COUNTIES MANUKAU HEALTH

Asian Health Plan

2017/18

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Foreword

The diversity of our Asian and migrant people living in Counties Manukau is unique and valuable. By 2020, we estimate that 26 percent of the people living in our district will identify with one or more Asian ethnicities. That is approximately 150,000 people and is almost the same as the total population of Hamilton.

Our Asian communities are not the same. They have different languages, cultures, religions and health beliefs. In addition to ethnicity, we cannot lose sight that many of them are migrants to New Zealand. Language and understanding of the New Zealand culture and health system can affect their engagement with and access to health services when they are needed. It is important for Counties Manukau Health to acknowledge this great diversity to provide a better experience of health care for patients and their families now and into the future.

For 2017/18, we are looking deeper into the health needs and health services experience of our diverse Asian and refugee communities. This will enable us to improve our community engagement to better understand what health system improvements will make the most difference to them. The actions in this Asian Health Plan build on our health developments both in the community and hospital services delivered across our district.

Counties Manukau Health cannot achieve this without the support and advice of our Asian and migrant communities and regional Asian health leaders. This plan includes a commitment to enhance our regional collaboration in Asian health gain planning and reporting to make best possible use of our collective knowledge and resources.

We look forward to learning more and building partnerships that will result in action and positive results for our Asian people living in Counties Manukau by learning from our communities and enhancing collaboration with Auckland and Waitemata District Health Board leaders.

1.0 Introduction

1.1 'Asian' as defined in New Zealand

The New Zealand health and disability sector classifies ethnicity data according to the Ministry of Health protocols. The term 'Asian' used in the New Zealand Census and related data sets, refers to people with origins in the Asian continent, from China in the north to Indonesia in the south and from Afghanistan in the West to Japan in the East. This differs from the definition used in other countries such as the United Kingdom or the USA.

This definition includes over 40 sub-ethnicities and these communities have very different cultures and health needs. Reviewing health data using this broad 'Asian' classification is problematic if the health status of Chinese, Indian and Other Asian communities is averaged. The risk is that averaged results can appear 'healthy', but potentially masks true health disparities such as cardiovascular disease (CVD) and diabetes in sub-ethnicity groups. Furthermore, many people classified as being 'Asian' do not identify with the term which may lead to under-utilisation of 'Asian' targeted services.

1.2 Our Partners

CM Health acknowledges that protecting the current and future health of our large Asian population will require strong collaborative partnerships. The means working with and alongside communities, local government, Primary Health Organisations, Non-Governmental Organisations, health and social service providers; and learning from our regional Asian health colleagues across the Auckland region.

Since 2017, the three DHBs covering Auckland, Waitemata and Counties Manukau share the same Board Chair with an opportunity to further enhance regional collaboration. We are actively working with Auckland and Waitemata District Health Boards and other regional Asian health leaders to learn from their experiences and to collaborate where we can achieve better outcomes together than apart. This includes participation at the Auckland Regional Asian and MELAA Primary Care Working Group and collegial contribution to the Northern Region Health Plan.

A significant national resource is the eCALD (Culturally and Linguistically Diverse) programme of courses and resources to support the health workforce to develop cultural competence for working with Asian patients, clients, families and colleagues. [1]

CM Health's locality approach to service development provides the foundation for community engagement. It is the people living and working in Counties Manukau that provide invaluable insights, local intelligence and inspiration about what our Asian communities need and our approaches that works best for different population groups.

In addition, CM Health will grow its Asian health advisory network of groups and people to undertake mental and physical health improvement initiatives. This will evolve over 2017 as we reshape the existing Mental Health and Addictions service development and intersectoral forums to include broader health and wellbeing approaches.

1.3 Te Tiriti o Waitangi

CM Health recognises and respects Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. The four Articles of Te Tiriti o Waitangi provide a framework for Maaori development, health and wellbeing by guaranteeing Maaori a leading role in health sector decision making in a national, regional, and whaanau/individual context. The New Zealand Public Health and Disability Act 2000 furthers this commitment to Maaori health advancement by requiring District Health Boards (DHBs) to establish and maintain responsiveness to Maaori while developing, planning, managing and investing in services that do and could have a beneficial impact on Maaori communicates.

[1] eCALD® resources and courses have been developed by Waitemata DHB to address the lack of CALD cultural competence training and information for the New Zealand health workforce. The provision of eCALD® courses and resources "for working with patients" is funded by the Ministry of Health as part of the Northern Regional Alliance's Asian, Migrant and Refugee Health Action Programme.

Te Tiriti o Waitangi provides four domains under which Maaori health priorities for CM Health can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the DHB's provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with mana whenua at a governance level.

Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to CM Health's activities.

Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

These guiding principles are applicable to our diverse Asian communities as they contribute to cultural safety and in particular, their contribution to positive health outcomes and experience of care. Cultural safety is underpinned by respectful communication, recognition of the diversity of world views (both within and between ethnic groups). The relevance of and respect for the importance of this framework is reflected in our integration of Te Reo terms in this Asian Health Plan.

1.4 National Context

There are three key national strategies that are important linkages to our Asian health aspirations.

The *Migrant and Integration Strategy*[2] is a whole-of-government strategy that sets out settlement objectives for collaboration across government agencies. Immigration New Zealand (INZ) leads the development and implementation of the Strategy to effectively settle and integrate migrants in New Zealand. The strategy identifies five measureable settlement and integration outcomes to focus on, with particular alignment in this Asian health plan to outcome 5 'Health and Wellbeing'.

The *Refugee Resettlement Strategy*[3] focuses on refugees' goals for settling here. The strategy aims to help refugees integrate into communities, find work and gain access to health services. It combines support from government agencies, non-governmental organisations (NGOs) and refugees themselves. Immigration New Zealand (INZ) leads the work. The strategy has 5 goals, with particular alignment in this Asian health plan to goal 3 'Health and Wellbeing'.

The third national strategy of note is in development and focuses on *New Zealand international student wellbeing*. When published, this strategy will include a 'Health and Wellbeing' outcome area.[4]

[2] Accessible online from https://www.immigration.govt.nz
[3] Accessible online from https://www.immigration.govt.nz
[4] Personal communication, Manager Asian, Migrant & Refugee Health Gain, Auckland and Waitemata DHB

1.5 Our Decision Making Kaupapa

CM Health strategic goal and values

Achieving "Healthy Futures for all people" (Paeora) is a priority for CM Health and aligns with our Healthy Together strategic goal. This means:

- Seeing Asian peoples living longer, healthier lives with whaanau and families in their own communities
- Working together to achieve health equity for Asian communities experiencing health disparities

To achieve this, our transformational challenge is:

> *"To systematically prevent and treat ill health as early and effectively as possible for every person every day, so that people in Counties Manukau are healthier and the health system is sustainable and high quality"*

We intend to progress and measure our progress by:

- Advocating for healthier environments and settings that make healthy choices easier
- Better supporting people and families to live well with a diagnosed, long term condition through ways of working that honour Asian peoples wellbeing
- Targeting service delivery to people at risk. Ensuring people get access to services earlier than they otherwise would, in planned, proactive models of integrated care
- Providing healthcare closer to home. By orientating our service delivery to Localities, services are better connected with people, families, and communities and with other health, social and community service providers supporting their wellbeing.

There is a Maaori whakatauki (proverb) that embodies this challenge – "Ko tou rourou, ko toku rourou ka ora ai te iwi."

> *If we ask ourselves – how can we achieve health equity and how can we value everyone - we can all contribute to this goal. And there, in our quest for health equity, we can continue to narrow the health gaps for all communities living in Counties Manukau.*

Our values reinforce and underpin our commitment to excellent, collaborative, compassionate and safe healthcare that we aspire to live and breathe every day.

- **Kind** (Manaakitanga**)**
  Care for other people's wellbeing
- **Excellent** (Rangatiratanga**)**
  Safe, professional, always improving
- **Valuing Everyone** (Whakawhanaungatanga)
  Make everyone feel welcome and valued
- **Together** (Kotahitanga)
  Include everyone as part of the team

2.0 The People We Serve

2.1 Auckland Region

Across New Zealand our diverse Asian and migrant communities are growing faster than any other population group. Auckland's population is growing and changing with more than 180 ethnicities living in the city, almost 40%[5] of Aucklanders were not born in New Zealand. Some Asian ethnic groups may have arrived on these shores as a new migrant by choice, whereas other such as refugees (and their families), and asylum seekers have come to New Zealand asking for protection.[6]

While there was an increase in the proportion of Asians living in every region, the biggest growth occurred in the Auckland region.[7] In 2006, 1 in 5 people (19 percent) living in the Auckland region identified with one or more Asian ethnic groups. By 2013 it was almost 1 in 4 people (23 percent) and by 2036 it is forecast to be about 1 in 3 people (34 percent)[8]. Socio-demographic and health status information tells us that life in New Zealand is changing for these communities.

