FaithAction

The Impact of Faith-Based Organisations on Public Health and Social Capital

A FaithAction review and policy paper

Lucy November, FaithAction, September 2014
Forward by Professor Kevin Fenton, Public Health England

Foreword
Professor Kevin Fenton

We know that the health of our population is affected by, and affects in turn, many aspects of individuals' lives. This much has been demonstrated by Sir Michael Marmot's Independent Review of Health Inequalities in England, Fair Society, Healthy Lives.

Public Health England is committed to improving the health of our population; not just adding years to life, but ensuring higher quality of life is a part of this. Working with people of faith – as a part of our rich and diverse society – is an important part of our agenda. I welcome this report as a contribution to this work, identifying as it does not only key issues but also exemplars of action from which we can learn. FaithAction is one of the Health and Social Care Voluntary Sector Strategic Partners working with the Department of Health, NHS England and Public Health England, and this relationship is already bearing fruit. This report is part of a wider project and is a first, and significant, step to enabling us to seize the public health opportunity of working with faith and faith communities.

This report takes us forward because it highlights the potentially important role that engaging in religious activities and with religious communities can play in health outcomes and the equally important role of faith communities in improving health and especially in reducing health inequalities. The main message of the report is that exploring faith communities as a setting for public health action could be an important means of achieving better health.

This report will help us use the research and experience already in existence to enable faith to be an effective setting for public health interventions, and provide practical tools that are evidence-based and enable both faith communities and public health teams to take appropriate action.

Professor Kevin Fenton
National Director of Health and Wellbeing
Public Health England

Foreword

Daniel Singleton, National Executive Director, FaithAction

FaithAction is a national network of faith and community-based organisations involved in social action. Very often these groups are serving their communities by delivering public services, including health and social care. FaithAction empowers these organisations by offering support, advice and training, equipping them to develop their reach and impact on the communities they serve. We also have a key role in disseminating information, facilitating partnerships, sharing good practice between organisations and between sectors, and acting as a connector between government and grassroots organisations. So on one hand FaithAction mobilises, trains and places people to serve their communities; and on the other it works to highlight the contributions that faith-based organisations are making to their communities up and down the country.

This is important because faith is too significant to ignore. The representation of marginalised communities among faith groups, and the work done by faith groups among such communities, means that faith reaches people and places that nothing else can. Our recent book *Faith with its Sleeves Rolled Up*[1] demonstrated the importance of faith to civil society and that faith community action is money well spent. This new report seeks to do two things: to identify the scientific rationale for faith impact on public health, and to showcase examples of where faith-based action is making a real difference, now. Faith-based action is, can and should be part of the solution, not part of the problem. We hope that this report, and the ongoing work of FaithAction, will demonstrate that.

Daniel Singleton
National Executive Director
FaithAction

[1] Singleton, D. (Ed.), *Faith with its Sleeves Rolled Up*. 2013, Lulu: London

Peer Reviewers' Foreword

As peer reviewers we came together from a variety of perspectives to review this report. What we all have in common as reviewers is public health expertise, experience and commitment; and an interest in the role of faith.

Some of us have live faith connections; some do not. All of us have a shared commitment to evidence-based public health action. And we all agree that while a first step, this report is an important step in building both a research and a policy agenda to demonstrate the importance of faith in the health of our population.

The role of faith in people's health is being elucidated with recent research suggesting that faith can be a protective factor in health behaviours and outcomes as well as a vulnerability factor,[2,3] and that faith communities are potentially important settings[4] for public health interventions[5] because cultural and faith assumptions and conventions are intimately linked with understandings of health, the behaviours and conventions around maintaining good health, and dealing with poor health.[6,7,8,9] This report, while not an exhaustive summary of all this, importantly summarises key evidence, identifies key themes for action by public health agencies and faith communities respectively and together, and provides some important case studies and examples of good practice.

What this report is

This report is part of a wider project that seeks to utilise the research and experience elsewhere to enable faith to be an effective setting for public health interventions, and provide practical tools that are evidence-based and enable both faith communities and public health teams to take appropriate action.

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[2] King, M., L. Marston, S. McManus, T. Brugha, H. Meltzer and P. Bebbington, Religion, spirituality and mental health: results from a national study of English households. *British Journal of Psychiatry*. 2013, 202(1) p. 68-73.

[3] Koenig, H., D. King and E. Carson, *Handbook of Religion and Health.* 2012, New York, NY: Oxford University Press USA. This is perhaps the largest scientific summary text on this and, while important from a scientific standpoint, its ability to shape policy through concrete examples in a UK context is one of the issues which led to this report.

[4] Whitelaw, S., A. Baxendale, C. Bryce, L. MacHardy, I. Young and E. Witney, 'Settings' based health promotion: a review. *Health Promotion International*. 2001, 16(4) p. 339-353.

[5] Campbell, M., M, Hudson, K. Resnicow, N. Blakeney, A. Paxton and M. Baskin, Church-Based Health Promotion Interventions: Evidence and Lessons Learned. *Annual Review of Public Health*. 2007, 28 p. 213-234.

[6] DeHaven, M., I. Hunter, L. Wilder, J. Walton and J. Berry, Health Programs in Faith-Based Organizations: Are They Effective? *American Journal of Public Health*. 2004, 94(6) p. 1030-1036.

[7] Eisenman, D., K. Cordasco, S. Asch, J. Golden and D. Glik, Disaster Planning and Risk Communication With Vulnerable Communities: Lessons From Hurricane Katrina. *American Journal of Public Health*. 2007, 97: Supplement 1, p. S109-S115.

[8] Sternberg, Z., F. Munschauer III, S. Carrow and E. Sternberg, Faith-placed cardiovascular health promotion: a framework for contextual and organizational factors underlying program success. *Health Education Research.* 2007, 22 (5) p. 619-629.

[9] Powell-Wiley, T., K. Banks-Richard, E. Williams-King, L. Tong, C. Ayers, J. de Lemos, N. Gimpel, J. Lee and M. DeHaven, Churches as targets for cardiovascular disease prevention: comparison of genes, nutrition, exercise, wellness and spiritual growth (GoodNEWS) and Dallas County populations. *Journal of Public Health.* 2013, 35(1) p. 99-106.

This report is an attempt, as part of that project, to summarise relevant empirical research on the relationship between faith and health, and on the role of faith communities in improving health and reducing health inequalities, and to provide some examples and themes for action. It is a first step, but recognises that there is already a body of scientific evidence and policy action that can provide lessons for a UK context, and indeed there is much existing action on the ground in the UK.

A number of empirical research projects have quantified a range of impacts of health on faith.[10,11] Many of the practical and policy lessons from this in an English language context have been from the US. This report helpfully identifies both applicable examples from the US and existing examples in the UK across a range of different faiths and socio-demographic settings, all of which demonstrate the potential of faith as a setting for public health.

This report is a first step, or pathfinder, in the conversation between faith communities and public health communities in England. If anything, this report almost underplays the importance of faith-based organisations as a conduit for action, as an important builder of social capital, as providers of charitable assistance for those who need it, and as advocates for a fairer society.

