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The Ola Fa’aautauta Project: the process of developing a church-based health programme

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Abstract

The aim of this paper is to describe the establishment of the Samoan Ola Fa’aautauta Project, its intervention elements and the evaluation processes. The project, a community-based health promotion programme (1995–1997), grew out of an increasing awareness among Pacific health workers and researchers of the burden of non-communicable disease among Pacific communities in New Zealand. A partnership between a University research team and three church communities comprising 1033 people, the Ola Fa’aautauta project aimed to assess the current health of the communities and to measure the impact of nutrition, exercise and educational programmes. Based on a quasi-experimental design, one church (Otarah) received a year of intervention activities while another (Glen Innes) acted as a control. The intervention was then shifted to the second church (Glen Innes). The third church (Glen Eden) received one year of intervention.

The interventions focused on aerobics sessions, nutrition education and diabetes support and education groups. During year one, a total of 170 aerobics sessions were held with an average attendance of 23 people. Two young people from one of the church completed aerobic instructors certificates. Twenty-two small group nutrition education sessions and nine large group sessions were also held during year one. These were based on the Pacific Islands Heartbeat programme and four people from the community were trained as Heartbeat leaders. The diabetes education and support groups proved difficult to initiate and sustain and only twenty-seven diabetes sessions were held during year one.

Evaluation occurred at all stages of the project. An advisory group played a key role in the formative evaluation, ensuring that stakeholders were able to influence the design and implementation of the project. Records of meetings, health surveys, feasts, aerobics classes, money spent and diabetes group meetings were kept throughout the project for ongoing process evaluation. Quantitative and qualitative outcome data were collected to determine the impact of the interventions.

The process of developing and implementing the Ola Fa’aautauta Project contributed much to our knowledge. The importance of influential people playing key roles emerged as a critical factor in the success of the project. Aerobics was a popular and visible aspect of the project and changes in food preparation were evident at church functions.

Introduction

Pacific people living in New Zealand carry a heavy burden of non-communicable diseases, especially coronary heart disease and non-insulin dependent diabetes. A reduction in these diseases can only come about with changes in health-related behaviours, especially through healthy eating, regular physical activity, non-smoking, and responsible alcohol use. Community development projects are an important approach which builds up the knowledge and skills of the community members and reorients the community environment and structures towards health. For Pacific people living in New Zealand, the church is the main centre for the community and is the logical setting for a community intervention project.

The Ola Fa’aautauta Project (Samoan Lifewise Project) is a health promotion programme aimed at healthy eating and regular physical activity within a church-based setting in Auckland. It began in 1994 in one church with another acting as a control church for one year. In the second year, the intervention activities were then taken into the control church and a third church. The aim of this paper is to describe the
establishment of the overall project, its intervention elements and the evaluation processes.

**Origins of the Ola Fa’autata Project**

The stimulus to establish community development programmes in the Pacific communities in Auckland arose from the increasing awareness among Pacific health workers and researchers working in the area of heart disease and diabetes of the large burden of disease and disability among the Pacific communities living in NZ. The Pacific Islands Heartbeat programme of the National Heart Foundation of New Zealand began a community awareness and education programme using small group sessions, pamphlets, videos and radio programmes in 1991. The increased knowledge about diabetes and heart disease, in particular, which arose from these and other programmes was the main stimulus for examining opportunities for interventions.

What was felt to be needed to complement the general and small group education programmes was a more community-centred approach to continue the education but also to try and bring down the culture of healthier living within the church environment and culture. The Ola Fa’autata Project and the South Auckland Diabetes Project started similar church-based health promotion projects at about the same time in a number of churches around Auckland. The pilot studies for the Ola Fa’autata Project took place in 1993. Churches were visited and the concept was put to the minister and elders. Parish sizes were assessed for statistical power calculations and questionnaires were drafted and tested. Following this pilot, funding for the full project was applied for. The study commenced in mid-1994 and there was a delay in enrolling the last church (Glen Eden) because there was no minister for over two years. From the time of the original application for a pilot study to the time of the baseline survey in the last church (Glen Eden) three years had passed – a considerable period of inactivity from the churches point of view.