Other than ethnic origins, the people grouped under the generic label of Asian are very diverse in health status, health beliefs and practices, housing, geographical distribution, migration history, English language proficiency and socio-economic status. [9]

These factors alongside available services and community networks impact how we monitor population health, design and deliver supporting services. While the three Auckland District Health Boards (DHBs) are committed to collaboration, each will need to complement these activities with a focus on specific health improvement actions that are specific to local population needs.

Figure 1: Summary 2017 Asian population demography across the three Auckland Metropolitan DHBs[10]

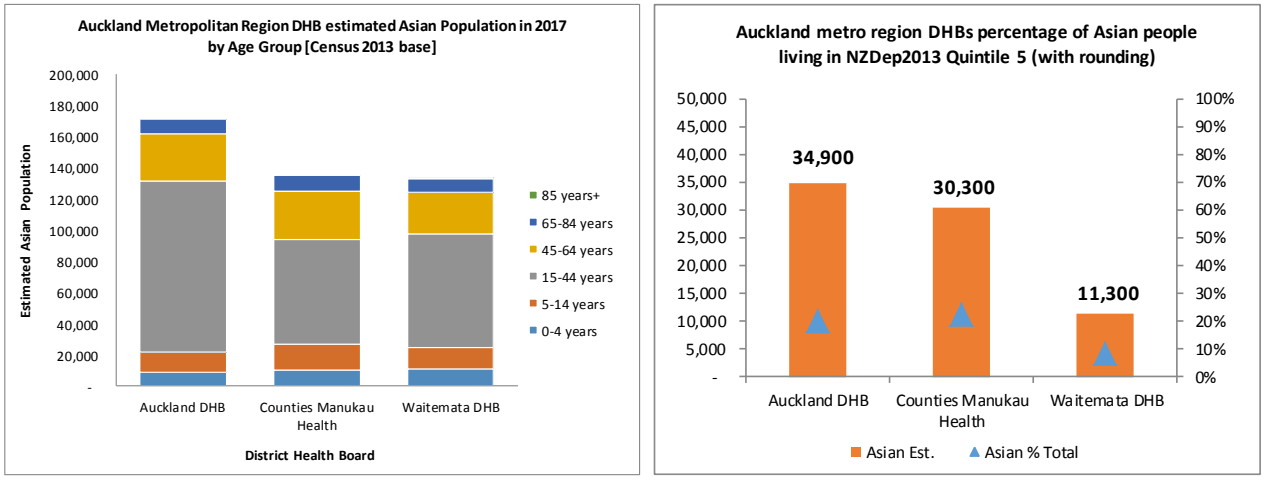


Figure 1 above highlights a larger 15 – 44 year old Asian adult group in Auckland compared to Waitemata and Counties Manukau DHBs that share a similar age distribution. The different scale of socioeconomic deprivation (measured by number of people living in areas classified as Quintile 5 - NZDep 9&10) across the region are marked. Asian peoples living in the Waitemata district have the lowest (9 percent) and Counties Manukau the highest (22 percent) proportion of the Asian population living in areas of high socioeconomic deprivation. These demographic

[5] http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/birthplace.aspx
[6] Lifeng Zhou and Samantha Bennett, *International Benchmarking of Asian Health Outcomes for Waitemata DHB and Auckland DHB*. (Auckland: Waitemata District Health Board, 2017).
[7] http://www.stats.govt.nz/Census/2013-census/profile-and-summary-reports/quickstats-culture-identity/asian.aspx
[8] It is important to note that the census ethnicity data reflects group or groups that people identify with or feel they belong to and can be different from ancestry, birthplace and nationality. Further information on census ethnicity coding is available from the Statistic New Zealand website http://www.stats.govt.nz.
[9] Suneela Mehta, *Health Needs Assessment of Asian people living in the Auckland Region* (Auckland: Northern DHB Support Agency, 2012).
[10] Census 2013 NZ Dep. District Health Boards. Ethnic Group Population Projections, (2013-Census Base) – October 2016 Update.

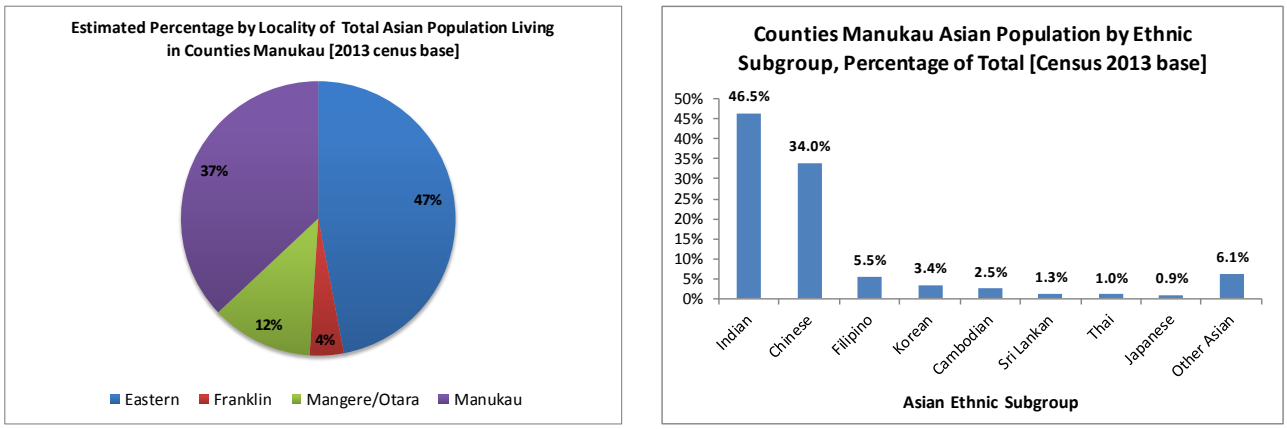
factors provide a context for common and unique action commitments and health outcome expectations across the DHB plans.

2.2 Asian Peoples Living in Counties Manukau

The diverse Asian communities that live in Counties Manukau are a significant proportion of the total population. In 2017, the estimated Asian population is 25 percent (estimated 136,000) of all people resident in Counties Manukau and is forecast to increase to 26 percent (estimated 150,000) by 2020.[11]

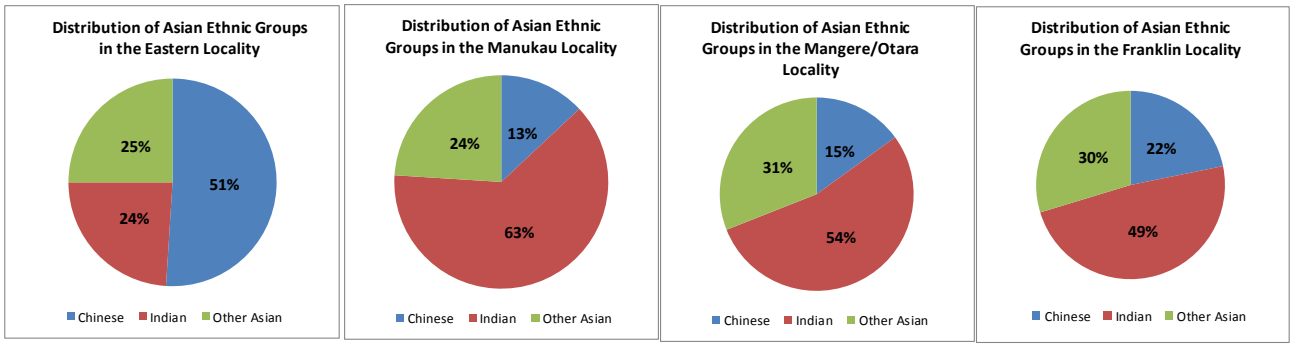
The largest Asian ethnic subgroups in Counties Manukau, based on Census 2013 total response ethnicity, consist of Indian and Chinese people. Indian people comprise almost half (47 percent) and Chinese a third (34 percent) of the total Counties Manukau Asian population (refer to Figure 2).

Figure 2: Distribution of Asian peoples living in Counties Manukau[12]



Recognising the super-diversity of Asian peoples living in Counties Manukau matters in relation to patient and family experience of CM Health services. We need to recognise the impacts of the different Asian community mix within each of CM Health's four geographical Localities (Eastern, Manukau, Mangere/Otara, and Franklin) is different. In parts of our district, more than 1 in 2 people you meet will have been born overseas, with areas like Papatoetoe, Manukau, Dannemora and Botany being more than 50 percent Asians (refer to Figure 3).

