Health Impact Assessment of the Cultural and Clinical Nursing Support and Training Programme

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She also commented “The development of nurse practitioners acknowledges nursing acceptance not just of primary health care responsibilities but also the need to develop seamless services which follow patients and populations groups across the primary/secondary interface.

Carryer went on to note that systems at that time had resulted in significant levels of nursing expertise and service being located outside the general practice setting with many in the secondary sector. Carryer considered the secondary sector had maintained some investment in nursing education in the specialist nursing caring for people with long term conditions but that this remained a barrier to developing an integrated health service being delivered in primary care.

Boyd (2006) reported that primary care nurses working with patients with long-term conditions using the Care Plus scheme considered there to be a need for workforce development. Boyd reported that there is poor workforce development for nurses providing chronic illness care and that many nurses do not have the time or financial resources to attend formal post graduate study in part due to the small business model in primary health care and the lack of education funding available. The nurses said very few practice nurses have had specific education in chronic illness care, self management skills, motivational interviewing and effective goal setting concepts.

These primary care nurses suggested education be coordinated, in module form and provided via distance learning mechanisms such as on-line learning, by DVD and other different education delivery methods (modularised education and internet based education that can be delivered by distance learning). They also recommended the development of centres of excellence which could act as core training centres.

International Literature

Learning to work in teams

Humphris et al. (2007) discussed the need for inter-professional learning for collaboration in primary care. They noted the growing complexity and demand which new frameworks for chronic conditions put on primary care services.

Humphris et al. (2007) said given the often complex needs of individuals with chronic diseases a team based approach to care delivery is seen as the most appropriate approach. This has implications for the way in which health care professionals are provided with opportunities to learn about working in an inter-professional team in the context of a shift from the traditional model of acute hospital inpatient care to a more community based self-care management model of care. In order to be able achieve these models healthcare professionals must develop a capability to work in teams and collaborate.

‘Inter- professional learning’ describes occasions when two or more professionals come together to learn with and from each other with the intention of promoting a collaborative practice. Central to this is the intention to build relations between professionals to enhance the quality and responsiveness of the services they deliver.

Humphris et al. (2007) quoted a study carried out within the National Health Service (NHS) in Britain which showed that effective inter-professional team working can improve communication, cost-effectiveness and efficiency of care and outcomes for people showing that a team makes collaborative work more powerful than working separately. (cited Borrill C, West M, Shapiro D, Rees A (2000) Team working and effectiveness in healthcare, British Journal of Health Care Management 6:364-371)

Humphris et al. commented that the significant challenge is how to create, within the existing and future workforce, the capability to work in multi-professional teams capable of effective collaboration. The development of such capability necessitates changes in how that workforce is prepared. As the demands for services increase so the workforce needs to continue to evolve, new forms of practitioner and new forms of delivery of care are inevitable. Developing capability for multi-professional working is only one means to deliver the end which remains a flexible and responsible workforce.

Community matrons – an example of community clinical nurse experts for patients with long-term conditions

The development of a 'Community Matron' service in the UK has been one of the ways used to develop new methods of care for patients with long term conditions in the community.

Some of the lessons learned in this programme may be useful in the development of the Hawkes Bay model.

Harrison and Lydon (2008) noted that new and effective health services increasingly focus on primary care and extend the support available to the growing and increasingly complex population of clients with long term conditions and chronic ill health. The most at risk patients are the disadvantaged patient groups with poorly controlled long-term conditions and poor access to existing health and social care services, particularly preventive services.

Warrington (UK) developed a 'community matron' service within existing health visiting health visitor and district nursing services. These specialist nursing roles deal with people with long-term conditions. The primary clinical role of the nurses is the care and coordination and case-management of the most complex clients in the vulnerable populations. The role involves close team working with both primary and secondary care colleagues and social care provider agencies to ensure that packages of care are realistic, flexible and meet a patient's overall needs. Health visitors who understand of family dynamics and the impact on the wider health of the family are important partners for the community nurses (who have the clinical skills). Joint working with community nurses and health visitors has been highly effective in addressing the needs of vulnerable families as each has different skills.

Harrison and Lydon (2008) noted a need for both clinical and community skills to achieve self care for patients with long-term conditions. Community nurses have the clinical skills but the strengths of the health visitors lie in their ability to follow-up and engage hard –to-reach clients and use every opportunity to promote health and support self-care.