**Project aims**

The project had two broad aims, one cross-sectional, one longitudinal. The cross-sectional survey was the baseline assessment in all three churches as they entered the study and its aim was to assess health behaviours, nutrition knowledge and the prevalence of risk factors. The aim of the longitudinal aspect was to demonstrate an effect of the church-based interventions and train sufficient people with the skills to continue the project after research funding ceased.

**Project design**

Three Samoan Pacific Islands Presbyterian churches were chosen and the study used a quasi-experimental design with one church serving as a control for one year (Figure 1). Otara church (507 parishioners) had the intervention in year 1 but during year 2 contact was less frequent. The Glen Innes church (339 parishioners) acted as a control for one year and received the intervention in year 2. The Glen Eden church (187 parishioners) received the intervention for year 1 only. An extensive baseline survey was carried out among the adults (20 years) in each church upon entry to the study with shorter questionnaires being used for adolescents and children. Follow up measurements at the end of each year were in adults only and involved a short questionnaire (selected eating habits, health behaviours, nutrition knowledge), anthropometry and blood pressure.

**Structures**

The Research team consisted of a physician/public health specialist (BS), a project coordinator (HA), a PhD student in charge of the qualitative data (CB) and other part-time staff such as a diabetes educator. The Church team consisted of a local committee led, in each of the churches, by the Minister’s wife. She generally worked closely with one or two other local coordinators and also with up to six others. Their involvement was linked to specific project activities such as aerobics classes or health surveys. Glen Eden’s team leader was also the project coordinator (HA). Some funding was available for the church-based projects and the coordinators were paid for a specified number of hours per week. In the early stages of the project, both the Research and Church teams were supported by an advisory group of Pacific health workers and scientists. A sub-committee of the three ministers wives vets all material submitted for publication.

**Intervention activities**

*Physical activity.* Aerobic sessions in the church were initially run by the Pacific Islands Heartbeat programme while aerobic instructors from each church were being trained. The church committees chose candidates for a Polytechnic course in aerobics instruction. The tuition was for 10 days over a four month period and was paid for by the project. The aim was to train two instructors per church. Six people started the course, but only two people from the communities completed the certificate stage. However, the churches proved to be adept at finding instructors from the wider community.
Table 1. Summary of Ola Fa'auta'uta churches and intervention activities*

<table>
<thead>
<tr>
<th></th>
<th>Otara</th>
<th>Glen Innes</th>
<th>Glen Eden</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parishioners</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults</td>
<td>316</td>
<td>187</td>
<td>106</td>
<td>609</td>
</tr>
<tr>
<td>Total</td>
<td>507</td>
<td>339</td>
<td>187</td>
<td>1033</td>
</tr>
<tr>
<td>Aerobics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sessions in 1 year</td>
<td>33</td>
<td>68</td>
<td>69</td>
<td>170</td>
</tr>
<tr>
<td>Mean attendance</td>
<td>16</td>
<td>22</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td>Nutrition education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Small group sessions</td>
<td>4</td>
<td>6</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td>Large group sessions</td>
<td>3</td>
<td>2</td>
<td>4</td>
<td>9</td>
</tr>
<tr>
<td>Diabetes support</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sessions</td>
<td>7</td>
<td>9</td>
<td>11</td>
<td>27</td>
</tr>
</tbody>
</table>

*Otara, Glen Eden activities in year 1, Glen Innes activities in year 2.

The aerobics sessions were popular, but they did require a driver in each community and this worked best in Glen Eden. The number of sessions and mean attendance throughout the year of intervention are shown in Table 1. In the summer, all three churches had informal walking groups operating, generally on a Saturday morning.

**Nutrition education.** The basis for the nutrition intervention was the Pacific Islands Heartbeat nutrition programme. Three people from the churches were trained as Heartbeat Leaders and one team leader had previously been trained. Heartbeat leaders are trained to conduct small group sessions in the community on risk factors for heart disease, healthy eating and cardio-pulmonary resuscitation (CPR). There were two sessions per group, each of two hours duration. Out of the four Heartbeat Leaders, the project coordinator (HA) led the majority of the sessions. The numbers of sessions in each community are shown in Table 1.