Figure 3: Distribution of Asian ethnic groups living in Counties Manukau by geographic Locality in 2013[13]



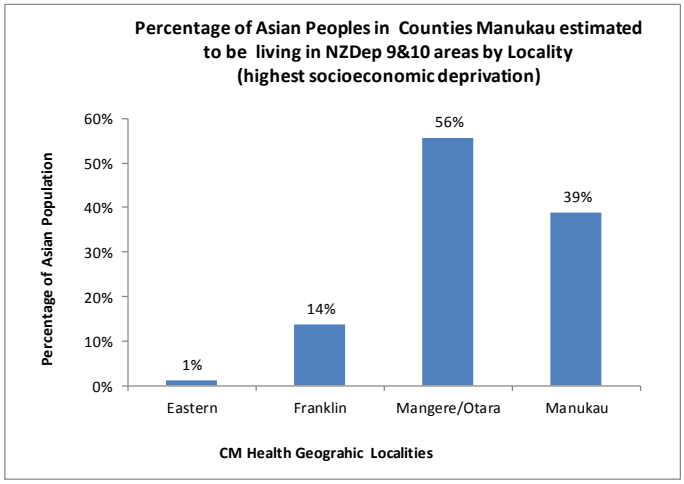
Indian communities are the largest in Papatoetoe, Ormiston and surrounding suburbs and Mangere South. Our Eastern Locality is home to the largest Asian population (estimated at 48,660[14] based on health service utilisation population in 2013) per local board or territorial authority in New Zealand. Chinese communities live more commonly in the Eastern suburbs such as Ormiston, Millhouse, Meadowland, Highland Park and Murvale. From a health service point of view, how these groups engage with health services will make a significant difference to population health overall.

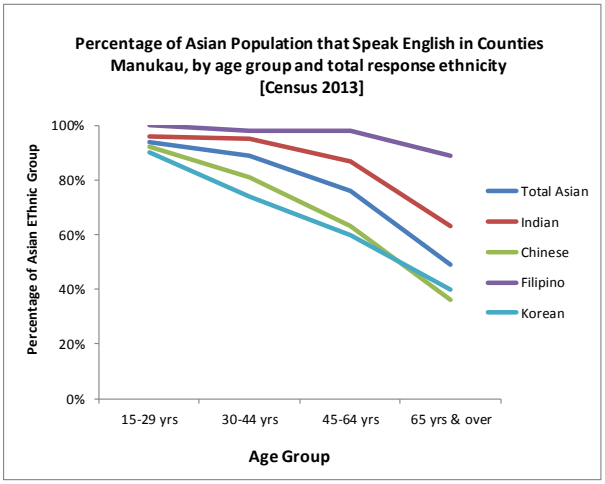
[11] Census 2013 NZ Dep. District Health Boards. Ethnic Group Population Projections, (2013-Census Base) – October 2016 Update.
[12] Locality projections by age group, StatsNZ release Sept 2015 [Census 2013 base].
[13] Health service utilisation population. from Demography of the Asian Population living in Counties Manukau by Doone Winnard June 2014. Note health service utilisation classifies Fijian Indian in the Pacific ethnicity as per MOH standards, (different from Stats NZ classification)
[14] Based on the Eastern locality estimated population of approximately 48,660 if using Asian constructed population in CM 2013.

Census 2013 data on "unpaid work helping or voluntary work" is 13 percent overall for Asian people usually resident in Counties Manukau. This highlights the significant strength of community connectedness in this population.

In addition to ethnicity, we cannot lose sight that many of these people are migrants to New Zealand. As such, socioeconomic status, language, and familiarity with the New Zealand health system can affect access to health services when they are needed. The 2013 census data indicated that 56 percent of Asian people living in Mangere/Otara Locality are in areas of high socioeconomic deprivation compared to only 1 percent in Eastern Locality (refer to Figure 4 and Figure 5). In addition, 73 percent of Asian people living in Counties Manukau were born overseas. Of these, 48 percent had been in New Zealand less than 10 years, and older people of Chinese, Korean and Indian ethnicities have relatively limited ability to speak English (Figure 4).

Figure 4: Counties Manukau Asian community key social factors impacting engagement with health services





There is also a view of our Asian population by total numbers of people by age group. This matters in terms of where we focus our health gain improvement actions across the life course and related health needs (refer Figure 6).

Figure 5: Usually Resident Total Asian people living in Quintile 5 areas in 2013 (Counties Manukau by census area unit)

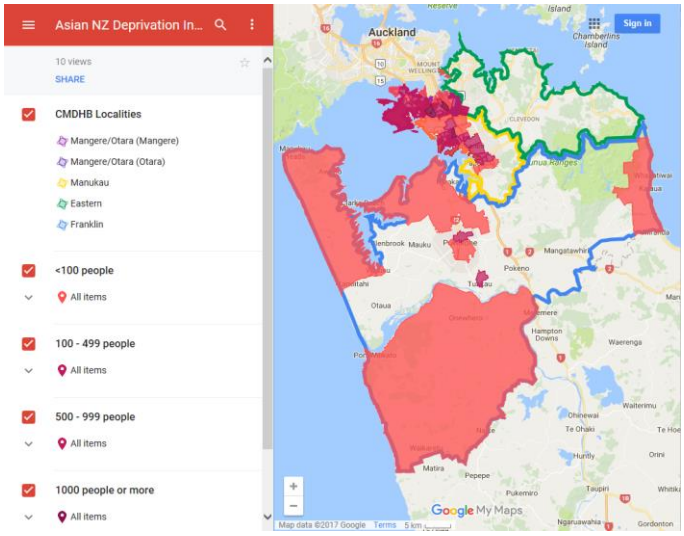
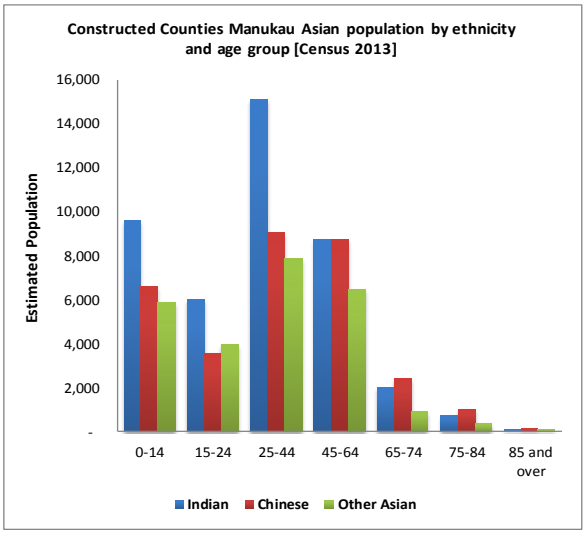


Figure 6: Counties Manukau Asian population by ethnicity and age group[15]



[15] Locality projections by age group, StatsNZ release Sept 2015 [Census 2013 base].

3.0 Key Achievements

In 2016/17 CM Health focused on health gain areas that were identified as national and local priorities. This included a mixture of actions to shore up our health systems alongside improvements to the way we work with Asian peoples to make a positive difference to health outcomes.

This meant working together and collectively CM Health achieved the following key outcomes in the past year.[16]

Maatua, Pepi me Tamariki (Parents, Infants and Children)

- Increased number of Asian children enrolled with Community Oral Health Services (from 69 percent in December 2015 to 87 percent in December 2016
- Fifty-six percent of Asian children were caries free at 5 years with further improvements planned in 2017/18

Pakeke me Whaanau (Adult and Family)

- Completed stocktake of Mental Health Services staff that completed CALD Cultural Competency Training (Modules 1 & 4)
- Completed gap analysis of current procedure for providing clinical cultural advice for Asian mental health service users
- Completed a proposal to establish the Asian Clinical Cultural Advisor role for Asian mental health service users
- Small increase in the proportion of Asian women aged 25-69 years who accessed cervical cancer screening

Te Roopu Whaanui o Counties Manukau (District Wide)

- Enhancing Asian health leader regional relationships and collaboration. This included regional advice and support for the new CM Health Asian Health Gain Advisor recruitment, participation in the Auckland Regional Asian and MELAA Primary Care Working Group and collegial contribution to the Northern Region Health Plan 2017/18
- Appointment of a new Asian Health Gain Advisor in December 2016
- Increased awareness of Asian health information through fortnightly Welcome Day presentations and engagement with health leaders
- Development of a community engagement strategy and advisory network resulting in reconfiguration and alignment of existing Pan Asian Health Interest Group, Mental Health and Addictions service development and intersectoral forums

[16] By the end of quarter 2;-31 December 2016

4.0 Performance Expectations for 2017/18

To identify key health inequities as a focus for health planning, we require a comparator population group that shows the **true story of inequities**, i.e. what is the gap in health outcomes and scale of health gain we plan for? Our thinking is that the comparator population is not so much right or wrong but appropriate or "fit for purpose" to the local lived realities for our community. CM Health has chosen the New Zealand 'European/Other' population as our health equity comparator group. For this reason, our baseline measures and related trend graphs outlined in Section 5 of this plan reflects this as our "local health equity target" in addition to the national targets reflecting government performance expectations.

