | 39% | 35% | 38% | 51% |
| 2 risk factors | 31% | 37% | 39% | 11% |
| 3 risk factors | 14% | 19% | 12% | 11% |
| 4 risk factors | 2.2% | 3.8% | 3.7% | 1.9% |
| Mean ***p<.001 | 1.53 | 1.81*** | 1.65 | 1.15*** |

### 4.2.4 Most helpful and important types of support

**Food parcels were the most helpful and important form of support, while four of the five top supports were expense-related**

As well as being the most common form of support, household, community provider, and Community Connector survey respondents all ranked food parcels as the most helpful and important form of support.

Household survey respondents were asked which of the supports they received helped their household the most. Community Connector and community provider survey respondents were asked to rank the supports that households received from them in order of priority. All three groups of survey respondents – households, Community Connectors, and community providers – were in alignment about the top five supports that were most helpful or important. Each survey group ranked their top five in a different order with the exception of food parcels which was ranked first by all three groups of survey respondents (Table 31).

After food parcels, the next four supports that were most helpful and important were general household items, support with urgent expenses, information about community supports, and

support with medical needs. Four of the top five most helpful or important supports were expense-related supports – food parcels, household items, and support with urgent expenses, and medical needs.

> *Food box and personal hygiene box was a big help. Also GP fee free and medications for COVID, plus free delivery.* (Household)

> *One income earner suffered severe mental health issues during and as a result of COVID and the lockdown and lost their job. Having this support available made it much easier to transition to being a one income household.* (Household)

*Table 31: Household support priorities (household, Community Connector and community provider surveys)*

| Types of support - helpfulness and prioritisation | Households | | | Community Connectors | | | Community providers | | |
|---|---|---|---|---|---|---|---|---|---|
| | Rank | Mean | n | Rank | Mean | n | Rank | Mean | n |
| Food parcels | 1 | 1.81 | 16 | 1 | 1.27 | 106 | 1 | 1.08 | 37 |
| General household items (e.g., clothing, blankets, bedding) | 2 | 2.00 | 15 | 4 | 4.96 | 96 | 5 | 4.27 | 30 |
| Support with urgent expenses (e.g., utilities, rent arrears) | 3 | 2.53 | 17 | 2 | 3.63 | 98 | 2 | 3.05 | 22 |
| Information about other supports available in the community | 4 | 2.56 | 34 | 5 | 5.55 | 99 | 4 | 4.11 | 36 |
| Support with medical needs (e.g., doctors bills and prescription costs) | 5 | 2.58 | 24 | 3 | 4.31 | 95 | 3 | 4.05 | 21 |
| Support with education (e.g., activity packs) | 6 | 3.50 | 14 | 8 | 6.72 | 83 | 10 | 5.89 | 19 |
| Support with social connection, wellbeing or pastoral care | 7 | 3.69 | 13 | 11 | 7.93 | 86 | 6 | 5.15 | 33 |
| Referral to other health or social services | 8 | 3.90 | 10 | 9 | 7.30 | 99 | 8 | 5.62 | 34 |
| Connection with employment support and opportunities | 9 | 4.11 | 9 | 10 | 7.55 | 69 | 11 | 6.63 | 16 |
| Transport costs (e.g., warrant of fitness, petrol) | 10 | 4.40 | 5 | 6 | 6.52 | 81 | 9 | 5.85 | 20 |
| Connection to MSD financial support via Work and Income | 11 | 4.75 | 12 | 7 | 6.71 | 79 | 7 | 5.26 | 19 |
| Advocacy to government agencies (e.g., Work and Income) | 12 | 6.00 | 11 | 12 | 8.49 | 84 | 12 | 7.50 | 24 |
| Other, please specify: | - | - | - | 13 | 9.91 | 22 | - | 8.86 | 7 |
| Advocacy to other organisations or situations (e.g., tenancy disputes) | 13 | 7.60 | 5 | 14 | 10.21 | 66 | 13 | 10.00 | 8 |

### 4.2.5 Food support

As described, food parcels were the most common, helpful, and important type of support received by households. This section summarises households' experiences of receiving food support, based on the responses from the 84% of households (n=216) that received food parcels.

#### The majority of food support was timely, appropriate, and supportive[37]

Nearly all household survey respondents (92%) reported that food arrived when they needed it. The majority of households reported that there was enough food for the household (85%), the household could get through isolation without going hungry (84%), and the food support met their nutritional needs (82%). They also reported that the food support met their households' cultural needs (78%), and religious needs (70%). Household survey respondents agreed that the food support made them feel supported (90%), and reduced household financial (86%), and mental (83%), stress.

> *Food package catered to cultural needs which was amazing.* (Household)

> *We felt really supported socially and emotionally and felt less stressed as we didn't need to worry about our basic needs (food, warmth, personal hygiene) because these were taken care for us and we were asked more than once if we needed anything else*. (Household)

> *Though I can't get everything I want, but the food parcel relieved my stress during isolation. It is not only about food, information or phone calls, I felt I was cared [for] and loved.* (Household)

A small number of survey respondents reported receiving too much food that they were unable to use, or inedible or expired food that the household had to take additional steps to dispose of.

> *A lot of the food was of no use, in other words unnecessary. Heaps of throw away bread from bakery we didn't need*. (Household)

> *Being delivered inedible, expired food. A tiny frozen ham (meat for a week apparently) a bag of carrots and four tins of mackerel. My mum who lives over an hour away had to come and do shopping and drop it off*. (Household)

Common reasons provided by community providers and Community Connectors for food not meeting households' needs included understaffing, high demand, standardisation of food parcels, and dependency of community providers on the food that was available.

[37] Detailed tables are provided in Appendix 4.

There were some differences experienced between Māori and priority group households. These differences are firstly described in relation to each of the factors covered in the household survey, as follows:

- *sufficiency* – households with at least one resident of Pacific ethnicity were significantly more likely to agree that there was enough food (93%, p<.05 compared with 85%), while households with at least one resident of Māori ethnicity (79%, p<.05), households where someone had a disability or health condition (78%, p<.05), and households reporting they did not have enough money to meet their everyday needs (77%, p<.05) were significantly less likely to agree that there was enough food for their household
- *nutritional needs* – households with at least one resident of Māori ethnicity were significantly less likely to agree that the food met their nutritional needs (74%, p<.05 compared with 82%), as were households with at least one resident with a disability or health condition (71% agreed, p<.05), while no significant differences were detected for the other priority groups
- *cultural needs* – households with at least one resident of Pacific ethnicity were significantly more likely to agree that food met their cultural needs (87%, p<.05 compared with 78%), while no significant differences were detected for the other priority groups.
- *religious needs* – households with at least one resident of Pacific ethnicity were significantly more likely to agree that food met their religious needs (81%, p<.05 compared with 70%), while no significant differences were detected for the other priority groups
- *reduced financial stress* – households with at least one resident of Pacific ethnicity were significantly more likely to agree that food support reduced financial stress (93%, p<.05 compared with 86%), while households where someone had a disability or health condition were significantly less likely (83%, p<.05). No significant differences were detected for the other priority groups.

In summary, the differences for Māori and priority population group households were:

- *Māori* – households with at least one resident of Māori ethnicity were significantly *less likely* to agree that there was enough food for their household and that the food met their nutritional needs
- *Pacific* – households with at least one resident of Pacific ethnicity were significantly *more likely* to agree that there was enough food, and that food met their cultural needs and religious needs
- *disability or long-term physical or mental health condition* – households where someone had a disability or health condition were significantly *less likely* to agree that there was enough food for their household, that the food met their nutritional needs, and that food support reduced financial stress
- *did not have enough money* – Households reporting they did not have enough money to meet their everyday needs were significantly *less likely* to agree that there was enough food for their household.

There were no significant differences between ethnic groups, health condition or disability, or income adequacy reported by household survey respondents in whether they received food when they needed it; the household could get through isolation without going hungry; the food support made them supported; or whether food support reduced mental stress for the household.

### 4.2.6 Sources of support

**Community Connectors were often part of a broader team within providers that delivered the response but were the key point of contact for most households**

Community providers reported that around half of the support provided to isolating households was delivered through a combination of Community Connectors and community provider staff. Three-quarters (75%) of household survey respondents reported receiving support from a Community Connector. For those who reported receiving no support from a Community Connector, household survey comments revealed that most received support from friends and family (28 respondents) or were self-sufficient (19 respondents).

The range in the number of community provider respondents who responded to the question about who provided support to isolating households reflects the differing types of support provided by community organisations, their staff, and Community Connectors (Table 32). For those community providers who provided food support (n=51), almost half (45%) of the food parcels were delivered by both Community Connectors and other staff, 41% were delivered by other community provider staff, and 14% of the food parcels were delivered to the household by Community Connectors themselves, indicating that there were multiple pathways for food provision. Community Connectors provided more support with medical needs, transport, and employment support and opportunities, whereas other staff tended to provide more education, support with urgent expenses, and advocacy to government agencies.

*Table 32: Support services provided to households by different staff (community provider survey)*

| Types of support | n | Community Connectors | Other staff | Both |
|---|---|---|---|---|
| Food parcels | 51 | 14% | 41% | 45% |
| Information about other supports available in the community | 43 | 12% | 44% | 44% |
| Referral to other health or social services | 41 | 15% | 49% | 37% |
| Support with social connection, wellbeing, or pastoral care | 40 | 18% | 40% | 43% |
| General household items | 36 | 11% | 47% | 42% |
| Advocacy to government agencies | 25 | 12% | 52% | 40% |
| Support with medical needs | 24 | 25% | 38% | 38% |
| Support with urgent expenses | 24 | 21% | 50% | 29% |
| Connection to MSD financial support via Work and Income | 23 | 22% | 22% | 57% |

| Types of support | n | Community Connectors | Other staff | Both |
|---|---|---|---|---|
| Support with education | 20 | 10% | 50% | 40% |
| Transport costs | 19 | 26% | 42% | 32% |
| Connection with employment support and opportunities | 18 | 28% | 28% | 44% |
| Advocacy to other organisations or situations | 7 | 0% | 43% | 57% |

### 4.2.7 Timeliness of the support

**Overall, support and food arrived when households needed it**

The majority (87%) of household survey respondents reported that support from the Community Connector arrived when they needed it, as did food when it was needed (92%). There were no significant differences between ethnic groups, health condition or disability, or income adequacy reported by household survey respondents in the timeliness of Community Connector support. The majority (86%) of Community Connector survey respondents also agreed that they were able to quickly connect people with support services in their community.

Community Connector respondents reported difficulties providing timely support around 'peak' need – the times when many households were having to isolate at the same time. For example, "*limited staffing and being overwhelmed by a high demand for immediate support such as food [affected timeliness*]". They also reported that quickly meeting demand at peak times negatively impacted the time needed to "*establish personal relationships with families to ensure their needs were met*".

Some household survey respondents' comments about support that did not meet their wellbeing needs referenced timeliness, for example, receiving support after they had had COVID-19.

> *Didn't receive any support at the time of isolation for COVID. I did receive support via the disability grant which was made available after we had been impacted by COVID.* (Household)

### 4.2.8 Post-isolation support

**Mental health and wellbeing support and continued food support were the most common post-isolation supports for households**

Over half (58%) of those responding to the household survey reported receiving support after they finished isolating. The most common types of follow-up support household respondents

reported receiving were support with mental health and wellbeing, and continued food support (Table 33).[38]

*Table 33: Post-isolation support households received (household survey)*

| Types of post-isolation support | Household (n=126)* |
|---|---|
| Support with mental health and wellbeing | 48% |
| Continued food support | 45% |
| Connection to Work and Income financial support | 21% |
| Support to reintegrate into school or education | 20% |
| Referral to other health or social services | 19% |
| Other, please specify | 19% |
| Connection with employment support and opportunities | 16% |
| Support to reintegrate with family and friends | 16% |

*This will total to more than 100% as respondents could tick more than one response.

## Households reported continued food support post-isolation was most helpful

While the number of household respondents that answered the question about helpfulness of follow-up support was relatively small, for those who received follow-up support, continued food support was ranked as the most helpful (Table 34). Other supports (including connection to Work and Income financial support, support with mental health and wellbeing, support to reintegrate with family and friends, and connection with employment support and opportunities) ranked around the same level. Referral to other health or social services and support to reintegrate into school or education were ranked the lowest.

*Table 34: Households' ranking of the helpfulness of follow-up support (household survey)*

| Types of post-isolation support | Rank | Mean | n |
|---|---|---|---|
| Continued food support | 1 | 1.40 | 15 |
| Connection to Work and Income financial support | 2 | 2.58 | 12 |
| Support with mental health and wellbeing | 3 | 2.73 | 15 |
| Support to reintegrate with family and friends | 4 | 2.75 | 8 |
| Connection with employment support and opportunities | 5 | 2.83 | 6 |
| Referral to other health or social services | 6 | 3.43 | 7 |
| Support to reintegrate into school or education | 7 | 3.67 | 6 |

[38] The data from household and community provider survey respondents have not been combined as the list of types of support are not similar enough.

Community provider survey respondents had a different list of types of follow-up support which did not include food.[39] The most common types of support they delivered to households post-isolation (Table 35) were pastoral care and wellbeing support to build confidence to re-engage, support to reconnect to usual activities, support with overdue or outstanding expenses, and support to get back to work.

*Table 35: Post-isolation support delivered by community providers (community provider survey)*

| Types of post-isolation support | n=62* |
|---|---|
| Pastoral care and wellbeing support to build confidence to re-engage | 61% |
| Support to reconnect to usual activities | 48% |
| Support with overdue or outstanding expenses | 47% |
| Support to get back to work | 42% |
| Financial planning | 21% |
| Support to get back to education | 18% |
| Career planning | 13% |

*This will total to more than 100% as respondents could tick more than one response.

Community providers' top-ranked assessments of household priorities were the same as the top four most common types of support they delivered – pastoral care and wellbeing support to build confidence to re-engage, support with overdue or outstanding expenses, support to reconnect to usual activities, and support to get back to work (Table 36).

*Table 36: Rank of household post-isolation support priorities (community provider survey)*

| Types of post-isolation support | Rank | Mean | n |
|---|---|---|---|
| Pastoral care and wellbeing support to build confidence to re-engage | 1 | 2.15 | 27 |
| Support with overdue or outstanding expenses | 2 | 2.21 | 19 |
| Support to reconnect to usual activities | 3 | 2.57 | 23 |
| Support to get back to work | 4 | 2.81 | 21 |
| Support to get back to education | 5 | 3.44 | 9 |
| Financial planning | 6 | 3.90 | 10 |
| Other | 7 | 4.40 | 5 |
| Career planning | 8 | 6.00 | 7 |

Of the 43 RLG survey respondents who responded to the statement 'The CiC welfare response was effective in supporting households who needed it to reintegrate after the isolation period', 58% agreed, 35% were neutral, and 7% disagreed.

[39] There was a separate section of the survey dealing with food support which was a separately funded work stream.

In terms of the diversity of services available to assist people to reintegrate after isolation, 52% of Community Connector survey respondents reported a lower availability of services compared to the diversity available to support households when they were isolating (79% agreed there was a diverse range of services available to support households who were isolating, Table 29).

## 4.3 Access and reach

This section describes survey respondents experience of whether Māori and priority populations were able to easily access CiC welfare support, and whether the welfare response enabled a greater reach into Māori and priority population communities. This section concludes with a discussion of the enablers and barriers to improving access and reach.

### 4.3.1 Access

This section firstly describes the ease with which Māori and priority group households appeared to access – in this case, be referred for and receive – the available CiC welfare support. As noted in Section 2.4, there was no available data on those who needed support but did not receive it, which meant they were not in the system or part of this evaluation workstream. Therefore, whether the CiC welfare response could be accessed by any household that needed it was asked about in the RLG, community provider, and Community Connector surveys.

#### 4.3.1.1 Households experience accessing support

**Households who received support reported that it was easy to ask for, and that Community Connectors helped them to access support**

As reported earlier, the household survey data revealed that those who received support while isolating generally found it easy to ask for support. Household survey respondents were also asked whether their Community Connector helped them to access support. The majority (83%) agreed, 14% were neutral, and 2.5% disagreed. There were no significant differences between ethnic groups, health condition or disability, or income adequacy reported by household survey respondents.

#### 4.3.1.2 RLGs experience of enabling access

**RLGs reported some difficulties enabling access for disabled people[40], older people, ethnic communities, and socio-economically disadvantaged communities**

Seventeen RLG survey respondents (49%) reported that their RLG did not struggle to enable access to welfare support for Māori or any priority groups (Table 37). The other 18 RLG

[40] The RLG, community provider and Community Connector surveys asked about 'disabled people'. The household survey asked whether anyone in the household had a disability, long-term condition or mental health condition that limited their ability to carry out everyday tasks.

respondents (51%) reported difficulties in enabling access to welfare support. Eight RLG respondents reported difficulties for disabled people (23%), six reported difficulties for older people (17%), five reported difficulties for ethnic communities (14%), and five reported difficulties for socio-economically disadvantaged people (14%). Four RLG survey respondents (11%) reported difficulties for Māori and Pacific peoples.

The comments from the RLG survey respondents indicate the main barriers to enabling access relate to a lack of representation of priority groups on the RLG, particularly disabled people and ethnic communities.

> *The disabled community needed greater visibility as to their specific needs, which is now starting to occur.* (RLG member)

A small number of RLG survey respondents stated that they had struggled with "*fragmented, centralised systems that were out of the control of local agencies and support networks*".

*Table 37: RLG respondents reporting difficulty in enabling access to welfare support for Māori and priority groups during isolation (RLG survey)*

| Māori and priority communities | RLG respondents (n=35)* |
|---|---|
| Māori | 11% |
| Pacific peoples | 11% |
| Socio-economically disadvantaged | 14% |
| Ethnic communities | 14% |
| Older people | 17% |
| Disabled people | 23% |
| Others | 20% |
| None of the above | 49% |

*This will total to more than 100% as respondents could tick more than one response.

#### 4.3.1.3 Community provider and Community Connector experience of access

**Community providers and Community Connectors reported some Māori and priority group households struggled to access support**

Like the RLGs, respondents from both the community provider survey and the Community Connector survey reported that some older people and disabled people struggled to access support for their welfare needs during isolation.

The largest number of community provider survey respondents (36%) reported that those in socio-economically disadvantaged communities struggled to access support (Table 38). Some community provider survey respondents reported older people (28%), Māori (28%), and disabled people (26%) struggled to access support.

Of the Community Connector respondents, 52% reported that older people struggled to access support for their welfare needs and 45% reported that disabled people struggled to access support for their welfare needs. Around one-third of Community Connector respondents reported that Māori, Pacific peoples, and ethnic communities struggled to access support for their welfare needs.

Around 30% of community provider and Community Connector survey respondents reported that Māori and other priority groups did not struggle to access support.

*Table 38: Community providers and Community Connectors reporting difficulty in enabling access to welfare support for Māori and priority groups during isolation (community provider and Community Connector surveys)*

| Priority communities | Community provider respondents (n=53)* | Community Connector respondents (n=126)* |
|---|---|---|
| Māori | 28% | 33% |
| Pacific peoples | 23% | 33% |
| Socio-economically disadvantaged | 36% | 34% |
| Ethnic communities | 23% | 34% |
| Older people | 28% | 52% |
| Disabled people | 26% | 45% |
| Others | 17% | 12% |
| None of the above | 28% | 31% |

*This will total to more than 100% as respondents could tick more than one response.

Comments from the community provider and Community Connector surveys indicate that the main enabler of access to welfare support was the provision of flexible funding to providers who had established links to priority groups, knew their needs well, and had an already-developed platform of trust.

> *We felt we were best positioned to know how to respond in the local setting. People trusted the local people who lead the response, and the volunteers knew the local area when it came to delivery (this included remote rural areas).* (Community provider)

> *[We were] able to make headway that government agencies are not able to because there is a stigma attached to "government"… we have the relationship and because we can talk those difficult conversations… we can get more information that they otherwise might not have been able to.* (Community Connector)

Comments from community providers about barriers to access referenced issues with covering large areas and spread-out communities, along with limited funding for, and representation of, priority populations at the community level.

> *Large area of coverage / spread out communities... This could make distribution of aid to far flung clients difficult.* (Community provider)

> *These groups didn't have enough representation around and enough translators working specifically with them to get the instant help they were so desperately in need of. Māori and NZ European were well catered for and aware of resources, but we felt so desperately for everyone else.* (Community provider)

**Māori and priority group households with a representative community provider were potentially more likely to be supported**

As described above, respondents from the RLG, community provider, and Community Connector surveys all reported that some older people, disabled peoples, socio-economically disadvantaged communities, Māori, Pacific peoples, and ethnic communities struggled to access support while isolating. However, many of those same groups reported as struggling to access also reported that they found it easy to ask for support in the household survey. Given household survey respondents positive feedback about the community provider support they experienced, and the reported key role of Community Connectors, it is likely that those communities with a well-connected Community Connector or similar (e.g., Whānau Ora navigator) enabled better access for Māori and priority households who had to isolate.

### 4.3.2 Reach

The previous section described RLGs, community providers, and Community Connectors' experience of the ease with which Māori and priority group households accessed the available welfare support. This section focuses on 'reach' – the ability of organisations or individuals to engage with diverse populations and communities.

**RLGs, community providers, and Community Connectors enabled the increased reach of the CiC welfare response into Māori, Pacific and socio-economically disadvantaged communities**

The majority of the community provider (81%) and Community Connector (89%) survey respondents agreed that community providers and Community Connectors were able to increase the reach of support to everyone who needed it (Table 39). There was no comparable data from the RLG survey. Interview participants also agreed that the CiC welfare response model enabled a greater reach into communities.

There was strong agreement among the RLG (88%), community provider (81%), and Community Connector (96%) survey respondents that they had increased the reach of support into Māori communities, with 4 of the 5 iwi RLG survey respondents also agreeing.

There was also strong agreement between the three groups of survey respondents that they had increased reach into Pacific and socio-economically disadvantaged communities. Three-quarters (75%) of RLG, 78% of community provider, and 92% of Community Connector survey respondents agreed that they enabled increased reach into Pacific communities. Just under three-quarters (73%) of RLG, 82% of community providers, and 95% of Community Connector

survey respondents agreed that they enabled increased reach into socio-economically disadvantaged communities.

There were differences in agreement between RLG, community provider, and Community Connector survey responses in whether they had enabled increased reach into ethnic communities, older populations, and disabled people. Half (51%) of RLG, two-thirds (68%) of community provider, and the majority (83%) of Community Connector survey respondents agreed that they enabled increased reach into ethnic communities. Half (51%) of RLG, three-quarters (73%) of community provider, and the majority (87%) of Community Connector survey respondents agreed that they enabled increased reach into older populations.

The lowest rates of agreement were observed for disabled people. One-third (33%) of RLG and two-thirds (64%) of community providers agreed that they had enabled increased reach into disabled peoples' communities. In contrast, most (79%) Community Connectors reported that they had enabled increased reach.