What this report is not

This provides a public health, scientific and policy perspective. It is not intended to provide a guide to religious beliefs about health for health professionals. That has been done elsewhere.[12] Equally, more needs to be said about religion both as a protective and a vulnerability factor in health than can be summarised in this report. Nor is the report a work of theological anthropology or comparative religion looking at beliefs on health. That can be done elsewhere.

Equally the report is not intended to provide a theological perspective from any tradition. There is a flourishing genre of theological literature on health in most faith traditions.[13]

Finally, the report is not intended to be a reflection on why people of faith engage in health work, though the author mentions and recognises that people of faith importantly engage in health work as part of their deeply felt calling to solidarity with people of all faiths and none. To take but one example, Pope Francis said recently that:

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[10] Koenig et al. 2012 (op. cit.)

[11] Cotton, S., K. Zebracki, S. Rosenthal, J. Tsevat and D. Drotar, Religion/spirituality and adolescent health outcomes: a review. *The Journal of Adolescent Health*. 2006, 38(4) p. 472-480.

[12] See for example guidance from the Government of Queensland on Islamic beliefs affecting healthcare, available at www.health.qld.gov.au/multicultural/health_workers/hbook-muslim.asp and this more generic guide www.albertahealthservices.ca/ps-1026227-health-care-religious-beliefs.pdf

[13] From a Christian perspective one of the most insightful in recent years has been Messer, N., *Flourishing: Health, Disease and Bioethics in Theological Perspective*. 2013, Grand Rapids, MI and Cambridge, UK: William B Eerdmans Publishing.

> "*[People of faith's] commitment does not consist exclusively in activities or programmes of promotion and assistance; what the Holy Spirit mobilizes is not an unruly activism, but above all an attentiveness which considers the other "in a certain sense as one with ourselves". This loving attentiveness is the beginning of a true concern for their person which inspires me effectively to seek their good."*[14]

Moving forward

There is much more to be said than this report can encompass, and future work from academics, policymakers, practitioners and local communities can and should build on this. But we hope that this report will encourage faith communities to think both theologically and practically about what they do and what they can do; and encourage public health communities to think scientifically and practically about what they do and what they can do. There is much to be gained.

The Reviewers

Chris Brookes – Director, Global Business Development, UK Health Forum

Chris Brookes has worked in the health field for 15 years, and for the 10 years prior to that worked in development, including leading on statutory donor funding for a major UK development charity. He has extensive experience of project management and design. He leads on health inequalities and EU work in the UKHF, and helps support overall business development, most recently completing a Joint Action with fifteen governments of EU member states and Norway on health inequalities. Previously he was International Project Manager for Health Inequalities in the Department of Health for England. This involved developing policy positions for the Department of Health in relation to the European Union, supporting high-level work and engagement with WHO, and supporting inward and outward missions focusing on health inequalities and action on the social determinants of health.

Helena Korjonen – Director, Research and Information Services, UK Health Forum

Leading on researching information needs and behaviour, optimal dissemination and knowledge translation tools in public health, Helena is also investigating the critical relationship between biodiversity and human health/wellbeing. She has qualifications in information science, human geography, international and environmental studies and a PhD investigating transparency in information dissemination of clinical trials. She is a Fellow of the Royal Geographical Society and a member of the Public Health England content development group.

Jim McManus - Director of Public Health for Hertfordshire

[14] Pope Francis, *Evangelii Gaudium: The Joy of the Gospel*. 2013, available at http://w2.vatican.va/content/francesco/en/apost_exhortations/documents/papa-francesco_esortazione-ap_20131124_evangelii-gaudium.html#The_special_place_of_the_poor_in_God%E2%80%99s_people

Jim McManus is Director of Public Health for Hertfordshire, a Fellow of the Faculty of Public Health, a Chartered Psychologist, Chartered Scientist and Associate Fellow of the British Psychological Society. He holds degrees in theology and psychology. He has been involved in research and policy work on health and faith for some time and is a Visiting Research Fellow at Heythrop College, the specialist theology and philosophy college of the University of London. He co-chairs the British Psychological Society's cross divisional network on applied psychology in public health. He is vice chair of the Health and Social Advisory Group for the Catholic Bishops of England and Wales. He was awarded the Good Samaritan Medal by Pope Benedict XVI for his work on health and health care and is a member of various faith and public health expert advisory groups, including representing the Faculty of Public Health on the health inequalities forum of the Academy of Medical Royal Colleges.

About the author

Lucy November is an independent researcher and public health practitioner, writing and delivering bespoke courses around maternal and public health. A registered midwife, she holds an MSc in Public Health from the London School of Hygiene and Tropical Medicine. Her publications include articles in the *British Journal of Midwifery* and the *British Journal of School Nursing* on changing secondary school students' attitudes to breastfeeding; a book chapter on reducing maternal and infant mortality in Liberia, and an article for the Royal College of Midwives on teaching using drama in Sierra Leone. Lucy spent several years living in Sierra Leone working with ex-combatant children, setting up a schools' health project and developing a training programme for traditional birth attendants and community health workers. She volunteers for a faith-based charity that supports isolated women referred by statutory social and mental health services, where she provides postnatal support for new mothers and has been involved in teaching English to mothers who are speakers of other languages. She is also a trained and registered parent-and-child foster carer.

Acknowledgements

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We are very thankful to Jim McManus, Helena Korjonen and Chris Brookes for their invaluable help in reviewing this document and for their comments and suggestions. Aya Faissal of Faiths Forum For London, Seeta Lakhani of Peepal Care and Sonia Douek of Jewish Care kindly provided guidance on the health-related beliefs of some of the faiths featured. Any errors or omissions are of course our own.

Executive summary and recommendations

The vision of Public Health England in its Outcomes Framework is to "improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest" [1]. Pressing public health problems are never far from the headlines, with rising trends in obesity, diabetes, heart disease and mental ill-health, including dementia, showing no signs of slowing down. The recent positioning of public health within local government has been a welcome step in extending perceptions of what constitutes a health issue, with the wider determinants of health being recognised and represented within the Outcomes Framework: issues such as housing, debt and poverty. It is also being recognised that some health issues are particularly problematic for certain ethnic groups. For example, South Asians have a significantly higher risk of diabetes [2] and an increased risk of cardio-vascular disease [4], while smoking is considerably more prevalent in some ethnic communities than others.

This report focuses on the particular space that faith-based organisations (FBOs) inhabit within the third sector in their potential for helping to address these issues. It first outlines their considerable reach within the population, and the current recognition of that reach within policy. The Outcomes Framework provides a clear mandate for faith groups, as part of the voluntary sector, to recognise their unique position in society and to take seriously their responsibility to contribute to improving public health. However, the extent to which local and national government policy recognises the specific potential of faith groups as partners in improving health and wellbeing varies considerably. While faith groups are mentioned specifically in some places as a link into communities, elsewhere the role of faith is not acknowledged, even where the evidence for its significance – for example in its links with mental health and wellbeing – suggests that it should be.