Priority Area	Key Indicators	Baseline 2015/16 Total[17]	Baseline 2015/16 European/Other	Baseline 2015/16 Asian	Target 2017/18 Result
Maatua, Pepi me Tamariki (Parents, Infants and Children)					
Oral health[18]	Percentage of children aged – 4 years enrolled in DHB-funded Community Oral Health Services	79%	90%	87%	95%
	Percentage of population of children aged 5 years who are caries free	48%	65%	56%	60%
	Mean DMFT score of year 8 school children (12/13 years)	0.96	0.62	0.72	0.81
Immunisation	Percentage of eligible girls fully immunised with HPV vaccine	62%	54%	61%	75%
Pakeke me Whaanau (Adults and Family Group)					
Cancer screening	Percentage of eligible women aged 25-69 who received a cervical screen within past 36 months	75%	79%	67%	80%
Cardiovascular disease	Percentage of eligible population who have had their cardio-vascular risk assessed in the last five years	92%	93%	92%	90%
	Percentage of patients with CVD risk >20 percent on dual therapy (dispensed)[19]	49%	44%	43% (Indian 51%)	46% (Indian 54%)[20]
	Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)[19]	58%	57%	51% (Indian 69%)	53% (Indian 73%)[20]
Diabetes	Percentage of eligible population with Hb1Ac ≤ 64mmol/mol	65%	73%	75%	69%
	Percentage of enrolled patients (aged 15-74) whose latest systolic blood pressure measured in the last 12 months is <140 mmHg	*The baseline and target is in development as part of a regional collaboration.*			
	Percentage of enrolled patients (aged 15-74) who have microalbuminuria and are on an ACE inhibitor of Angiotensin Receptor Blocker	*The baseline and target is in development as part of a regional collaboration.*			
Smoking Cessation	Percentage of people who smoke and are enrolled in General Practice are offered brief advice and cessation support	92%	92%	93%	90%
	Percentage of people who smoke and are hospitalised are offered brief advice and cessation support	96%	96%	94%	95%
Immunisation Against Influenza	Percentage of people aged over 65 years receive free flu vaccinations	47%	44%	47%	75%
Te Roopu Whaanui o Counties Manukau (District Wide)					
Primary care	Percentage of the population enrolled in a PHO	98%	97%	83%	95%

Baseline data referenced is based on Quarter 4 2015/16 (30 June 2016) results unless otherwise stated. This baseline was chosen to align with the metropolitan Auckland District Health Board 2017/18 Annual Plan indicator baselines.

[17] Total means the indicator result for the all Counties Manukau population groups as at 30 June 2016 (unless otherwise noted).
[18] Baseline data is based on the calendar year (to 31 December 2016). A 'non-Maaori/non-Pacific' health equity comparator group applies as disaggregated 'European/Other' other data was not available in 2016. Note 2017/18 targets reflect national expectations for the total population.
[19] Baseline data is for the 12 months ended 30 September 2016 to align with the 2017/18 Auckland Region System Level SLM Improvement Plan
[20] 2017/18 targets represent a 5 percent increase from baseline per the 2017/18 Auckland Region SLM Improvement Plan.

5.0 Asian Health Gain Focus for 2017/18

The diverse Asian communities living in Counties Manukau are growing fast and the Indian ethnic group is growing faster than the Chinese ethnic group. The differences in Asian population in Counties Manukau compared to the Auckland and Waitemata district health boards are the most pronounced for our Indian community. In Counties Manukau, the Indian ethnic group comprises 47 percent of our total Asian population, compared to 23 percent for Waitemata and 33 percent for Auckland.

The different lived realities of our Asian populations are reflected in the proportion of Asian peoples living in areas of high socioeconomic deprivation. Population and health status data shows us where we need to work together with greater focus to protect the future health of our Asian community in priority areas. For 2017/18, these are:

- Healthier Asian children through better oral health and HPV immunisation
- Healthy and well supported Asian young people through improved oral health and more responsive/accessible services for mental, sexual and reproductive health
- Improve the health of Asian adults through cervical screening, influenza vaccination, smoking cessation and effective treatment of long term health conditions (diabetes and cardiovascular disease)
- Improve the experience of mental health care for Asian people

What this means for Counties Manukau Health is working better with patients and families alongside culturally responsive services are important focus areas for this plan. To achieve this, we are committed to working with communities to better understand their needs, strengths and service approaches that will make a meaningful difference.

5.1 Maatua, Pepi me Tamariki - Parents, Infants and Children

Good child health is important not only for children and family now, but also for good health later in adulthood. A number of the risk factors for many adult diseases such as diabetes, heart disease and some mental health conditions such as depression arise in childhood. In addition, child health, development and wellbeing have broader effects on educational achievement, violence, crime and unemployment. These impacts start in pregnancy and therefore our action focus is on the home environment, good nutrition, oral health and reduction in potentially avoidable diseases. In 2017/18, our action focus for Asian infants, children and family is on good oral health and immunisations.

5.1.1 Oral health in pre-school aged children

What are we trying to do?

We want Asian children to be dental pain and disease free, with functional dentition (development of teeth and their arrangement in the mouth) from an early age. The means a full set of baby teeth to enable eating, and speech development, plus a positive dental self-esteem.

Why is this a priority?

Early childhood caries or dental decay remains the most prevalent chronic and irreversible disease in the western world. In New Zealand disparities still exist in oral health by ethnicity, deprivation level, and age group. This is evident in Counties Manukau where Asian children have higher rates of caries.

Prevention of oral disease in infants and pre-

Where do we want to get to?

- 95 percent of preschool Asian children 0 – 4 years enrolled in DHB funded Community Oral Health Services
- 52 percent of Asian children aged 5 years who are caries free.
- Mean DMFT score of Asian children is 0.90

2016 Total	2016 non-Maaori/ non-Pacific	2016 Asian	2017 Target
Percentage of preschool children 0 – 4 years enrolled in DHB funded Community Oral Health Services			
79%	90%	87%	95%
Percentage of children caries free at age 5 years			
48%	65%	56%	60%
Mean DMFT score of children at year 8 of school (12/13 years) (the lower mean score is better)			
0.96	0.62	0.72	0.81

Baseline data based on the calendar year (to 31 December). Note 2017/18 target results reflect national expectations for the total population. Disaggregated Asian data pre- 2016 was unavailable

schoolers reduces the risk of dental, gingival and periodontal disease in permanent teeth and will have positive impact on their long term oral health, general health and well-being.

What will we focus on?

We want to reduce lifetime oral health inequities by preventing caries in preschool children and maximise use of our funding for children's community oral health services, programmes and nutritional advice.

Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q2	Stocktake current translated materials and where required translate priority health education material into Hindi, Chinese and Korean for preschool early engagement programme.	Hindi, Chinese and Korean materials available for family access.
2.	Q1-Q2	Develop Asian dental support workforce to implement the infant fluoride varnish campaign to priority Asian populations.	Asian dental support workforce is developed.
3.	Q1-Q4	Dental examinations for high needs Asian infants/children by 1 year of age.	85% of Asian infants/children were examined.
4.	Q1-Q4	Implement Fluoride Varnish Application (FVA) programme and nutritional advice to Asian infants including FVA re-application every 6 months.	FVA programme implemented.
5.	Q4	Establish baseline data of Asian infants/children receiving a clinical dental examination by 1 year of age.	Baseline data of Asian infants/children established.

5.1.2 Immunisations

What are we trying to do?

We want Asian girls and women to be protected against cervical cancer. Screening and immunisation together will offer the most effective protection.

Why is this a priority?

Cervical cancer is caused by certain types of HPV.[21] There is no treatment for persistent HPV infections but immunisation is now available to help protect young women against the two common types of high-risk HPV that cause up to 70 percent of cervical cancer. In 2016, only 61 percent of Asian girls were fully immunised with HPV vaccine.