*Table 39: RLGs', community providers' and Community Connectors' increase in reach of support during the welfare response by Māori and priority communities (RLG, community provider and Community Connector surveys)*

| Priority communities | RLG | | Community provider | | Community Connector | |
|---|---|---|---|---|---|---|
| | n | Agree | n | Agree | n | Agree |
| Everyone | - | - | 57 | 81% | 122 | 89% |
| Māori | 40 | 88% | 48 | 81% | 114 | 96% |
| *Māori (iwi responses only)* | 5 | 80% | - | - | - | - |
| Pacific peoples | 40 | 75% | 50 | 78% | 112 | 92% |
| Socio-economically disadvantaged | 40 | 73% | 51 | 82% | 115 | 95% |
| Ethnic communities | 39 | 51% | 47 | 68% | 111 | 83% |
| Older population | 39 | 51% | 51 | 73% | 114 | 87% |
| Disabled people | 39 | 33% | 44 | 64% | 113 | 79% |
| Other | - | - | 13 | 69% | 17 | 94% |

### 4.3.3 Enablers and barriers to increasing access and reach

This section describes the conditions survey respondents and national stakeholder interview participants believe contributed to increased access and reach for Māori and priority population group households. It also describes the likely barriers when increased access and reach did not occur.

### Partnering with providers trusted by communities enabled greater reach of the CiC welfare response

Interview participants reported that a key mechanism that enabled greater reach was MSD partnering with providers and Community Connectors who are trusted by communities, particularly communities that government agencies struggle to reach.

> *I think they did a great job of finding providers and communities that hadn't been reached before [who were] wary of MSD and government. [MSD made] new relationships and support[ed] people where they hadn't been before.* (National stakeholder)

> *With Care in the Community, we partnered through people who have the trust with those invisible communities.* (National stakeholder)

Comments in the RLG, community provider, and Community Connector surveys also supported that including providers with established connections into, and trust within, priority communities was key to increasing service reach.

> *Community Connectors have proven valuable as they are the ones that their communities trust…they can reach far, far further than any MSD worker can go.* (Community Connector)

Some interview participants noted that there were lessons from the approach taken by community providers and Community Connectors to identify and reach groups that may not have an existing relationship with government-funded services. Community providers and Community Connectors proactively helped people to 'get in the door' to receive services and entitlements by reaching out to people, rather than expecting them to reach in.

An interview participant noted that their experience working on the CiC welfare response showed that there will always be people who need support from the communities they are part of, "*regardless of how accessible and culturally competent government services are".*

> *The response showed me you will always have people that won't come to government services and will prefer community supports as they are a part of a community. [This was the situation] for many Asian peoples. The concept of a welfare state is foreign and when [they] do understand it's there, the trust isn't there.* (National stakeholder)

### The CiC welfare response may have enabled communities to better access support they were entitled to

Interview participants agreed that the CiC welfare response enabled *"a more even distribution of resources and better meeting of local needs"*. However, three interview participants stated that they were cautious about attributing improvements in reach directly to the CiC welfare response, given that many communities were already well connected and were supporting

whānau through the pandemic. They saw that the CiC welfare response provided appropriate resources to what have been historically under-served communities.

> *I probably emphasise the structure of CiC didn't enable communities to do anything. It enabled communities to receive something that everyone agreed they were always entitled to receive, and they probably received it a bit faster as a result of input from a lot more people than they would have if they've gone through the generic process that they always go through.* (National stakeholder)

Some interview participants were also concerned that the CiC welfare response was being framed as *"a holistic way to support families".* They saw that the response enabled better access to grants and entitlements that already existed.

> *I don't think it does that [providing holistic support]. I think it helps people get in the door to their relevant grants and entitlements they should be able to access anyway*. (National stakeholder)

### Representation on, and coordination by, RLGs increased reach

The more common examples given by RLG survey respondents as to how RLGs increased reach into communities were around representation on the RLG, such as *"leaders at the table ensured the information about these groups came to the RLG immediately thereby enabling us to respond in a timely manner".* RLG survey respondents also highlighted clear communications and processes *"ensuring all providers on the ground knew each other and were well linked up operationally with clear escalation points for any questions or concerns*".

### Support to Pacific peoples needs to be relationally driven

MSD interview participants reported that they were able to mobilise support to Pacific peoples in Auckland through existing relationships (e.g., via an organisation representing an amalgamation of Pacific community organisations and nine government agencies).

Ministry for Pacific Peoples interview participants observed that they were able to quickly get the key messages out to communities due to their *"two degrees of separation"* and the strong community interest in hearing from the Minister for Pacific Peoples.

> *… our two degrees of separation - you know we use that as our strength. We knew that we could really quickly get these health messages out to our communities by utilising our key Pacific leaders, churches, schools, what have you. We really employed that. We linked people such as Minister [for Pacific Peoples], because if he showed up to zoom we had so many more people (like our fonos) because they all wanted to have the airtime with the Minister.* (National stakeholder)

Ministry for Pacific Peoples interview participants reported strong Pacific community connections in metropolitan areas such as Auckland, Wellington, and Christchurch. However, their reach was not as strong into growing Pacific communities in rural areas such as Northland, Te Tairāwhiti, and Hawkes Bay. This meant that there was a slower response in those regions, and these rural regions were not as prepared.

> *And therefore, there was a lag that happened, that regions in particular weren't as prepared… by the time the COVID wave hit… There was a lot of pressure on… RSE workers with questionable immigration status and specific [Pacific] ethnic communities that may or may not have engaged or had the services and regions to engage.* (National stakeholder)

Interview participants from the Ministry for Pacific Peoples spoke about needing to continue to strengthen their relationships with newer rural and regional Pacific communities.

### MSD needed to engage earlier with the disability sector, design complementary and accessible support and funding, and collect good data

MSD interview participants acknowledged that they did not engage with the disability sector *"as it needed to from the start".* An interview participant described drawing on their existing relationships with providers who delivered across the range of population groups, for intelligence about *"where we were light"* and *"needed to bolster"* their response, particularly when there were outbreaks that impacted specific communities.

Interview participants from Whaikaha spoke about their "*upfront*" absence in the design process at the government national level. They also highlighted the absence of disabled communities' representation and involvement at the regional level. The interview participants noted that if regional approaches are to be based on the *"voice of the community"* and *"part of the community has not had that opportunity to use their voice, then it almost creates further inequity".* Whaikaha interview participants emphasised that government needs to be *"quite purposeful"* as disabled people and their families *"have a pretty tiring life without having to step forward to these things so the system needs to step forward"*. The interview participants described that MSD was subsequently responsive to issues raised by disabled communities.

Whaikaha interview participants reported that they provided advice on the Cabinet papers for both the health and welfare responses at about the same time. The Office for Disability Issues drew on their national networks to access a small group of people for MSD to undertake a *"tight, targeted engagement"* in-confidence. The Office for Disability Issues also ran community engagements with disabled people and their representative organisations to identify key issues and risks and test out solutions.

The Whaikaha interview participants identified three key aspects of the response that worked well. Firstly, there was a dedicated disability fund, which was *"flexible and high trust"*. This was a result of the engagements described above. The fund provided additional funding for providers to support disabled people who needed assistance to meet their needs in addition to the available CiC welfare support. The interview participants noted that some disabled people needed different supports, particularly those who were immune-compromised and could not leave their homes. The interview participants highlighted that an important feature

of this fund was its design to *"complement"* the welfare response rather than be the *"funding for all disabled people"*. This was described as the 'twin track approach' where services are designed to be universally accessible, with bespoke support for when those services do not work for disabled peoples.

Secondly, there was a landing page for disabled peoples as part of the Unite for COVID-19 website which enabled navigation of the relevant MSD and Ministry of Health website pages. The webpage was designed in direct response to advocacy from the disabled community after difficulties navigating multiple websites.

Lastly, the requirement for disabled peoples to repeatedly submit medical certificates to keep receiving benefit payments was removed.[41] This reduced stress for disabled peoples needing to go to their doctor, especially when COVID-19 was at its peak along with reducing the burden on GPs.

Interview participants identified that an overall positive of the CiC welfare response was the confidence it gave disabled peoples to participate in their communities. They reported that a lot of people were isolating on a voluntary basis given international evidence was showing poorer health outcomes of COVID-19 for disabled peoples.

Another key learning was that Māori and Pacific disabled peoples were *"much more likely"* to access support through Māori and Pacific providers. The interview participants identified that they would like to strengthen disability support through these providers in the future.

Both Whaikaha and other interview participants raised the lack of data to measure access and the reach of the CiC welfare response to disabled peoples (including how many people were accessing welfare support at the regional level) as a key challenge. Addressing this took *"a bit of advocacy"* to have a question about disability status included as part of the CiC welfare response data. MSD subsequently did a snapshot over a few locations to test the reach of the response to disabled peoples.

## 4.4 Household outcomes

This section firstly addresses the short-term, then the medium to long-term outcomes for households as laid out in the intervention logic model and shown below. The section concludes with a summary of households' comments regarding unexpected experiences and their final comments at the end of the survey.

[41] https://carematters.org.nz/information-from-ministry-of-social-development-msd/

| Short-term outcomes |
| --- |
| • people's immediate needs are met<br>• people access services and stay home<br>• people's dignity is maintained. |
| **Medium to long-term outcomes** |
| • spread of COVID-19 is minimised<br>• improved cohesion, connectedness, resilience, and wellbeing of people<br>• equity of outcomes for priority groups. |

Household comments on their experiences are woven throughout Section 4 and included in this section to illustrate the outcome findings. The comments from households in response to open text questions are predominantly very positive.[42] Only small numbers of respondents, ranging from 4 to 17 from a total of 255 household survey respondents, described negative experiences in response to open-ended questions. In these cases, the common themes were that the support did not meet households' specific needs, the food was poor quality or insufficient (as described previously), and/or the support needed to be more culturally aware.

### 4.4.1 Short-term outcomes for households

#### The immediate welfare needs of households were met

The high number of households (84%) who reported receiving food parcels, and those that ranked this as the most helpful form of support, suggests that support with food was a key immediate need. There was a high level of agreement among survey respondents regarding the timeliness, quality, and contribution of food support to wellbeing. There was also strong support regarding the wider welfare response's timeliness and ability to address diverse needs. This strongly suggests that the immediate needs of isolating households who were supported by a community provider and/or Community Connector were met.

*Timeliness*

Nearly all households (92%) said that food parcels arrived when needed. The majority (87%) of household survey respondents reported that support from the Community Connector arrived when they needed it. The majority (86%) of Community Connector survey respondents also agreed that they were able to quickly connect people with support services in their community.

*Quality and value of the food support*

Between 70% to 90% of households agreed on a range of factors covering the quality and wellbeing value of food support. Where significant differences were reported, the level of agreement by Māori and priority group households was still high (above 70%).

[42] This section includes commentary and quotes from an analysis of household responses to open text questions commissioned by MSD.

*Ability to address diverse needs*

Most Community Connectors (79%) agreed that there was a diverse range of services available to isolating households. The majority of survey respondents (households, community providers, and Community Connectors) agreed that the support met households cultural and wellbeing needs (ranging from 82% to 94%). Between 52% to 74% agreed that the available support met religious needs.

### For those who accessed services, the response was successful in supporting households to stay at home

RLGs, community providers, and Community Connectors all reported some difficulties for Māori and priority group households to access services. For those that did access services, the CiC welfare response was successful in enabling households to isolate.

The majority (83%) of household survey respondents agreed that they were able to successfully isolate because of CiC welfare support. No significant differences were found for Māori and priority group households. The majority of the respondents to the RLG (81%) and community provider (86%) surveys, and nearly all Community Connector survey respondents (92%), agreed that the CiC welfare response was effective in supporting households to stay in isolation during the isolation period. Less than 5% of RLG, community provider, and Community Connector survey respondents disagreed.

> *It was awesome, very grateful for all support we got and was thankful that our government made it easy to be safe and stay home while sick.* (Household)

> *My household got delivered a load of wood for heating of our home as we were in isolation and needed to stay at home. Just so grateful.* (Household)

> *It meant we could stay at home. We don't have family in NZ so wouldn't know how to get food and extra help*. (Household)

### The provision of food was a key enabler for households to isolate

Along with the earlier findings about the helpfulness and importance of food support, around one-third of households who responded to an open-ended question about the difference the welfare support made highlighted the receipt of food parcels.[43]

> *It made such a difference, as we all could eat, did not have to worry about food or going out. There was even yummy treats in the food parcels.* (Household)

[43] This is the largest group of respondents (36%, n=56) who commented in relation to the question. The total number of households that responded to this question was 157 which is 62% of the total number (255) of household survey participants.

> *Made a lot [of difference], meant we got enough food to get through isolation and was very grateful.* (Household)

The survey workstream gave little insight into factors preventing households from isolating as the survey only gathered data from isolating households who were supported by a community provider while isolating. Eight percent of households who were supported by the CiC welfare response disagreed that they were able to isolate because of the support. As described earlier, there were a small number of household survey respondents who indicated that the quality of food received was poor, which may have forced people out of isolation.

> *The service received was useless, of no help, so I had to wait until I could go out myself and buy all the essentials.* (Household)

### There was little difference across the regions in whether the support meant households could successfully isolate

The small numbers of household survey respondents across each region means that any results need to be interpreted cautiously. Broadly, however, compared to 83% of all household survey respondents who agreed that the support helped them to isolate:

- fewer (78%) respondents residing in Northland and Auckland agreed
- fewer (77%) respondents residing in Bay of Plenty agreed
- fewer (70%) respondents residing in Hawkes Bay and the East Coast agreed
- more (91%) respondents residing in Waikato, Taranaki-King Country, and Manawatū-Whanganui agreed
- more (93%) respondents residing in Greater Wellington agreed
- more (91%) respondents residing in the South Island agreed.

### People's dignity was maintained

RLG survey respondents were asked whether the CiC welfare response was effective in maintaining people's dignity and mana while they were isolating. The majority (81%) of respondents agreed, 14% were neutral, and 5% disagreed. The mana-enhancing approach taken by community providers and Community Connectors was evidenced by the household survey results. Most households reported that it was easy to ask for support (65%), the support from the Community Connector met their cultural needs (83%), the support from the Community Connector met their religious needs (68%), and the Community Connector was respectful (90%). Comments from other survey respondents also illustrated that people's dignity and mana was maintained.

> *Having a food parcel delivered to the door when we were isolating was hugely supportive but along with that came care, concern, genuine checks on how we were.* (Household)

> *The ability to deliver to whānau in self-isolation with minimal support networks, food poverty and financial stress in a high deprivation area enabled whānau to maintain dignity and have basic needs met whilst coping with COVID-19 self-isolation requirements.* (Community provider)

> *It gave our own people a chance to educate and care for one and other without the overwhelming feeling that the 'government was going to invade' (dramatic quote made by members of the community).* (Community Connector)

### 4.4.2 Household medium to long-term outcomes

#### The CiC welfare response likely contributed to minimising the spread of COVID-19

The CiC welfare response likely contributed to containing the spread of COVID-19 by enabling households who accessed support to stay isolated after a household member had a positive COVID-19 test. This claim is supported by the achievement of the short-term outcome – 'people access services and stay home'. A majority of the four survey respondent groups (81% to 92%) agreed that households were able to successfully isolate because of CiC welfare support. When household survey respondents were asked an open-text question about the difference the support made to the household while impacted by COVID-19, around one-fifth (n=34) described that it meant that they did not need to go out into the community, particularly to the supermarket.

> *Provided the opportunity to isolate and not need to worry about infecting community because I need kai.* (Household)

> *Made us feel supported and meant we could manage without going to the supermarket.* (Household)

#### There were signs that the CiC welfare response contributed to household connectedness, resilience, and wellbeing

It is not possible to measure improvement in terms of cohesion, connectedness, resilience, and wellbeing of households, which often requires baseline data. Attributing improvements to the CiC welfare response is also difficult due to the complex economic and social policy environment. However, there are signs that the response contributed to increasing connectedness, resilience, and wellbeing of households during isolation. The evidence includes their contact with a Community Connector, food and other support as described in Sections 3 and 4, and support after isolation (e.g., support with employment opportunities and reintegrating with normal daily activities).

When asked the open-text question about the difference CiC welfare support made to the household while impacted by COVID-19, just under one-fifth (n=29) described how the support enhanced their emotional wellbeing and morale.

> *Stress was lightened and wellbeing was able to be balanced for my whole whānau.* (Household)

> *It meant I was able to look after my wellbeing with the medication I really needed. Also not having any food available at the time, I was able to eat. Also having follow-up calls meant that I could talk to someone if I needed help but also that I was safe and not dying on the floor somewhere.* (Household)

> *It's provided comfort, made things easy, made me feel more secure and cared. Good for mental wellbeing*. (Household)

A reduction in stress and improvements to wellbeing was a major theme that 28 household survey respondents commented on, along with a reduction in financial stress (n=19) and an increased ability to focus on getting well from COVID-19 (n=14).

> *Less stress worrying about feeding the household during isolation, was able to focus on staying well and supporting those who were suffering with COVID.* (Household)

> *It was a huge support for what you did for us. Helping with our power bill, food and clothing for our children was a big weight of our shoulder and we didn't have to worry as much.* (Household)

> *I'm a single mum as my husband passed away so I didn't have to worry that I didn't have any sick leave to pay for anything – they helped so much*. (Household)

Household survey respondents (n=22) described how they felt connected and cared for by the community providers and Community Connectors.

> *Phone calls from organisation were important in making me feel cared for while in solitary isolation.* (Households)

> *We didn't feel isolated because we had the support from community connectors. They were efficient and they cared which made things so much easier for our family especially our young children.* (Households)

### The CiC welfare response showed some promise in achieving more equitable outcomes for Māori and priority population groups

There were positive signs regarding the response resulting in an increased reach into Māori, Pacific, and socio-economically disadvantaged communities. However, RLG, community provider, and Community Connector survey respondents reported that there were still access issues for Māori and all priority groups during the CiC welfare response, in particular for older populations, disabled people or people with a health condition, and socio-economically disadvantaged communities.

### 4.4.3 Unexpected experiences and concluding comments from households

**The most common 'unexpected' experience described was the impact of COVID-19 and isolating on the everyday functioning of households**

Household survey respondents were asked to describe any unexpected experiences they had when accessing or receiving support while isolating. For the 84 respondents who commented, the largest group (n=23) of respondents spoke about the challenges and unanticipated needs created by COVID-19, for example, changes to routine, emotional wellbeing of themselves or others, financial stress, and new needs such as devices for online schooling.

> *We realised quite quickly we needed support with food and internet to be able to connect my children to their online learning and also a device to alleviate the stress.* (Household)

> *The strain on the physical and mental wellbeing of just being in isolation (though we realise it could have been worse)*. (Household)

> *Concerns about the cat, vet expenses and cat food. Accessing groceries or medical supplies without leaving home*. (Household)

The largest proportion (n=75) of comments were positive, ranging across the following themes:

- the ease of the process
- their initial and ongoing contact with the community provider or Community Connectors
- the amount and quality of the food
- the breadth, timeliness, tailored nature, cultural appropriateness, and respectfulness of the support.

There were 17 comments expressing disappointment about the adequacy or appropriateness, mainly in relation to support with food and groceries.

**Households that received support were grateful for the CiC welfare response and the way in which it was delivered, which made them feel supported**

Household survey respondents were given the opportunity to end the survey with any final comments about the support they received. Fifty-four percent (n=137) of survey respondents chose to do so. The largest number of comments (n=86) were expressions of gratitude for the support they received. The reasons for people's gratitude were expressed in the comments relating to the ways in which they interacted with community providers and Community Connectors, and how this affected them. As already described:

> *Many people mentioned the positive, helpful, and friendly support that they received from service providers. Others further elucidated upon how empathetic, respectful, and*

*non-judgemental those providers were in their time of need. Because of this, people felt emotionally supported throughout their isolation which reduced stress and made them feel cared for. Additionally, the efficiency and timeliness of the support received was remarked upon frequently. The provision of food parcels was also especially well appreciated. (MSD commissioned analysis of the open text comments).*

# Part C: Improvements and lessons

# 5 Learning and improvements

This section reports on findings addressing KEQ 1.6 – How could the response have been better? What could have been done differently?

## 5.1 Learning

This section summarises key lessons identified by the national stakeholder interview participants, and RLG, community provider, and Community Connector survey respondents.

### The locally-led, regionally-enabled, and nationally supported model underpinning the CiC welfare response has strong potential to become business as usual

Many national stakeholders considered that the main learning from the CiC welfare response is that the locally-led, regionally-enabled, and nationally supported model has strong potential and should be incorporated into business as usual practice for government agencies.

> *There should be a new norm after everything they have done in the last three years… What should we be doing? It's incorporating the things that we've learned over the last three years and being different. I have reservations when you start to see people going back to the same types of procurement processes… when we've got this amazing opportunity to continue to work with [the welfare response processes].* (National stakeholder)

### Partnering with regional staff, iwi, and local providers who know their communities is an effective way of meeting need

At the national level, the CiC welfare response challenged the traditional structure of service delivery within some government agencies. It saw a shift away from traditional 'MSD-centric' approaches to a partnership approach which placed trust in those on the ground at the regional and local levels to know what was best for their communities, and to deliver tailored services to meet need. Interview participants and community provider and Community Connector survey respondents were eager to continue this approach to partnering with regional staff and local providers to enable better service delivery.

> *Most of the funding that we got for COVID was for community and that changed the dynamic of this organisation. Now it's normal to say, 'right, how we gonna work with our community partners?'… You see it in some policy documents, before they were very MSD-centric, [now] there is a recognition of partnerships or community even just to say we've acknowledged it and we've had a think about it.* (National stakeholder)

> *The COVID pandemic showcased just how an iwi-based community can respond effectively. I believe we were able to serve our whānau to a great breadth and depth and we were able to get to the most vulnerable and prevent undue suffering. Of course, this was empowered by the funding and support of MSD, and actually the fact that a government department let us take a leading role, by allowing flexibility in the way we utilised the funds that were allocated. Ngā mihi ki a koutou.* (Community provider)

> *This made a difference for us because we learned a lot through the Care in the Community model. One thing it's made me think about is partnership and who's around the table and I think it's made me think about what [our agency's] role is too and as a partner what we need from these arrangements even if the funding is further away from us and it's devolved modelling, having a shared understanding in the future*. (National stakeholder)

> *One of the things we've really tried hard to strengthen is our relationship with our regional teams; the Commissioners and their regional advisers and regional contract people. Because inevitably they're the ones on the ground having to deal with the community and many of them are in the community doing the heavy lifting too.* (National stakeholder)

### Regional leadership is an effective tool for enabling partnership and dialogue between government and communities

At the regional level, a key lesson that participants in the survey workstream highlighted was that the CiC welfare response had demonstrated the value of regional leadership to enable effective partnership and dialogue between central government agencies and communities.

> *I think our leadership groups done well. From the regional leadership group, there was then the Pacific leadership group of Pacific leaders who were the voice of the community that fed information onto the main regional leadership group. This model worked well for the Pacific communities.* (RLG member)

There were concerns that government agencies did not listen to insights coming from the RLGs, resulting in decisions that did not benefit communities. This may have meant that less emphasis was placed on local contexts in policy development, resourcing, and contracted outcomes. Additionally, there were risks of those at the regional level becoming disengaged or cynical in regards to decisions being made about service delivery in their region.