Harrison and Lydon (2008) also noted that these skills are the foundation of supporting people with long term illnesses and suggested the new community nurses who did not have a background in community nursing would benefit from spending time with the health visiting colleagues, observing the subtle, highly-skilled assessments and client interactions.

Harrison and Lydon (2008) commented 'At the root of reactive clinical care management lies better anticipatory care for clients… an area where health visiting skills are particularly useful." However they also stressed the importance of good clinical care.

"The community matron role is not about hierarchy or the transformation of nurses into pseudo-medics, it is a timely and realistic response to very real patient needs, particularly in vulnerable communities. A background in health visiting has greatly influenced professional practice and encouraged joint learning experiences with colleagues from other disciplines. It is only with teamwork and the sharing of skills and information that clinical care management will be an effective measure for people living with long-term conditions.'

Drennan et al. (2005) have also commented on the development of the role of community nurses noting that many National Health Service hospital trusts and primary care organisations employed hospital nurses, experienced in the care of people with long term conditions, for case management and community nurse roles.

The Drennan et al. (2005) study aimed to identify the key knowledge and support that hospital based nurses, experienced in caring for patients with long term conditions, require working in primary care contexts as community nurses. A key message from the study was that nurses who move from the hospital environment to the community, irrespective of level of clinical expertise, become novice practitioners again. There are four main reasons:

a. The patient is in control of all decisions affecting their health and well being, including their home environment. Assessments, treatment, care and advice giving are continually negotiated acts between the nurse, the patient and their family carers/informal network of support. Achieving positive patient outcomes are therefore reliant on the nurse's ability to establish and maintain a relationship with the patient. This is unlike a hospital where the decision-making is led by professionals, including everything from the ward environment to the timing of treatments.

b. The patients and their carers undertake most of their own health maintenance, treatment and care activities. The nursing contribution is a small part of the overall patient's daily experience. This is in contrast to the hospital environment.

c. The multiple systems and infrastructures that support the delivery of health and social care vary between local areas. This is unlike a hospital with a single system and infrastructure.

d. The nurse has to make clinical and professional decisions, sometimes rapidly in less than ideal circumstances, at a physical distance from professional colleagues.

The study findings suggested two elements were necessary for the successful transition for the nurses and safe and effective services for their patients/clients:

- Ensure there is a range **of mechanisms for supported learning** for nurses to - progress from novice to an expert practitioner working in primary care without - compromising the patient, the care network or the nurse. -
- Ensure that there is **overt support and recognition from stakeholders** within the organisation and across the local network of health and social care for both the new role and the new to primary care nurse.

The authors also recommended the nurses;

- work with role models and practice educators
- have access to expert mentors with different skills and knowledge and possibly an - expert resource group -
- use clinical supervision activities with mentors
- have a 'buddy' or peer to have daily de-briefing
- have the opportunity for case review and discussion with an experienced mentor with a high level of frequency in the early stages

Bowler (2006) noted the long-term conditions team and specialist nurses provided the training and clinical supervision for community nurses.

Whānau Ora Appropriate Care and Health Outcomes for Māori

There is a large body of literature which comments on health inequalities in the Māori population which identifies a lack of access to culturally acceptable health care services as one of the barriers to health. However there does not appear to yet be research which measures the health outcomes of services which are considered to be culturally appropriate. Ellison-Loschmann and Pearce (2006) commented that while it is too soon to assess the effects Māori provider organisations have on the health status of Māori it is clear that health service provision with little Māori participation results in poor Māori outcomes.

CBG Research (2009) in an evaluation of the Māori Provider Development Scheme noted that there was not a method in place to measure the outcomes of the services provided. Presently only changes in capacity and capability are measured. Janssen (2008) also noted there is little research on Māori health provider outcomes. Wilson (2008) researched Māori women's perceptions of health and their interactions with mainstream health care noting that there was a paucity of research in this area.

However anecdotal evidence suggests Māori are more responsive to care provided 'by Māori for Māori ' and there is evidence that mainstream services fail to meet Māori health needs because they fail to take account of Māori health beliefs and practices and perhaps more importantly treat the patient and the illness individually without consideration of the "whole" person and their wellbeing in the context of the whānau.