Two strands of work on public health and faith

The report goes on to highlight key pieces of literature, drawing out and collating what has been learnt from previous work. The evidence is structured into two 'strands'. The first considers diseases associated with lifestyle or behaviours; the second, issues around wellbeing, mental health and social capital. For both of these strands, evidence is reviewed and current examples examined to assess how the unique assets and positioning of faith groups can contribute to fulfilling the vision of reducing health inequalities.

Strand 1 explores the finding that ethnicity is linked to health inequalities and that some ethnicities confer higher risk for certain diseases. When these diseases have a behavioural element, such as dietary, physical exercise, smoking or health-seeking behaviours, it makes sense to target interventions in social and geographical settings which are commonly used by, and familiar to, people of high-risk ethnicities. Language and other barriers can mean that people from certain communities fall outside of the primary health care structure, often

missing out on opportunities for screening or health advice, and thus becoming difficult to access with traditional methods of engagement.

FBOs' involvement in addressing these issues may come about when public health bodies may approach faith leaders to engage their members in activities such as screening or behaviour-modification interventions. Alternatively, informed members of faith communities may highlight a common health need and seek to address this themselves with lay facilitators and, potentially, professional advisors. This gives rise to a useful distinction between faith-*placed* interventions, where the instigator and driver of the intervention is from without, versus faith-*based* interventions, which spring from within the faith community itself [36].

The report identifies a body of literature from the US, including several reviews of many studies, that deals mostly with interventions in Black American churches. The reasons for this are twofold: this group reports high affiliation and attendance at places of worship [37] and, since ethnicity is a strong social determinant of ill-health in the US, interventions that target Black Americans have the potential for reducing health inequalities. The interventions described in this literature are primarily aimed at behaviour change for prevention and management of behaviour-modifiable diseases such as diabetes and cardiovascular diseases, and uptake of screening programmes.

Most UK studies concerning health promotion interventions within minority ethnic groups focus on South Asians for similar reasons. At present, there is a relative paucity of UK-based studies, possibly due to the fact that many South Asians are still first and second generation immigrants, whereas the Black American population is a long-established group in the US. The UK literature therefore deals with individual studies rather than having the benefit of reviews of many studies over time.

Lessons can be learned from both of these bodies of literature, with keys to success being associated with factors such as: careful attention to partnership development and building trust; involving FBOs in recruitment of participants; understanding the cultural and social context of the FBO through research and the involvement of advisors; acknowledging participants' faith position by including religious content and references; interventions that can be delivered at least in part by the community; and incorporating plans for programme sustainability. These lessons are drawn together more fully in our recommendations.

The evidence from Strand 2 around wellbeing, mental health and social capital shows that regular engagement in religious activities is positively related to various aspects of wellbeing, and negatively associated with depressive symptoms [105-115]. There is also evidence to show that volunteering can positively affect the health and wellbeing of volunteers, [117, 118], and that faith communities represent a large proportion of national volunteering [120].

The mechanisms of association between faith and health

The associations between faith and physical and mental health found in the literature seem to operate through three main mechanisms: more healthy behaviours, more social support, and an increased sense of coherence, or meaning [104]. Faith communities also have a number of assets that can be maximised for health interventions, such as buildings in accessible locations; their culture of volunteering; and longevity within communities, with trusted relationships with community members built up over a period of years. Through sharing physical resources, the richness of their connections and networks, their involvement in governance, and their collaborative work with others, they contribute substantial and distinctive social capital [124]. At the same time, it must be acknowledged that there are some undeniable examples of the negative effects of the social capital conferred by faith groups, such as exclusivity or fundamentalism.

Any programmes that seek to take action against socioeconomic inequalities are also likely to have an effect on health and wellbeing. Health outcomes have been shown to be closely linked to factors such as socioeconomic status [35], poverty [127], unemployment [119] and relationship breakdown [130]. There are a wealth of examples of FBOs seeking to address these factors, some of which are highlighted alongside the evidence from Strand 2. There is also a small body of literature that examines the role of religious settings in directly affecting issues of mental health and illness. This recognises the need for more partnership working between FBOs and mental health services.

Faith based, not just faith placed

From the analysis of evidence and practice, the report lays out some recommendations for faith groups themselves and for those in the public health arena responsible for developing and commissioning services. The strong theme throughout is that there is significant gain to be had where organisations work collaboratively together, each maximising their unique contributions.

By working together in genuine collaborative partnerships, where interventions are faith-*based*, not just faith-*placed*, interventions and projects can be developed that work well within the cultural and religious context of 'hard-to-reach' groups. The invaluable assets within FBOs of buildings, volunteers, expertise and the trust of the community will often allow for a much higher impact than when these assets are ignored, the wheel reinvented, and interventions left struggling to be culturally relevant and to recruit participants. Respectful working partnerships that leave organisations richer in knowledge and expertise will be a much more sustainable model than the 'hit and run' approach of some interventions, and will have the potential to leave a lasting legacy for FBOs, health providers and the people they serve.

Summary of recommendations

FBOs should:

- **Review the assets of their organisation**, whether physical or in terms of staff and volunteers. This approach can also foster an environment where those accessing the FBO's projects can also recognise their strengths, skills and ideas, and make a contribution, rather than focusing exclusively on their needs, so challenging a 'dependency culture'.

- **Be proactive in developing relationships with statutory providers**, and emphasise their unique flavour and contribution of assets. Build trusted relationships with professionals, who may also be able to provide training for staff and volunteers.

- **Recognise that they have built up expertise that can be shared**. All relationships across the agencies should be viewed as two-way in terms of referrals and expertise. This will include contributing to the 'faith literacy' of statutory providers. Involvement in governance and taking opportunities to contribute to local decision making are also important means of sharing assets.

- **Evaluate their work**. Despite the wide range of projects being run by FBOs, there is little evidence of effectiveness for these projects. By evaluating a project, the organisation can understand what is working well and what needs to change, and the difference the project makes in real lives; being able to evidence the effectiveness of their work will also open up sources of funding.

As public health bodies seek to engage with diverse communities with diverse needs, it is recommended that they:

- **Become familiar with local FBOs and the work they are doing**. Invariably, faith groups that have been working in an area for some years will have strong and trusted relationships with residents and may be a source of information, expertise or other community assets. These assets may help avoid costly replication of resources, and provide a 'foot in the door' with hard-to-reach groups.

- **Recognise the potential inherent in faith groups as partners in addressing particular health issues** such as diabetes, cardio-vascular disease, obesity and smoking, alongside other community-based interventions.

- **Appreciate that FBOs can provide nuanced insight into the cultural spaces that at-risk groups inhabit**. Accessing this insight through genuine joint working can

avoid common pitfalls and misunderstanding of social norms, being the difference between success and failure for an intervention.

- **Collaborate with faith groups in a participatory fashion**, using formative qualitative research with group members to ensure a programme that is culturally sensitive, with the inclusion of spiritual content alongside traditional health content. Ensuring that a robust evaluation is part of the project, can contribute to the growth of the evidence base.

- **See FBOs that offer support to those who are marginalised as partners**. Many mental health and social care practitioners struggle with the fact that their role is limited by time and professional boundaries; by partnering with FBOs, they can help their clients to access the added value of grassroots support and social connections that is not bound by these constraints.