What will we focus on?

We want to ensure Asian girls and their families are aware of availability of HPV vaccine to support improved uptake of the vaccine.

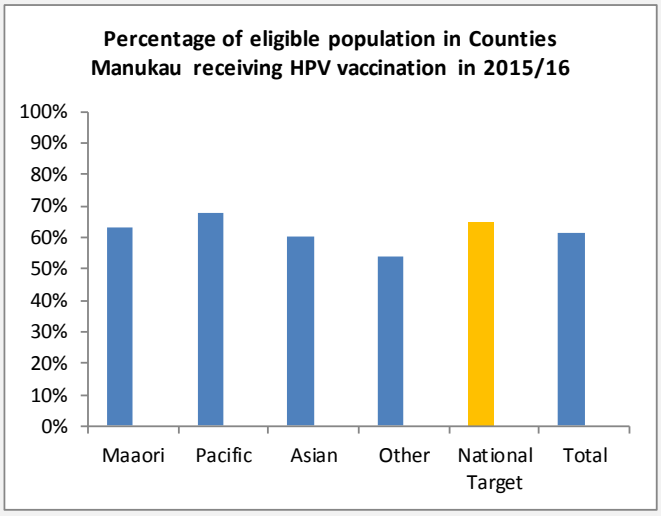
Where do we want to get to?

- 75 percent of eligible Asian girls is fully immunised with HPV vaccine

2015/16 Total	2015/16 European/Other	2015/16 Asian	2017/18 Target
Percentage of eligible girls fully immunised with HPV vaccine			
62%	54%	61%	75%

Baseline data for Quarter 4 2015/16 unless otherwise noted.

Where are we now?



[21] HPV stands for human papillomavirus, a group of very common viruses that infect about four out of five people at some time in their lives. HPV causes cells to grow abnormally, and over time, these abnormalities can lead to cancer.

Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q2	Ensure promotional materials (in priority Asian languages) developed by the Ministry of Health are available for the Asian community and promoted in localities where high number of Asian peoples reside.	Translated materials are available to Asian peoples.
2.	Q1-Q2	Interview parents/families of Asian girls who declined receiving three doses of HPV vaccine to identify the reasons and opportunities to improve.	Asian parents/families are interviewed and a report is documented.
3.	Q3-Q4	Utilise the findings from the Asian parents/families interview and international literature review to develop culturally responsive promotional activities and implementation strategy for Asian community.	Culturally responsive promotional activities implementation strategy for Asian community completed.
4.	Q4	Establish baseline data of eligible Asian boys fully immunised with three doses of HPV vaccine.	Baseline data established.

5.2 Rangatahi - Young People

Good health enables young people to succeed in their studies, opportunities to achieve their dreams and aspirations, and to make meaningful contributions to their families and communities. In CM Health, we are committed to supporting young people living in Counties Manukau to be healthy, feeling safe and supported. Our young people are exposed to risk factors for adult diseases that are potentially avoidable. In 2017/18, our action focus for Asian young people is on improved access to sexual and reproductive health and oral health, and mental health and addictions services.

5.2.1 Sexual and reproductive health

What are we trying to do?

To identify and address the barriers preventing access to family planning and sexual health care in our young Asian population.

Why is this a priority?

Sexual and reproductive health is a taboo subject among many Asian cultures. Embarrassment, stigma, shame and confidentiality issues are often barriers preventing Asian young people accessing to sexual and reproductive health services. Evidence has shown Chinese and Indian youth underuse of contraception, and high rate of pregnancy termination among Asian students[22].

What will we focus on?

Better understand the current service needs of young Asian people under 22 years of age with a focus on sexual and reproductive health.

Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q4	Identify sexual health education needs of Asian young people.	Asian young people are engaged.
2.	Q1-Q4	Identify youth sexual health training needs of school nurses and counsellors.	Training needs defined.
3.	Q1-Q4	Develop a promotion plan to promote free 'walk-in' sexual health service offered at specific GP clinics in Eastern locality to Asian young people in particular Chinese and Indian youth.	Promotion plan developed.
4.	Q1-Q4	Develop a free sexual health service referral pathway in Eastern Locality.	Referral pathway developed.
5.	Q4	Establish 2016/17 baseline data of Asian young people (under 22 years) accessed free 'walk-in' sexual health service in Eastern Locality (via adolescent sexual health template).	5 percent increase of Asian young people (under 22 years) accessed free 'walk-in' sexual health service in Eastern Locality.
6.	Q4	Establish baseline data of termination referral rates (public and private) among Asian young people (under 22 years) domiciled in the Eastern locality.	Baseline data completed.
7.	Q4	Establish baseline data of Asian young people (under 22 years) accessed to long acting reversible contraception.	Baseline data completed.

[22]Mehta, Health Needs Assessment of Asian people living in the Auckland Region, 110.

5.2.2 Oral health in young people

What are we trying to do?

We want Asian adolescents to be free of avoidable dental pain and disease and to have positive dental self-esteem.

Why is this a priority?

Low utilisation of DHB funded dental services by Asian adolescents.

What will we focus on?

Promote free dental services among Asian young people and establish baseline data for Asian adolescent access to DHB funded dental services.

Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q4	Develop a promotion plan for free dental services to Asian young people; in particular, Chinese and Indian young people.	Promotion plan developed.
2.	Q4	Establish baseline data among Asian adolescents in school year 9 (13/14 years), up to and including 17 years of age utilised DHB funded dental services.	Baseline data established.

5.2.3 Mental Health and Addictions

What are we trying to do?

Improve the wellbeing of Asian young people through earlier intervention and access to integrated mental health and additions (MH&A) care.

Why is this a priority?

Asian people have disproportionately lower access rates to mental health and addictions services compared to other ethnic groups. Of all young people (12 – 19 years) who accessed mental health brief interventions in 2015/16, 10 percent were Asian compared to 29 percent European/Other.

What will we focus on?

Improving engagement with Asian young people who access primary care. Providing integrated care at each of the four geographic localities in the Counties Manukau District.

Ref.	Timing	What are we going to do?	Measures/Milestones
Primary Care Services			
1.	Q1-Q4	Engage Asian young people, their families and wider community during the review of the Chronic Care Management Programme for Depression.	Two consultation sessions with Asian community are coordinated.
Secondary Care Services			
2.	Q2-Q4	Develop a data collection framework to enable monitoring and analysis of the health outcomes of Asian young people (12-19 years).	Asian Health Outcome Data Collection Framework proposal is approved.
3.	Q3-Q4	Record Asian young people who utilised direct and indirect integrated consult liaison services and/or integrated specialist episodic care at each of the four localities.	Q3: HCC record of service use. Q4: Automated reports available.

5.3 Pakeke me Whaanau – Adults and Family Group

Adults and older people face different health issues than younger people. Diabetes, heart disease, cancer, smoking and mental health and addictions are some of the conditions adult experienced. In CM Health, we are committed to supporting adults and older people living in Counties Manukau to be healthy, and managing their health conditions. This supports them to look after their loved ones, enjoy lives with them, succeed in careers, and see their grandchildren grow up. In 2017/18, our action focus for Asian adults and family is on the cervical cancer screening, cardiovascular disease management, diabetes management, smoking cessation, immunisations and mental health and addictions.

5.3.1 Cervical cancer screening

What are we trying to do?

Reduce Asian cervical cancer mortality.

Why is this a priority?

Having a smear test every three years is the best way to detect changes to the cells of the cervix that may later lead to cancer. Having regular cervical smears can reduce the risk of developing cancer by about 90 percent. Asian women have a lower coverage rate for cervical screening compared with non-Asian women[23].

What will we focus on?

We will focus on reducing ethnic disparities in the cervical screening rate.

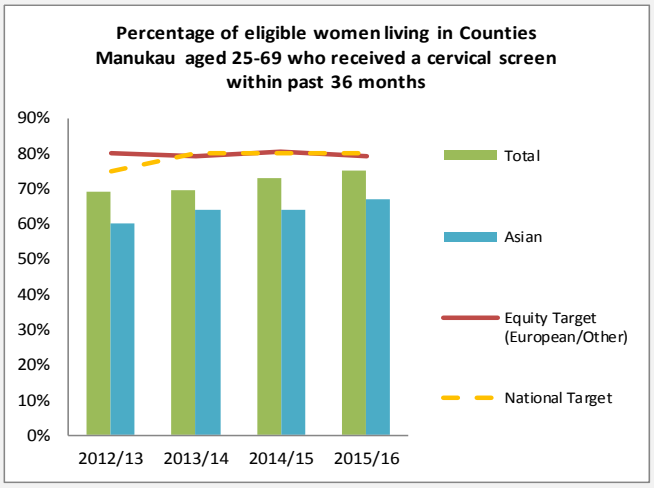
Where do we want to get to?