Large group sessions included healthy food demonstrations at to'ona'i (feast), cooking demonstrations and healthy eating presentations to large groups. A newsletter (mainly in Samoan) was circulated to all churches once a month via the Sunday service. This usually contained healthy eating information, recipes, nutrition messages, and feedback from the study. In addition, Pacific Islands Heartbeat nutrition resources and videos were widely used.

**Diabetes Support Groups.** These were modelled on the support groups held for European people with diabetes. Altogether there were 59 people with diabetes in the churches (37 at Otara, 11 at Glen Innes, 11 at Glen Eden). Small group meetings were arranged for people with diabetes and their families to discuss topics such as the causes and consequences of diabetes, diabetes and food, exercise, foot care, blood glucose monitoring and nutrition label reading. The low numbers with diabetes and a natural reluctance to talk about their health problems meant that the groups were difficult to sustain. Those who did attend and contribute felt they gained from the process, but they were in the minority. Over time there appeared to be some shift in attitudes towards such groups. Amalgamation with support groups in nearby churches increased the chances of achieving a critical mass and for Otara and Glen Eden, this was improving attendance. Substantial development of this concept will probably be needed if it is to become fully established in the Samoan communities.

**Influencing ministers.** Part of the aims of the project was to get the ministers to reinforce healthy living behaviours in their parish. Ministers play a central role in determining the behaviours of their parishioners and setting the standards for that community. The importance of lifestyle behaviours to the health of the parishioners was discussed with the Ministers and they were encouraged to support the Ola Fa'auta'uta Project. Their wives were instrumental in leading the church team, so they had a close knowledge of the issues and
appropriate health messages. The aim was to blend the programme into church activities, including healthy food choices at church activities and regular messages about fostering physical and spiritual health together.

**Evaluation procedures**

The evaluation of the project used a variety of methods.

**Need assessments.** Needs assessments were conducted as part of the formative evaluation process and this took the form of regular meetings between the relevant groups and also a series of focus groups with community members. The meetings were termed ‘Advisory Group’ meetings and they involved Pacific health professionals from Middlemore Hospital, Pacific Islands Heartbeat, the Health Research Council and the community. Representatives from the South Auckland Diabetes Project were also involved as were representatives from each of the three communities and the research team. This group was responsible for ensuring that the programme was well planned, culturally acceptable and able to achieve its goals. The focus groups were designed to gain further insight from the communities into their priorities for the intervention activities. After several attempts, only one focus group had sufficient numbers to be held. However, informal feedback from the community was sought, and gained, throughout the project to assess the ongoing needs and expectations of the community.

**Process evaluation:** Details of what occurred during the project were documented in a number of ways. Minutes were taken at the Advisory Group meetings and notes were taken at other meetings, conducted before and during the project. These became a diary of events. Records of the staff involved, time spent on various data collection activities, money spent, dates of meetings, health surveys, church feasts, and aerobics training classes were collected and updated.

The intervention activities were also closely documented. At each of the aerobics sessions attendance was documented as were the weights of those attending. The number of nutrition education sessions was recorded at each church along with the number attending. A record was also kept of the number of healthy feasts and associated events each of the churches held.

**Quantitative outcome data:** At baseline and at the end of each year, a church-wide survey was held in each church (i.e. three for Otara and Glen Innes and two for Glen Eden); see Figure 1. The baseline assessments were carried out on all ages with a detailed questionnaire for the adults (20 years and over). This included an 89-item food frequency questionnaire, demographic data, medical history, smoking, alcohol intake, exercise patterns, dietary patterns, knowledge about fat in food, and finally, stage of change questions on reducing dietary fat and reducing weight. Height, weight, waist and hip circumferences and blood pressure were measured and blood was taken for lipids and glucose. Teenagers (10–19 years) were asked about their smoking and alcohol habits and had height, weight and circumferences measured. Children (<10 years) only had height and weight measured. The follow up assessments were with adults only and used a shortened behavioural and knowledge questionnaire along with the anthropometry and blood pressure measurements.