- **'Leave something behind'** when the project comes to the end of a cycle, or research is completed, by taking opportunities to develop organisational capacity in the FBO, training volunteers, and sharing responsibility for programme development and recruitment of participants. This should include working with the faith groups to ensure financial sustainability after the programme period.

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Introduction

The purpose of this report

This report is the first document of its kind in the UK, bringing together evidence around the reach of faith-based organisations (FBOs) by drawing on published literature. It has come about because, as a network of FBOs, FaithAction is aware that there are many faith groups up and down the country doing health-related work in their communities. However, the value of this work is in danger of not always being recognised, both by the groups themselves and by policymakers, in large part because there is a lack of evidence around what is taking place and its effectiveness.

The challenge can be summed up in three key sets of issues:

- First, while FBOs by no means have universal reach, they do reach communities that do not always benefit from public services. Faith groups therefore need to recognise that this access gives them a role to play in improving health and wellbeing.
- Second, there remains at best uneven recognition within policy that the faith sector has the potential to be an agent for change and a partner in service delivery.
- Third, there is a lack of evidence as to the kind of interventions that might be effective and how these might best be delivered with and through FBOs.

This report is a first step in addressing these issues. It seeks to uncover where there is evidence on the current and potential involvement in public health of FBOs in the United Kingdom, highlighting what works as well as gaps in research and practice; to learn from the evidence of such impacts elsewhere; and to highlight innovative practice that appears to be having an impact. From this, it hopes to understand the current and potential role of FBOs and communities in addressing and preventing poor public health outcomes and supporting other areas of wellbeing. It also makes recommendations for greater collaboration between FBOs and statutory bodies, including the public health system.

As such, the report is designed to be a working document for FBOs and public health bodies. A separate but related strand of work by FaithAction and partners around faith as a setting for public health, articulating the scientific basis for work between faith and health is also underway. Meanwhile, we hope that this report will spark interest and enthusiasm among FBOs as to how they can help to improve health and wellbeing; and that it will support policymakers to broaden their range of approaches, with confidence that there is evidence to support the involvement of faith. We also hope that it will spark further research in order to strengthen the evidence base.

Introduction to the link between faith and public health

The vision of the Public Health England Outcomes Framework is to "improve and protect the nation's health and wellbeing, and improve the health of the poorest fastest" [1]. In this report, that vision is explored through the lens of the diverse faith sector working throughout the UK. Census data from 2011 shows 68% of the population of England and Wales reporting that they belong to a religion.[15] Although religious belief does not necessarily represent active belonging, we estimate (in Chapter 2) that there are potentially over 6 million people attending places of worship every week. This means that FBOs have real potential as settings through and with whom public health issues can be addressed. We also know that, although the boundaries of faith and ethnicity are by no means the same, there are certain health issues that are more prevalent in some ethnic communities, and that FBOs can provide a way of reaching those communities.

Studies that add to the understanding of health-related behaviours are an important part of the work of tackling health inequalities. For example, the Race Relations (Amendment) Act 2000 places a statutory duty on listed public bodies, including public health functions in local authorities and health agencies, to actively promote race equality, including within service delivery. This requires that issues specific to diverse groups be taken into consideration when public health campaigns or services are planned, in order to avoid 'one size fits all' approaches.

Faith groups are, then, a means of accessing diverse communities and so ensuring that services meet real needs. Furthermore, this report argues that FBOs not only engage those in their own communities who might be considered traditionally 'hard to reach', but that in their pursuance of a faith-inspired vision to reach the poorest and most marginalised of UK society, they are at the front line in tackling some of the wider determinants of ill-health and disadvantage which allow for the persistent health inequalities that the framework seeks to address.

Scope of the report

As this report is based on evidence drawn from the literature, it focuses on published descriptions and evaluations of projects, while acknowledging that there exists a significant number of faith-inspired projects around the UK[16] for which there is no published evidence, but whose effects are keenly felt by those with whom they have contact. This report is the

[15] [15] http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/index.html

[16] The Charity Commission estimated in 2009 that there were 30,000 faith-based charities in England and Wales.

beginning of a journey describing in evidence and policy terms the impact of faith and faith based organisations on health, not its fruition. It was not within the scope of this project to undertake a comprehensive, systematic review of all the available literature; nor is it the intention of the report to produce a directory of FBOs and their activities; rather, the report sets out to give a flavour of what is currently happening, to highlight key pieces of evidence and to open up the arena of possibilities for future work and research. For this reason, only a small proportion of organisations will be mentioned or presented as case studies, with a range of faith groups and variety of intervention types being chosen. As a work in progress and aimed at helping action, we look forward to this report being superseded by a growing awareness of the possible and actual work being done across the country.

The report focuses on how FBOs affect mental and physical health through two main strands of action:

Strand 1

- How some faith groups represent communities with particularly poor health outcomes, and so provide a unique opportunity for public health services to access these 'hard to reach' groups. Particular attention will be focused on health promotion activities for diseases related to lifestyle that can be modified by behaviour.

Strand 2

- How the social and spiritual capital gained by belonging to a faith community can in itself confer physical and mental health benefits and mitigate other determinants of poor health. Particular attention will be focused on the health benefits of having social connections, and examples will be drawn from faith-inspired projects that address issues of injustice and poverty, particularly reaching those marginalised by society, and thus having an impact on the wider determinants of health. This has important links to the wellbeing and public mental health agendas, and reinforces the need to regard the human person as a physical, psychological, social and spiritual entity.

This is not to say that these strands describe the *only* ways in which FBOs are likely to affect physical and mental health. For example, this report does not have a specific focus on the charitable actions that many FBOs undertake to relieve poverty or to help those who are homeless, through running food banks, soup kitchens or shelters, acting as Street Pastors or undertaking many other types of care for those most in need. Nor have we focused specifically on the advocacy activities that FBOs undertake on behalf of vulnerable people, whether recently, such as through the campaigns for the 'living wage' and against payday lending, or through the work of long-established faith-based aid organisations working

within the UK and internationally. These areas are, however, likely to provide rich sources of evidence for future 'strands' of research.

Structure and approach

Following this Introduction, **Chapter 2** gives an overview of the significance of faith in the UK, beginning with a picture of the population in England and Wales that professes to hold a religious faith, in terms of its ethnic and age profiles. It goes on to estimate what this means in terms of numbers of people who might be attending places of worship weekly, and thus the potential reach of faith based groups in giving access to different communities. It then considers some of the particular public health problems that are known to be prevalent within different ethnic and faith communities. Finally, the chapter looks at the relationship between government and FBOs, with particular reference to when and how faith is mentioned in a number of health-related documents, strategies and policy initiatives; this will help FBOs to map their activities against health priorities.

Chapter 3 is based on the fact that faith groups do represent many communities with poor health outcomes, who may have unequal access to health provision. Faith groups therefore provide a unique opportunity for public health services to access these 'hard to reach' groups, contributing to fulfilling the outcomes framework vision to "improve the health of the poorest fastest". This chapter summarises some key evidence from Strand 1 around interventions targeted at these groups, based on literature from the US and UK, and with particular attention paid to health promotion activities for diseases related to lifestyle that can be modified by behaviour.