- 80 percent of eligible Asian women aged 25-69 have received a cervical screen within the past 36 months

2015/16 Total	2015/16 European/Other	2015/16 Asian	2017/18 Target
Percentage of eligible women aged 25-69 years who have had a cervical smear in the past 3 years[24]			
75%	79%	67%	80%

Baseline data for Quarter 4 2015/16 unless otherwise noted.

Where are we now?



Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q4	Primary health organisations to work with CM Health Support to Screening Service to improve access to cervical screening services among Asian women.	Increased percentage of Asian women accessing cervical screening.
2.	Q1-Q4	Primary health organisations and practices implement a range of options to incentivise screening uptake and to improve access to screening. Specific strategies to target and engage Asian women developed.	Mobile and/or satellite clinics, e.g. community sand work place. Text reminders & personalised phone calls sent to Asian women.
3.	Q1-Q4	CM Health Support to Screening Service to assist and support General Practice teams that have high Asian population enrolment with low Asian coverage with smear-taking, recall and invite, and quality improvement systems.	Identified General Practice teams received assistance and support from CM Health Support to Screening Service.

[23]National Screening Unit, https://www.nsu.govt.nz/national-cervical-screening-programme/hpv-and-cervical-cancer/hpv-immunisation-and-vaccines (accessed April 9, 2017).
[24]Ministry of Health, NCSP New Zealand District Health Board Coverage Report: period ending 31 December 2016 (Wellington: MOH 2017).

5.3.2 Long term conditions – cardiovascular disease management

What are we trying to do?

Reduce cardiovascular disease related morbidity and mortality among Indian people.

Why is this a priority?

Cardiovascular disease (CVD) is one of the leading causes of death among Asian peoples. In particular, Indian people have a higher prevalence of risk factors associated with cardiovascular disease, and Indian aged 35 to 74 years had higher CVD hospitalisation rates as compared to the European/Other group in Counties Manukau.[25] CVD related mortality rates were also higher than the European/Other group. Understanding the needs of Indian people with CVD is important for CM Health. This contributes to the Regional System Level Measures Improvement Plan.[26]

What will we focus on?

Identify CVD needs among Indian using data using the existing CVD risk assessment (CVDRA) process and a focus on effective prevention and treatment of their condition.

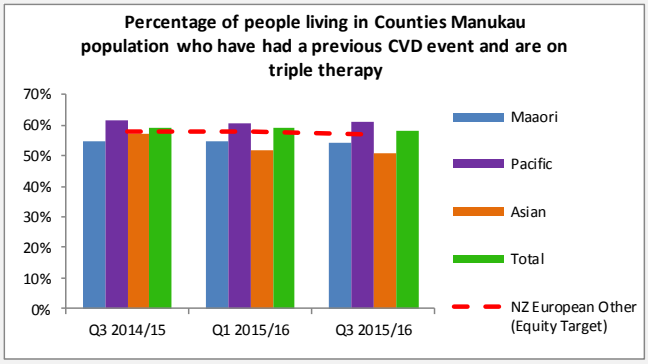
Where do we want to get to?

- 46 percent of Asian patients and 54 percent of Indian patients with CVD risk >20 percent dispensed dual therapy
- 53 percent of Asian patients and 73 percent of Indian patients with prior CVD who are dispensed triple therapy

2015/16 Total	2015/16 European/Other	2015/16 Asian/Indian	2017/18 Target
Percentage of eligible population who have had their cardio-vascular risk assessed in the last five years (as at Q4)			
92%	93%	92% (Asian)	90%
Percentage of patients with CVD risk >20 percent on dual therapy (dispensed)			
49%	44%	43% (Asian) 51% (Indian)	46% (Asian) 54% (Indian)
Percentage of patients with prior CVD who are prescribed triple therapy (dispensed)			
58%	57%	51% (Asian) 69% (Indian)	53% (Asian) 73% (Indian)

Baseline data for dual and triple therapy is for the 12 months ended 30 September 2016 in order to align with the regional 2017/18 Auckland Region System Level Measures Improvement Plan except CVDRA which is as at Quarter 4 2015/16.

Where are we now?



Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1	Implementation of updated CVDRA guidelines to ensure best practice, including lifestyle and exercise guidance.	Maintenance of CVD risk assessment coverage.
			Increase in proportion of eligible people receiving dual therapy.
			Increase in proportion of eligible people receiving triple therapy.
2.	Q1-Q4	Prevention: Ensure data and electronic decision support tools are used appropriately to identify patient who would benefit from CVD risk assessment or advice.	Maintenance of CVD risk assessment coverage.
			Improvement in proportion of patients receiving dual therapy.
3.	Q1-Q4	Primary and Secondary care clinicians will work together in multi-disciplinary teams to manage patients with a >20 percent risk.	Increase in proportion of patients receiving dual therapy.
4.	Q1-Q4	Explore data to identify CVD prevention or management needs among the Indian population.	Needs are explored using available data.

[25] Mehta, Health Needs Assessment of Asian people living in the Auckland Region, 29-41.
[26] 2017/18 Metro AucklandSystem Level Measures (SLM) Improvement Plan. (Auckland, Waitemata & Counties Manukau Health Alliance, 2017).

5.3.3 Long term conditions - diabetes management

What are we trying to do?

Reduce diabetes related morbidity and mortality among Indian people via improved access to quality diabetes care.

Why is this a priority?

Prevalence, morbidity and mortality rates from diabetes are higher for Indian than other groups; therefore targeted initiatives are required to reduce the prevalence of risk factors for the development of diabetes and to improve identification, screening and management of diabetes, particularly to achieve good glycaemic control. Diabetes in pregnancy was also higher among Indian women as compared to European/Other women[27].

What will we focus on?

We will redesign the Diabetes Care Improvement package to focus on those who have poor glycaemic control. Clinical Governance Structures will be implemented with a strong focus on data, reporting and performance.

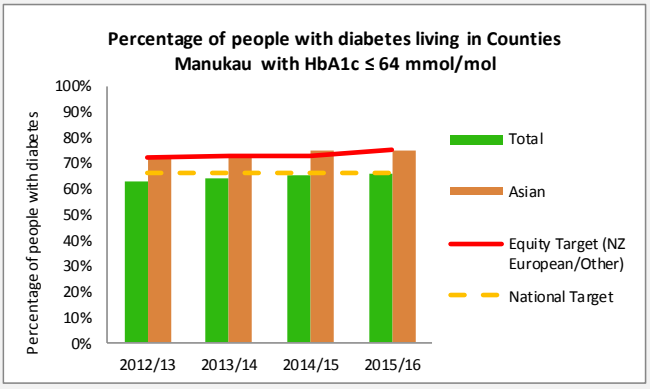
Where do we want to get to?

- 69% of Asian adults with diabetes have an HbA1c less than or equal to 64 mmol/mol

2015/16 Total	2015/16 European/Other	2015/16 Asian	2017/18 Target
Proportion of people with diabetes who have satisfactory or better diabetes management (HbA1c ≤ 64 mmol/mol)			
65%	73%	75%	69%
Percentage of patients with blood pressure measures <140 mmHg			
The baseline and target is in development.			
Percentage of patients are on an ACE inhibitor or Angiotensin Receptor Blocker			
The baseline and target is in development.			

Baseline data for Quarter 4 2015/16.

Where are we now?



Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1	Five diabetes indicators will be reported by ethnicity including establishing baseline measures, so performance can be monitored and analysed with the aim of reducing variation between practices and variation between ethnicities.	Indicators are reported by ethnicity. Baseline measures are established.
2.	Q1-Q4	Practices will work to identify Asian people who have not had a retinal screen, or who are overdue for a retinal screen and ensure they are referred to the service or follow up.	Percentage of Asian people referred to retinal screen, and attended follow up by retinal service.
3.	Q1-Q4	Ensure Asian peoples are accessing podiatry, dietetics and health psychology at the same rates as other ethnicities by providing these services in community based settings.	Percentage of Asian people accessing podiatry, dietetics and health psychology.
4.	Q1-Q4	Asian people with diabetes will be assessed for psychological problems during the Annual Review through the use of the PHQ-2.	Percentage of Asian people assessed using PHQ-2.

[27] Mehta, Health Needs Assessment of Asian people living in the Auckland Region, 42-48.

5.3.4 Mental Health and Addictions

What are we trying to do?