**Qualitative outcomes:** At the end of the intervention programmes, focus groups were held to gain some understanding of how the programme had influenced the attitudes and behaviour of individuals, and the community, relating to healthy lifestyle. Two focus groups were held in each church, one included 20–40 year olds and the other included those over 40 years. In addition, the Minister and his wife from each church were interviewed in depth. The focus groups were conducted by a trained Samoan interviewer and the analysis was done by the interviewer with supervision from an experienced, independent researcher.

**Discussion**

As with all community development projects, the Ola Fa‘auta Project evolved over time to meet the needs of the three different Samoan communities. The original project design was basically adhered to although one church was without a minister for about 2 years which delayed the start in that church. Maintaining relationships between the research
team and the churches throughout this period of preparation and seeking funding (apparent inactivity from the churches’ point of view) were difficult. The difficulty in getting sufficient people for the assessment processes always presented a challenge and scientific considerations had to be tempered with the practicalities of research at the community level. The number of church activities was considerable and kept the community fully occupied so that the project’s activities were always in addition to the busy church schedule.

The role of the Minister’s wives in the project was a significant one. All the Minister’s wives had a pre-existing interest in health and a genuine concern for the well-being of the church members. Their position in the church hierarchy, their significant influence over Ministers and their willingness to work meant that these women became the key players in supporting the health initiatives. However, these health activities became one more thing these busy women had to attend to as many of the other church activities were under their supervision. Having one of the Minister’s wives (HA) as the project coordinator proved to be invaluable for the project. The acceptance and respect from the communities for the position a minister’s wife holds added significant credibility. As project coordinator, with considerable influence over the administrative and financial aspects of the project, she was able to empower the communities and facilitate their ownership of project.

Despite the strong links that existed between the research and Church teams tensions still arose, particularly regarding money. More often than not these grew out of the cumbersome University process of making payments. Tensions were also evident as scientific deadlines and busy church schedules were coordinated. It was here that regular meetings proved their worth as constant communication and negotiation were needed.

The aerobic exercise sessions were probably the most effective of the interventions and were a very positive and visible part of the project. The drop-out rate from the aerobics instructors courses was disappointing and perhaps was due to the pressures placed on these youngsters by more senior members of the church. It was encouraging to see instructors from outside the community come and take the aerobics sessions at minimal cost. Turnouts were high and regular and as the sessions became integrated into the church activities people from the wider community attended at all of the three churches.

Nutrition education was also valuable but far more powerful if combined with a church ‘policy’ for healthy food at church gatherings and feasts. Targeting the nutrition education towards the caterers of church functions and getting the church leaders to lend their support to healthier foods at feasts is likely to lead to the most widespread and long term changes in diet. Over the course of the Ola Fa’aautaua project there were substantial changes in the foods presented at church functions such as more fruit and vegetables, meat dishes with less fat, and smaller quantities. With time, these changes will hopefully filter down to family level.

In terms of influence and sustainability, the diabetes support groups were the least effective of the interventions. As we persisted with the groups a number of barriers became obvious. Firstly, people tended to be very private about their condition and were intimidated by the prospect of having other church members know. Many of those with diabetes were already visiting their family doctor and the advantage of a support group was not seen. The support groups were based on a European model and the groups were the intervention least closely related to church activities.

With relatively few people having diabetes it was difficult to establish a critical mass. The amalgamated support groups appeared to be more successful. In terms of education the support groups were considered very useful by those who came. Education and support was provided on a variety of diabetes related topics, often in Samoan, and most felt their understanding of diabetes had improved considerably.

**Conclusion**

Community-based projects such as the Ola Fa’aautaua Project are very valuable, as much for the process as for the outcomes. Both the research team and the church team learned much in the process of establishing the project in the churches. The main lessons learned were the importance of influential community people and we were fortunate in this regard with the ministers wives being team leaders, one of them being the project coordinator, and in gaining the support of the ministers. Aerobics in the church hall was a very popular and visible aspect of the project, eating habits seemed to be changing and healthy habits were taking root within the church culture.
Acknowledgments

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References


Distribution of food was something Samoans endeavoured to understand because incorrect distribution before matai or guests could be a punishable offence.

A pig roams but is already distributed
A chicken wanders but is already divided
A pigeon soars but is already distributed
A fish swims but is already divided

A. Tolova’a
In Science of Pacific Island People, Volume 2, 1994