> *I don't think the RLG influenced the CiC in any way that benefitted our communities as the decisions were made centrally and presented to the RLG as a done deal.* (RLG member)

> *Our response was successful because iwi leaders took the lead and looked after their communities. Central government, except for MSD, funded some really poor initiatives, were not transparent and did not look for community owned outcomes.*

> *The bridge was the RLG which pushed back on central government and supported community lead initiatives.* (RLG member)

National stakeholder interview participants emphasised the need to ensure that RPSCs and regional leaders had the right people involved in RLGs, along with the resources and support from government agencies to effectively enable community-based delivery of services.

### High-trust, balanced contracting and flexible funding resulted in better, tailored service delivery and immediate outcomes

Local-level lessons focused on the value of applying a high-trust model with providers, which allowed for locally tailored responses to the welfare needs of Māori, Pacific, and other priority communities. The high-trust model was backed by practical changes, including a contracting model that struck a balance between flexibility and accountability. The contract model enabled providers to get on with service delivery without excessive administration, tailor their response to the specific needs of their communities, and extend their reach. National stakeholders emphasised that the shift away from more conventional funding practices enabled agencies to better address the unique needs of their communities and achieve more impactful outcomes. The high-trust model and flexible contracting were important aspects of the CiC welfare response model that evaluation participants considered should be incorporated into business as usual.

> *[The resourcing] was enough for us for the support we provided and it was great to be able to use it with flexibility and high trust - thank you.* (Community provider)

> *Trusting each other to have done the mahi was key and once that was established, I thought it went really well.* (Community provider)

### There is a need to balance delivery flexibility with checks and balances

There was concern that while the CiC welfare response model fitted well with the immediate and complex needs of households having to abruptly isolate, the support was open to manipulation by some households.[44] More checks and balances were suggested during non-crisis or business as usual times.

> *I think this was amazing through the lockdown period as it was really strict and limited to what you could and couldn't do. Also ISO [isolation] rules being strict through 2020-2021 making this response model fantastic, however now that ISO rules have changed and so many other options to access support virtually is now a part of society - the trust model sees lots of dishonesty happening. As an*

[44] The reasons for any manipulation that occured were not explored in this evaluation and would need further investigation, e.g., whether it reflected unmet need within households.

> *example, without personally identifying anyone, having different family members contact at different times from the same address.* (Community Connector)

> *Because it was done at speed, there's this tension between risk and control and… there were situations not on the MSD side where people did take advantage of the system and the ambiguity and the lack of checks and balances. I think the key learning is that we need to be able to have the local flexibility. But with enough rigor in the system that it prevents people from taking advantage of that system.* (National stakeholder)

### MSD's current and ongoing role in ensuring access to support needs further discussion

Interview participants discussed the need for MSD to consider how proactive the organisation needs to be in ensuring access to support. They also highlighted that MSD needs to continue partnering with providers trusted by *"underserved"* communities, who often do not trust MSD.

> *For MSD, CiC started a conversation about invisible communities - they're invisible to government because we put the wall up so that they can't walk through or don't want to walk anywhere near us, and MSD's responsibility in a welfare system. I feel like historically there is this question of the degree to which an organisation chooses to proactively reach the people who are in need.* (National stakeholder)

> *It's really important we trust our community partners. We are just never going to get our [MSD] response to everyone. An important learning. [People are] harder to engage, rather than hard to reach. They are underserved by government and through our partnership, within their community they are easy to reach.* (National stakeholder)

> *The challenge for government is to… say, OK, here's the funding to go and reach out and do whatever is needed for those people who perhaps… may not ever trust us or take generations to change that relationship.* (National stakeholder)

An interview participant noted that the demand for Community Connectors speaks to the inability of the mainstream welfare system to reach some Māori whānau to deliver the support they need to improve their wellbeing.

> *Because MSD can't reach the same people as our Māori providers, you got Māori providers with MSD which are going out to whānau to bring those whānau into MSD because MSD couldn't do it itself.* (National stakeholder)

### A critical assessment is needed, including whether shifting to a devolved, high-trust model will shift the underlying causes of inequity

There is a need to look critically at the benefits and risks of a devolved high-trust model, and distinguish this from a crisis support model, asking whether this is the best approach as the "*long-term benefits, investment and the programme are unproven"* (national stakeholder interview). The CiC welfare response model prioritised addressing immediate needs, while the underlying reasons for requiring support, such as income inadequacy, persisted.

> *Let's be real it is same groups as always that are disenfranchised. One has to reach out to overcome the same barriers and help bridge the gap*. (Community provider)

> *I think that the long-term benefits investment and the programme are unproven because if you provided food packs and gave some discretionary funding and helped people get their prescriptions from the chemist or whatever, it was just addressing immediate need… it wasn't changing kind of medium to longer term outcomes for those people because they still have income adequacy issues.* (National stakeholder)

## 5.2 Improvements

The findings from the survey workstream indicate that some aspects of the implementation of the CiC welfare response model could have been improved. The following improvements continue to be applicable to MSD's ongoing work programmes.

### The CiC welfare response was an effective model for getting services to diverse communities, but greater relationships with, and representation of, Pacific peoples, disabled peoples and ethnic communities are needed

The involvement of Pacific peoples, disabled peoples, and ethnic community representatives in the RLGs was low, and survey responses show that this led to a lower reach of the response to these communities.

> *We [were a] bit light on the disability [communities] probably, although I think in hindsight most of the providers that we used were providers that delivered to all of those communities right there and we had a very good view of where we were light.* (National stakeholder)

While there were strong existing relationships with some urban-based Pacific communities, MSD needs to further develop relationships with Pacific communities in regional and rural areas.

### Less emphasis on governmental process would enable collaborative efforts between government agencies and communities

Interview participants across different agencies emphasised how, at times, government processes inadvertently hindered the pace at which communities were able to respond. They reported that applying a top-down approach can lead to a misalignment of priorities which could be improved by streamlining government processes and ensuring that community voices are integrated into policy making decisions. Some government representatives felt that community feedback was not always listened to or trusted by central government agencies, given the subsequent lower levels of resourcing in response to the need identified by community providers.

> *People will get stuff done if they need to and we don't give them enough credit. We should design policy around them and give them the credit they deserve. We are concerned about what the outcomes are going to be for people, found ourselves counting widgets rather than the best outcomes for people. That is something we need to grapple with as a public service. We lose the pace of needing to get resources to people.* (National stakeholder)

### Power imbalances between agencies need to be addressed

Interview participants reported that while they did notice a difference in the engagement approach from government agencies, they still felt that they lacked decision-making power in cross-agency meetings.

> *You feel it in some of the high-level meetings as well. You know you're not gonna argue… So Public Service Leadership Group might be better run by a more neutral party like the Public Service Commission than by the bigger state agency with a vested interest in the delivery of services... But in their view, they were probably just doing their damnedest to try and knock everyone together and coordinate something that was almost un-coordinate-able. But when you're in a small agency, and you're sitting in one of those forums, you don't really feel like you have any decision-making power. At least it's not an equal relationship.* (National stakeholder)

Though it is evident that there was an effort to intergrate a partnership approach, this excerpt illustrates the perceived power imbalance between smaller Māori and population-based agencies and MSD. Consequently, achieving equitable representation and participation in government decision-making is a crucial endeavour to ensure that Māori and population-based agencies can make their unique contributions and perspectives heard and that these are integrated into responses that impact their communities.

# Appendices

# Appendix 1: Detailed methodology

This appendix gives further detail on the methodology for the survey workstream including KEQs, engagement and survey distribution, survey response rates, and stakeholder interviews.

## KEQs and indicators

To answer the KEQs, we developed a series of indicators which articulate performance standards for the CiC welfare response (i.e., what good 'looks like' for the aspect of the response being explored through the KEQ). The full set of evaluation questions and corresponding evaluation indicators are provided in Table 40. The indicators have been derived through a review of documentation related to the CiC welfare response, including the intervention logic model, policy documents and aide memoires.[45] The indicators informed the development of data collection tools and framed the data analysis and reporting.

[45] The policy documents including the Cabinet Paper (Office of the Minister for Social Development and Employment, Cabinet Social Wellbeing Committee - COVID-19: A whole of system welfare approach under the COVID-19 and Protection Framework, and Cabinet Social Well-being Committee Care in the Community - Welfare Response to Omicron).

*Table 40: KEQs and indicators*

| KEQs | Key evaluation indicators (KEIs) |
|---|---|
| **Implementation questions** | |
| KEQ 1.1 How well was the welfare response implemented?<br>KEQ 1.1a How and in what ways did the Community Connector and Regional Leadership models enable an effective response?<br>KEQ 1.1b To what extent was the response flexible, appropriate, relevant, timely, culturally informed, respectful, and equitable? | KEI 1.1.1 Community Connectors were able to work effectively to arrange support to households.<br>KEI 1.1.2 The RLG model enabled engagement, collaboration and coordination.<br>KEI 1.1.3 The model was flexible to enable community providers to tailor support to meet and respond to changing circumstances.<br>KEI 1.1.4 Support was relevant and appropriate to households' and priority population groups' diverse needs.<br>KEI 1.1.5 Support was timely; households received support as and when it was needed.<br>KEI 1.1.6 Priority populations had equity of access; there were no barriers to accessing welfare support.<br>KEI 1.1.7 Priority populations were involved in delivery of the CiC welfare response. |
| KEQ 1.2 What were the conditions and levers that enabled implementation of the response? What were the barriers to implementation and how were these addressed?<br>KEQ 1.2a What was the role and contribution of collaborations within regions and across government; the use of digital pathways; and the role other agencies played in facilitating MSD's response at all levels? | KEI 1.2.1 People were aware of the relevant support available.<br>KEI 1.2.2 Appropriate referral pathways were used to connect households with CiC support.<br>KEI 1.2.3 The CiC welfare response facilitated positive relationships between government, regional leaders, community providers, and iwi.<br>KEI 1.2.4 Digital pathways enhanced the delivery of the CiC welfare response.<br>KEI 1.2.5 There was effective flow of information between central government, regional leadership, and community providers.<br>KEI 1.2.6 Collaborative decision-making was evident between public service agencies, regional leadership, community providers, community stakeholders, and iwi.<br>KEI 1.2.7 There were effective support networks between MSD national office, regional leadership, and community providers. |

| KEQs | Key evaluation indicators (KEIs) |
|---|---|
| KEQ 1.3 How accessible was welfare support? What was the reach of the response?<br><br>KEQ 1.3a To what extent was the welfare response accessible for older people, disabled peoples, those in rural or isolated areas, those with limited digital access, Māori, Pacific peoples, and ethnic communities?<br><br>KEQ 1.3b What was the profile of those that accessed support within the scope of the welfare response?<br><br>KEQ 1.3c To what extent was the distribution of access equitable?<br><br>KEQ 1.3d To what extent did support reach those not previously engaged with the welfare system, and how was this achieved? | KEI 1.3.1 Providers in the community identified and contacted those households who required support.<br><br>KEI 1.3.2 A range of communication methods were used to reach different population groups.<br><br>KEI 1.3.3 The welfare response incorporated new ways of working to reach specific communities. |
| KEQ 1.4 How did the implementation of the welfare response enable and embody MSD's organisational strategies: Te Pae Tawhiti, Te Pae Tata (inclusive of MSD's commitment as a Te Tiriti partner), and Pacific Prosperity? | KEI 1.4.1 Māori were partners in design and decision-making in the CiC welfare response at the regional level.<br><br>KEI 1.4.2 Māori and Pacific community providers were invested in and appropriately resourced to deliver the CiC welfare response. |
| KEQ 1.5 How and in what ways did the welfare response complement support from the Ministry for Pacific Peoples and Te Puni Kōkiri, including how services were provided and allocated on the ground? How was duplication addressed? | KEI 1.5.1 There is evidence that the welfare response complemented support from the Ministry for Pacific Peoples.<br><br>KEI 1.5.2 There is evidence that the welfare response complemented support from Te Puni Kōkiri. |
| KEQ 1.6 How could the response have been better? What could have been done differently? | Descriptive question (no performance indicators). |

| KEQs | Key evaluation indicators (KEIs) |
|---|---|
| **Outcome questions** | |
| KEQ 2.1 To what extent did the welfare response achieve its intended immediate results and short-term outcomes?<br>KEQ 2.1a Whānau outcomes, community provider outcomes, and regional and national outcomes<br>KEQ 2.1b What were the regional differences in outcomes achieved? | KEI 2.1.1 Community providers had the resources needed to deliver support to households impacted by COVID-19.<br>KEI 2.1.2 Households were able to stay isolated in their "bubble" for the required time period.<br>KEI 2.1.3 Welfare support met households' wellbeing, cultural, and religious needs.<br>KEI 2.1.4 People's dignity and mana was maintained. |
| KEQ 2.2 What progress is being made to achieve medium to longer-term outcomes of the welfare response? | KEI 2.2.1 Households accessed had continuity of support to reintegrate after isolation.<br>KEI 2.2.2 Documentation of unintended outcomes that occurred for households while they were isolating. |
| KEQ 2.3 What were the unintended outcomes of the welfare response? | KEI 2.3.1 Documentation of unintended outcomes that occurred for households while they were isolating. |
| KEQ 2.4 To what extent did the welfare response help to create, maintain, and/or improve relationships between national, regional, and community partners in the response? | KEI 2.4.1 The community sector is becoming better networked and able to respond to future needs.<br>KEI 2.4.2 New and diverse relationships have been created through the CiC welfare response. |

# Evaluation approach

As briefly described in Section 2, the survey workstream of the evaluation drew on a utilisation-focussed approach which was developed by Michael Quinn Patton. An overview can be found here: **https://www.betterevaluation.org/methods-approaches/approaches/utilisation-focused-evaluation.**

# Overarching principles

The overarching principles and standards guiding the survey workstream were those from the following UN Evaluation Group Norms and Standards.

- Utility: A focus on providing critical information on the CiC welfare response activities and delivering written and other knowledge products in a way that the primary audience can use to make decisions.
- Credibility: Acting in an independent and transparent manner, applying a rigorous methodology, and providing clarity to MSD and other stakeholders.
- Ethics: Conducting evaluation with the highest standards of integrity and respect for the social and cultural environment, for human rights and gender equality, and the appropriate treatment of confidential information.
- Professionalism: Conducting evaluations with professionalism and integrity, respecting evaluation norms and standards and ethical considerations that contribute to the credibility of the evaluation. [46]

# Mana-enhancing practice

The approach to the survey workstream was grounded in mana-enhancing practice, as described in Table 41.

Our engagement with community providers and Community Connectors to distribute the survey was respectful and cognisant of their busy and essential role in community's health and wellbeing. Engagement with households (via the survey) recognised the kaitiaki role of community providers regarding household contact and engagement, and as such the household survey distribution was led by the community providers. An additional contract payment was offered to providers to recognise the costs associated with household survey distribution.

[46] United Nations Evaluation Group UNEG (2016). Norms and Standards for Evaluation. Geneva: United Nations (UN).

*Table 41: Principles of mana-enhancing practice*

| Principle | Application |
|---|---|
| Valuing te ao Māori, concepts of wellbeing and cultural identity | We implemented Māori engagement methods (including wānanga with community providers) by applying a Māori lens to the interpretation of data collected through the surveys. |
| Understanding the historical relationships embedded in Te Tiriti o Waitangi | We recognise the historical and contemporary impacts of colonisation that led to inequities and higher levels of hardship amongst Māori. Survey data analysis was done within a Māori-centred framework, drawing on key ethical principles from Te Mana Raraunga to ensure that there are no unintended negative outcomes and that Māori, iwi, and hapū interests are recognised.[47] |
| Relationships defined by authenticity, respect, integrity, and dignity | We provided consistent, clear engagement with participants, ensuring they understood the purpose of the evaluation and why we asked them to participate. We will 'close the loop' with participants by providing them with a brief summary report where possible outlining the key findings of the survey workstream of the evaluation. The summary will be shared with MSD for review first. |
| Emphasising the roles of whakapapa and cultural narrative | Our team included Māori researchers who prioritised centring the collection and interpretation of data through a te ao Māori lens. |
| Reaffirming and supporting self-determination | The survey workstream processes enabled people to uphold their right to participate on their terms. All participation was voluntary and based on informed consent. |

## Ethical considerations

Approval for the survey workstream was sought through MSD's Research and Evaluation Ethics Panel and a separate Privacy Assessment was also conducted. As members of the Aotearoa New Zealand Evaluation Association and Australian Evaluation Society (AES), we followed the practice guidelines for participant safety and privacy outlined by these organisations. These include the Aotearoa New Zealand Evaluation Association's Evaluation Standards and the Australian Evaluation Society Guidelines on Ethical Conduct of Evaluation and Code of Ethics. Adherence to these guidelines included undertaking our work in culturally safe ways, using information sheets, and collecting informed consent prior to engaging with evaluation participants. The informed consent process ensured that participants:

- had the opportunity to read information sheets and background information about the evaluation and the survey workstream

[47] Te Mana Raraunga (Māori Data Sovereignty Network) advocates for the realisation of Māori rights and interests in data and the ethical use of data. Te Mana Raraunga has released a set of principles of Māori data sovereignty, available here: https://www.temanararaunga.maori.nz/s/TMR-Maori-Data-Sovereignty-Principles-Oct-2018.pdf

- were given sufficient time to consider whether to participate in the evaluation
- were satisfied with the answers they were given regarding the evaluation and were provided a copy of the consent form and information sheet
- understood they had the right to decline to participate in any part of the evaluation
- knew who to contact if they had any questions about the evaluation in general
- understood that their participation in the evaluation is confidential
- understood that taking part in the evaluation was voluntary and that they could withdraw at any time without penalty.

# Data collection

This section outlines the survey workstream evaluation activities undertaken from February to September 2023.

A social media sentiment analysis was originally included in the scope of work, but this was removed with agreement from MSD due to ethical concerns and the intensive resource requirements to deliver this work.

# Document review

## Review of contextual documents

Our team undertook a review of background documents relevant to the design, implementation, and delivery of the CiC welfare response. The review included documentation on the implementation of the CiC welfare response, including joint agreements between agencies, real-time updates, the CiC Welfare Response Dashboard, and other documents provided by MSD. This informed the evaluation team's understanding of the CiC welfare response and assisted with the development of the survey instruments.

## Literature scan

We also conducted a database search to identify additional published research, grey literature, and evaluation reports describing similar COVID-19 welfare responses. The scope included welfare responses in comparable jurisdictions that have used similar processes for locally-led and regionally-enabled decision-making. The purpose was to help contextualise the CiC welfare response and understand the impact of COVID-19 on the welfare needs of different populations.

We conducted a search using Google Scholar and databases such as Cochrane Library, PubMed, ScienceDirect, Scopus, and Web of Science. Searches prioritised Aotearoa New Zealand, and countries with similar political systems and social historical contexts: Australia, United States of America, Canada, and the United Kingdom. Given the small number of documents initially identified, the search was broadened and identified approximately 70 pieces of literature that appeared relevant.

The title and abstracts of the initial returns were reviewed for relevance to the areas of interest for the overall evaluation questions. The references used in articles or reports that passed this initial review, as well as lists of documents that had cited these articles or reports (generated by the databases searched), were also checked for any further relevant information sources. We reviewed the context and findings of each study in terms of its relevance to the evaluation and its applicability to the Aotearoa New Zealand setting. Items that did not describe welfare responses were excluded, as were documents that were not written in English, or the subject matter did not provide lessons that were relevant to the scope of the evaluation. This left a total of 38 articles and reports included in the final literature scan.

Once documents and articles were selected, the full text documents were imported using Zotero (a citation tool). A thematic analysis of the full text of documents was undertaken to identify key themes that provided relevant contextual information to the evaluation and/or assisted in addressing the key evaluation questions. The findings of the thematic analysis were then written up in a report format. The literature scan was provided to MSD as a separate document.

## Key informant interviews

We undertook interviews with 16 key informants from central government agencies that were part of the CiC welfare response. We worked with MSD to identify relevant key personnel to be interviewed.

*Table 42: Key informant interview participants by organisation*

| Organisation | Number of interview participants |
|---|---|
| MSD | 4 |
| Treasury | 2 |
| Oranga Tamariki | 2 |
| Te Puni Kōkiri | 1 |
| Ministry for Pacific Peoples | 2 |
| Te Whatu Ora | 2 |
| RPSC | 1 |
| Whaikaha - Ministry of Disabled People (originally Office for Disability Issues) | 2 |
| **Total** | **16** |

These interviews were used to explore:

- the CiC welfare response context and aspirations
- regional operations and interactions
- the extent to which the cross-agency response enabled a locally-led welfare approach

- what was different about the welfare response compared to usual ways of working
- what worked well and what could be improved in future
- key lessons learned for future locally-led, regionally-enabled, nationally supported responses.

Each interview lasted 60-90 minutes and were mostly conducted online. Interviews took a semi-structured approach, using an interview guide (see Appendix 2) to ensure that key points were covered while allowing space and time to explore any areas of interest that emerged through the discussion.

All interview participants were provided with an information sheet and consent form (see Appendix 2) that outlined the purpose of the interview, how the information would be used and privacy conditions. Interviews were recorded with the interview participants' permission, so that we could verify our written notes taken during the session against what was said. In this final report, we have ensured that the interview participants remain anonymous and specific quotes have generic descriptors to protect the identity of participants, for example, 'government official'.

# Survey methodology

The survey methodology was submitted to the MSD Ethics Panel for approval.

## Survey questionnaires

This evaluation workstream included four surveys targeted at specific groups within the CiC welfare response: RLGs (including RPSCs), community providers, Community Connectors, and households who received support through the CiC welfare response. While there were common elements between the four survey questionnaires, each addressed different parts of the process and outcome questions. We developed the survey instruments through a collaborative design process with MSD, the cross-agency CiC Reference Group, and key stakeholders. The set of survey questionnaires are included in Appendix 3.

We piloted the RLGs, community provider, and Community Connector survey with a small subset of the target respondents to ensure the flow of the questionnaire and duration of the survey was acceptable to participants.

The household survey was tested with MSD and in three wānanga with a small number of community providers. The household survey questionnaire was then translated into Te Reo Māori, Cook Island Māori, Samoan and Tongan languages.

The surveys were hosted on the Qualtrics platform. In addition, a paper-based version was developed for distribution by community providers.

Reporting has been aggregated to ensure anonymity.

## Engagement

We worked with key MSD teams to facilitate and tailor engagement to the stakeholder groups, with an initial 'no-surprises' email distributed to RLGs, community providers and Community Connectors. This email introduced the evaluation and the survey workstream, and notified the recipient that a survey would be sent to them seeking their views on the CiC welfare response. The survey link was then sent via email. The approach to engagement with households was developed in collaboration with selected community providers.

Any contact details shared with the evaluation team were stored securely and not shared outside of the core *Allen + Clarke* evaluation team.