The social and spiritual capital gained by belonging to a faith community can, in itself, confer physical and mental health benefits and mitigate other determinants of health. The evidence for this is summarised in **Chapter 4**, with particular reference to the role of wellbeing. In terms of the activities of FBOs which seek to look beyond the walls of the church, mosque, temple or synagogue into the wider community, particular attention will be focused on how these health benefits can be widened, with examples drawn from faith-inspired projects that address issues of injustice and poverty – especially reaching those marginalised by society – and thus seek to have an impact on the wider determinants of health. The chapter concludes with a set of illustrative case studies.

The final section of the report consists of our **Conclusions and recommendations**, both for FBOs and for public health bodies, on how they might work effectively in partnership to realise the potential for faith groups of improving health and wellbeing.

Methodology and search strategy

The methodology for this report was essentially a literature review of published research, using a variety of search strategies to identify published research. It was peer reviewed by three people, who have written a peer reviewers' foreword, above.

Literature was identified through searches carried out in April-May 2014 using Pubmed, CINAHL, Embase, PsycINFO, and Google Scholar. Search terms included terms for faith (general terms such as 'religion' and 'faith-based organisation', and specific terms for various faiths) across both strands of research, combined with, for strand 1, terms for those diseases associated with lifestyle (diabetes, cardiovascular disease, obesity, coronary heart disease), as well as 'screening'. For strand 2 the terms for faith were combined with terms associated with wider determinants of physical and mental health (mental health, depression, homelessness, refugee, asylum seeker, poverty, social exclusion). While the search focused on literature from the UK, a substantial body of rigorous evidence from the US was uncovered in the course of the searches and it was thought relevant to include this because of the lessons that might be drawn from it.

In addition, a search was made of UK government and NHS publications, particularly focusing on the Department of Health (DH), Department for Communities and Local Government (DCLG) and the National Institute for Health and Care Excellence (NICE). Finally, a further search of 'grey' (unpublished) literature in the form of organisational websites was made for descriptions of projects focused on public health.

Some terms used in this document

Assets
The tangible and non-tangible resources and characteristics that equip FBOs to serve their communities, such as: buildings; volunteers and the time, skills and resources they possess; a culture of giving time to helping others; longevity within the community; and trusted relationships with community members.

Faith / religion
These terms are used interchangeably within the report. However, we tend to prefer the term "faith" where it reflects the beliefs held by an individual or community. When reporting census data we use "religion", as does the census itself.

Hard to reach
We have adopted this widely used term for the sake of convenience – to indicate groups of people whom it might be difficult to approach or influence with the methods traditionally used by public services – while recognising that it is highly problematic. This is so not least because it implies a problem within the group of people themselves, rather than with the methods being used to approach them. For the purposes of this report, the term most

commonly applies to members of ethnic minority communities who might not be accessing health services because of language or cultural barriers or a lack of awareness of what exists. It also applies in this report to anyone who might find information or services hard to access – whether for the reasons as above, or due to other factors such as poor physical or mental health, disability, communication/literacy problems, social isolation, severe deprivation or lack of a fixed address.

Social capital
Broadly speaking, the advantages that come from social connections and networks that might not be experienced by someone living in social isolation. The concept is explored further in Chapter 4.

The UK / England
Health policy in the UK is a devolved matter, and this study focuses primarily on England. However, the different information and data available, and different research studies, refer variously to England, England and Wales, or the whole of the UK. We have tried as far as possible to note which country/ies are being talked about.

1. Context: Faith and Ethnicity in UK Society and Policy

This chapter gives an overview of the significance of faith in the UK, beginning with a picture of the population in England and Wales that professes to hold a religious faith, in terms of its ethnic and age profiles. It goes on to estimate what this means in terms of numbers of people who might be attending places of worship weekly, and thus the potential reach of faith based groups in giving access to different communities. It then considers some of the particular public health problems that are known to be prevalent within different ethnic and faith communities. Finally, this chapter looks at the relationship between government and FBOs, with particular reference to when and how faith is mentioned in a number of health-related documents, strategies and policy initiatives; this will help FBOs to map their activities against health priorities. First, however, it is worth briefly noting the faith groups under consideration here, and how beliefs might relate to health.

The faith groups included in this report are those used in the 2011 census and represented in the published literature:[17] Christianity, Islam, Hinduism, Sikhism, Judaism and Buddhism. We are aware that this has limitations because not every faith community is represented. For example, none of the studies that we identified focused specifically on Buddhism. But it was important to ensure a rigorous and consistent methodology was applied to this initial report.

Although a detailed exposition of the beliefs of each faith relating to aspects of health is beyond the scope of this report, those beliefs found within each faith are likely to affect the health behaviours and attitudes of individuals. This is particularly so in relation to teachings around the need to care for the body, and in the attitudes of the different faiths towards consumption or excessive consumption of food, alcohol and drugs. In addition, wider determinants of health such as social exclusion and poverty are issues that are often addressed directly by the major faiths as part of a broad concern for social justice – for example, in Christian teachings such as "Treat others as you would like to be treated" (Luke 6:31), Sikh teachings such as "A place in God's court can only be attained if we do service to others in this world" (Guru Granth Sahib Ji 26) and the paying of alms (*zakat*) to benefit the poor that is one of the Five Pillars of Islam.

Olivier and Paterson have written elsewhere [142] on the challenges of reviewing the beliefs on health and faith of so many different faith communities. But faith communities do have beliefs on health, illness and wellbeing. For many of these, health is seen in teleological context [143]: Islamic beliefs around health care, for example, arise from a specific Islamic view of what it means to be human.[18] The same is true for Judaism, Christianity and other faiths. These beliefs need to be understood in order for their impact on health, and the

[17] http://www.ons.gov.uk/ons/guide-method/census/2011/census-data/index.html

[18] See for example guidance from the Government of Queensland on Islamic beliefs affecting healthcare, available at http://www.health.qld.gov.au/multicultural/health_workers/hbook-muslim.asp

potential for working with public health agencies, to be fully understood and seized. Health, like all of life for people of faith, is understood not just in functional, but in theological context as one aspect of life in relation to God. Experience in compiling this report shows that recognising this is important for faith communities and public health agencies. The work of Olivier and Paterson [142] is one important example of how the assumptions around health on the part of professionals can instruct or obstruct working together. These theologically and philosophically informed analyses can be profound and helpful for faith communities and health agencies alike. Messer [143] gives an important philosophical and theological critique, for example, of a variety of poorly conceptualised definitions of health.

Religion and ethnicity in the 2011 census

The 2011 census has provided up-to-date data on religion and ethnicity in the UK, with 68% of the population of England and Wales reporting that they belong to a religion.[19] England and Wales were revealed as more ethnically diverse than in previous census years, with more people identifying with minority ethnic groups. Against this population change, religious belief remains important for many people in the population, and these data and the changes that have occurred since 2001 have considerable implications for public health and public health policy in the coming years. The association between ethnicity and health is well recognised, and this report seeks to put the spotlight on faith groups – which often represent particular ethnic communities – not only as foci for growing health disparities, but in order to examine ways in which they can contribute unique solutions to some entrenched public health issues.