Meeting the needs of Māori patients

Maniapoto and Gribben (2003) in an evaluation of a primary care clinic set up to deliver accessible, culturally acceptable care to Māori living in a high-need area commented. 'One strategy to ensure health services for Māori become more effective is to provide services that are more responsive to the needs and expectations of all Māori, and acknowledge traditional Māori models of health. Implicit in these traditional models of healthcare is the traditional practice of 'Tikanga' (Māori customs), which are acceptable to many Māori consumers of Māori health services. Whilst Māori and non- Māori live side by side, they do not always share the same environments or the same narratives, nor do they subscribe to identical values or aspirations.'

The researchers said their qualitative research confirmed the reason for the rapid growth and acceptance of the service by Māori was a large degree of cultural acceptance by Māori of a service that met their diverse needs. In addition the location of the facility was critical for

Māori, as it was easy for people without transport to get to. They identified the main reasons for people accessing this facility were affordability, cultural acceptability and close proximity to where patients' lived.

Maniapoto and Gribben (2003) concluded that 'The added value that 'by Māori for Māori' strategies offer the provision of culturally appropriate models of healthcare delivery. This can be summarised in the following points:

- Tikanga Mo Nga Iwi Me Nga Hapu – appropriate engagement of Māori
- Tino Rangatiratanga – Māori control over healthcare
- Taha Whānau – involving the whānau (family) in healthcare
- Taha Tinana – maintaining physical wellbeing
- Taha Wairua – maintaining spiritual wellbeing

- Taha Hinengaro – maintaining emotional and mental wellbeing

The evaluation found clients of the service reported very high levels of satisfaction with the service in a comprehensive sense and that although the fee levels were important, the overall patient focus of the service was also a major driver of patient satisfaction.

Janssen (2008) carried out a study to explore the effectiveness of a culturally appropriate nurse-led diabetes and heart disease programme for Māori clients. Janssen noted little prior research had looked in-depth into the functioning of small Māori health providers.

Janssen (2008) reported the programme was culturally appropriate, supportive and beneficial to the health objectives. The atmosphere, wellness approach and whanaungatanga in particular, were appreciated by all participants and that the sense of community, which is strongly influenced by Māori values and staff attributes, such as the use of self-deprecating humour were appreciated by the patients. Being part of a community allowed clients to feel safe, to reveal their inadequacies yet remain engaged and supported so they could work on lifestyle change when they felt ready.

Janssen commented that as the study progressed the complexity of clients' health status became apparent. One key revelation was that for several participants diabetes proved to be the least of their problems as the impact of their other co-morbidities became apparent. The study reinforced the importance of continuing with Māori service provision. It affirmed the objectives of rangatiratanga in allowing Māori to determine what services are most appropriate for their people. The study demonstrated the effectiveness and commitment of Māori nurse-led health services and underlined the importance of continuing Māori health workforce development, because Māori clients do have a unique understanding and rapport with Māori health staff.

Barriers to care for Māori

Ellison-Loschmann and Pearce (2006) discussed the disparities in health between Māori and non-Māori and identifed a number of complex factors which contribute to this. One of these factors is "access to" and "access through" healthcare. The "access through" concept takes account the quality of the service offered. The barriers to accessing care among Māori included the attitudes of health workers toward Māori, unsatisfactory encounters with professionals and experiences of dispowerment and discrimination. They also commented on evidence which shows that doctors are less likely to advocate for Māori and Māori are less likely to be referred on for secondary treatments.

Rumball-Smith (2009) reviewed the evidence for disparities in the quality of public hospital care for Māori and non-Māori. She noted that though there was very limited evidence, the evidence that was available indicated that Māori received poorer treatment than non-Māori according to standards and clinical need. She noted the need for the development and validation of Māori-specific quality indicators.

Wilson (2008) found Māori women consistently encountered health services and health care providers that were problem focused, who compartmentalised their health issues or problems. This resulted in the women's needs not being recognised and planned interventions being inappropriate. The research reinforced the need for culturally appropriate and acceptable interventions and health care providers are vital to improve access and ongoing care for Māori.

Wilson (2008) observed that when interventions "go wrong" or outcomes are not achieved it is not unusual for patients to be blamed and labeled 'non-compliant' but anecdotally it is the service itself which is failing because it is culturally inappropriate and unacceptable to Māori.

Barton and Wilson (2008) asserted that contemporary nursing practice focuses on illness rather than health, on the individual rather than the whānau and is strongly based on the biomedical model rather than an holistic approach and does not fit with the Māori worldview.

Malony-Moni (2006) commented that engagement must be with the whānau in dealing with health issues, and that failing to do so will not result in better health outcomes.