The Mental Health Services Cultural Capability Plan 2016/17 - 2017/18 was developed in alignment to the Healthy Together Strategic Plan 2015 – 2020 and CM Health Mental Health 5 Year Plan.

The Cultural Capability Plan includes initiatives that enable CM Health Mental Health Services to demonstrate cultural capability and to improve the equity and wellbeing of Asian peoples through better access to Mental Health and Addictions Services.

Why is this a priority?

Asian people in Auckland have significantly lower rates of access to mental health services compared to other ethnic groups, despite a high and increasing burden of mental health issues[28].

What will we focus on?

We are focusing on improved cultural engagement with Asian service users and their families as well as improved data collection, monitoring and analysis systems.

Ref.	Timing	What are we going to do?	Measures/Milestones
Primary Care Services			
1.	Q1-Q4	Engage Asian adults, their families and wider community during the review of the Chronic Care Management Programme for Depression.	Two consultation sessions with Asian community are coordinated.
Secondary Care Services			
2.	Q1-Q2	Develop Strategy and proposal to recruit and retain Asian Clinical Cultural Advisors.	Proposal approved for implementation.
3.	Q1-Q2	Cultural input provided for Asian service users and families is recorded in the Health Care Communities (HCC) electronic clinical records.	HCC records and reports Asian cultural input.
4.	Q2-Q4	Develop a data collection framework and proposal to enable monitoring and analysis of the health outcomes of Asian service users.	Proposal approved for implementation.
5.	Q4	Increase Mental Health workforce cultural competencies in working with Asian service users and their families.	50% of Mental Health Services staff completed CALD Cultural Competency Training (Modules 1 & 4).
			20% of Mental Health Services staff completed CALD Cultural Competency Training (Modules 5 & 9).

28 Mehta, Health Needs Assessment of Asian people living in the Auckland Region, 59-63.

5.3.5 Smoking cessation

What are we trying to do?

Asian people who smoke received smoking cessation advice and support; and increase in smokers who successfully quit, and a reduction in smoking prevalence.

Why is this a priority?

Cigarette smoking is a well-recognised risk factor for many health conditions and is a major cause of preventable death in OECD countries. This associated with health conditions such as cardiovascular disease, respiratory conditions and many cancers.

According to Census 2013, an estimated 6,000 people who smoke are Asian and are mostly located in the Eastern Locality. The rate of Asian completing smoking cessation programme was low in particular Chinese men.

What will we focus on?

Establish smokefree champions and utilise language appropriate resource to support smoking cessation. Promotion and education in community, and establish baseline data.

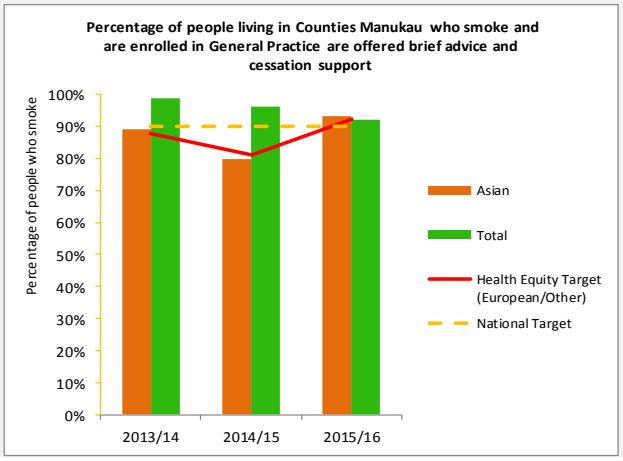
Where do we want to get to?

- 90 percent of Asian people who smoke and are enrolled in General Practice are offered brief advice & cessation support
- 95 percent of Asian People who smoke and are hospitalised are offered brief advice & cessation support

2015/16 Total	2015/16 European/Other	2015/16 Asian	2017/18 Target
Percentage of people who smoke and are enrolled in General Practice are offered brief advice and cessation support			
92%	92%	93%	90%
Percentage of people who smoke and are hospitalised are offered brief advice and cessation support			
96%	96%	94%	95%

Baseline data for Quarter 4 2015/16 unless otherwise noted.

Where are we now?



Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q4	Establish smokefree champions in community settings.	Number of smokefree champions.
2.	Q1-Q4	Develop and deliver Stop Smoking Service by healthcare professionals in identified localities to support Asian people to stop smoking	Healthcare professionals identified, trained and developed to become qualified Stop Smoking Practitioners.
			Asian people who smoke are supported by Stop Smoking Practitioners who are health professionals in identified localities.
3.	Q1-Q4	Trial and evaluate Drop-In Clinic (face to face clinic; one to one or family settling) with a prescribed service specification to include targeted campaigns and approaches for Asian people who smoke.	Drop-In Clinic is trialled and evaluated.
4.	Q1-Q4	Develop a promotion plan targeting Chinese men in Eastern Locality.	Promotion plan developed.
5.	Q1-Q4	Utilise language appropriate resources to support smoking cessation.	Increased language support.
6.	Q1-Q4	Establish smokefree education sessions and awareness sessions e.g. breathing sessions targeting Asian people in Eastern Locality.	Smokefree sessions accessible to Asian people.
7.	Q4	Establish baseline data of four week quit rates among Asian people who smoke.	Baseline data established.
8.	Q4	Establish baseline data of referrals received by Secondary and Primary Care for Asian people who smoke.	Baseline data established.

5.3.6 Immunisation against influenza

What are we trying to do?

Improve number of Asian elderly people and pregnant women received Seasonal Influenza vaccines.

Why is this a priority?

Asian elderly people and pregnant women might not aware they are eligible for free Seasonal Influenza vaccines. They often staying at home looking after infants and children, thus may increase the chances of spreading the flu within family members.

What will we focus on?

Promotion of Seasonal Influenza vaccines among Chinese and Indian elderly and pregnant women.

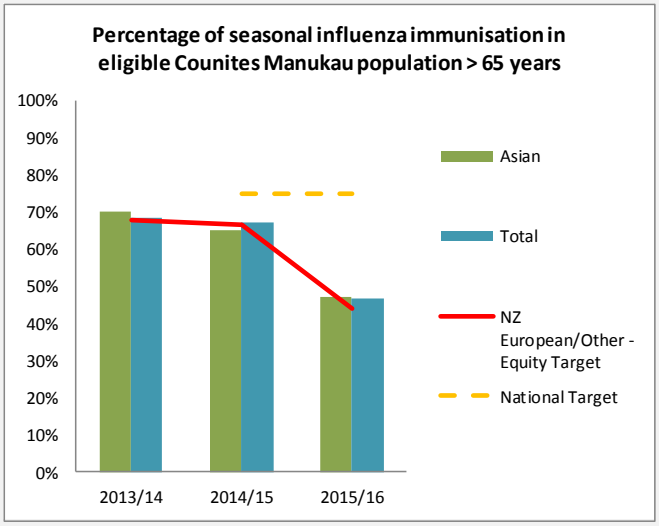
Where do we want to get to?

- 75 percent of the Asian aged over 65 years receive free flu vaccinations

	2015/16 Total	2015/16 European/Other	2015/16 Asian	2017/18 Target
Percentage of people aged over 65 years receive free flu vaccinations				
	47%	44%	47%	75%

Baseline data for Quarter 4 2015/16 unless otherwise noted.

Where are we now?



Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q4	Implementation of targeted communications plan.	Develop promotion materials and these are translated into priority Asian languages. Promotion cards distributed at GP clinics and pharmacies.
2.	Q1-Q4	During flu season ensure that PHOs are actively promoting flu vaccinations and are targeting communications at the eligible 65+ Asian population and pregnant women.	Flu vaccinations are actively promoted to 65+ Asian population and pregnant women.
3.	Q1-Q2	Interview Asian elderly people and pregnant women to identify the reasons they didn't receive Seasonal Influenza vaccines and Boostrix.	Asian elderly people and pregnant women are interviewed and a report is documented.
4.	Q3-Q4	Utilise the findings from the Asian elderly people and pregnant women interview and international literature review to develop culturally responsive promotional activities and implementation strategy for Asian community.	Culturally responsive promotional activities and implementation strategy for Asian community are developed.
5.	Q4	Establish baseline data of pregnant women receiving Seasonal Influenza vaccines and Boostrix.	Baseline data of pregnant women established.

5.4 Te Roopu Whaanui o Counties Manukau - District Wide

There are health systems that are potential barriers to health gain for Asian peoples in our district. In 2017/18, our action focus for district wide service improvement is on regional planning and reporting, community engagement, building culturally responsive services, workforce development, primary care enrolment and refugee health.