In 2011, over nine in ten Christians in England and Wales were White (93%). Muslims were more ethnically diverse: two-thirds of Muslims were from an Asian background and the proportion of Muslims reporting as Black/African/Caribbean/Black British (10%) was similar to those reporting as 'other ethnic group' (11%). The majority of Hindus and Sikhs were from an Asian ethnic background and Buddhists were also ethnically diverse.

Just over half of all Muslims in 2011 were born outside the UK, with these numbers almost doubling since 2001. A similar pattern can be seen for the number of Muslims born in the UK, where there was also a rise of over a half a million from 2001 to 1.2 million in 2011.

Christians had the oldest age profile of the main religious groups in the census, with around a fifth of aged 65 and over. Muslims had the youngest age profile of the main religious groups: nearly half of Muslims were aged under 25 (1.3 million) and nine in ten Muslims (88%) were under 50. Hindus were the least likely of all religious groups to be born in UK (33%), followed by Buddhists (40%) and Muslims (47%); this pattern remains unchanged

[19] It should be noted that the census question on religion is voluntary.

since 2001. Figure 1 below shows the number of adherents to the main religious groups in England and Wales, and Table 1 shows the ethnicities among each religious group, by percentage.

Figure 1 – Percentage of adherents to religious groups in England and Wales (Source: 2011 Census)

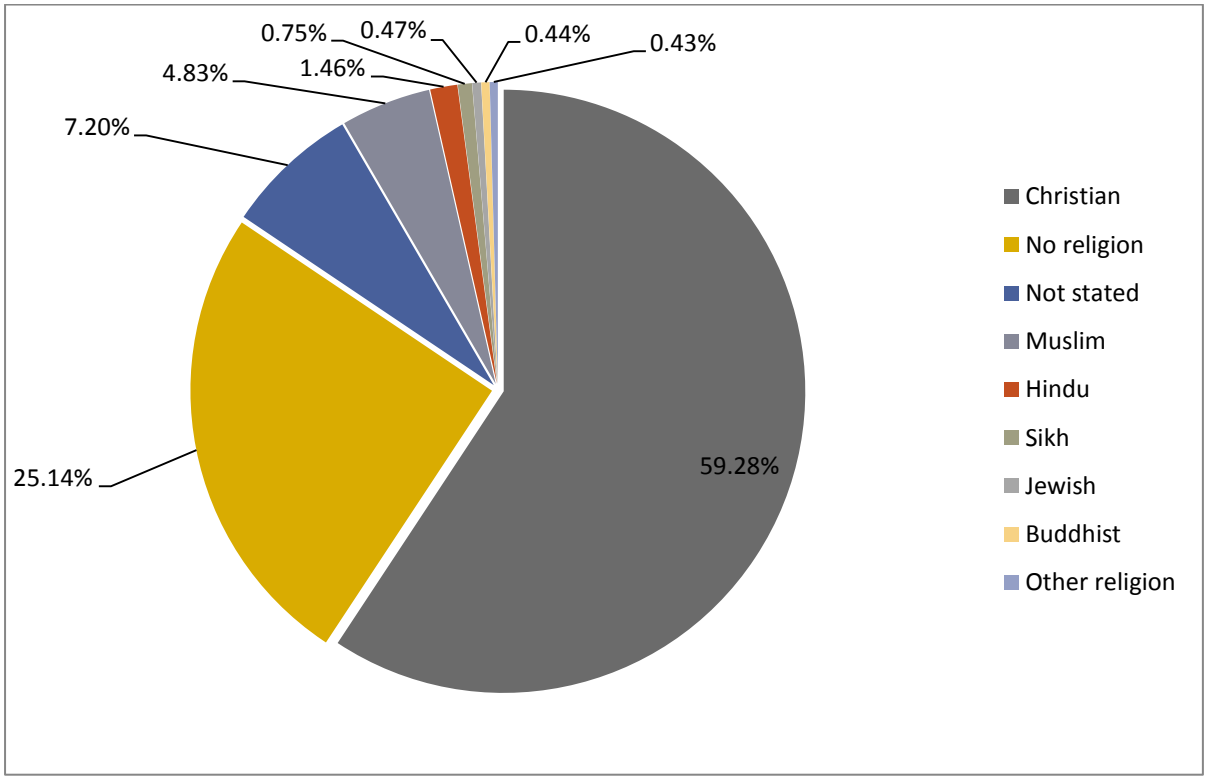

Table 1 – Percentage ethnicities of the main religious groups in England and Wales (Source: 2011 Census)

Main religious groups	**Number of adherents**	**Of whom percentage…**				
		White	Mixed/ multiple ethnic group	Asian/Asian British	Black/African/ Caribbean /Black British	Other
Christian	33,243,175	93%*	2%	1%	4%	0%
Muslim	2,706,066	8%	5%	68%	10%	11%***
Hindu	816,633	1%	1%	96%	1%	1%
Sikh	423,158	2%	1%	87%	0%	10%
Jewish	263,346	92%	2%	1%	1%	4%
Buddhist	247,743	34%	4%	60%**	1%	1%

* 88% are categorised as White British and 5% as Other White. Note that this category will include Christians from areas such as Ireland, Eastern Europe and Latin America.
** 20% are categorised as Chinese, and 38% as Other Asian
*** 7% are categorised as Arab

Religion, ethnicity and attendance at places of worship

Though providing some useful information, self-reported religion is a poor measure of the potential effectiveness of faith settings for public health interventions, since self-reporting a religious affiliation does not necessarily reflect involvement with a faith community or attendance at places of worship (i.e. there is a difference between 'believing' and 'actively belonging'). Data on 'actively belonging' is more difficult to source; however, the Determinants of Adolescent Social Wellbeing and Health (DASH) Study[20] gives some useful information about engagement with faith settings [3]. This longitudinal cohort study of 6500 11 to 13-year-olds in 51 secondary schools in London was designed to examine systematically the influence of social conditions on the health and wellbeing of ethnic minority young people. Of the cohort, 80% were from ethnic minorities. As part of the study, data was collected on weekly attendance at places of worship.

This is useful information because it allows some insight into the potential for reaching different ethnic and religious groups via interventions within faith settings. Table 2 uses the information on self-reported religion from the census alongside the data from the DASH study to estimate the numbers of people from different ethnic groups who may have regular contact with a faith setting. Bringing together data in this way requires caution: for example, it is based on an assumption that religious attendance is similar in all age groups to that in 11 to 13-year-olds, which may not be the case. However, for the purposes of this report, it is helpful in highlighting the importance and potential that religious affiliation may have for some ethnic groups.