Māori nursing practice

Simon (2006) in a paper which discussed a programme for training Māori nurses identified five characteristics of Māori nursing practice:

- the promotion of cultural affirmation including cultural awareness and identity
- the support of, and access to, Māori networks
- the adoption of Māori models of health
- the enabling of visibility and pro-activity as Māori nurses
- the validation of Māori nurses as effective health professionals

Simon (2006) recommended for all nursing staff to be alert to:

- the impact of western scientific models on Māori healthcare
- the (often passive) non-acceptance of Māori within mainstream institutions
- the benefits of valuing indigenous nursing programmes

Simon (2006) noted that it is difficult to identify what might constitute Māori nursing practice and to identify Māori nurses and nurse practitioners as 'Māori' refers to an increasingly diverse category of people. She also noted how little nursing literature exists on Māori nursing practice. In part this may be because traditionally Māori practice has been passing information on orally and passing knowledge from one generation to the next. Māori knowledge and practice has remained largely with Māori and is validated within Māori understandings of that knowledge.

With reference to the training of Māori nurses Simon noted that Māori society is diverse and not all Māori have the cultural background or experiences and that it is misleading to presume all Māori will benefit to the same degree from similar cultural input. However with regard to Māori nursing she highlights the importance of Māori models of health because they operate within the cultural context of the whānau and not just illness as is often the case in mainstream health services.

Simon (2006) stressed the need for Kaupapa Māori programs that provide an environment based on Māori cultural values, processes and beliefs to improve Māori health outcomes but notes that the future practice for Māori is not about returning to traditional practice only, rather it is about a blend of contemporary and traditional practice. She also noted that her research among nurses trained through a special Māori nursing programme showed the importance of being able to identify as Māori as well as the use of Māori practices and Māori models of care.

Culturally Specific Nursing Care

McMurray and Param (2008) discussed whether or not, and to what extent, culture-specific care can redress health inequities. They noted that a primary healthcare approach has the ideal framework to focus on equity, access, empowerment and intersectoral partnerships and provide the essential elements for maintaining health. The authors note that many

indigenous people are disadvantaged by the Australian health system and discuss the need for culture –specific care. Their conclusions noted the need for a focus on the breaking down of the power relations which pervade clinical interactions and the need for a partnership approach to providing health care. The partnership approach means that health providers are not always the dominant group and requires decision making to be with rather than for another group. A partnership approach would help ensure the diagnosis and plan for treatment includes culturally embedded input and decision-making in relation to how people maintain their health in the context of relationships with the social and natural environment and the social order. So, health care professionals do not provide culture –specific care rather, through partnerships health professionals work with indigenous people to plan culturally appropriate care which encompasses needs which determine health such as infrastructure, housing, family support within cultural, family and community groups.

Wilson (2008) quoted a number of researchers who have shown nursing is linked to the quality of patient outcomes and that culture and health is a concept established in nursing. She also noted that one of the underlying premises of cultural safety is the recognition that diversity exists not only between cultural groups but also within them. So nurses learning about specific beliefs and practices are unlikely to learn enough to achieve culturally safe nursing practice. She said "the establishment of relationships with clients to elicit the cultural beliefs and practices that need to be respected and integrated into their health experience is essential. Consequently, it is the recipient of nursing care who determines whether a nurse's practice is safe not nurses."

Wilson also noted "Failure to identify key cultural beliefs and practices, or the worldview of health, well being and illness risks providing healthcare that lacks relevance and compromises its efficacy.' She went to say 'Culturally appropriate services are fundamental for improving the access and use of services by Māori women.' However Māori are not a homogenous groups and there is a great diversity of views and practices.

Wilson expressed concern that despite nurses being taught cultural safety they still failed to ascertain the cultural beliefs and practices of the Māori women in the study.

Wilson said "Positive health experiences stem from meaningful partnerships established between nurses and clients, and influence the efficacy of healthcare providers. In such partnerships nurses bring health and illness expertise while Māori women bring the knowledge about their health beliefs and practices and life circumstances."