## Sample and distribution strategy

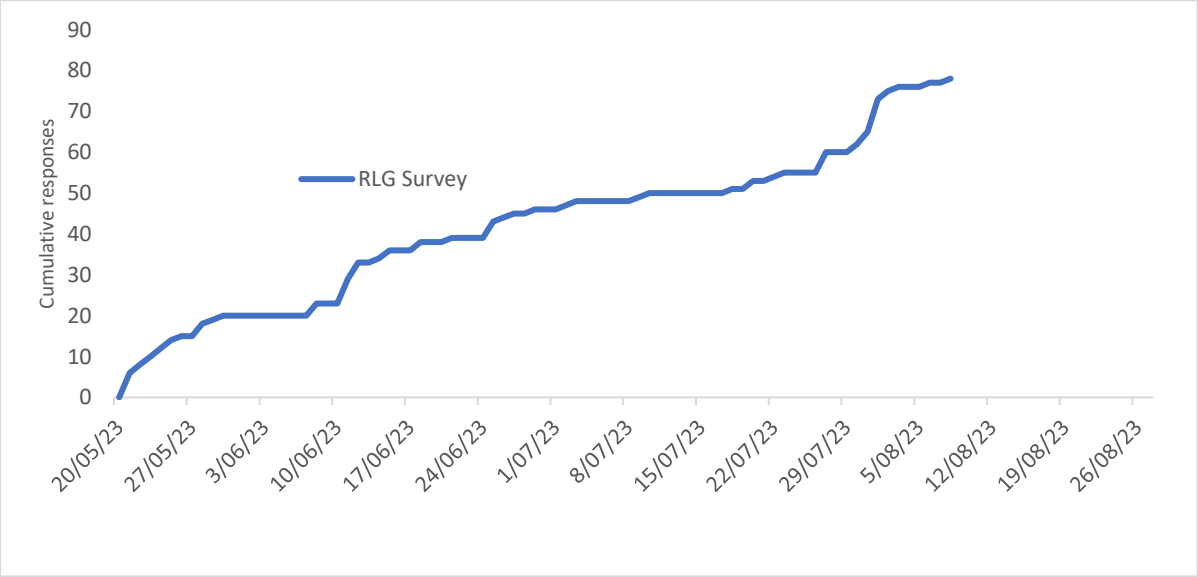
The sample frame, distribution, and response rates for each of the four groups is described in the section following.

### RLGs

The eleven RLGs are organised around the eleven MSD regional offices across the fifteen regions of Aotearoa New Zealand. The membership of these is variable but at the minimum comprises representatives from MSD, iwi, and local government, as well as other agencies such as health, housing, and education.

A snowball survey approach was taken with MSD sending a survey link to all MSD RPSCs and Regional Public Service Directors containing a link to the survey and detailing the purpose of the evaluation workstream and the RLG survey. The respondent then forwarded the link onto members of RLGs who were active when the COVID-19 Protection Framework was in place (December 2021 – September 2022). A total of 78 RLG members responded to the survey. Figure 3 below shows how the RLG survey was in the field nearly three months with a relatively slow build of responses.

*Figure 3: Survey responses over time for the RLG survey*



It is not possible to calculate a response rate for the RLG survey as we have no estimate of the number of emails the survey link was forwarded to. After the data cleaning process, of the 78 who opened the survey, 53 gave at least one valid response. One-quarter (25%) operated in Manawatū-Whanganui, 18% in Southland/Murihiku, 15% in Canterbury/Waitaha, and 11% in Bay of Plenty/Te-Moana-a-Toi (Table 43).

*Table 43: Regional distribution of RLG survey respondents*

| Region | Percent (n=83)* |
|---|---|
| Northland/Te Tai Tokerau | 2% |
| Auckland/Tāmaki Makaurau | 7% |
| Waikato | 9% |
| Bay of Plenty/Te Moana-a-Toi | 11% |
| East coast/Tairawhiti | 7% |
| Manawatū-Whanganui | 25% |
| Greater Wellington | 4% |
| Nelson-Tasman/Whakatū-Te Tai o Aorere | 5% |
| Marlborough/Te Tau Ihu | 9% |
| West Coast/Te Tai Poutini | 7% |
| Canterbury/Waitaha | 15% |
| Otago/Ōtākou | 7% |
| Southland/Murihiku | 18% |

*Totals to more than 100% as community providers may operate in more than one region.

Almost one-third (30%) of RLG survey respondents reported representing local government (Table 44), one-quarter were RPSCs, almost one-fifth (18%) represented central government, and 16% were iwi representatives. Two-thirds (66%) met prior to the CiC welfare response and almost the same number (64%) continued to meet after the COVID-19 Protection Framework was no longer in place.

*Table 44: Organisations represented (RLG survey)*

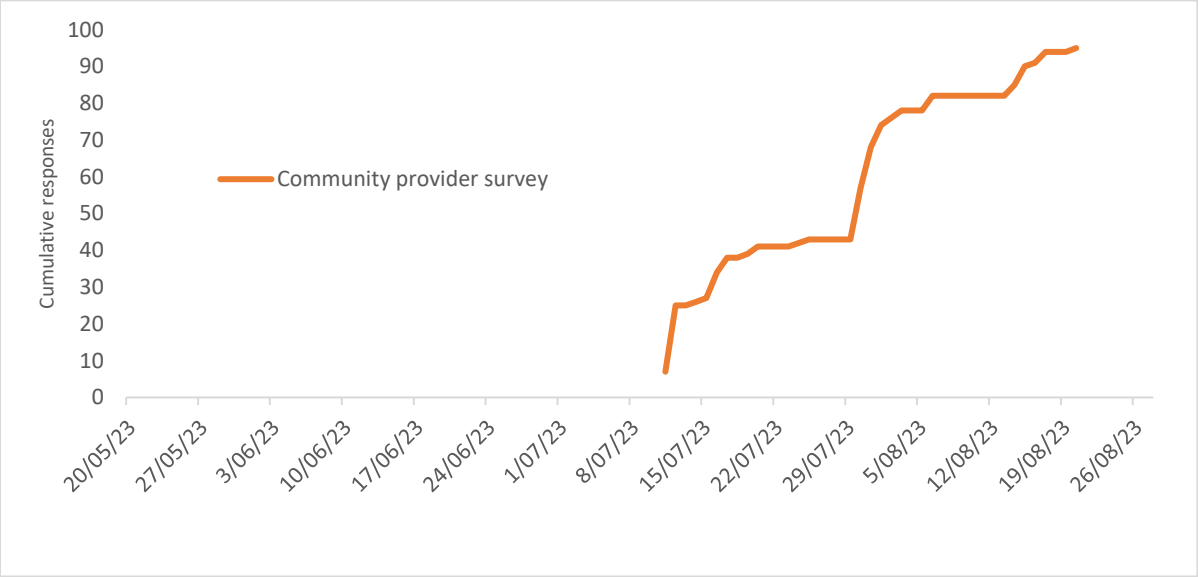
| Organisation | Percent (n=56)* |
|---|---|
| Iwi | 16% |
| RPSC | 25% |
| Māori health provider | 4% |
| Pacific organisation (e.g., Pacific NGOs, churches) | 4% |
| District Health Board | 7% |
| Local government | 30% |
| Central government, please specify | 18% |

*Totals to more than 100% as community providers may operate in more than one region.

## Community providers

An email list of 221 community providers was provided to *Allen + Clarke* by MSD. An email containing a link to the survey and detailing the purpose of the survey workstream was sent to each provider by *Allen + Clarke*. A total of 95 community providers responded to the survey. Figure 4 below shows how the community provider had two distinct phases with an initial high response rate then a second 'surge' in responses after almost three weeks following a reminder email.

*Figure 4: Survey responses over time for the community provider*




From 221 surveys distributed, 95 valid responses were received, giving a response rate of 43%. 22% operated in Auckland/Tāmaki Makaurau, 17% in Manawatū-Whanganui, 14% in Otago/Ōtākou, 11% in Canterbury/Waitaha, and 10% in Waikato, Bay of Plenty/Te Moana-a-Toi (Table 45).

*Table 45: Regional distribution of community provider survey respondents*

| Region | Percent (n=83)* |
|---|---|
| Northland/Te Tai Tokerau | 10% |
| Auckland/Tāmaki Makaurau | 22% |
| Waikato | 10% |
| Bay of Plenty/Te Moana-a-Toi | 10% |
| East Coast/Tairāwhiti | 4% |
| Hawkes Bay/Heretaunga-Ahuriri | 5% |
| Taranaki-King Country | 7% |
| Manawatū-Whanganui | 17% |
| Greater Wellington | 8% |
| Nelson-Tasman/Whakatū-Te Tai o Aorere | 2% |
| Marlborough/Te Tau Ihu | 4% |

| Region | Percent (n=83)* |
|---|---|
| West Coast/Te Tai Poutini | 4% |
| Canterbury/Waitaha | 11% |
| Otago/Ōtākou | 14% |
| Southland/Murihiku | 7% |

*Totals to more than 100% as community providers may operate in more than one region.

Over two-thirds (69%) identified as a community organisation (Table 46) and one-fifth (20%) as a Māori organisation. Almost three-quarters (71%) specialised in helping socio-economically disadvantaged communities, over half older people (57%) and Pacific peoples (52%), and almost half ethnic communities (48%) and disabled peoples (45%).

*Table 46: Organisation type (community provider survey)*

| Organisation type | Percent (n=80)* |
|---|---|
| Iwi organisation | 6% |
| Māori organisation | 20% |
| Pacific organisation | 3% |
| Ethnic/migrant organisation | 6% |
| Community organisation | 69% |

*Totals to more than 100% as community providers may identify as more than one provider type.

Four out of ten (41%) respondents to the community provider survey had a management role and one-third (34%) were an executive (Table 47).

*Table 47: Role in organisation (community provider survey)*

| Role | Percent (n=83) |
|---|---|
| Executive (CE, DCE, Director, Tumu Whakarae) | 34% |
| Management (General Manager, Manager, Kaiwhakahaere Matua, other management) | 41% |
| Team or Group Leader, Kaiarataki | 10% |
| Service delivery staff | 5% |
| Administrative staff | 2% |
| Other, please specify: | 8% |

## Community Connectors

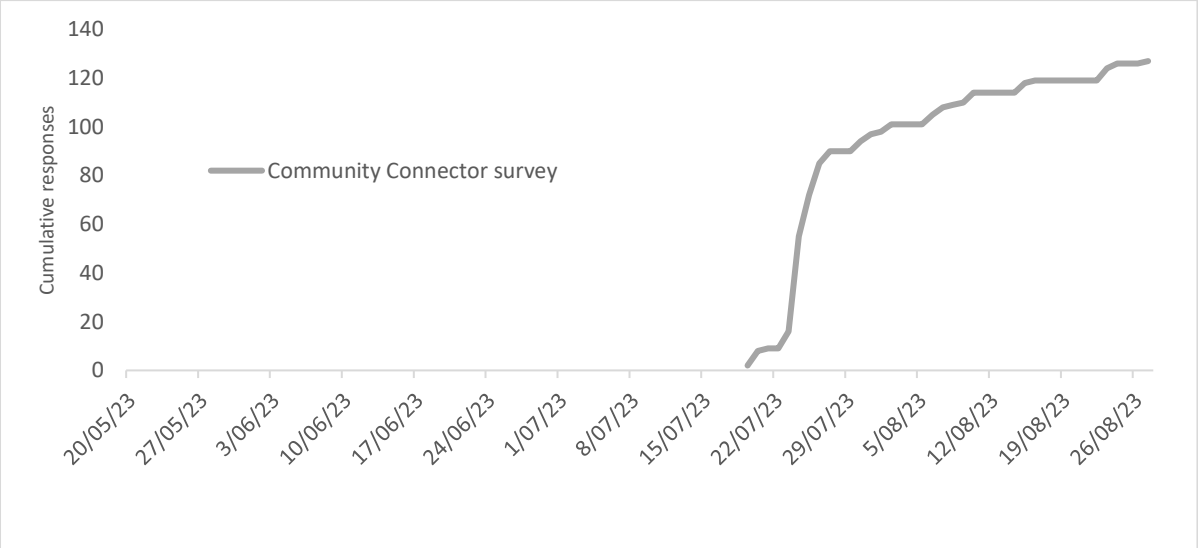
An email list of 251 community providers who provided Community Connector services was provided to *Allen + Clarke* by MSD with an email sent to each provider by *Allen + Clarke* asking either:

- that they provide a list of emails of the Community Connectors who are part of their service and who provided Community Connector services when the CPF was in place (December 2021 – September 2022); or
- that they distribute an anonymous survey link to all the Community Connectors employed by the community provider.

We also requested that the community provider only include those Community Connectors who were employed when the CPF was in place.

Of the 251 community provider emails sent, 89 responded with 179 Community Connector emails and 10 community providers said they wished to distribute anonymous links. From the direct email survey link sent to Community Connectors, 123 responded to the survey and 54 from the anonymous survey link. From the 177 possible Community Connectors respondents 139 gave valid responses. Figure 5 below shows how the Community connector saw a high initial response then a relatively steady response rate after that.

*Figure 5: Survey responses over time for the Community Connector survey.*




Three-quarters (75%) were employed fulltime. One-fifth (20%) were working in Auckland/Tāmaki Makaurau, 13% in Northland/Te Tai Tokerau, 11% in the Waikato, and 10% in Canterbury/Waitaha (Table 48).

*Table 48: Regional distribution of respondents to Community Connector survey*

| Region | Percent (n=139) |
|---|---|
| Northland/Te Tai Tokerau | 13% |
| Auckland/Tāmaki Makaurau | 20% |
| Waikato | 11% |
| Bay of Plenty/Te Moana-a-Toi | 9.4% |
| Taranaki-King Country | 1.9% |
| East Coast/Tairāwhiti | 4.4% |
| Manawatū-Whanganui | 8.2% |

| Region | Percent (n=139) |
|---|---|
| Hawkes Bay/Heretaunga-Ahuriri | 3.1% |
| Greater Wellington | 9.4% |
| Nelson-Tasman/Whakatū-Te Tai o Aorere | 3.1% |
| Marlborough/Te Tau Ihu | 1.9% |
| West Coast/Te Tai Poutini | 1.3% |
| Canterbury/Waitaha | 10% |
| Southland/Murihiku | 3.8 % |

## Households

Community providers held all contact details for households who had to isolate, which required a much more personalised approach to determine the best method of survey distribution for each community provider. Since there was no centrally held contact database of households who had received support through the CiC welfare response, distributing the survey via any postal or face-to-face sampling techniques would be prohibitively expensive, and snowball sampling techniques were considered impractical as there would be no way of limiting respondents to those who had to isolate due to a positive COVID-19 test when the CPF was in place.

Given the high level of engagement required with each provider, a random sample of community providers stratified by region and population cohort (general, Māori, Pacific peoples, culturally and linguistically diverse [CALD], health and disability) was generated. This ensured the proportions of providers in the sample matched the regional breakdown of households supported by community providers, whilst also including in organisations representing each of the priority populations.

This sampling strategy guided initial selection of 49 providers. Evaluation requirements alongside advice and information from MSD were used to prioritise the order of provider engagement. A top-up sample of an additional 24 community providers was included after around four weeks using the same methodology to boost the total number of responses.

We then worked with the providers within the selected sample through a series of three online wānanga to consult on the survey and agree on a small number of additional questions of specific interest to providers. This ensured that the household survey collected data that would mutually benefit MSD and the providers. This was also used as a mechanism to facilitate provider engagement with the surveys.

We used the connections made through the wānanga to work with providers to distribute the survey to those to who provided the CiC welfare response. We took advice from providers around how best to distribute the survey to households they supported through the CiC welfare response. Providers were offered an additional payment to recognise their time and costs in supporting the evaluation team to access Community Connectors and households.

Based on our experience in survey work, response rates for Māori, Pacific peoples, and any economically deprived population are traditionally very low. To help incentivise participation, we included a prize draw of 100 draws of $100 Prezzy Cards. Where households wished to be part of the prize draw, a separate survey link was provided at the end of the asking for at least one of two contact details (phone and email) with no further questions added.

All household surveys were distributed to just one individual in each household by the community providers selected in the stratified random sample as an open link or a paper survey so that participation was anonymous. For those providers opting to distribute the survey via paper-based questionnaire, 'bundles' were distributed to each provider comprising the questionnaire and a pre-paid return envelope address to *Allen + Clarke*.

From 18 July – 30 October 2023, *Allen + Clarke* engaged with providers about the household survey. A total of 74 providers were contacted and an estimated total of 196 emails (147 for the first pool and 49 for the second pool) were sent to providers to ask them to participate in distributing CiC surveys to households.

The first pool of 49 providers were emailed from 18 July 2023. Three of these providers also required phone conversations/Teams meetings to help them to understand the purpose of the survey and their involvement. From this pool, 20 providers responded that they would provide either physical or virtual surveys to the households. A total of 1261 physical surveys were printed and sent to 12 providers and the other 8 providers conducted the surveys virtually.

A second pool of 25 providers were emailed on the 23 August 2023. Four providers replied stating that they will contact households for the survey. Three conducted it virtually and one provider requested 40 physical surveys. Two providers contacted their community through putting the survey out on social media.

Between the two pools, a total of 50 providers were not able to distribute the surveys to households known to have isolated. Overall, 108 physical surveys out of 1301 were sent back to *Allen + Clarke*. Most did not reply but a few listed that they did not have capacity to undertake this task as they had other pressing work or the people who joined the organisation during COVID-19 had since left. By the time the survey collection was closed 223 online and 108 paper based responses had been received.

Once data collection was complete, duplicates were identified (e.g., multiple responses from the same household completed through the same link or via different providers) through a probabilistic matching technique based on IP address, household characteristics, provider, and region. Close matches meant the most complete (or first response if all were complete) were selected. The threshold for determining whether a response was from the same household was set at 95% or higher. No duplicates were detected.

Of the 342 responses received, after cleaning, there were 255 valid responses remaining. Not every question was answered by respondents so the number of valid responses varied further depending on the analysis.

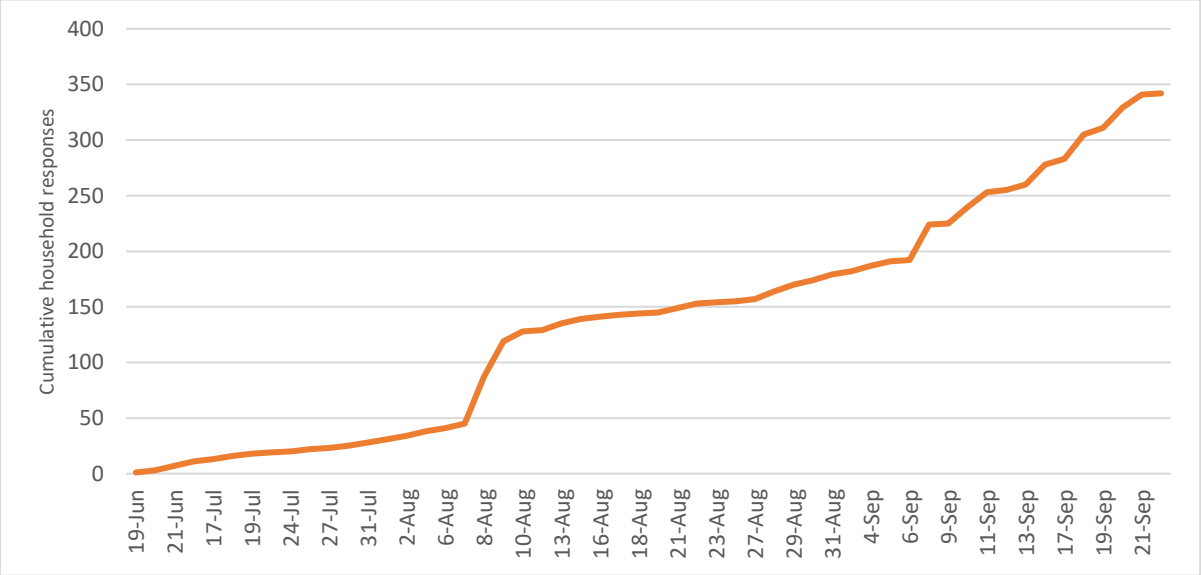
Noting that households could have residents from multiple ethnic groups, 38% of households had a resident of Māori ethnicity, 32% a resident of Pacific ethnicity, and 16% a resident of Asian ethnicity. 29% of households had a resident with a disability, long-term condition, or

mental health condition, and 28% reported not having enough total income to meet everyday needs for such things as accommodation, food, clothing, and other necessities. Seventy-two percent reported having school age children resident and 34% had someone aged 65 or older resident. Almost one-third (32%) of the respondents were in Auckland/Tāmaki Makaurau when they had to isolate, with concentrations from Bay of Plenty/Te Moana-a-Toi (16%), Greater Wellington (13%), and Canterbury/Waitaha (13%). Twenty-two percent were from provincial (rural/remote) parts of Aotearoa.

The response rate for the household survey cannot be calculated as we were reliant on community providers distributing the survey to households who had to isolate. There were also no administrative records available with the number of households requiring support across the country. Of the 342 responses received, after cleaning, there were 255 valid responses remaining. Not every question was answered by respondents so the number of valid responses varied further depending on the analysis.

Figure 6 shows how long it took to collect the sample for the household survey, with one tranche of data related to an initial high response for the online survey and a much longer tail from mid-August onwards as the questionnaires arrived and were manually input.

*Figure 6: Survey responses over time for household survey.*



# Appendix 2: Key informant interview guide, information sheet and consent form

## Information sheet and consent form

You are invited to participate in the evaluation of the Care in the Community (CiC) welfare response.

You have been identified as a key knowledge-holder who may be able to provide valuable insight into the cross-agency implementation of the CiC welfare response.

Please read this form and ask the evaluation team any questions you have before deciding whether to take part.

**What is the evaluation about?**

The evaluation is intended to assess the implementation of the CiC welfare response, the extent to which the intended outcomes were achieved, and to identify 'lessons learned' for future work involving locally-led, regionally-enabled, and nationally supported delivery of services.

**The purpose of this evaluation is threefold:**

1. To understand how effectively the programme has been implemented to date and the extent to which the intended outcomes were achieved for those who accessed the support, including individuals, whānau and communities.
2. To explore the effectiveness of the partnering model used to work across the various government agencies, contract providers and community connectors throughout the response.
3. To identify lessons learned and recommendations for future work in sustaining community resilience.

There are two main workstreams informing this evaluation: surveys of all those involved in the CiC welfare response conducted by *Allen + Clarke*; and six regional case-studies conducted by Kaipuke. MSD will be leading the synthesis of all the information and reporting to deliver a final evaluation report.

**What is involved?**

If you agree to participate in this evaluation, we will organise a 60 minute interview which will preferably be run over MS Teams or Zoom. The interview will be recorded with your consent.

The interview will be led by a senior consultant from the *Allen + Clarke* evaluation team.

**Do I have to take part in this evaluation?**

You do not have to take part in this evaluation. Your participation is completely voluntary. Your decision to participate or not will not impact your relationship with MSD or *Allen + Clarke*.

If you choose to take part and then change your mind later, you can pull out at any time. If you decide to stop taking part, the information you have given us that has not been analysed will be deleted.

No other individuals or organisations outside of the core *Allen + Clarke* evaluation team will know if you decline to participate or withdraw at a later stage.

**How will my privacy be protected?**

The evaluation is anonymous and the information you provide us will be treated as confidential. We will not include any personal or identifiable information from the interviews in reports and presentations about this evaluation. Any quotes used in reporting will have all identifying information removed.

Only *Allen + Clarke* staff will have access to the information and the audio files, which will be stored on a secure *Allen + Clarke* server. All transcript and audio data will be securely deleted at the completion of the evaluation.

You can request a summary of the information we collect from you and about you. To receive a copy of this information please contact the Lead Evaluator, [name and email removed] and he will arrange a copy to be sent to you.

**Are there any risks or benefits of taking part?**

Your participation will help by providing valuable information about the value of the CiC welfare response.

