

Health Promoting Church Programme

*A Pacific approach for delivery of
population health messages*

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**Pacific Islands
Heartbeat
Programme**

Overview

Why the church approach?

Sharing the journey of the 'Health Promoting Church Programme' (HPC)

Is the HPC approach a successful model?



Background

Cardiovascular disease conveys a major burden on Pacific people in NZ.

- Highest death rates from stroke, death rates from coronary heart disease higher than Europeans and non Maori, rates of obesity, diabetes and smoking are also high



Background

- Heart Foundation mission – lead the fight against CVD
- Services for Pacific people focus on addressing the prevalence of smoking, and increasing rates of obesity, through improved nutrition and increased physical activity



Why the Church Approach

Reflecting on the village experience,

- Village structure, leadership and support structures, networks
- Church is the substitute for village life, in NZ
- Church seemed most strategic avenue to reach 84% of Pacific population affiliation



Health Promoting Churches Programme (HPC)

The Heartbeat Pacific Lifestyle Project (HBPLP) sought to capitalise on the this strong foundation with the aim of reaching Pacific people in their own communities with heart health interventions, to help reduce the prevalence of cardiovascular disease.



History

- Project developed and piloted from 2000 to 2002 with two Auckland-based Samoan churches
- Independent evaluation in 2003
- Launched in Auckland 2004 and rolled out under the brand name of 'Health Promoting Churches'
- Extended to Wellington late 2005



HPC Programme

Partnership Programme to facilitate the development and implementation of lifestyle interventions in nutrition, physical activity and smokefree

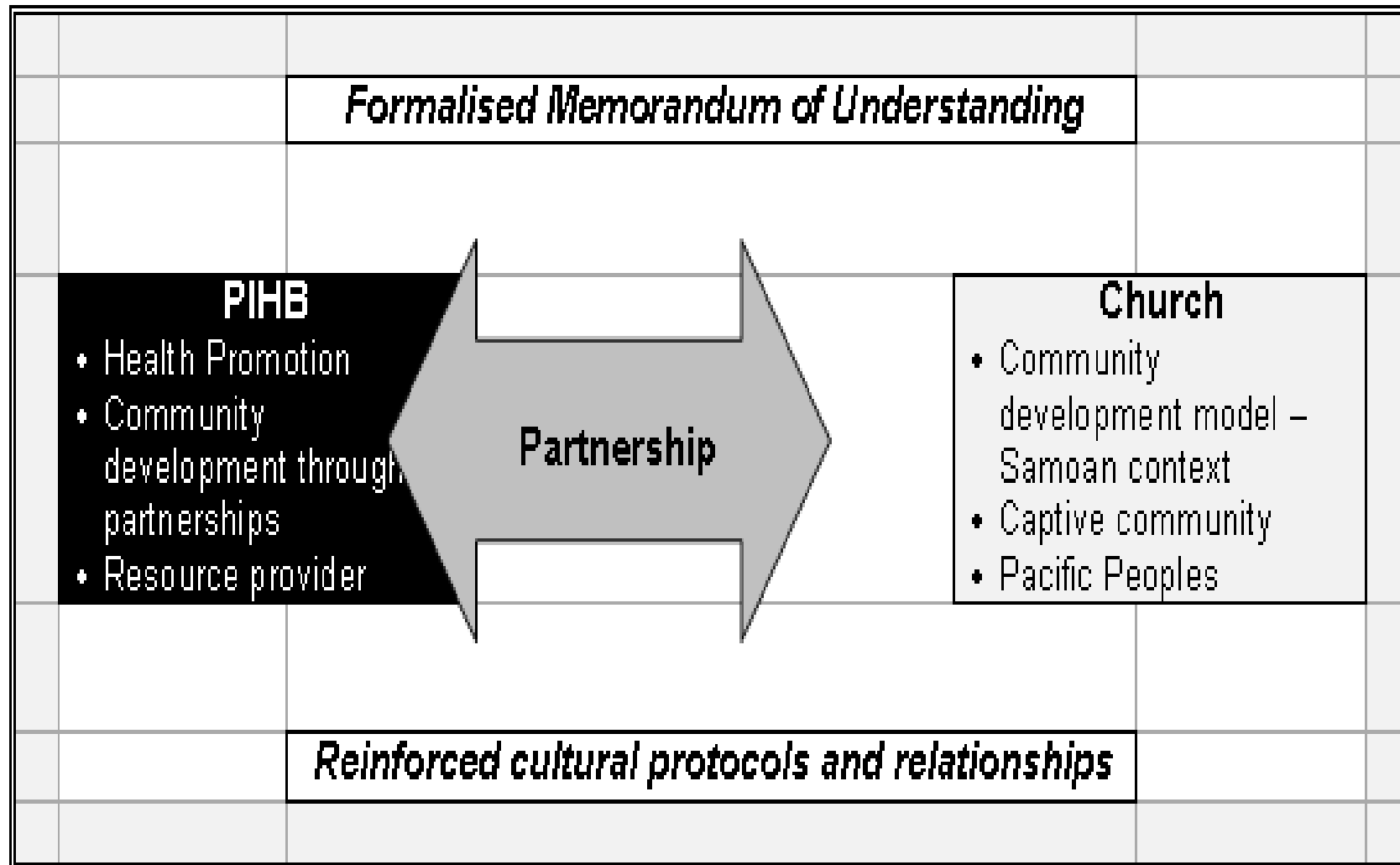


HPC cont'd

- Access to other health services, and social services
- Monetary donation
- Formalised by Memorandum of Understanding
- Church ownership and control



FIGURE 1 RELATIONSHIPS BETWEEN KEY STAKEHOLDER GROUPS IN THE PILOT



Key Stages

- Phase 1 Engagement and relationship building
- Phase 2 Development and of capacity and infrastructure
- Phase 3 Implementation, monitoring and reporting
- Phase 4 Maintenance – relationship and support



Important Learning

- Setting Complexities – engagement can be a challenge
- Relationships as the glue
- Church reality vs health provider expectations
- ‘One size fits all’ approach



Important Learning cont'd

- Leadership change and programme continuity
- Resource constraints a barrier to
- Sustainability and collaboration



Is HPC a Successful Model

- Increased reach to diverse populations - Samoan, Tongan, Cook Islands, Tuvalu, Tokelau
- Increased church participation in capacity and capability building activities
- Positive leadership and role modelling demonstrated by church leaders and elders



Is HPC a Successful Model

- Increased participation in lifestyle interventions reported
- Self reported changes in lifestyle by individuals
- National roll out driven by demand
- Waiting list to join in Auckland and Wellington



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Conclusion

- HPC is showing the church approach to be appropriate and innovative as a 'health promoting' model
- Evidence supportive
- View working with church as **WORK IN PROGRESS**
- Church readiness to engage
- Is the Health Sector ready?