Achieving Cultural Safety for Nurses

Mixer (2008) in a review of literature on teaching cultural care and ethnonursing asserted that despite many years of research of transcultural nursing knowledge development there remains a lack of formal, integrated culture education in nursing. She said that 'cultural competence' development has been described as a journey rather than a destination and suggests that one does not become culturally competent but constantly works towards 'cultural competence'[8] throughout a professional nursing career. She also noted that simply belonging to a minority group does not make one culturally competent and suggested nursing education research has found that cultural immersion helped personal growth, increased sensitivity to the needs of others and a general expansion of one's worldview and assisted nurses to address a more holistic perspective and cultivate cultural sensitivity and awareness.

Mixer also reported the results of a pilot study which looked at how culture care was taught to student nurses. One of her findings was the importance of mentoring as a means of learning

[8] In New Zealand the term cultural safety is used in preference to cultural competence.

how to “care“. Caring was taught to students through mentoring and role modelling: listening, “being approachable” “checking in”. Mixer also noted that the care was reciprocal and mutual and multidimensional.

Campinha-Bacote (2008) commented that there is generally agreement in the literature that teaching cultural competency should focus on attitudes, skills and knowledge but that “cultural desire” – the motivation of the nurse to want to engage in the process of becoming culturally competent is also necessary. The author asserts that this desire is more likely to be “caught “ rather than “taught” and that there is no consensus on how to teach it but suggests that caring, love, sacrifice, social justice, humility, compassion and sacred encounters are important components of wanting to be culturally sensitive.

Whānau and Patient Centred Nursing Models of Care

Lyford and Cook (2005) described a Kaupapa nursing service at Tauranga Hospital which uses a Whanaungatanga Model of Care to guide nursing practice. The authors noted that Māori are poor users of primary health services, over represented in secondary services and carry a high burden of disease. The authors quoted Durie noting “Health for indigenous people is a multidimensional, temporal way of being and is not necessarily the absence of disease. In the development of health initiatives designed to impact positively on Māori health statistics, this philosophy of wellness and wellbeing must be considered.” The service developed, Te Puna Hauora Kaupapa Māori, offered a range of health services and offered Māori the choice of the Kaupapa service or the mainstream service.

The model is whānau based and it is recognised that whānau involvement is essential in the restoration of health for Māori. Traditional healing methods are offered as a choice and tikanga is used in practice in the unit.

Lyford and Cook (2006) described how two specialist educator positions acknowledge whakapapa and establish links before attempting to commence any education noting that sometimes the first session may be purely introduction and listening. The Kaupapa nurse educators acknowledge how treatment regimes will affect life of the person and not just their condition and education is personalised to the individual’s social context and whānau. Although non-Māori staff are employed the emphasis is on Māori directorship and Whānau centred care. The authors commented on the compartmentalisation of care by different diseases and noted that this results in the fragmentation of care and fails to provide cohesive clinical management.

Lyford and Cook(2006) say the service offers a culturally safe alternative for Māori requiring secondary health care and makes a difference to the health experience of tangata whaiora. The success and strength of the service lies in, among other things, the kinship connections with whānau, hapu, iwi and local Hauora.

Barton and Wilson (2008) noted that Māori centred practice models are not well articulated in the literature but that such a model constructed within the cultural context of a Māori world can provide guidance for working with Māori clients. Te Kapunga Putohe uses the hands to depict a partnership between nursing practice and Māori practices.

Barton and Wilson (2008) cited a number of papers which have identified that Māori experiences of non-Māori doctors have not been positive and have created fear about health services. These have also suggested that holistic healthcare delivered to Māori in a respectful and collaborative manner can impact positively on the health of Māori.

Te Kapunga is an approach to guide nursing practice to focus on developing meaningful relationships with Māori and can aid nurses to keep Māori central to their practice by being guided by Māori values, beliefs and Māori clients and whānau.

In her book Malony-Moni (2006) described her practice as a Māori community nurse and gave many examples of how knowing and observing Māori tikanga achieved positive health outcomes for the individuals and whānau she was treating. She put her success down to the fact that she was Māori, cared about her patients, knew what she was talking about, and that her patients understood what she was saying. She explained her success and nursing method as a synergy of clinical nursing skills and intimacy with tikanga Māori.

She stressed the principles of He Korowai Oranga and noted that the health system should; engage with whānau, rather individuals – to focus on the family's potential, rather than individual's problems; that health and wellness cannot be separated from each other or from the all the issues that confront whānau; recognise that for Māori it is not possible separate wellness from whakapapa, reo, tikanga as all these things create and sustain identity.