MSD will use the findings of this evaluation help to grow a resilient networked community sector that is well-placed to plan for and respond to current and future community needs, build a joined-up regional public service well connected to the community sector and to iwi, and embed new ways of working in a unified public service that organises flexibly around the needs of New Zealanders.

The agency that you work for may know that you are participating in an interview to discuss the CiC welfare response. Your employer will not be able to access any of the information that you provide, and we will ensure that you are not able to be identified in any reports on the findings.

**Any questions?**

If you have any further questions about the evaluation, you can contact the Lead Evaluator, [name and email removed].

**What happens next?**

Please reply to the email this document was attached to with either a yes or no and someone from *Allen + Clarke* will be in touch to arrange a time for the interview.

If the interview is remote (Teams or Zoom) we will seek verbal consent, otherwise could you please complete the section below.

Statement of consent:

☐ I have read the above information.

☐ Questions I had about the evaluation have been answered.

☐ I consent to take part in the evaluation.

☐ I consent to *Allen + Clarke* making an audio recording of the interview.

Signature _____

Printed name _____

Date _____

# Interview Schedule

| Interview details | |
|---|---|
| Interview participant | |
| Organisation | |
| Sector | |
| Interviewer and notetaker | |
| Date and time | |
| Consent given | |

**Introduction**

*Karakia*

If appropriate, offer to begin an opening karakia.

| Reo Māori | Rough translation to English |
|---|---|
| He waka herenga | Where canoes are tethered together |
| He whitiwhiti whakaaro | Thoughts are provoked |
| He whitiwhiti kōrero | Dialogue is exchanged |
| Ka ū te māramatanga | Enlightenment comes |
| Tīhei mauri ora! | |

**Whanaungatanga**

Introductions: name/pepeha, who we work for and our position/role in the project, details of professional background as appropriate.

**Introduction (adapt as necessary)**

Thank you for agreeing to participate in this interview. The information you provide will contribute to an evaluation of the Care in the Community (CiC) welfare response, focussing on period the COVID-19 Protection Framework was in place.

The evaluation is intended to explore how effectively the CiC welfare response has been implemented to date and the extent to which its intended outcomes were achieved. We are particularly interested in your views on the effectiveness of the partnering model used to work across the various government agencies, and your thoughts on what worked well and what did not, to identify lessons for future work in sustaining community resilience.

Refer interview participants to information sheet for more detailed information on the evaluation.

While we have a set of questions to help us guide the interview, some may be more relevant to you than others. If you don't have any experience or knowledge about a particular area or topic, just let us know and we'll move on to the next question.

**Consent**

We sent through an information sheet earlier which contained more background about the CiC welfare response and the evaluation. Have you have had time to read it? If not, could you please read it now.

Before we begin, do you have any further questions about the evaluation?

To make sure we accurately represent what you have told us in this interview, we have asked your permission to record this interview. As with the written transcript of this interview, we will securely store the recording on an *Allen + Clarke* server with access granted to the project team only, and it will be deleted along with other project records after project completion. Are you okay if we record the interview?

Ask the participant to complete the consent form, if they have not already done so.

Kia ora, we will begin the interview now.

**Contextual questions**

What is your role at [organisation]?

Can you describe your involvement with the CiC welfare response?

**Process questions**

*Collaboration and relationships*

First, we have some questions to get your views about collaboration between those involved in the CiC welfare response.

Can you describe the collaborative processes or structures that were set up to deliver the CiC welfare response? [Prompt: collaboration across central government, regional, local organisations]

KEI 1.2.1 To what extent has collaboration across public service agencies and regional organisations led to effective implementation of the welfare response?

KEI 1.2.2 To what extent have digital pathways enhanced collaboration between groups involved in implementation?

KEI 1.2.3 Have public service agencies had adequate resources to build positive relationships between public service agencies, community providers, community stakeholders (e.g., marae), and iwi?

To what extent has the CiC welfare response, contributed to stronger relationships between public service agencies, community providers, community stakeholders (e.g., marae), and iwi?

*Communications*

We are keen to hear your views on communications related to the CiC welfare response.

Can you describe the communication processes that were established between yourselves, and others involved in the welfare response? How effective were these communication processes?

KEI 1.2.5 Do you think that the messaging from central government, regional public service agencies, regional leadership, community providers was clear and consistent? Why/why not?

KEI 1.3.4 Were communications tailored for groups [at the regional level for [Regional level for Regional Leadership Groups OR Community for Providers/Connectors] with different languages and different levels of access to in-person or online contact? Can you provide some examples?

*Involvement of priority communities*

Next we have some questions on the involvement of different communities within the CiC welfare response.

In what ways were the following communities involved in the design and decision-making of the CiC welfare response:

- Māori communities (KEI 1.4.1)
- Pacific communities (KEI 1.4.1)
- The disability sector (KEI 1.4.3)
- Refugee and migrant communities (KEI 1.4.4)

KEI 1.4.2 To what extent were Māori and Pacific communities invested in and resourced to deliver the CiC welfare response?

*Complementarity with other welfare support*

We are aware that there was other support provided to households the needed to isolate, particularly from the Ministry for Pacific Peoples and Te Puni Kokiri. We interested in understanding how the CiC welfare response interacted with this.

KEI 1.5.1 Can you describe how MSD worked with Ministry for Pacific Peoples and Te Puni Kokiri on the implementation of COVID-19 welfare responses?

KEI 1.5.2 In your view, did the CIC welfare response complement support from the Ministry for Pacific Peoples? Why/why not?

KEI 1.5.3 In your view, did the CiC welfare response complement support from Te Puni Kokiri? Why/why not?

**Outcome questions**

We'd like to know about changes or outcomes you have observed that you attribute to the CiC welfare response.

To what extent did your organisation deliver services to communities differently during the CiC welfare response? Could you provide some examples?

KEI 2.2.1 To what extent has your organisation made changes to the way it delivers services to communities, based on learning from the CiC welfare response? Could you provide some examples?

KEI 2.2.2 Based on your observations and experience, to what extent have agencies demonstrated new and more flexible ways of working with local communities (including specifically iwi Māori and Pacific peoples)?

KEI 2.4.1 In your view, to what extent has the community sector become better networked and able to respond to future needs because of the welfare response?

KEI 2.3.3 Did anything unexpected happen because of the CiC welfare response? Could you provide some examples? [Prompt: at a regional or community level, between public service and regions, between public service and communities]

**Learning and improvement questions**

KEI 1.6.1 In your view, what were the challenges or barriers to the implementation of the CiC welfare response?

What contributed to the success of the Care in the Community Welfare Response?

KEI 1.6.2 Were there any opportunities to enhance the CiC welfare response that you can identify?

**Wrap up**

Do you have any final comments about the Care in the Community welfare response?

(Please do not use any personally identifying information in your comments)

Thank interview participant for their time.

Summarise next steps for the evaluation.

*Karakia Whakamutunga*

Nāku tō rourou

Nā taku rourou

Ka ora ai te iwi

# Appendix 3: Survey questionnaires

## RLG survey

### Survey questions

Kia ora, welcome to the Care in the Community welfare response survey.

**What is this survey for?**

This survey is part of an evaluation of the Care in the Community (CiC) welfare response by the Ministry of Social Development (MSD). The evaluation is intended to assess the implementation of the CiC welfare response, the extent to which the intended outcomes were achieved, and to identify 'lessons learned' for future work involving locally-led, regionally-enabled, and nationally supported delivery of services. We are focussing on when the COVID-19 Protection Framework was in place (December 2021 – September 2022).

**Why have I been asked to respond to this survey?**

Regional Leadership Groups were instrumental to delivering the CiC welfare response. Your responses will provide unique insights into the implementation, impacts, and outcomes of the CiC welfare response within your region. As a member of a Regional Leadership Group, we want to learn from your experience. Completing this survey is voluntary but we would greatly appreciate your help.

**Why should I take part?**

This evaluation is an opportunity to draw out lessons from the innovative practices that your region adopted to mobilise welfare support for communities during COVID-19. Your information will be used to identify ways of working during the response that should be maintained going forward. It will inform valuable insights on future initiatives such as the Social Sector Commissioning work programme, how the public sector can adapt to more relational approaches to commissioning, the Regional Public Service framework, and MSD's commitment to cross-agency alignment and coordination in the regions – especially with regard to meaningfully partnering with iwi, Māori organisations, local government, and regional stakeholders.

**Who is running the survey?**

*Allen + Clarke* has been contracted by MSD to conduct surveys of the Regional Leadership Groups as part of a larger outcomes-focused evaluation by MSD of the broader Care in the Community Welfare Response including the Community Connector and the food secure community initiatives. *Allen + Clarke* is an independent policy, evaluation, and research company. *Allen + Clarke* will analyse the data and report the results to MSD.

**How will my privacy and confidentiality be protected?**

All data collected for this survey will be stored securely by *Allen + Clarke* and will not be shared with anyone outside the research team. MSD will only see anonymised and de-identified responses. This data will be deleted at the completion of the evaluation. You may also choose to withdraw from the evaluation by sending an email to cic.evaluation@allenandclarke.co.nz before 14 July 2023 without any consequence.

**How do I complete the survey?**

By clicking on the link provided you are giving consent for your de-identified responses to be used for this evaluation. The survey should take about 10 minutes to complete. While you are completing the survey questions, please specifically reflect on the time that the COVID-19 Protection Framework was in place (December 2021 – September 2022).

Please use the '←' and '→' arrows at the bottom of the page to move through the survey - do not use your browser buttons. You can continue later by clicking the same link from this email.

**Any questions?**

If you have any questions or problems completing the survey, please contact **cic.evaluation@allenandclarke.co.nz**

Which region do you operate within? (Tick all that apply)

1. Northland/Te Tai Tokerau
2. Auckland/Tāmaki Makaurau
3. Waikato
4. Bay of Plenty/Te Moana-a-Toi
5. East Coast / Tairāwhiti
6. Hawkes Bay/ Heretaunga-Ahuriri
7. Taranaki-King Country
8. Manawatū-Whanganui
9. Greater Wellington
10. Nelson-Tasman/ Whakatū-Te Tai o Aorere
11. Marlborough/Te Tau Ihu
12. West Coast/Te Tai Poutini
13. Canterbury/Waitaha
14. Otago/Ōtākou
15. Southland/Murihiku

Which organisation or body did you represent on your Regional Leadership Group?

1. Iwi
2. Regional Public Service Commissioner
3. Community organisation
4. Māori health provider
5. Pacific organisation (e.g.,, Pacific NGOs, churches)
6. Other health provider
7. District Health Board
8. Local government
9. Central government, please specify: _____
10. Other, please specify: _____

Did your Regional Leadership Group meet prior to the CiC welfare response (before December 2021)?

[Yes, No]

Has your Regional Leadership Group continued to meet after the COVID-19 Protection Framework was no longer in place (since September 2022)?

[Yes – The same group meets, Yes –but the group has changed, No - we no longer meet]

Please indicate the extent to which you agree with the following statements about how your Regional Leadership Group functioned:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. All relevant organisations were represented in my Regional Leadership Group.
2. The members of my Regional Leadership Group collaborated effectively with each other.
3. The frequency of meetings was about right.
4. My Regional Leadership Group created effective sub-structures (such as working groups).
5. My Regional Leadership Group was supported by the MSD national office to enable the CiC welfare response.

Please indicate the extent to which you agree with the following statements about the Regional Public Service Commissioner:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. The Regional Public Service Commissioner in my region had existing relationships that were important to the success of the CiC welfare response.
2. The Regional Public Service Commissioner in my region had sufficient resources to support the CiC welfare response

To what extent were the following groups actively involved in your Regional Leadership Group?

[Strongly involved; Somewhat involved; Not involved]

1. Iwi
2. Local government
3. Community organisations

Please indicate the extent to which you agree with the following statements about how your Regional Leadership Group supported the CiC welfare response:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. My Regional Leadership Group enabled community providers to lead the CiC welfare response in my region.
2. My Regional Leadership Group supported funding to be prioritised effectively in my region.
3. My Regional Leadership Group was critical in ensuring the CiC welfare response was well coordinated in my region.

What worked particularly well with your Regional Leadership Group?

[Open text]

What did not work so well with your Regional Leadership Group? Why?

[Open text]

My Regional Leadership Group was able to build positive relationships during the CiC welfare response with:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Iwi
2. MSD
3. Ministry of Health
4. Other central government agencies
5. DPMC Response Group
6. Care in the Community hubs
7. Community providers
8. Other community organisations

What aspects of the CiC welfare response model were important for your Regional Leadership Group to build relationships with these groups?

[Very important; Somewhat important; Not important]

1. Formal meetings with key stakeholder groups
2. Ad hoc meetings with key stakeholder groups
3. Existing Regional Public Service Commissioner networks and relationships
4. The structure of my Regional Leadership Group
5. The funding of the Regional Leadership Groups

The following groups were involved in collaborative decision-making related to the CiC welfare response in my region:

[Strongly involved; Somewhat involved; Not involved]

1. Iwi
2. Central government public service agencies
3. Community organisations
4. Community leaders
5. Local government
6. Other community stakeholders, please specify: _____

[Survey routing so that those that ticked ‘Iwi’ are directed to these questions]

Please indicate the extent to which you agree with the following statements about iwi involvement in your Regional Leadership Group:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. The dedicated funding for iwi was important to enabling iwi participation in my Regional Leadership Group
2. My Regional Leadership Group enabled the CiC welfare response to meet Tiriti o Waitangi obligations.
3. There were opportunities for iwi and Māori leadership in my Regional Leadership Group.

[All respondents]

In what ways was your Regional Leadership Group structured to be responsive to iwi?

[Yes; No; Unsure]

1. Iwi were involved in the design of the CiC welfare response
2. Iwi were members of my Regional Leadership Group
3. Iwi were leaders of my Regional Leadership Group
4. Iwi were involved in disseminating communications about the CiC welfare response
5. Other, please specify: _____

[Survey routing for 'yes' responses]

What were the benefits of iwi involvement in the CiC welfare response in your region?

[Open text]

In what ways was your Regional Leadership Group structured to be responsive to Pacific peoples?

[Yes; No; Unsure]

1. Pacific peoples were involved in the design of the CiC welfare response
2. Pacific peoples were members of my Regional Leadership Group
3. Pacific organisations were leaders of my Regional Leadership Group
4. Pacific peoples were involved in disseminating communications about the CiC welfare response
5. Other, please specify: _____

[Survey routing for ‘yes’ responses]

What were the benefits of Pacific peoples’ involvement in the CiC welfare response in your region?

[Open text]

In what ways was your Regional Leadership Group structured to be responsive to ethnic communities?

[Yes; No; Unsure]

1. Ethnic communities were involved in the design of the CiC welfare response
2. Ethnic communities were members of my Regional Leadership Group
3. Ethnic community organisations were leaders of my Regional Leadership Group
4. Ethnic communities were involved in disseminating communications about the CiC welfare response
5. Other, please specify: _____

[Survey routing for ‘yes’ responses]

What were the benefits of ethnic communities’ involvement in the CiC welfare response in your region?

[Open text]

To what extent was there duplication of MSD’s CiC welfare support with that of other agencies such as the Ministry for Pacific Peoples (MPP) and Te Puni Kōkiri (TPK)?

[No duplication; Some duplication; Substantial duplication]

[Survey routing for ‘some’ and ‘substantial’ duplication]

Please provide details about what duplication you observed.

[Open text]

To what extent do you agree with the following statements regarding flow of information the CiC welfare response:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. There was effective flow of information from central government to enable my Regional Leadership Group to support the welfare response
2. There was effective flow of information between members of my Regional Leadership Group to support the welfare response
3. There was effective flow of information between the DPMC Response Group and my Regional Leadership Group to support the welfare response

To what extent do you agree with the following statements:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. My Regional Leadership Group facilitated the development of new networks within the community sector in my region
2. My Regional Leadership Group strengthened existing networks within the community sector in my region
3. The community sector in my region has become better able to respond to community priorities because of my Regional Leadership Group

To what extent do you agree that your Regional Leadership Group enabled a tailored response to the needs of the following communities during the CiC welfare response:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Māori
2. Pacific peoples
3. Socio-economically disadvantaged
4. Ethnic communities
5. Older population
6. Disabled people
7. Others, please specify: _____

In what ways did your Regional Leadership Group enable a tailored response to the needs of these communities?

[Open text]

Did your Regional Leadership Group struggle to enable access to welfare support for any of the following groups throughout the response? (Tick all that apply)

1. Māori
2. Pacific peoples
3. Socio-economically disadvantaged
4. Ethnic communities
5. Older population
6. Disabled people
7. Others, please specify: _____
8. None of the above

[If ticked responses 1-7]

What do you think the main barriers were to enabling these groups to access welfare support?

[Open text]

To what extent do you agree that your Regional Leadership Group enabled increased reach into the following communities during the CiC welfare response:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Māori
2. Pacific peoples
3. Socio-economically disadvantaged
4. Ethnic communities
5. Older population
6. Disabled people

Could you give us examples of how your Regional Leadership Group increased the reach of support to these communities?

[Open text]

To what extent do you agree with the following statements:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. There was sufficient funding available in my region for community providers to deliver the CiC welfare response
2. The CiC welfare response was effective in supporting households to stay in isolation
3. The CiC welfare response was effective in maintaining people's dignity and mana while they were isolating
4. The CiC welfare response was effective in supporting households who needed it to reintegrate after the isolation period

Do you have any final comments about the CiC welfare response in your region?

(Note: please do not use any personally identifying information in your comments)

[Open text]

# Community provider survey

## Survey questions

Kia ora, welcome to the Care in the Community welfare response survey.

### What is this survey for?

This survey is part of an evaluation Care in the Community (CiC) welfare response by the Ministry of Social Development (MSD). The evaluation will help to understand the benefits and challenges of a locally-led, regionally-enabled, and nationally-supported way of delivering welfare support to communities. The evaluation focuses on the time when the COVID-19 Protection Framework was in place (December 2021 – September 2022).

### Why have I been asked to respond to this survey?

You have been asked to complete this survey because your organisation was contracted to deliver welfare support to households impacted by COVID-19. Community providers were instrumental to delivering the CiC welfare response, providing tailored support designed to meet household needs. Your responses will provide unique insights into the implementation, impacts, and outcomes of the CiC welfare response within communities. We want to learn from your experience. Completing this survey is voluntary but we would greatly appreciate your help.

### What difference will my involvement make?

This evaluation is an exciting opportunity to draw out lessons from the innovative practices that you adopted to mobilise welfare and support for communities during COVID-19. It will capture the unique solutions and challenges community providers faced in delivering the CiC welfare response. Your responses will inform the design and delivery of future welfare responses. The survey data will also help MSD to understand what works best in terms of funding, contracting and resourcing to enable community providers to deliver support to communities.

### Who is running the survey?

*Allen + Clarke* has been contracted by MSD to conduct surveys of the Regional Leadership Groups as part of a larger outcomes-focused evaluation by MSD of the CiC welfare response. *Allen + Clarke* is an independent policy, evaluation and research company. *Allen + Clarke* will analyse the data and report the results to MSD.

### How will my privacy and confidentiality be protected?

All data collected for this survey will be stored securely by *Allen + Clarke* and will not be shared with anyone outside the research team. MSD will only see anonymised and deidentified responses. This data will be deleted at the completion of the evaluation. You may also choose to withdraw from the evaluation by sending an email to cic.evaluation@allenandclarke.co.nz before XX XXXX 2023 without any consequence.

**How do I complete the survey?**

By clicking on the link provided you are giving consent for your de-identified responses to be used for this evaluation. The survey should take about 10 minutes to complete. While you are completing the survey questions, please specifically reflect on the time that the COVID-19 Protection Framework was in place (December 2021 – September 2022).

Please use the '←' and '→' arrows at the bottom of the page to move through the survey - do not use your browser buttons. You can continue later by clicking the same link from this email.

**Any questions?**

If you have any questions or problems completing the survey, please contact cic.evaluation@allenandclarke.co.nz

Which region do you operate within? (Tick all that apply)

1. Northland/Te Tai Tokerau
2. Auckland/Tāmaki Makaurau
3. Waikato
4. Bay of Plenty/Te Moana-a-Toi
5. East Coast / Tairāwhiti
6. Hawkes Bay/ Heretaunga-Ahuriri
7. Taranaki-King Country
8. Manawatū-Whanganui
9. Greater Wellington
10. Nelson-Tasman/ Whakatū-Te Tai o Aorere
11. Marlborough/Te Tau Ihu
12. West Coast/Te Tai Poutini
13. Canterbury/Waitaha
14. Otago/Ōtākou
15. Southland/Murihiku

Which of the following does your organisation identify as? (Tick all that apply)

1. An iwi organisation
2. A Māori organisation
3. A Pacific organisation
4. An ethnic/migrant organisation
5. A disability organisation

6. Community organisation
7. Other, please specify: _____

Does your organisation specialise in helping any of the following groups? (Tick all that apply)

1. Māori
2. Pacific peoples
3. Socio-economically disadvantaged
4. Ethnic communities
5. Older population
6. Disabled people
7. Other, please specify: _____
8. None of the above

What role do you hold within your organisation?

1. Executive (CE, DCE, Director, Tumu Whakarae)
2. Management (General Manager, Manager, Kaiwhakahaere Matua, other management)
3. Team or Group Leader, Kaiarataki
4. Service delivery staff
5. Administrative staff
6. Other, please specify: _____

How many employees does your organisation have (full or part time)?

1. 5 or fewer employees
2. 6 to 19
3. 20 to 49
4. 50 to 99
5. 100+

What was your organisation contracted to provide as part of the CiC welfare response when the COVID-19 Protection Framework (CPF) was in place?

(Tick all that apply)

1. The Community Connection service
2. Food support for households in self-isolation
3. Food rescue
4. Distribution hub (regional distribution)
5. A provider that has 'opted in' to deliver services under the CPF through MSD
6. Other (note we are only interested in COVID-19 related work), please specify: _____

When did your organisation begin providing support for the CiC welfare response?

MM/YYYY

From which channels did your organisation receive referrals for CiC welfare support? Please rank the channels from where you received most referrals to least.

1. Referral from MSD
2. Referral from Ministry of Health
3. Referral from a health or social service provider
4. Referral from the Care in the Community hubs
5. Self-referral - Existing client of your organisation
6. Self-referrals - 0800 number
7. Self-referrals - MSD website
8. Self-referrals – MSD service centres and case managers
9. Self-referrals – Social media

Please rank the referral channels in the order from which you found easiest to manage to most difficult.

1. Referral from MSD
2. Referral from Ministry of Health
3. Referral from a health or social service provider
4. Referral from the Care in the Community hubs
5. Self-referral - Existing client of your organisation
6. Self-referrals - 0800 number

7. Self-referrals - MSD website
8. Self-referrals – MSD service centres and case managers
9. Self-referrals – Social media

What worked particularly well regarding CiC welfare response referral channels to your organisation?

[Open text]

What did not work well regarding CiC welfare response referral channels to your organisation?