Table 2 - Religious affiliation and attendance of main ethnic groups

Ethnicity*	Religious affiliation (2011 census) – percentage	Actual self-reported weekly attendance at place of worship, 11 to 13-yr-olds (DASH study) – percentage	Potential weekly attendance at place of worship (calculated from DASH study) – number
White British	64% Christian 28% No religion	9%	4,338,845

[20] http://dash.sphsu.mrc.ac.uk

Asian/Asian British: Indian	44% Hindu 22% Sikh 13% Christian 14% Muslim	53%	748,868
Asian/Asian British: Pakistani	91% Muslim 2% Christian	69%	775,913
Asian/Asian British: Bangladeshi	90% Muslim 1% Hindu 1% Christian	69%	308,569
African/Caribbean/Black British	69% Christian 15% Muslim	84% of Nigerian and Ghanaian 60% Other African 43% Black Caribbean	Insufficient data to make this estimate

*Sub-groups of the Asian ethnic grouping are shown due to the differences between Asian Indians and other South Asians. These differences were less stark for White and Black British ethnic groupings.

Public health issues faced by different communities

Having established that among some religious and ethnic groups there is a high level of attendance within a faith setting, it is pertinent to ask whether different groups have a tendency towards particular public health issues, whereby the faith setting might lend itself towards health-related interventions. The following table is not exhaustive, but summarises broadly at population level the particular health issues that different communities face.

Table 3 - Public health issues summarised by ethnicity or religion

Community	Public health issues or determinants of ill-health relevant to grouping
South Asians (predominantly Muslim, Hindu and Sikh)	*Cardiovascular disease (CVD)* The increased risk of CVD in the South Asian population is well recognised [4], with various factors given as explanations for this disparity including language barriers and cultural taboos [5]. *Diabetes* Type 2 diabetes is up to six times more common in people of South Asian descent than in the general population [6]. According to the Health Survey for England 2004, doctor diagnosed diabetes is almost four times as prevalent in Bangladeshi men, and almost three times as

prevalent in Pakistani and Indian men, compared with men in the general population. Among women, diabetes is more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and two-and-a-half times as likely in Indian women, compared with women in the general population.

During the month of Ramadan, Muslims are required to abstain from food and drink between dawn and sunset. The Koran exempts those whose health may be significantly affected, including diabetics, pregnant women and breastfeeding mothers. However in a population-based study 43% of patients with type 1 diabetes and 79% of patients with type 2 diabetes report fasting in 13 Islamic countries during Ramadan [7]. The same study showed that fasting during Ramadan significantly increased the risk of severe hypoglycaemia, with its associated health risks.

Smoking

Smoking has a lower prevalence (20%) in Indian men compared with the general population (24%), and a much higher prevalence in Bangladeshi men (40%) [8].

Hypertension

The other notable difference is the prevalence of hypertension, with a significantly higher prevalence in Indian men (33%) than in other South Asians (20% in Pakistanis and 16% in Bangladeshis), though comparable with the general population (32%) [9]. Prevalence for women in all South Asian populations is lower than the general population.

Some Muslim and Jewish communities

Consanguinity

Marriage to a blood relative is common in some Muslim and Jewish communities. This more than doubles the risk of recessively inherited disorders such as congenital deafness [10] and congenital heart disease [11]. However, social and cultural reasons, not religious belief, are behind consanguineous marriage [12], and public understanding of the genetic facts behind consanguineous marriage could be increased through the participation of the media, scholars, physicians, nursing staff and society leaders including religious leaders.

Christians

Because the Christian population is so diverse, generalisations based on ethnicity are less easily made. However, of note is that White Irish men and women, who are overwhelming Catholic, are more likely than any

other ethnic group to drink in excess of government recommended guidelines (58% of men and 37% of women) [13].

The DASH study shows the tendency towards obesity to be higher for Black Africans, especially in adolescent girls [3]. A high proportion of Black Africans report as Christian.

The majority of HIV infections in the UK is among heterosexual Black Africans, many of whom will be church (and to a lesser extent, mosque) attendees.

Men born in the Caribbean are 50% more likely to die of stroke than the general population [14].

Elevated incidence rates of schizophrenia in UK Black Caribbeans have been consistently reported [15].

The relationship between government and FBOs

The relationship between FBOs and government in the UK has taken many turns in the last few decades, but it seems that now, due to a more all-encompassing ethos than might have always been the case in the past, FBOs have a new opportunity to collaborate with government – as public funds have opened up in a new era of 'contracting out' public services. Faith groups are often well poised for this role, as many have won the trust of communities through their longevity and social activity, and tend to have human and material resources that other groups or institutions do not. For faith groups this change has not been without some interesting challenges, since funds come with restrictions and targeted outcomes which may not always be in keeping with an organisation's ethos of serving the most deprived, or of engaging in overtly spiritual service as well as in meeting people's physical needs.

In more recent years, publications such as the evaluation of the Faith Communities Capacity Building Fund [16], which was the first government grant programme aimed specifically at the faith sector, have raised important issues and set out some best practice for partnerships between FBOs and government. Similarly, the 2010 guidance *Ensuring a level playing field: funding faith-based organisations to provide publicly funded services* [17] lays out and 'busts' myths around the funding of FBOs.

Another theme that has been addressed in recent years is the need for higher levels of religious literacy in public sector bodies; this was highlighted, for example, in the DCLG's 2008 *The Government's Response to the Commission on Integration and Cohesion* [18].

Although referring more to the cohesion agenda than a public health agenda, this principle of working more closely for greater mutual understanding could be equally well applied to public health bodies. In fact, a DH guidance document published the following year, *Religion or Belief: A Practical Guide for the NHS* [19], applies this to the health sector, giving practical advice to NHS organisations around compliance with equality legislation, understanding the role of religion or belief in healthcare, and integrating this knowledge into single equality schemes.

Does government recognise the potential for faith groups in public health and wellbeing?

The degree to which government has recognised the potential of faith groups as agents for improved health and wellbeing is varied. For example, the 2009 DH guidance *Faith communities and pandemic flu* [20] shows a strong acknowledgement and awareness by government of the potential influence of faith groups and faith leaders in reinforcing health promotion messages:

"*There are in excess of 11,000 faith leaders in the UK who can coordinate communities and who have experience, expertise and assets which are a valuable resource to the public. In the event of an influenza pandemic, the role of faith communities is likely to be of particular importance.*" (p.5)

However, for other areas of public health there is a less clear message as to the potential for partnership with faith groups and their capacity to reach vulnerable people or contribute to the vision of reducing health inequalities. For example, although the 2011 cross-government Mental Health Strategy *No Health without Mental Health* raises the issue of religion and belief being potential sources of inequality of access for mental health services, there is no reference to faith organisations as potential partners in addressing this. With the well-established recognition by the mental health community of the positive role of spirituality and religion in many people's experience of mental wellbeing [21], one could even suggest that guidance examining the vital role of spiritual health (which for many people is expressed in a faith setting) in contributing to the prevention and recovery from mental illness would be a valid addition to the current guidance; many would argue that there is 'no mental health without spiritual health'.

Other documents do mention faith groups, albeit in a way that is arguably tokenistic [16]. Nevertheless, it is the intention of this report to promote the exploration of these ideas for collaborative working, and Table 4 gives a summary of government publications that refer to faith settings either directly or indirectly as potential partners. This is intended to be a prompt for both FBOs and health commissioners as they consider the development of these reciprocal partnerships.