Malony-Moni (2006) commented that engagement must be with the whānau in dealing with all these issues, and that failing to do so will not result in better health outcomes. She believes families need to acknowledge their own potential to do things for themselves. She identified the accessibility, affordability and appropriateness of health services as being of vitally importance of Māori health outcomes.

Malony-Moni (2006) described nursing in a kaupapa Māori framework as: being non-judgmental, caring, whānau-oriented, whare and mare –based, empowering clients in managing their health and working with kaumatua and kuia in developing co-ordinated and collaborative care.

Malony-Moni (2006) noted the success of seeing patients in their own environment particularly noting that there is often more than one person in the family with the same problem /illness and that sharing information and education all the whānau together is more effective than education the patients alone. She found in this environment patients frequently shared information with other in the community and marae.

Other success factors in her nursing of Māori included; collaboration and information sharing with other health professionals especially in coordinating care for patients within the hospital system and around discharge planning and care; being able to bridge communications gaps between Māori, community and hospital services and expert clinical skills.

Abbott et al. (2007) described the experience of Aboriginal health workers and general practitioners working together using patient-centred care for chronic disease self-management in an Aboriginal medical service. Aboriginal health workers were trained to work with general practitioners using patient-centred care for chronic disease self-management in an Aboriginal medical service.

Abbott et al. (2007) found that people gave more honest disclosure of their problems with an Aboriginal peer than a doctor and noted that in the trial many patients disclosed valuable information to the Aboriginal Health Workers that they had not previously disclosed to their GPs.

Abbott et al. (2007) Found patient-centred health measures were useful in the clinical setting. The major benefits were in facilitating communication and patient-centred health goals which motivated both workers and patients. The authors noted that much of the literature notes that patient-centred measures are useful for program evaluation and research but clinically their greatest advantage is in improving communication between health care providers and patients. They noted that this is potentially even more valuable when Aboriginal Health Workers administer the measures.

Abbott et al. (2007) found patient-centred measures can be empowering giving patients an opportunity to express their feelings about their healthcare and take the consultation beyond

the model of symptoms and treatments. Multiple, seemingly overwhelming, social and medical problems can paralyse both patients and health workers and make it unclear where to start. Patient-centred care was useful in developing plans based on the patients own priorities. The Aboriginal health workers reported the tools gave a better understanding of the patient problems and barriers to self-care. They also strengthened relationships between Aboriginal health workers, patients and doctors and improved teamwork. The experience was motivating and encouraging for Aboriginal health workers who often provided extensive support, both emotional and practical to patients with high burdens of chronic disease and self-management difficulties.

Appendix D: Work Programme, DHB activities to support Māori providers, 2009/10

*www.moh.govt.nz/moh.nsf/pagesmh/9650/$File/**dhb**-activities.doc*

HAWKES BAY DHB		
Theme	Activity	Specific Action
Funding / Contracting	Contracts	Whānau Ora contracts – Hawkes Bay DHB will work with Māori providers to support delivery of effective health promotion activities. Hawkes Bay DHB will offer health promotion courses through local EIT and through working more collaboratively with Hawkes Bay DHB health promotion advisors
		Tamariki Ora contracts - Hawkes Bay DHB will transition Tamariki Ora to National wellchild framework including support for Māori providers for workforce development and better IT systems reporting
		Hawkes Bay DHB will realign and support more resources to existing Māori provider contracts for greater capacity and delivery of effective ante- and post-natal programmes
Workforce	Implementation of Te Turuki, the Hawkes Bay DHB Māori Workforce Development Plan 2008-11	Hawkes Bay DHB will assist NGOs and Māori providers to develop their own Māori health workforce plans
		As part of retention strategy, Hawkes Bay DHB will identify potential secondment opportunities between NGOs, Māori providers, PHOs and the DHB
		Hawkes Bay DHB will establish an ongoing funding pool to assist Māori provider staff to gain formal qualifications
		Hawkes Bay DHB will support Māori provider training development
		Hawkes Bay DHB will encourage Māori health workers to attend development initiatives already in place
	Mentoring Māori providers to deliver effective population health programmes	Hawkes Bay DHB will support a population health project (HEHA) *Kahungunu Hikoi Whenua*
Other Themes: Specific Health Areas	Reproductive Health	Hawkes Bay DHB will support workforce development with family planning services – providing contraception under standing orders
	Ante and Post-Natal Programmes	Hawkes Bay DHB will realign and support more resources to existing Māori provider contracts to support greater capacity and delivery of effective ante natal and post natal programmes