[Open text]

What type(s) of support did your organisation deliver to support households that were impacted by COVID-19? (Tick all that apply)

1. Food parcels
2. Information about other supports available in the community
3. Connection with employment support and opportunities
4. Support with education (e.g., activity packs)
5. Support with medical needs (e.g., doctors bills and prescription costs)
6. Support with urgent expenses (utilities, rent arrears)
7. General household items (e.g., clothing, blankets, bedding)
8. Transport costs (e.g., warrant of fitness, petrol)
9. Connection to MSD financial support via Work and Income
10. Referral to other health or social services
11. Support with social connection, wellbeing or pastoral care
12. Advocacy to government organisations (e.g., Work and Income)
13. Advocacy to other organisations or situations (e.g., tenancy disputes)
14. Other, please specify: _____

[Survey routing which only shows ticked items]

Based on your experience, please rank the supports from what appeared to be the top priority to households to the lowest priority.

1. Food parcels
2. Information about other supports available in the community
3. Connection with employment support and opportunities
4. Support with education (e.g., activity packs)
5. Support with medical needs (e.g., doctors bills and prescription costs)
6. Support with urgent expenses (utilities, rent arrears)
7. General household items (e.g., clothing, blankets, bedding)
8. Transport costs (e.g., warrant of fitness, petrol)
9. Connection to MSD financial support via Work and Income
10. Referral to other health or social services
11. Support with social connection, wellbeing or pastoral care
12. Advocacy to government organisations (e.g., Work and Income)
13. Advocacy to other organisations or situations (e.g., tenancy disputes)
14. Other, please specify: _____

[Survey routing which only shows ticked items]

Were the following supports provided by Community Connectors, other staff within your organisation, or both?

[Community Connectors; other staff; both]

1. Food parcels
2. Information about other supports available in the community
3. Connection with employment support and opportunities
4. Support with education (e.g., activity packs)
5. Support with medical needs (e.g., doctors bills and prescription costs)
6. Support with urgent expenses (utilities, rent arrears)
7. General household items (e.g., clothing, blankets, bedding)
8. Transport costs (e.g., warrant of fitness, petrol)
9. Connection to MSD financial support via Work and Income
10. Referral to other health or social services
11. Support with social connection, wellbeing or pastoral care
12. Advocacy to government organisations (e.g., Work and Income)

13. Advocacy to other organisations or situations (e.g., tenancy disputes)
14. Other, please specify: _____

What type(s) of follow up support did your organisation deliver to support households after the self-isolation period finished? (Tick all that apply).

1. Support to get back to education
2. Support to get back to work
3. Support to reconnect to usual activities
4. Support with overdue or outstanding expenses
5. Pastoral care and wellbeing support to build confidence to re-engage
6. Financial planning
7. Career planning
8. Other, please specify: _____

[Survey routing which only shows ticked items]

Based on your experience, please rank the follow up supports from what appeared to be the top priority to households to the lowest priority.

1. Support to get back to education
2. Support to get back to work
3. Support to reconnect to usual activities
4. Support with overdue or outstanding expenses
5. Pastoral care and wellbeing support to build confidence to re-engage
6. Financial planning
7. Career planning
8. Other, please specify: _____

[Survey routing for those that ticked ‘Community Connection service’]

What aspect of the Community Connecter model was most valuable in enabling your organisation to deliver support to isolating households? Please rank from most valuable to least valuable.

1. Community Connector understanding of the needs of your community
2. Community Connector understanding of government supports available
3. Community Connector understanding of community supports available

4. Community Connector networks within your community
5. The flexibility of the Community Connector role
6. The availability of support services targeting specific cultural and population groups
7. Well-developed referral pathways to other support service providers
8. Other, please specify:_____

[Survey routing for those that ticked ‘Food provider contracts’]

From where did you procure food services? (Tick all that apply)

1. NZ Food Network
2. Food Rescue
3. Local food producers
4. Foodbanks
5. Marae
6. Churches
7. Other, please specify:_____

To what extent do you agree with the following statements about the food your organisation received from the food distribution service?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Your organisation received food on time
2. Your organisation received enough food to meet community needs
3. Your organisation received food that was fit for nutritional needs
4. Your organisation received food that met cultural needs

Which aspects of the food distribution service worked well?

[Open text]

Which aspects of the food distribution service did not work well?

[Open text]

To what extent do you agree your organisation able to provide support to households that met their:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Cultural needs
2. Religious needs
3. Wellbeing needs

[If ‘disagree’ or ‘strongly disagree’ ticked]

What were the barriers to meeting these needs?

[Open text]

Did your organisation provide tailored welfare support for any of the following groups during the CiC welfare response? (Tick all that apply)

1. Māori
2. Pacific peoples
3. Socio-economically disadvantaged
4. Ethnic communities
5. Older population
6. Disabled people
7. Other, please specify: _____
8. None of the above

In what ways did your organisation deliver a tailored response to the needs of these communities?

[Open text]

Based on your experience, did any of the following groups struggle to access support for their welfare needs during isolation? (Tick all that apply)

1. Māori
2. Pacific peoples
3. Socio-economically disadvantaged

4. Ethnic communities
5. Older population
6. Disabled people
7. Other, please specify: _____
8. None of the above

[If ticked responses 1-7]

What were the main barriers for your organisation in supporting these groups to access welfare support?

[Open text]

To what extent do you agree your organisation was able to increase the reach of support to the following groups during the CiC welfare response?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Everyone
2. Māori
3. Pacific peoples
4. Socio-economically disadvantaged
5. Ethnic communities
6. Older population
7. Disabled people
8. Other, please specify: _____

Could you give us examples of how your organisation increased the reach of support to these communities?

[Open text]

What methods did your organisation use to communicate with households that you were supporting during isolation? (Tick all that apply)

1. Phone calls
2. Text messages
3. Email

4. Online messaging platforms (e.g., Whatsapp, Facebook Messenger)
5. In person discussions
6. Printed materials e.g., pamphlets
7. Other, please specify: _____

[Survey routing so that only ticked responses appear]

Please rank the communication methods from the most to the least effective.

1. Phone calls
2. Text messages
3. Email
4. Online messaging platforms (e.g., Whatsapp, Facebook Messenger)
5. In-person discussions
6. Printed materials e.g., pamphlets
7. Other, please specify: _____

What aspect of the CiC welfare response contracting model was most valuable in enabling your organisation to deliver the welfare response? Please rank from most valuable to least valuable.

1. The flexibility that was built into contracts
2. Certainty of funding
3. The direct sourcing procurement model
4. Other, please specify: _____

To what extent do you agree with the following statements about the CiC welfare response contracting model?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Your organisation received adequate information regarding the CiC contracting arrangements
2. The contracts were sufficiently flexible to enable your organisation to tailor the support to community needs
3. The contracts were sufficiently flexible to enable your organisation to respond to changing circumstances
4. The contracts enabled your organisation to build capacity to meet community needs

5. The contracting model used for CiC enabled your organisation to meet people's needs more effectively than traditional models

To what extent do you agree with the following statements about the resourcing your organisation received to deliver CiC welfare response?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Your organisation was adequately funded to deliver the CiC welfare response
2. Your organisation had flexibility to use funding to meet community needs
3. The CiC welfare response funding enabled your organisation to hire skilled staff
4. The CiC welfare response funding enabled your organisation to retain skilled staff
5. The funding for CiC enabled your organisation to meet people's needs more effectively than traditional funding models

How often did your organisation rely on volunteer workers to deliver the CiC welfare response?

[Always; Often; Sometimes; Rarely; Never]

Please provide any additional details in relation to the adequacy of resourcing for the CiC welfare response.

[Open text]

To what extent were you supported to deliver the CiC welfare response by:

[Well supported; Somewhat supported; Not well supported]

1. The MSD national office
2. The Regional Leadership Group in your region
3. The Regional Public Service Commissioner in your region
4. The Care in the Community hub in your region

To what extent do you agree that there was effective flow of information regard the CiC welfare response between your organisation and:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. The MSD national office
2. The Regional Leadership Group in your region
3. The Regional Public Service Commissioner in your region
4. The Care in the Community hub in your region

To what extent do you agree that it was easy to share insights back to the MSD national office?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

To what extent do you agree your organisation was able to build positive relationships during the CiC welfare response with:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. MSD
2. Ministry of Health
3. Other central government public service agencies
4. Care in the Community hubs
5. Other community providers delivering the CiC welfare response
6. Other social, health and wellbeing service providers (not contracted to deliver the CiC welfare response)
7. Iwi and/or Māori groups or organisations
8. Pacific groups or organisations
9. Ethnic community groups or organisations
10. Other stakeholders, please specify: _____

How important were Community Connectors in enabling the building of relationships during the CiC welfare response with:

[Very important; Somewhat important; Not important]

1. Everyone
2. Māori communities

3. Pacific communities
4. Socio-economically disadvantaged areas
5. Ethnic communities
6. Older peoples
7. Disabled peoples
8. Other, please specify: _____

To what extent do you agree that the following factors were important in building positive relationships with stakeholders in your region during the CiC welfare response:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Formal meetings with other community providers or community groups in your region
2. Ad hoc or informal meetings with other community providers or community groups in your region
3. Community Connectors within your organisation
4. The Regional Public Service Commissioner
5. Care in the Community hubs
6. Co-location with other social, health and wellbeing agencies
7. MSD Regional Relationship Managers
8. Other, please specify: _____

To what extent do you agree with the following statements about the SORT tool:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. The SORT tool was easy to use
2. The time required to complete the SORT tool was about right
3. Captured the right information about CiC welfare response delivery

[Survey routing for ‘disagree; and ‘strongly disagree’ for response 3]

What other or different information should have been captured through the SORT tool?

[Open text]

To what extent do you agree with the following statements?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. The CiC welfare response facilitated the development of new networks within the community sector in your region
2. The CiC welfare response strengthened existing networks within the community sector in your region
3. The community sector in your region has become better able to respond to community priorities because of the CiC welfare response

To what extent do you agree with the following statements:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. People were aware of the welfare support available
2. The welfare support was timely (people did not have to wait to receive support)
3. The welfare support was tailored to people's unique circumstances
4. The CiC welfare response was effective in supporting households stay in isolation during the isolation period
5. The CiC welfare response was effective in maintaining people's dignity and mana while isolating
6. The CiC welfare response was effective in supporting households who needed it to reintegrate after the isolation period

What aspects of the CiC welfare response worked well to support your organisation to deliver support to households impacted by COVID-19?

[Open text]

What aspects of the CiC welfare response did not work well or were barriers to your organisation being able to deliver support to households impacted by COVID-19?

[Open text]

Do you have any final comments about the CiC welfare response?

(Please do not use any personally identifying information in your comments)

[Open text]

# Community Connector survey

## Survey Questions

Kia ora, welcome to the Care in the Community welfare response survey.

### What is this survey for?

This survey is part of an evaluation Care in the Community (CiC) welfare response by the Ministry of Social Development (MSD). The evaluation will help to understand the benefits and challenges of a locally-led, regionally-enabled, and nationally-supported way of delivering welfare support to communities. The evaluation focuses on the time when the COVID-19 Protection Framework was in place (December 2021 – September 2022).

### Why have I been asked to respond to this survey?

You have been asked to complete this survey because you are or were a Community Connector delivering welfare support to households impacted by COVID-19. Community Connectors were instrumental to delivering the CiC welfare response, providing tailored support designed to meet household needs. Your responses will provide unique insights into the implementation, impacts, and outcomes of the CiC welfare response within communities. We want to learn from your experience. Completing this survey is voluntary but we would greatly appreciate your help.

### What difference will my involvement make?

This evaluation is an exciting opportunity to draw out lessons from the innovative practices that you adopted to provide welfare support to households in your community during COVID-19. It will capture the unique solutions and challenges Community Connectors faced in delivering the CiC welfare response. Your responses will inform the design and delivery of future welfare responses. The survey data will also help MSD to understand what works best in terms of enabling Community Connectors to deliver support to communities.

### Who is running the survey?

*Allen* + *Clarke* has been contracted by MSD to conduct surveys of the Community Connectors as part of a larger outcomes-focused evaluation by MSD of the CiC welfare response. *Allen* + *Clarke* is an independent policy, evaluation and research company. *Allen* + *Clarke* will analyse the data and report the results to MSD.

### How will my privacy and confidentiality be protected?

All data collected for this survey will be stored securely by *Allen* + *Clarke* and will not be shared with anyone outside the research team. MSD will only see anonymised and deidentified responses. This data will be deleted at the completion of the evaluation. You may also choose to withdraw from the evaluation by sending an email to cic.evaluation@allenandclarke.co.nz before 25 August 2023 without any consequence.

**How do I complete the survey?**

By clicking on the link provided you are giving consent for your de-identified responses to be used for this evaluation. The survey should take about 10 minutes to complete. While you are completing the survey questions, please specifically reflect on the time that the COVID-19 Protection Framework was in place (December 2021 – September 2022).

Please use the '←' and '→' arrows at the bottom of the page to move through the survey - do not use your browser buttons. You can continue later by clicking the same link from this email.

**Any questions?**

If you have any questions or problems completing the survey, please contact cic.evaluation@allenandclarke.co.nz

Which region do you operate within as a Community Connector? (Tick all that apply)

1. Northland/Te Tai Tokerau
2. Auckland/Tāmaki Makaurau
3. Waikato
4. Bay of Plenty/Te Moana-a-Toi
5. East Coast / Tairāwhiti
6. Hawkes Bay/ Heretaunga-Ahuriri
7. Taranaki-King Country
8. Manawatū-Whanganui
9. Greater Wellington
10. Nelson-Tasman/ Whakatū-Te Tai o Aorere
11. Marlborough/Te Tau Ihu
12. West Coast/Te Tai Poutini
13. Canterbury/Waitaha
14. Otago/Ōtākou
15. Southland/Murihiku

In your role as a Community Connector, YOU were employed:

1. Full time
2. Part time (20 hours per week or more)
3. Part time (less than 20 hours per week)

From which channels did you receive referrals for CiC welfare support? Please rank the channels from where you received most referrals to least.

1. Referral from MSD
2. Referral from Ministry of Health
3. Referral from a health or social service provider
4. Referral from the Care in the Community hubs
5. Self-referral - Existing client of your organisation
6. Self-referrals - 0800 number
7. Self-referrals - MSD website
8. Self-referrals – MSD service centres and case managers
9. Self-referrals – Social media

Please rank the referral channels in the order from which you found easiest to manage to most difficult.

1. Referral from MSD
2. Referral from Ministry of Health
3. Referral from a health or social service provider
4. Referral from the Care in the Community hubs
5. Self-referral - Existing client of your organisation
6. Self-referrals - 0800 number
7. Self-referrals - MSD website
8. Self-referrals – MSD service centres and case managers
9. Self-referrals – Social media

What worked particularly well regarding CiC welfare response referral channels?

[Open text]

What did not work well regarding CiC welfare response referral channels?

[Open text]

What type(s) of support did you deliver to support households that were impacted by COVID-19? (Tick all that apply)

1. Food parcels
2. Information about other supports available in the community
3. Connection with employment support and opportunities
4. Support with education (e.g., activity packs)
5. Support with medical needs (e.g., doctors bills and prescription costs)
6. Support with urgent expenses (utilities, rent arrears)
7. General household items (e.g., clothing, blankets, bedding)
8. Transport costs (e.g., warrant of fitness, petrol)
9. Connection to MSD financial support via Work and Income
10. Referral to other health or social services
11. Support with social connection, wellbeing or pastoral care
12. Advocacy to government organisations (e.g., Work and Income)
13. Advocacy to other organisations or situations (e.g., tenancy disputes)
14. Other, please specify: _____

[Survey routing which only shows ticked items]

Based on your experience, please rank the supports from what appeared to be the top priority to households to the lowest priority.

1. Food parcels
2. Information about other supports available in the community
3. Connection with employment support and opportunities
4. Support with education (e.g., activity packs)
5. Support with medical needs (e.g., doctors bills and prescription costs)
6. Support with urgent expenses (utilities, rent arrears)
7. General household items (e.g., clothing, blankets, bedding)
8. Transport costs (e.g., warrant of fitness, petrol)
9. Connection to MSD financial support via Work and Income
10. Referral to other health or social services
11. Support with social connection, wellbeing or pastoral care
12. Advocacy to government organisations (e.g., Work and Income)
13. Advocacy to other organisations or situations (e.g., tenancy disputes)
14. Other, please specify: _____

How does your Community Connector role differ from other welfare support services provided by your organisation?

[Open text]

What aspect of the Community Connecter role was most important in enabling you to deliver support to isolating households? Please rank from most important to least important.

1. Understanding the needs of your community
2. Understanding of government supports available
3. Understanding of community supports available
4. Having existing networks within your community
5. The flexibility of the Community Connector role
6. Relationships with others offering non-government support services for the community
7. Relationships with those offering government support services for the community
8. Well-developed referral pathways to other support service providers
9. Other, please specify:_____

Based on your experience as a Community Connector, to what extent do you agree with the following statements:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. There was a diverse range of services available in your region to support households who were isolating
2. There was a diverse range of services available in your region to assist people to reintegrate after isolation
3. There was a diverse range of services available in your region to assist individuals significantly impacted by COVID-19 (other than those in isolation)
4. I was able to quickly connect people with support services in my community

To what extent do you agree that were you able to provide support to households that met their:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Cultural needs
2. Religious needs
3. Wellbeing needs

[If ‘disagree’ or ‘strongly disagree’ ticked]

What were the barriers to meeting these needs?

[Open text]

In your role as Community Connector, did you provide tailored welfare support for any of the following groups during the CiC welfare response? (Tick all that apply)

1. Māori
2. Pacific peoples
3. Socio-economically disadvantaged
4. Ethnic communities
5. Older population
6. Disabled people
7. Other, please specify: _____
8. None of the above

In what ways did you deliver a tailored response to the needs of these communities?

[Open text]

Based on your experience as Community Connector, did any of the following groups struggle to access support for their welfare needs during isolation? (Tick all that apply)

1. Māori
2. Pacific peoples
3. Socio-economically disadvantaged
4. Ethnic communities
5. Older population
6. Disabled people
7. Other, please specify: _____
8. None of the above

[If ticked responses 1-7]

What were the main barriers for you in supporting these groups to access welfare support?

[Open text]

To what extent do you agree you were able to increase the reach of support to the following groups during the CiC welfare response?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Everyone
2. Māori
3. Pacific peoples
4. Socio-economically disadvantaged
5. Ethnic communities
6. Older population
7. Disabled people
8. Other, please specify: _____

Could you give us examples of how you increased the reach of support to these communities?

[Open text]

What methods did your organisation use to communicate with households that you were supporting during isolation? (Tick all that apply)

1. Phone calls
2. Text messages
3. Email
4. Online messaging platforms (eg Whatsapp, Facebook Messenger)
5. In person discussions
6. Printed materials e.g., pamphlets
7. Other, please specify: _____

To what extent do you agree that it was easy to share insights back to the MSD national office?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

To what extent do you agree with the following statements about the SORT tool:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. The SORT tool was easy to use
2. The time required to complete the SORT tool was about right
3. The SORT tool captured the right information about the CiC welfare response delivery

[Survey routing for ‘disagree; and ‘strongly disagree’ for response 3]

What other or different information should have been captured through the SORT tool?

[Open text]

Were the following located within the same building or complex from which you were operating as a Community Connector? (Tick all that apply)

[Yes; No; Unsure]

1. MSD staff
2. Work and Income case managers
3. Other regional branches of public service agencies
4. Other social, health and wellbeing service providers
5. Iwi and/or Māori organisations
6. Pacific groups or organisations
7. Ethnic organisations
8. Other community groups (e.g., marae, churches, sports clubs etc.)
9. Other, please specify: _____

In your role as a Community Connector, to what extent do you agree that you were able to build positive relationships during the CiC welfare response with:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. MSD
2. Ministry of Health
3. Other central government public service agencies
4. Care in the Community hubs
5. Other Community Connectors

6. Other community providers delivering the CiC welfare response
7. Other social, health and wellbeing service providers (not contracted to deliver the CiC welfare response)
8. Iwi and/or Māori groups or organisations
9. Pacific groups or organisations
10. Ethnic community groups or organisations
11. Other stakeholders, please specify: _____

To what extent do you agree that the following factors were important in building relationships with stakeholders in your region during the CiC welfare response:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. Formal meetings with other Community Connectors or community providers in your region
2. Ad hoc or informal meetings with Community Connectors or community providers in your region
3. The Regional Public Service Commissioner
4. Care in the Community hubs
5. Co-location with other social, health and wellbeing service providers
6. MSD Regional Relationship Managers
7. Other, please specify: _____

To what extent do you agree with the following statements?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. The CiC welfare response facilitated the development of new networks within the community sector in your region
2. The CiC welfare response strengthened existing networks within the community sector in your region
3. The community sector in your region has become better able to respond to community priorities because of the CiC welfare response

To what extent do you agree with the following statements:

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. People were aware of the welfare support available
2. The welfare support was timely (people did not have to wait to receive support)

3. The welfare support was tailored to people's unique circumstances
4. The CiC welfare response was effective in supporting households stay in isolation during the isolation period
5. The CiC welfare response was effective in maintaining people's dignity and mana while isolating
6. The CiC welfare response was effective supporting households who needed it to reintegrate after the isolation period

What aspects of the CiC welfare response model worked well to support your role as Community Connector?

[Open text]

What aspects of the CiC welfare response model did not work well or were barriers to your role as Community Connector?

[Open text]

Do you have any final comments about the CiC welfare response? (Please do not use any personally identifying information in your comments)

[Open text]

# Household survey

## Survey Questions

Kia ora, welcome to the Care in the Community welfare response survey.

**Why have I been asked to respond to this survey?**

You are invited to take this survey because you received support (like food packages, financial or wellbeing support) while you or someone from your household had to isolate because of COVID-19. The questions in this survey are about the support you received while isolating.

**What is this survey for?**

This survey is part of an evaluation of the welfare support provided to households impacted by COVID-19. The evaluation is for the Ministry of Social Development (MSD). It will help MSD learn how well this support worked for people and communities.

**Why should I take part?**

This is your chance to give feedback on the support you received while isolating. Your information will help to shape future delivery of support for people and communities, to ensure supports are tailored to what people want and need.

**Prize draw**

Once you complete the survey, you will be asked if you want to be in a prize draw for a $100 Prezzy Card voucher. There will be 100 prize winners selected at random, with the prize draw conducted in July 2023. We will let you know if you won via email or phone.

**Do I have to take part?**

The survey is completely voluntary. Whether you choose to do the survey or not, it won't affect your relationship with MSD.

**Who is running the survey?**

*Allen + Clarke*, a consultancy firm in Wellington, is working with MSD to run the survey.

**How will my privacy and confidentiality be protected?**

This survey is completely confidential. The survey results will only be seen by a small research team. MSD will not see anyone's individual answers. All survey responses will be deleted at the completion of the evaluation. Your contact details for the prize draw are not connected with your answers to the survey questions. Your contact details will be deleted after the prize draw.

**How do I complete the survey?**

By clicking on the survey link you are consenting to your anonymous answers being used for this evaluation. The survey should take about 10 minutes to complete. While you are completing the survey questions, please think about the time that the COVID-19 Protection Framework was in place (December 2021 – September 2022).

Please use the '←' and '→' arrows at the bottom of the page to move through the survey - do not use your browser buttons. You can continue later by clicking the same link from this email.

**Any questions?**

If you have any questions or problems completing the survey, please contact cic.evaluation@allenandclarke.co.nz

How many times has your household had to isolate due to a positive COVID-19 test?