5.4.1 Regional Asian health gain planning and reporting

What are we trying to do?

The metropolitan Auckland District Health Boards (DHBs) have a common goal to accelerate health gain in their respective Asian populations. Together, we aim to review and learn from our health gain activities, insights and outcomes so we can benefit from our collective knowledge and relationships with community and health leaders.

Why is this a priority?

There are emerging health inequities for some Asian groups that will need different approaches to make a positive change in health outcomes. Where it is helpful to do so, we need to work together to achieve best value from available resources, experience and skills in the Auckland region.

What will we focus on?

We will focus on priorities alignment and joining up conversations and expertise where appropriate. We will share available Asian health status data; leverage respective Asian health oversight, advisory and governance forums.

Where do we want to get to?

We will translate our conversations and learning to develop a three year Auckland Regional Asian Health Gain Plan.

Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q2	Develop a metropolitan Auckland Asian health equity picture for DHB respective planning, monitoring and governance processes	Developmental Auckland Regional Asian Health Equity Scorecard.
2.	Q1-Q2	Explore potential opportunities for to work regionally to raise Asian health equity awareness.	Regional Asian Health planning approach
3.	Q3-Q4	Prepare an Asian Health Outcomes Benchmarking report to complement the Waitemata DHB and Auckland DHB 2017 report	Benchmarking report
4.	Q3-Q4	Conduct an Asian Health Gain Workshop to identify health gain priorities that would benefit most from future regional collaboration.	Regional Asian Health Gain workshop
5.	Q3-Q4	Develop a Metropolitan Auckland Asian Health Gain Plan 2018-2020.	Draft plan for respective DHB Board review by May 2018.

5.4.2 Community engagement

What are we trying to do?

Develop opportunities for the Asian community and CM Health services to mutually engage with each other.

Why is this a priority?

To increase health system capacity to address the growing needs of Asian peoples and to contribute to achieving the CM Health's strategic goal of achieving health equity for population with health disparities.

What will we focus on?

Develop strategies to engage better with the Counties Manukau community of Asian people with a research focus on the diverse Indian population.

Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q2	Reconfigure existing MH&A service development and intersectoral forums to include broader wellbeing approaches.	Redesigned Asian advisory network established.

5.4.3 Building culturally responsive service

What are we trying to do?

Improve Asian peoples with limited English proficiency access to CM Health services.

Why is this a priority?

Research found that people with limited English proficiency are less likely to receive the care they need, more likely to have a poorer understanding of the care they have received, and are less satisfied with their communication with health care providers.

What will we focus on?

Determine language needs and to provide translated resources in high needs areas.

Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q4	Analyse CM Health service access by Asian sub ethnicity within available data sets.	Analysis completed.
2.	Q1-Q4	Analyse CM Health Interpreter and Translation Service utilisation by ethnicity.	Analysis completed.
3.	Q1-Q4	Translate three priority information resources into major Asian languages with appropriate cultural context.	Priority information resources are translated.
4.	Q1-Q2	Establish an intersectoral Asian Research Advisory Team to guide development of a research proposal to better understand the health service needs and opportunities to improve experience of health services.	Research proposal completed and tabled with the CM Health Alliance Leadership and Executive Leadership Teams endorsement to implement.
5.	Q3-Q4	Develop a proposal to better understand of health service satisfaction and patient experience among Asian peoples.	Report findings utilised used for service improvement approaches.

5.4.4 Workforce development

What are we trying to do?

Build workforce capability and confidence to work cross culturally to respond to the health needs of the Culturally and Linguistically Diverse (CALD) Asian population living in Counties Manukau.

Why is this a priority?

Improving cultural awareness, knowledge and skills of workforce can help reduce miscommunication, misdiagnosis and non-compliance with treatment and improve service responsiveness.

What will we focus on?

Accuracy of CALD training enrolment records and baseline of CALD training completion rate.

Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q2	Ensure staff enrolled with CALD training are accurately captured in the most appropriate system.	More accurate record of staff completed CALD training.
2.	Q4	Establish baseline CALD training staff completion rate by service and by professions.	Baseline established.

5.4.5 Refugee health

What are we trying to do?

Improve access to and utilisation of primary health services (this is a free or with a small co-payment service) for our refugee families by providing early opportunities for interventions that are culturally and linguistically responsive.

Why is this a priority?

Refugee families have low access to and utilisation of health services.

What will we focus on?

Promote primary care services among refugee communities, improve cultural competence among primary care practices and to promote the use of Primary Health Interpreting Services (PHI Services).

Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q4	Raise awareness within the Refugee communities of the services available through primary care for refugees.	Increase in number of Refugees enrolled with refugee primary care services in CM Health.
2.	Q1-Q4	Work with other stakeholders to increase access to and uptake of the services amongst the eligible refugee populations.	
3.	Q1-Q4	Encourage and promote CALD training with the participating practices of this service.	Increase the number of practices staff attending CALD3 'Working with Refugees' training module.
4.	Q1-Q4	Encourage and promote the use of the Primary Health Interpreting Services (PHI Services).	Increased Practices offering this service to refugee families.

5.4.6 Primary care enrolment

What are we trying to do?

Improve access to primary health care services, to improve Asian health outcomes and reduce health inequities.

Why is this a priority?

PHO enrolment is considered an important indicator of good access to primary health care services.

What will we focus on?

Promote PHO enrolment among Asian peoples.

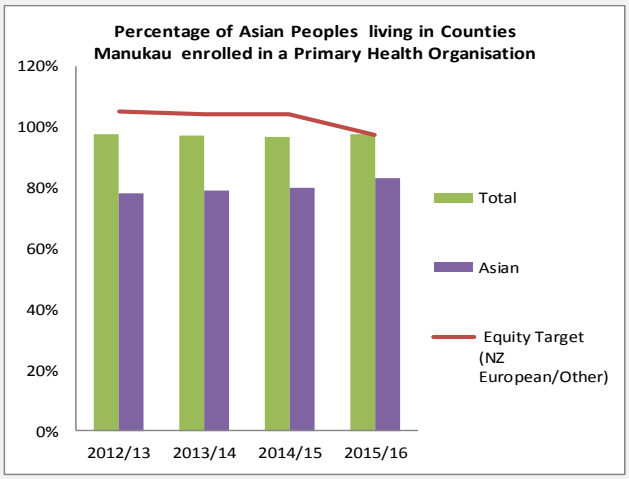
Where do we want to get to?

- 95 percent of Asian peoples are enrolled in a PHO

2015/16 Total	2015/16 European/Other	2015/16 Asian	2017/18 Target
Percentage of Asian enrolled in a PHO			
98%	97%	83%	95%

Baseline data for Quarter 4 2015/16 unless otherwise noted.

Where are we now?



Ref.	Timing	What are we going to do?	Measures/Milestones
1.	Q1-Q4	Promote PHO enrolment among Asian peoples via networks, events, social media and existing translated resources e.g. http://www.yourlocaldoctor.co.nz/ developed by Auckland DHB.	Percentage of Asian enrolled in a PHO is increased.

6.0 Appendices

6.1 Glossary

Term	Definition
CALD	Culturally and Linguistically Diverse
CH Health	Counties Manukau Health
CVD	Cardiovascular disease
CVDRA	Cardiovascular disease Cardiovascular disease risk assessment
DHB	District Health Board
DMFT	Measure of oral health (Decayed/Missing/Filled/Teeth)
FVA	Fluoride varnish application for teeth (in pre-school aged children)
GP	General Practitioner
Hb1Ac	Measure of blood sugar levels
HCC	Health Care Communities electronic clinical records
HPV	Human papilloma virus
Maatua	Parents (plural)
MELAA	Middle Eastern, Latin American or African
MH&A	Mental health and addictions services
NGO	Non-government organisation
OECD	Organisation for Economic Co-operation and Development
Pakeke	Adults
PAHIG	Pan Asian Health Interest Group
Pepi	Babies and infants
PHI Services	Primary Health Interpreting Services
PHO	Primary health organisation
PHQ-2	Patient Health Questionnaire
Rangatahi	Young people
SLM	System level measure (national set of six health indicators)
Tamariki	Children
Te Roopu Whaanui o Counties Manukau	Counties Manukau district wide (action focus)
Whaanau	Family group

Spelling and writing Maaori in Counties Manukau Health documents

Counties Manukau Health respect and acknowledge the variation between Māori dialects in New Zealand. We seek to follow the Tainui kawa (marae) protocol spelling for CM Health published documentation and communications.

The key dialect differences relate to **double vowel spelling**, e.g. whaanau that is reflected by a macron (whānau) in other districts.

6.2 References

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