_____

[If more than once display]

When answering the questions below think about your experiences the last time your household had to isolate due to a COVID-19 positive test.

[If once display]

When answering the questions below think about your experiences isolating as a household.

Which ethnic groups did the members of your household identify with? (Tick all that apply)

1. New Zealand European
2. Māori
3. Samoan
4. Cook Islands Māori
5. Tongan
6. Niuean
7. Chinese
8. Indian
9. Other, please specify: _____

Where were you living when you were isolating?

1. Northland/Te Tai Tokerau
2. Auckland/Tāmaki Makaurau
3. Waikato

4. Bay of Plenty/Te Moana-a-Toi
5. East Coast / Tairāwhiti
6. Hawkes Bay/Heretaunga-Ahuriri
7. Taranaki-King Country
8. Manawatū-Whanganui
9. Greater Wellington
10. Nelson-Tasman/Whakatū-Te Tai o Aorere
11. Marlborough/Te Tau Ihu
12. West Coast/Te Tai Poutini
13. Canterbury/Waitaha
14. Otago/Ōtākou
15. Southland/Murihiku

Including yourself, how many people were isolating in your household?

_____

How many were under 5 years old?

_____

How many were at school (year 1 to 13)?

_____

How many were aged 19 to 64?

_____

How many aged 65 or older?

_____

Did anyone in this household have a disability, long-term condition, or mental health condition that limits their ability to carry out everyday tasks?

1. Yes
2. No
3. Don’t know

How well did your total income (you and your partner's combined income) meet your everyday needs for such things as accommodation, food, clothing and other necessities? Would you say you had:

1. Not enough money
2. Only just enough money
3. Enough money
4. More than enough money

How did you find out about the support available to isolating households? (Tick all that apply)

1. MSD or Work and Income
2. A health or social service provider
3. From friends or family
4. Social media (e.g., Facebook)
5. Radio
6. Notices at public places (eg. libraries, supermarkets)
7. Other, please describe: _____

How were you referred to the organisation that provided the welfare support?

1. Referral from MSD
2. Referral from Ministry of Health
3. Referral from a health or social service provider
4. Referral from the Care in the Community hubs
5. Self-referral – I was already working with the community provider
6. Self-referral - 0800 number
7. Self-referral - MSD website
8. Self-referral – MSD service centres and case managers
9. Self-referral – Social media

How easy was it to ask for support for your needs while isolating?

[Very easy; Easy; Neither; Hard; Very hard]

[If selected ‘Hard or ‘Very hard]

What made it difficult for you to ask for support?

[Open text]

[If selected ‘Easy or ‘Very easy]

What made it easy for you to ask for support?

[Open text]

Did you receive support from a Community Connector while you were isolating? (A Community Connector was someone from a community-based organisation whose job it was to support you and your household with your food and wellbeing needs following a positive test for COVID-19)

1. Yes
2. No

[If did not receive support from Community Connector]

Who did support you while you were isolating?

[Open text]

[If supported by Community Connector ask the following questions]

Which of the following supports did you receive from your Community Connector while your household was isolating? (Tick all that apply)

1. Information about the different supports available in your community
2. Connection with employment support and opportunities
3. Support with education (e.g., activity packs)
4. Support with medical needs (e.g., doctors bills and prescription costs)
5. Support with urgent expenses (e.g., power bills, rent)
6. General household items (e.g., clothing, blankets, bedding)
7. Transport costs (e.g., warrant of fitness, petrol)

8. Connection to Work and Income financial support
9. Referral to other health or social services
10. Support with social connection, wellbeing or pastoral care
11. Help dealing with government organisations (e.g., Work and Income)
12. Help dealing with other organisations or situations (e.g., tenancy disputes)
13. Other, please specify: _____

[Survey routing so only ticked responses from previous question appear]

Which of the supports you received helped your household the most? Please rank from the most helpful to the least helpful by clicking and dragging an item up or down the list.

1. Information about the different supports available in your community
2. Connection with employment support and opportunities
3. Support with education (e.g., activity packs)
4. Support with medical needs (e.g., doctors bills and prescription costs)
5. Support with urgent expenses (e.g., power bills, rent)
6. General household items (e.g., clothing, blankets, bedding)
7. Transport costs (e.g., warrant of fitness, petrol)
8. Connection to Work and Income financial support
9. Referral to other health or social services
10. Support with social connection, wellbeing, or pastoral care
11. Help dealing with government organisations (e.g., Work and Income)
12. Help dealing with other organisations or situations (e.g., tenancy disputes)
13. Other, please specify: _____

Did you receive follow up support after the isolation period had finished?

1. Yes
2. No

[Route if yes]

What follow up support did you receive? (Tick all that apply)

1. Connection with employment support and opportunities
2. Support to reintegrate into school or education

3. Support to reintegrate with family and friends
4. Support with mental health and wellbeing
5. Connection to Work and Income financial support
6. Referral to other health or social services
7. Continued food support
8. Other, please specify:_____

[Survey routing so only ticked responses from previous question appear]

Which of the follow up supports you received helped your household the most? Please rank from the most helpful to the least helpful by clicking and dragging an item up or down the list.

1. Connection with employment support and opportunities
2. Support to reintegrate into school or education
3. Support to reintegrate with family and friends
4. Support with mental health and wellbeing
5. Connection to Work and Income financial support
6. Referral to other health or social services
7. Continued food support
8. Other, please specify:_____

To what extent do you agree with the following statements about the support your household received from the Community Connector?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. The support from the Community Connector arrived when you needed it
2. The support from the Community Connector met your wellbeing needs
3. The support from the Community Connector met your cultural needs
4. The support from the Community Connector met your religious needs

To what extent do you agree with the following statements about your experience with the Community Connector?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

1. The Community Connector was easy to talk to
2. The Community Connector was respectful

3. The Community Connector built a relationship of trust with your household
4. The Community Connector understood the needs of your household
5. The Community Connector helped your household to access support
6. The Community Connector checked in on your household regularly

Did the Community Connector tell you about any support services you didn't already know about?

[Yes/no]

1. Government support services (e.g., Work and Income entitlements, Kāinga Ora housing support)
2. Community-based support services (e.g., budgeting services)

[Route if any 'yes' responses to previous question]

Can you please tell us what new support services you learned about?

[Open text]

[Route to show only responses that were ticked 'yes']

Did you engage with and/or receive support from the services that you heard about?

[Yes/no]

1. Government support services (e.g., Work and Income entitlements, Kāinga Ora housing support)
2. Community-based support services (e.g., budgeting services)

[Route to show only responses that were ticked 'yes']

Did continue to use this support after you finished isolating?

[Yes/no]

1. Government support services (e.g., Work and Income entitlements, Kāinga Ora housing support)
2. Community-based support services (e.g., budgeting services)

To what extent did your experience receiving support from the Community Connector change your trust in the following:

[I trust them more; About the same; I trust them less]

1. Work and Income
2. Other government agencies
3. Community-based support services

Did you receive any food packages?

1. Yes
2. No

[If received food packages ask the following]

To what extent do you agree with the following statements about the food your household received?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree, NA]

1. Your household received food when you needed it
2. Your household received food that met your nutritional needs
3. Your household received food that met your cultural needs
4. Your household received food that met your religious needs

To what extent do you agree with the following statements about your experience with the food support provider?

[Strongly agree; Agree; Neither; Disagree; Strongly disagree, NA]

1. There was enough food for your household
2. The food support meant your household could get through isolation without going hungry
3. The food support made your household feel supported
4. The food support reduced financial stress for your household
5. The food support reduced mental stress for your household

The support I received meant your household could stay isolated during the isolation period (nobody visited you and everybody stayed home)

[Strongly agree; Agree; Neither; Disagree; Strongly disagree]

Which of the following was the most important in helping you to stay home? (Please tick only one response)

1. Food parcels
2. Information about the different supports available in your community
3. Connection with employment support and opportunities
4. Support with education (e.g., activity packs)
5. Support with medical needs (e.g., doctors bills and prescription costs)
6. Support with urgent expenses (e.g., power bills, rent)
7. General household items (e.g., clothing, blankets, bedding)
8. Transport costs (e.g., warrant of fitness, petrol)
9. Connection to Work and Income financial support
10. Referral to other health or social services
11. Support with social connection, wellbeing or pastoral care
12. Help dealing with government organisations (e.g., Work and Income)
13. Help dealing with other organisations or situations (e.g., tenancy disputes)
14. Other, please specify: _____

Please describe any unexpected experiences your household had when accessing or receiving support while isolating. (Please do not use any personally identifying information in your comments)

[Open text]

What difference did the support you received while impacted by COVID-19 make to your household?

[Open text]

Do you have any final comments about the support you received while impacted by COVID-19? (Please do not use any personally identifying information in your comments)

[Open text]

Would you like to enter the prize draw?

1. Yes
2. No

[Route if yes]

Please enter one of the following contacts for you. Your contact details will not be linked to your survey responses.

Email: _____

Phone: _____

Ngā mihi,

Thank you for taking the time to do this survey.

# Appendix 4: Detailed tables

## Detailed tables for Section 3

### System infrastructure

*Table 49: Feedback on the contracting model (community provider survey)*

| Statements about the CiC contracting model | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Your organisation received adequate information regarding the CiC contracting arrangements | 66 | 86% | 9.1% | 4.5% |
| The contracts were sufficiently flexible to enable your organisation to tailor the support to community needs | 65 | 82% | 12% | 6.2% |
| The contracts were sufficiently flexible to enable your organisation to respond to changing circumstances | 66 | 85% | 7.6% | 7.6% |
| The contracts enabled your organisation to build capacity to meet community needs | 65 | 80% | 12% | 7.7% |
| The contracting model used for CiC enabled your organisation to meet people's needs more effectively than traditional models | 66 | 79% | 17% | 4.5% |

*Table 50: SORT tool effectiveness (community provider survey)*

| Statements about the SORT tool | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| The SORT tool was easy to use | 57 | 75% | 14% | 11% |
| The time required to complete the SORT tool was about right | 57 | 77% | 12% | 11% |
| The SORT tool captured the right information | 57 | 61% | 19% | 19% |

*Table 51: SORT tool effectiveness (Community Connector survey)*

| Statements about the SORT tool | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| The SORT tool was easy to use | 126 | 75% | 21% | 3.2% |
| The time required to complete the SORT tool was about right | 124 | 69% | 22% | 9.7% |
| The SORT tool captured the right information | 124 | 53% | 15% | 32% |

*Table 52. RPSC resourcing and relationships (RLG survey)*

| Statements about the RPSC | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| The RPSC in my region had existing relationships that were important to the success of the CiC welfare response | 46 | 87% | 11% | 2.2% |
| The RPSC in my region had sufficient resources to support the CiC welfare response | 46 | 70% | 20% | 11% |

*Table 53: RLG information flows (RLG survey)*

| Statements about information flows | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| There was effective flow of information between members of my RLG to support the welfare response | 44 | 89% | 6.8% | 4.5% |
| There was effective flow of information from central government to enable my RLG to support the welfare response | 44 | 71% | 18% | 11% |
| There was effective flow of information between the DPMC Response Group and my RLG to support the welfare response | 44 | 61% | 25% | 14% |

*Table 54. Networked sector (community provider survey)*

| Statements about networks | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| The CiC welfare response facilitated the development of new networks within the community sector in your region | 63 | 68% | 24% | 7.9% |
| The CiC welfare response strengthened existing networks within the community sector in your region | 62 | 71% | 19% | 9.7% |
| The community sector in your region has become better able to respond to community priorities because of the CiC welfare response | 61 | 67% | 21% | 12% |

*Table 55. Networked sector (Community Connector survey)*

| Statements about networks | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| The CiC welfare response facilitated the development of new networks within the community sector in your region | 123 | 85% | 15% | - |
| The CiC welfare response strengthened existing networks within the community sector in your region | 123 | 89% | 11% | -- |
| The community sector in your region has become better able to respond to community priorities because of the CiC welfare response | 124 | 87% | 13% | |

# Community Connector support

*Table 56: Community Connector support meeting household needs (household survey)*

| Statements about the support households received from the Community Connector | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| The support from the Community Connector arrived when you needed it | 201 | 87% | 10% | 2.5% |
| The support from the Community Connector met your wellbeing needs | 197 | 86% | 12% | 2.0% |
| The support from the Community Connector met your cultural needs | 193 | 83% | 13% | 4.1% |
| The support from the Community Connector met your religious needs | 193 | 68% | 27 | 5.2% |

*Table 57: Community Connector support meeting wellbeing needs by ethnicity, health condition or disability, and income adequacy (household survey)*

| Met household wellbeing needs | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | - | 197 | 197 | 197 | 191 | 193 |
| $\chi^2$ | - | 7.89, p<.05 | 3.26, p=0.196 | 0.823, p=0.663 | 0.258, p=0.879 | 1.94, p=0.378 |
| Agree | 86% | 80% | 91% | 88% | 86% | 92% |
| Disagree | 2% | 2.0% | 2.6% | 0% | 1.8% | 1.9% |
| Neither | 12% | 18% | 6.6% | 12% | 13% | 5.8% |

*Table 58. Community Connector support meeting cultural needs by ethnicity, health condition or disability, and income adequacy (household survey)*

| Met household cultural needs | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | - | 193 | 193 | 193 | 187 | 189 |
| $\chi^2$ | - | 0.538, p=0.764 | 1.84, p=0.399 | 5.63, p=0.060 | 1.16, p=0.559 | 2.79, p=0.247 |
| Agree | 83% | 85% | 86% | 69% | 86% | 88% |
| Disagree | 4.1% | 4.1% | 5.3% | 6.3% | 1.8% | 0% |
| Neither | 13% | 11% | 9.2% | 25% | 13% | 12% |

*Table 59: Community Connector support meeting religious needs by ethnicity, health condition or disability, and income adequacy (household survey)*

| Met household religious needs | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | - | 193 | 193 | 193 | 187 | 189 |
| $\chi^2$ | - | 1.70, p=0.428 | 2.24, p=0.326 | 4.66, p=0.097 | 5.94, p=0.051 | 6.24, p<.05 |
| Agree | 68% | 65% | 74% | 61% | 80% | 80% |
| Disagree | 5.2% | 7.1% | 5.3% | 0% | 5.6% | 0% |
| Neither | 27% | 28% | 21% | 39% | 15% | 20% |

*Table 60: Community Connector was easy to talk to by ethnicity, health condition or disability, and income adequacy (household survey)*

| Community Connector was easy to talk to | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 202 | 202 | 202 | 196 | 198 |
| $\chi^2$ | | 3.57, p=0.167 | 1.73, p=0.421 | 1.30, p=0.523 | 2.04, p=0.361 | 2.10, p=0.350 |
| Agree | 87% | 83% | 91% | 86% | 87% | 93% |
| Disagree | 2.0% | 3.1% | 1.3% | 0% | 0% | 0% |
| Neither | 11% | 14% | 7.7% | 14% | 13% | 7.5% |

*Table 61: Community Connector was respectful by ethnicity, health condition or disability, and income adequacy (household survey)*

| Community Connector was respectful | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 201 | 201 | 201 | 195 | 197 |
| $\chi^2$ | | 3.01, p=0.222 | 1.07, p=0.586 | 1.24, p=0.539 | 1.93, p=0.380 | 3.07, p=0.216 |
| Agree | 90% | 86% | 92% | 94% | 89% | 96% |
| Disagree | 1.5% | 2.0% | 1.3% | 0% | 0% | 0% |
| Neither | 9.0% | 12% | 6.4% | 5.7% | 11% | 3.8% |

*Table 62: Community Connector built trust with household by ethnicity, health condition or disability, and income adequacy (household survey)*

| Community Connector built trust | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 198 | 198 | 198 | 192 | 194 |
| $\chi^2$ | | 11.0, p<.01 | 0.996, p=0.608 | 1.19, p=0.551 | 3.18, p=0.204 | 1.52, p=0.469 |
| Agree | 81% | 71% | 83% | 86% | 73% | 85% |
| Disagree | 2.0% | 3.1% | 2.6% | 0% | 1.8% | 0% |
| Neither | 17% | 26% | 14% | 14% | 26% | 15% |

*Table 63: Community Connector understood the needs of household by ethnicity, health condition or disability, and income adequacy (household survey)*

| Community Connector understood needs | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 136 | 136 | 136 | 133 | 136 |
| $\chi^2$ | | 0.937, p=0.626 | 6.77, p<.05 | 5.13, p=0.077 | 0.415, p=0.813 | 1.58, p=0.454 |
| Agree | 92% | 93% | 97% | 81% | 92% | 96% |
| Disagree | 0.7% | 0% | 1.6% | 0% | 0% | 0% |
| Neither | 7.4% | 6.6% | 1.6% | 19% | 8.3% | 4.3% |

*Table 64: Community Connector helped household to access support by ethnicity, health condition or disability, and income adequacy (household survey)*

| Community Connector helped access support | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 198 | 198 | 198 | 192 | 194 |
| $\chi^2$ | | 3.03, p=0.220 | 2.84, p=0.242 | 0.0203, p=0.990 | 2.15, p=0.342 | 4.14, p=0.126 |
| Agree | 83% | 79% | 89% | 83% | 85% | 92% |
| Disagree | 2.5% | 4.1% | 2.6% | 2.9% | 0% | 0% |
| Neither | 14% | 17% | 9.0% | 14% | 15% | 7.7% |

*Table 65: Community Connector checked in on household regularly by ethnicity, health condition or disability, and income adequacy (household survey)*

| Community Connector checked in regularly | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 197 | 197 | 197 | 191 | 193 |
| $\chi^2$ | | 1.79, p=0.408 | 8.42, p<.05 | 6.54, p<.05 | 0.428, p=0.807 | 4.88, p=0.087 |
| Agree | 65% | 65% | 77% | 46% | 68% | 75% |
| Disagree | 7.6% | 5.2% | 3.9% | 11% | 5.7% | 9.8% |
| Neither | 28% | 30% | 20% | 43% | 26% | 16% |

*Table 66: Community Connector introduced new government support services by ethnicity, health condition or disability, and income adequacy (household survey)*

| Community Connector introduced new government support services | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 205 | 205 | 205 | 198 | 200 |
| $\chi^2$ | | 1.08, p=0.299 | 7.04, p<.01 | 7.81, p<.01 | 0.341, p=0.559 | 1.30, p=0.254 |
| No | 52% | 49% | 40% | 73% | 48% | 45% |
| Yes | 48% | 52% | 69% | 27% | 52% | 55% |

*Table 67: Community Connector introduced new community-based support services by ethnicity, health condition or disability, and income adequacy (household survey)*

| Community Connector introduced new community-based support services | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 203 | 203 | 203 | 196 | 198 |
| $\chi^2$ | | 2.48, p=0.115 | 2.60, p=0.107 | 9.81, p<.01 | 1.54, p=0.215 | 3.66, p=0.056 |
| No | 61% | 56% | 54% | 56% | 54% | 50% |
| Yes | 39% | 44% | 46% | 44% | 46% | 50% |

*Table 68. Community Connector met households needs (community provider survey)*

| Type of need | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Cultural needs | 67 | 82% | 13% | 4.5% |

| Type of need | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Religious needs | 66 | 52% | 42% | 6.1% |
| Wellbeing needs | 77 | 94% | | 6.1% |

*Table 69. Community Connector met households needs (Community Connector survey)*

| Type of need | N | Agree | Neither | Disagree |
|---|---|---|---|---|
| Cultural needs | 128 | 89% | 7.8% | 3.1% |
| Religious needs | 128 | 74% | 23% | 3.1% |
| Wellbeing needs | 128 | 96% | 1.6% | 2.3% |

*Table 70. Community Connector experience changed trust in Work and Income by Māori and priority groups (household survey)*

| Community Connector changed trust in Work and Income | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 194 | 194 | 194 | 188 | 109 |
| $\chi^2$ | | 6.64, p<.05 | 0.223, p=0.895 | 9.06, p<.01 | 0.458, p=0.795 | 7.01, p<.05 |
| About the same | 73% | 81% | 75% | 59% | 75% | 66% |
| I trust them less | 8.8% | 8.0% | 9.3% | 5.9% | 7.0% | 17% |
| I trust them more | 18% | 11% | 16% | 35% | 18% | 17% |

*Table 71. Community Connector experience changed trust in other government agencies by Māori and priority groups (household survey)*

| Community Connector changed trust in government agencies | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 194 | 194 | 194 | 188 | 190 |
| $\chi^2$ | | 10.4, p<.01 | 0.850, p=0.654 | 33.5, p< .001 | 3.37, p=0.185 | 5.40, p=0.067 |
| About the same | 78% | 85% | 81% | 50% | 86% | 68% |
| I trust them less | 6.7% | 8.0% | 6.7% | 2.9% | 3.5% | 11% |
| I trust them more | 15% | 7.0% | 12% | 47% | 11% | 21% |

*Table 72. Community Connector experience changed trust in community-based support services by Māori and priority groups (household survey)*

| Community Connector changed trust in community support | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 204 | 204 | 204 | 198 | 200 |
| $\chi^2$ | | 0.971, p=0.615 | 1.34, p=0.511 | 2.26, p=0.324 | 1.26, p=0.534 | 3.18, p=0.204 |
| About the same | 46% | 48% | 45% | 40% | 52% | 35% |
| I trust them less | 2.9% | 3.9% | 1.3% | 0% | 3.4% | 3.7% |
| I trust them more | 51% | 49% | 54% | 60% | 45% | 61% |

## Relationships

*Table 73. Ability of community providers to build positive stakeholder relationships (community provider survey)*

| Stakeholders | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| MSD | 63 | 78% | 16% | 6.3% |
| Ministry of Health | 60 | 32% | 53% | 15% |
| Other central government public service agencies | 61 | 39% | 44% | 16% |
| Care in the Community hubs | 62 | 60% | 36% | 4.8% |
| Other community providers delivering the CiC welfare response | 62 | 74% | 21% | 4.8% |
| Other social, health and wellbeing service providers | 61 | 71% | 26% | 3.3% |
| Māori groups or organisations | 63 | 59% | 33% | 7.9% |
| Pacific groups or organisations | 62 | 48% | 42% | 9.7% |
| Ethnic community groups or organisations | 63 | 44% | 46% | 9.5% |
| Other stakeholders | 21 | 45% | 45% | 10% |

*Table 74: Ability of Community Connectors to build positive stakeholder relationships (Community Connector survey)*

| Stakeholders | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| MSD | 123 | 88% | 9.8% | 2.4% |
| Ministry of Health | 122 | 59% | 35% | 5.7% |
| Other central government public service agencies | 123 | 64% | 30% | 5.7% |
| Care in the Community hubs | 119 | 82% | 13% | 5.0% |
| Other Community Connectors | 122 | 83% | 17% | - |
| Other community providers delivering the CiC welfare response | 122 | 84% | 13% | 2.5% |
| Other social, health and wellbeing service providers (not contracted to deliver the CiC welfare response) | 123 | 81% | 20% | - |
| Iwi and/or Māori groups or organisations | 123 | 81% | 16% | 3.3% |
| Pacific groups or organisations | 120 | 67% | 29% | 4.2% |
| Ethnic community groups or organisations | 120 | 63% | 33% | 4.2% |
| Other stakeholders | 38 | 50% | 45% | 5.3% |

*Table 75: Factors important in building positive stakeholder relationships (community provider survey)*

| Factors | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| MSD Regional Relationship Managers | 58 | 76% | 14% | 10% |
| Ad hoc or informal meetings with other community providers or community groups in your region | 60 | 70% | 23% | 6.7% |
| Formal meetings with other community providers or community groups in your region | 61 | 64% | 21% | 15% |
| Care in the Community hubs | 58 | 57% | 33% | 10% |
| Community Connectors within your organisation | 56 | 54% | 18% | 29% |
| Co-location with other social, health and wellbeing agencies | 56 | 48% | 45% | 7.1% |
| The Regional Public Service Commissioner | 54 | 26% | 58% | 16% |
| Other | 10 | 40% | 20% | 40% |

*Table 76: Factors important in building positive stakeholder relationships (Community Connector survey)*

| Factors | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Formal meetings with other Community Connectors or community providers in your region | 124 | 79% | 19% | 1.6% |
| Ad hoc or informal meetings with Community Connectors or community providers in your region | 124 | 76% | 23% | 0.8% |
| MSD Regional Relationship Managers | 123 | 73% | 24% | 2.4% |
| Care in the Community hubs | 122 | 71% | 22% | 7.4% |
| Co-location with other social, health and wellbeing service providers | 123 | 62% | 33% | 4.9% |
| The Regional Public Service Commissioner | 124 | 41% | 50% | 9.2% |
| Other | 14 | 14% | 86% | - |

*Table 77. Ability of RLG to build positive stakeholder relationships (RLG survey)*

| Stakeholders | N | Agree | Neither | Disagree |
|---|---|---|---|---|
| Iwi | 46 | 83% | 15% | 2.2% |
| Iwi (iwi respondents only) | 7 | 71% | 14% | 14% |
| MSD | 44 | 93% | 6.8% | |
| Ministry of Health | 34 | 82% | 15% | 2.9% |
| Other central government agencies | 45 | 80% | 13% | 6.7% |
| DPMC Response Group | 45 | 58% | 36% | 6.7% |
| Care in the Community hubs | 45 | 69% | 27% | 4.4% |
| Community providers | 46 | 74% | 20% | 6.5% |
| Other community organisations | 46 | 76% | 17% | 6.5% |

# Detailed tables for Section 4

## Referral pathways and ease of asking for support

*Table 78: Referral to welfare support by ethnicity, health condition or disability, and income adequacy (household survey)*

| Referral pathway | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | 271 | 266 | 266 | 266 | 259 | 262 |
| $\chi^2$ | | 26.80, p< .001 | 12.30, p=.137 | 16.40, p<.05 | 8.86, p=.354 | 7.78, p=.455 |
| Referral from a health or social service provider | 29% | 43% | 23% | 20% | 32% | 19% |
| Self-referral – you were already working with the community provider | 17% | 12% | 20% | 8.2% | 13% | 23% |
| Self-referral – Social media | 13% | 11% | 13% | 25% | 15% | 12% |
| Referral from the Care in the Community hubs | 7.9% | 6.3% | 11% | 6.1% | 11% | 11% |
| Referral from Ministry of Health | 11% | 8.7% | 12% | 14% | 5.3% | 9.6% |
| Self-referral - 0800 number | 8.6% | 9.4% | 8.5% | 6.1% | 12% | 9.6% |
| Referral from MSD | 8.3% | 6.3% | 9.4% | 10% | 5.3% | 8.2% |
| Self-referral - MSD website | 4.9% | 2.4% | 0.9% | 10% | 6.6% | 5.5% |
| Self-referral – MSD service centres and case managers | 1.5% | 1.6% | 1.9% | 0% | 1.3% | 1.4% |

*Table 79: Ease of asking for support by ethnicity, health condition or disability, and income adequacy (household survey)*

| Ease of asking for support | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | 272 | 272 | 272 | 272 | 264 | 267 |
| $\chi^2$ | - | 12.7, p<.01 | 0.877, p=0.645 | 13.9, p< .001 | 1.34, p=0.510 | 3.69, p=0.158 |
| Easy | 65% | 74% | 68% | 87% | 62% | 62% |
| Hard | 14% | 12% | 13% | 1.9% | 13% | 20% |
| Neither | 21% | 14% | 19% | 12% | 26% | 18% |

*Table 80: Ease of asking for support for older and rural/remote households (household survey)*

| Ease of asking for support | Total | Rural/remote | Age 65+ |
|---|---|---|---|
| n | 272 | 263 | 146 |
| $\chi^2$ | | 5.99, p=.05 | 6.02, <.05 |
| Easy | 65% | 54% | 68% |
| Hard | 14% | 13% | 18% |
| Neither | 21% | 34% | 14% |

# Types of support

*Table 81: Support received while isolating by household characteristics (household survey)*

| Support type | | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money | Rural/ remote | Has school age children resident | Has resident aged 65+ |
|---|---|---|---|---|---|---|---|---|---|---|
| Received food packages (n=258) | | 84% | 73% ($\chi^2$=19.4, p<.001) | 86% ($\chi^2$=1.28, p=.526) | 100% ($\chi^2$=11.5, p<.01) | 78% ($\chi^2$=3.98, p=.137) | 97% ($\chi^2$=13.5, p<.001) | 47% ($\chi^2$=73.9, p<.001) | 88% ($\chi^2$=.616, p=.735) | 77% ($\chi^2$=5.76, p=.056) |
| Support from Community Connector while isolating (n=191) | Information about the different supports available | 47% | 52% ($\chi^2$=1.94, p=.164) | 49% ($\chi^2$=331, p=.565) | 59% ($\chi^2$=5.52, p=.112) | 47% ($\chi^2$=008, p=.928) | 47% ($\chi^2$>.001, p=.976) | 48% ($\chi^2$>.008, p=.928) | 50% ($\chi^2$>.432, p=.511) | 53% ($\chi^2$>.0295, p=.864) |
| | Support with medical needs | 35% | 41% ($\chi^2$=3.28, p=.07) | 32% ($\chi^2$=.358, p=.550) | 25% ($\chi^2$=1.71, p=.190) | 36% ($\chi^2$=0226, p=.881) | 36% ($\chi^2$=.0399, p=.842) | 50% ($\chi^2$>5.94, p<.05) | 29% ($\chi^2$>1.81, p=.178) | 37% ($\chi^2$>.685, p=.408) |
| | Support with education | 28% | 29% ($\chi^2$=.123, p=.726) | 35% ($\chi^2$=3.14, p=.076) | 38% ($\chi^2$=1.82, p=.177) | 27% ($\chi^2$=0439, p=.834) | 23% ($\chi^2$=.367, p=.545) | 35% ($\chi^2$>1.65, p=.199) | 31% ($\chi^2$>.504, p=.478) | 34% ($\chi^2$>.869, p=.351) |
| | General household items | 26% | 33% ($\chi^2$=4.73, p<.05) | 21% ($\chi^2$=1.49, p=.222) | 22% ($\chi^2$=.368, p=.544) | 33% ($\chi^2$=1.49, p=.223) | 21% ($\chi^2$= 643, p=.422) | 39% ($\chi^2$>5.69, p<.05) | 25% ($\chi^2$>.148, p=.700) | 26% ($\chi^2$>1.24, p=.266) |
| | Support with urgent expenses | 21% | 26% ($\chi^2$=2.17, p=.141) | 24% ($\chi^2$=.412, p=.521) | 13% ($\chi^2$=1.83, p=.176) | 29% ($\chi^2$=2.16, p=.141) | 28% ($\chi^2$=1.25, p=.264) | 29% ($\chi^2$>1.16, p=.282) | 26% ($\chi^2$>.694, p=.405) | 26% ($\chi^2$>2.49, p=.115) |
| | Referral to other health or social services | 20% | 25% ($\chi^2$=2.27, p=.132) | 20% ($\chi^2$=.034, p=.853) | 25% ($\chi^2$=.496, p=.481) | 24% ($\chi^2$=.460, p=.497) | 19% ($\chi^2$=.0449, p=.832) | 24% ($\chi^2$>.663, p=.416) | 25% ($\chi^2$>2.03, p=.154) | 32% ($\chi^2$>4.59, p<.05) |

| Support type | | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money | Rural/ remote | Has school age children resident | Has resident aged 65+ |
|---|---|---|---|---|---|---|---|---|---|---|
| | Support with social connection, wellbeing and/or pastoral care | 19% | 19% ($\chi^2$=.084, p=.772) | 21% ($\chi^2$=.223, p=.637) | 16% ($\chi^2$=.345, p=.557) | 56% ($\chi^2$=1.47, p=.225) | 17% ($\chi^2$=.181, p=.670) | 15% ($\chi^2$=.486, p=.486) | 19% ($\chi^2$=.115, p=.735) | 21% ($\chi^2$=.085, p=.770) |
| | Connection to Work and Income financial support | 15% | 14% ($\chi^2$=.086, p=.769) | 18% ($\chi^2$=.858, p=.354) | 9.4% ($\chi^2$=1.01, p=.316) | 16% ($\chi^2$=.116, p=.734) | 13% ($\chi^2$=.108, p=.743) | 15% ($\chi^2$>007, p=.933) | 16% ($\chi^2$>.145, p=.703) | 21% ($\chi^2$>1.49, p=.222) |
| | Connection with employment support and opportunities | 14% | 17% ($\chi^2$=4.83, p<.05) | 16% ($\chi^2$=.171, p=.679) | 6.3% ($\chi^2$=1.97, p=.160) | 14% ($\chi^2$=0252, p=.874) | 11% ($\chi^2$=.340, p=.560) | 24% ($\chi^2$>4.66, p<.05) | 16% ($\chi^2$>.150, p=.699) | 16% ($\chi^2$>.307, p=.580) |
| | Help dealing with government organisations | 11% | 7.2% ($\chi^2$=.110, p=.740) | 11% ($\chi^2$=0086, p=.926) | 13% ($\chi^2$=089, p=.765) | 13% ($\chi^2$=209, p=.647) | 15% ($\chi^2$=1.02, p=.312) | 12% ($\chi^2$>.137, p=.712) | 13% ($\chi^2$>.709, p=.400) | 16% ($\chi^2$>2.03, p=.154) |
| | Transport costs | 8% | 8.2% ($\chi^2$=042, p=.837) | 8.5% ($\chi^2$=0557, p=.813) | 3.1% ($\chi^2$=1.19, p=.276) | 5.5% ($\chi^2$=.859, p=.354) | 0% ($\chi^2$=5.24, p<.05) | 11% ($\chi^2$>.562, p=.453) | 8.6% ($\chi^2$>.165, p=.685) | 11% ($\chi^2$>.429, p=.513) |
| | Help dealing with other organisations or situations | 8% | 20% ($\chi^2$=4.43, p<.05) | 11% ($\chi^2$=1.82, p=.177) | 9.4% ($\chi^2$=.123, p=.726) | 13% ($\chi^2$=2.00, p=.157) | 8.5% ($\chi^2$=.0663, p=.797) | 8.7% ($\chi^2$>.0168, p=.897) | 11% ($\chi^2$>1.12, p=.291) | 16% ($\chi^2$>4.70, p<.05) |

# Food support

*Table 82: Timeliness and appropriateness of food support (household survey)*

| Statements about the food household received | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Your household received food when we needed it | 210 | 92% | 6.2% | 1.9% |
| There was enough food for your household | 209 | 85% | 7.7% | 7.2% |
| The food support meant your household could get through isolation without going hungry | 213 | 84% | 10% | 5.6% |
| Your household received food that met your nutritional needs | 210 | 82% | 14% | 4.3% |
| Your household received food that met your cultural needs | 209 | 78% | 19% | 3.3% |
| Your household received food that met your religious needs | 205 | 70% | 27% | 3.4% |

*Table 83: The contribution of food support to wellbeing outcomes (household survey)*

| Statements about experience with the food support provider | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| The food support made your household feel supported | 212 | 90% | 6.2% | 3.8% |
| The food support reduced financial stress for your household | 210 | 86% | 11% | 3.3% |
| The food support reduced mental stress for your household | 210 | 83% | 13% | 3.8% |

The following set of tables provide feedback on food support from household survey respondents, for all households and by ethnicity, disability or health condition, and income adequacy.

*Table 84: Household received food when they needed it by ethnicity, health condition or disability, and income adequacy (household survey)*

| Timely | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 211 | 211 | 211 | 204 | 207 |
| $\chi^2$ | | 4.76, p=0.092 | 2.43, p=0.297 | 1.73, p=0.420 | 3.85, p=0.146 | 1.89, p=0.389 |
| Agree | 92% | 87% | 95% | 96% | 88% | 91% |
| Disagree | 2.4% | 3.3% | 1.2% | 0% | 1.7% | 4.5% |
| Neither | 6.2% | 10% | 3.6% | 4.4% | 10% | 4.5% |

*Table 85: Households received enough food by ethnicity, health condition or disability, and income adequacy (household survey)*

| Received enough food | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | - | 210 | 210 | 210 | 203 | 206 |
| $\chi^2$ | - | 7.66, p<.05 | 6.82, p<.05 | 0.950, p=0.622 | 6.39, p<.05 | 6.34, p<.05 |
| Agree | 85% | 79% | 93% | 87% | 78% | 77% |
| Disagree | 7.6% | 14% | 3.6% | 4.3% | 8.6% | 14% |
| Neither | 7.6% | 7.9% | 3.6% | 8.7% | 14% | 9.1% |

*Table 86: Food support meant household could isolate without going hungry by ethnicity, health condition or disability, and income adequacy (household survey)*

| Could isolate without going hungry | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 213 | 213 | 213 | 206 | 209 |
| $\chi^2$ | | 4.75, p=0.093 | 4.07, p=0.131 | 3.99, p=0.136 | 2.56, p=0.278 | 4.97, p=0.083 |
| Agree | 84% | 78% | 90% | 92% | 78% | 78% |
| Disagree | 5.6% | 8.8% | 3.6% | 0% | 6.8% | 10% |
| Neither | 10% | 13% | 6.0% | 8.5% | 15.3% | 12% |

*Table 87: Household received nutritional food by ethnicity, health condition or disability, and income adequacy (household survey)*

| Received nutritional food | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | - | 209 | 209 | 209 | 202 | 206 |
| $\chi^2$ | - | 7.74, p<.05 | 5.19, p=0.075 | 3.76, p=0.152 | 8.29, p<.05 | 3.64, p=0.162 |
| Agree | 82% | 74% | 89% | 91% | 71% | 79% |
| Disagree | 3.8% | 6.7% | 3.6% | 0% | 5.1% | 7.6% |
| Neither | 14% | 19% | 7.2% | 8.9% | 24% | 14% |

*Table 88: Household received food that met cultural needs by ethnicity, health condition or disability, and income adequacy (household survey)*

| Food met cultural needs | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 209 | 209 | 209 | 202 | 206 |
| $\chi^2$ | | 5.38, p=0.068 | 6.47, p<.05 | 0.273, p=0.872 | 1.05, p=0.592 | 1.23, p=0.541 |
| Agree | 78% | 76% | 87% | 78% | 73% | 73% |
| Disagree | 3.3% | 6.7% | 1.2% | 2.2% | 3.4% | 4.5% |
| Neither | 19% | 18% | 12% | 20% | 24% | 22% |

*Table 89: Household received food that met religious needs by ethnicity, health condition or disability, and income adequacy (household survey)*

| Food met religious needs | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | - | 205 | 205 | 205 | 199 | 202 |
| $\chi^2$ | - | 5.61, p=0.060 | 7.90, p<.05 | 1.46, p=0.482 | 0.196, p=0.907 | 1.98, p=0.372 |
| Agree | 70% | 61% | 81% | 76% | 67% | 68%, |
| Disagree | 3.4% | 4.6% | 1.2% | 4.4% | 3.4% | 6.1% |
| Neither | 27% | 35% | 18% | 20% | 29% | 26% |

*Table 90: Food support made household feel supported by ethnicity, health condition or disability, and income adequacy (household survey)*

| Food made household feel supported | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 211 | 211 | | 204 | 207 |
| $\chi^2$ | | 5.86, p=0.053 | 4.05, p=0.132 | 2.85, p=0.241 | 5.94, p=0.051 | 2.35, p=0.308 |
| Agree | 90% | 84% | 95% | 92% | 86% | 86% |
| Disagree | 3.8% | 6.7% | 2.4% | 0% | 1.7% | 6.1% |
| Neither | 6.2% | 8.9% | 2.4% | 8.5% | 12% | 7.6% |

*Table 91: Food support reduced financial stress by ethnicity, health condition or disability, and income adequacy (household survey)*

| Food reduced financial stress | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | | 210 | 210 | 210 | 210 | 206 |
| $\chi^2$ | | 2.55, p=0.280 | 7.58, p<.05 | 3.61, p=0.164 | 7.66, p<.05 | 2.11, p=0.347 |
| Agree | 86% | 83% | 93% | 94% | 83% | 84% |
| Disagree | 3.3% | 5.6% | 3.6% | 0% | 0% | 6.0% |
| Neither | 11% | 11% | 3.6% | 6.4% | 18% | 10% |

*Table 92: Food support reduced mental stress by ethnicity, health condition or disability, and income adequacy (household survey)*

| Food reduced mental stress | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | - | 210 | 210 | 210 | 203 | 206 |
| $\chi^2$ | - | 4.85, p=0.088 | 4.65, p=0.098 | 2.66, p=0.264 | 0.704, p=0.703 | 0.143, p=0.931 |
| Agree | 83% | 78% | 90% | 89% | 81% | 83% |
| Disagree | 3.8% | 6.7% | 2.4% | 0% | 3.4% | 4.5% |
| Neither | 13% | 16% | 7.3% | 11% | 15% | 12% |

## Support provided by Community Connector

The following set of tables provide feedback on Community Connectors from household survey respondents, for all households and by ethnicity, disability or health condition, and income adequacy.

*Table 93: Timeliness of Community Connector support by ethnicity, health condition or disability, and income adequacy (household survey)*

| Community Connector support was timely | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | - | 201 | 201 | 201 | 195 | 197 |
| $\chi^2$ | - | 4.98, p=0.083 | 1.76, p=0.414 | 1.10, p=0.576 | 3.45, p=0.178 | 1.94, p=0.379 |
| Agree | 87% | 82% | 91% | 89% | 86% | 93% |
| Disagree | 2.5% | 3.0% | 1.3% | 0% | 0% | 0% |
| Neither | 10% | 15% | 7.8% | 11% | 15% | 7.5% |

*Table 94: Timeliness of services to households (Community Connector survey)*

| Statement about timeliness | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| I was able to quickly connect people with support services in my community | 128 | 86% | 9.4 % | 4.7 % |

## Reach

The following tables provide additional detail on the reach of the CiC welfare response.

*Table 95: Community provider enabled increased reach (community provider survey)*

| Groups to whom community provider increased reach | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Everyone | 57 | 81% | 18% | 1.8% |
| Māori | 48 | 81% | 17% | 2.1% |
| Pacific peoples | 50 | 78% | 20% | 2.0% |
| Socio-economically disadvantaged | 51 | 82% | 14% | 3.9% |
| Ethnic communities | 47 | 68% | 28% | 4.3% |
| Older population | 51 | 73% | 20% | 7.8% |
| Disabled people | 44 | 64% | 25% | 11% |
| Other | 13 | 69% | 31% | - |

*Table 96: Community Connector enabled increased reach (Community Connector survey)*

| Groups to whom Community Connector increased reach | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Everyone | 122 | 89% | 5.7% | 4.9% |
| Māori | 114 | 96% | 1.8% | 2.6% |
| Pacific peoples | 112 | 92% | 6.3% | 1.8% |
| Socio-economically disadvantaged | 115 | 95% | 4.3% | 0.9% |
| Ethnic communities | 111 | 83% | 16% | 0.9% |
| Older population | 114 | 87% | 12% | 0.9% |
| Disabled people | 113 | 79% | 20% | 1.8% |
| Other | 17 | 94% | 5.9% | - |

*Table 97: RLG enabled increased reach (RLG survey)*

| Groups to whom RLG increased reach | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| Māori | 40 | 88% | 7.5% | 5.0% |
| Māori (iwi responses only) | 5 | 80% | - | 20% |
| Pacific peoples | 40 | 75% | 20% | 5.0% |
| Socio-economically disadvantaged | 40 | 73% | 23% | 5.0% |
| Ethnic communities | 39 | 51% | 36% | 13% |
| Older population | 39 | 51% | 39% | 10% |
| Disabled people | 39 | 33% | 56% | 10% |

# Isolation outcomes for households

*Table 98: Ability to stay isolated by Māori and priority populations (household survey)*

| Could stay in isolation | Total | Māori | Pacific | Asian | Disability or health condition | Not enough money |
|---|---|---|---|---|---|---|
| n | 250 | 250 | 250 | 250 | 243 | 246 |
| $\chi^2$ | | 4.82, p=.090 | 0.309, p=.857 | 5.55, p=.062 | 4.32, p=.115 | 7.02, p=.135 |
| Agree | 83% | 77% | 82% | 92% | 81% | 80% |
| Disagree | 8.0% | 10% | 9% | 0% | 4.3% | 13% |
| Neither | 9.2% | 13% | 9% | 8% | 14% | 7.0% |

*Table 99: The effectiveness of the CiC welfare response in supporting households to stay in isolation (RLG, community provider and Community Connector surveys)*

| Could stay in isolation (by stakeholder group) | n | Agree | Neither | Disagree |
|---|---|---|---|---|
| RLG | 44 | 81% | 17% | 2.4% |
| Community provider | 62 | 86% | 9.7% | 4.8% |
| Community connector | 123 | 92% | 6.5% | 1.6% |

*Table 100: Ability to stay isolated by region (household survey)*[48]

| Could stay in isolation (by region) | n | Aggregated region ($\chi^2$=16.9, p=.076) | n | Agree |
|---|---|---|---|---|
| Northland/Te Tai Tokerau | 1 | Northland/Auckland | 78 | 78% |

[48]The 14 individual regions were collapsed into 6 contiguous areas as some regions had too small a response rate to be analysed separately.

| Could stay in isolation (by region) | n | Aggregated region ($\chi^2$=16.9, p=.076) | n | Agree |
|---|---|---|---|---|
| Auckland/Tāmaki Makaurau | 77 | | | |
| Manawatū-Whanganui | 10 | Waikato/Taranaki/King Country/ Manawatū-Whanganui | 35 | 91% |
| Taranaki-King Country | 1 | | | |
| Waikato | 24 | | | |
| Bay of Plenty/Te Moana-a-Toi | 39 | Bay of Plenty | 39 | 77% |
| East Coast / Tairāwhiti | 4 | Hawkes Bay/East Coast | 16 | 69% |
| Hawkes Bay/Heretaunga-Ahuriri | 12 | | | |
| Greater Wellington | 29 | Greater Wellington | 29 | 93% |
| Nelson-Tasman/Whakatū-Te Tai o Aorere | 4 | South Island | 44 | 91% |
| Canterbury/Waitaha | 33 | | | |
| West Coast/Te Tai Poutini | 1 | | | |
| Otago/Ōtākou | 1 | | | |
| Southland/Murihiku | 5 | | | |
| Total | 241[49] | Total | 241 | 83% |

[49] Not every household answered the region question, meaning the total number of responses to this question is lower than the overall number of household surveys (n=255).

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