Table 4 - Government publications encouraging FBOs as partners for public health

Document	**Reference to the activities of FBOs** (**bold** type added)
Lightening the Load: Tackling overweight and obesity (National Heart Forum, 2007) [22]	**Faith groups** listed as partners in preventing overweight and obesity, particularly in: • Engaging local people in healthy lifestyle initiatives • Developing awareness of overweight and obesity and its prevention and management among vulnerable, at-risk communities.
Putting prevention first. Vascular Checks: Risk assessment and management (DH, 2008) [23]	This document states that "[PCTs] *will also understand how best to reach those not in touch with organised health care and so, in some places, will want to look to the third sector (community, voluntary and **faith sector**) to help provide services for these people*"
Faith Communities and Pandemic Flu: Guidance for faith communities and local influenza pandemic committees (DCLG, 2009) [20]	This guidance aims to encourage and support **faith communities** in planning for a human influenza pandemic, covering issues such as mass gatherings, the distribution of antivirals, 'flu friends'.
Health Inequalities National Support Team: A Diagnostic Framework for Addressing Inequalities in Outcome at Population Level from Evidence-based Alcohol Harm Reduction Interventions (DH, 2011) [24]	The document states that "*service links into communities can be superficial, of poor quality, unsystematic, and based on low levels of understanding. Connectivity between services can be disorganised and confusing. Use of the voluntary, community and **faith sector** as a bridge between services and community based structures needs to be more systematic and based on need rather than supply. Commissioning is key to this.*"
Health Inequalities National Support Team Diagnostic Workbook. CANCER: Systematic Delivery of Interventions to Reduce Cancer Mortality and Increase Cancer Survival at Population Level (DH, 2011) [25]	The document states that "*service links into communities can be superficial, of poor quality, unsystematic, and based on low levels of understanding. Connectivity between services can be disorganised and confusing. Use of the voluntary, community and **faith sector** as a bridge between services and community based structures needs to be more systematic and based on need rather than supply. Commissioning is key to this.*"

A Fresh Approach to Drugs. The Final Report of the UK Drug Policy Commission (UK Drug Policy Commission, 2012) [26]	Under the heading 'Stimulating and promoting recovery from drug dependence', the document states "*the role of **faith groups** as partners in drug dependency recovery should be enhanced*".
Let's Get Moving – A physical activity care pathway. Commissioning Guidance (DH, 2012) [27]	This document states that "*it is also intended that LGM could be delivered through other service providers. This may be particularly important to reach groups not registered at a GP surgery who would benefit from this intervention*". Though faith groups are not mentioned, according to the 'Vascular checks' guidance, this is a mandate for **faith groups**.
Wellbeing: Why it matters to health policy (DH, 2014) [28]	Surprisingly, considering the evidence, this document does not directly mention faith groups. However, the following aspects of activity highlighted in the document have very strong resonance with the activities of faith groups: • Identifying local need • Taking a holistic approach • Engaging the target group, understanding the barriers to participants' involvement • Using safe, welcoming and easy to access venues • Project staff who are empathic and enthusiastic • The use of volunteers in projects

The Public Health Outcomes Framework

In England, the Public Health Outcomes Framework, *Healthy lives, healthy people: Improving outcomes and supporting transparency* [1], sets out a vision for public health and the outcomes and indicators for ascertaining how well public health is being improved and protected.

The framework describes two overarching indicators to be achieved across the public health system: increased healthy life expectancy, and reduced inequalities in terms of differences in life expectancy and healthy life expectancy between communities. It groups further indicators into four 'domains' that cover the full spectrum of public health:

- Wider determinants of health (e.g. poverty, school readiness, social isolation, crime)
- Health improvement (e.g. uptake of health screening, falls, obesity, physical activity)
- Health protection (e.g. transmissible disease incidence and vaccination coverage)
- Healthcare and premature mortality (mortality from preventable causes)

The shared responsibility between the statutory and voluntary sector for these outcomes is clearly articulated by the DH in the Introduction to the Framework [29]:

"S*ervices will be planned and delivered in the context of the broader social determinants of health, like poverty, education, housing, employment, crime and pollution. The NHS, social care, the voluntary sector and communities will all work together to make this happen*." (p.1)

This provides a clear mandate for FBOs as part of the voluntary sector to recognise their unique position in society and take this responsibility seriously, seeking partnership and funding to improve public health at its various levels.

The framework has a user-friendly, regularly updated, web-based tool[21] which can be used to map activities against specific public health indicators and allows both faith and health organisations to make a case for their contribution to the health of the community. The tool gives information about how specific areas of the country compare with the benchmark, and so could give faith groups the opportunity to develop innovative solutions to deal with particularly stubborn problems in their local area.

For example, for FBOs that work with those who are socially excluded or in financial crisis, the domain of 'Wider determinants of health', has indicators of loneliness and isolation (1.18), children in poverty (1.01), fuel poverty (1.17), while the 'Health Improvement' domain includes self-reported wellbeing (2.23).

For those who seek to improve the health of their communities through faith-based health promotion interventions, the domain of 'Health Improvement' has indicators around obesity in children (2.06) and adults (2.12), physical activity (2.13), smoking (2.14), diabetes (2.17), cancer screening (2.20) and NHS health checks (2.23), while the 'Health Protection' domain includes vaccination coverage (1.19).

Mental Health Dashboard

The Mental Health Outcomes strategy, *No Health without Mental Health* [30], sets out government priorities for action and improvement at a local level. The Mental Health Dashboard [31] groups indicators into six domains:

- More people have better mental health
- More people with mental health problems will recover
- More people with mental health problems will have better physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

[21] http://www.phoutcomes.info/

The dashboard shows how current results against the indicators compare with those of the previous year; with indicators around issues such as subjective wellbeing, homelessness and poverty, it is a further way of helping FBOs to map their activities within public health policy.

2. FBOs and Public Health Interventions for 'Hard to Reach' Groups – Evidence from Strand 1

The previous chapter considered the landscape of public health as it relates to faith and different faith communities. Many faith groups represent communities with poor health outcomes, who may have unequal access to health provision. Faith groups therefore provide a unique opportunity for public health services to access these 'hard to reach' groups, contributing to fulfilling the outcomes framework vision to "improve the health of the poorest fastest". This chapter summarises some key evidence around interventions targeted at these groups, based on literature from the US and UK, and with particular attention paid to health promotion activities for diseases related to lifestyle that can be modified by behaviour.

Faith communities and behaviour-modifiable diseases

Socioeconomic group and ethnicity are linked to health inequalities and, as we saw in the previous chapter, some ethnicities confer higher risk for certain diseases. When these diseases have a behavioural element, such as dietary, physical exercise, smoking or health-seeking behaviours, it makes sense to target interventions in social and geographical settings which are commonly used by, and familiar to, people of high-risk ethnicities. In addition, language and other barriers can mean that people from certain communities fall outside of the primary health care structure, often missing out on opportunities for screening or health advice, and thus becoming difficult to access with traditional methods of engagement. There is ample evidence of delayed health-seeking behaviour in minority ethnic populations, leading to delayed diagnosis and treatment, and therefore inevitably, increased mortality [32-34]. Communication difficulties and lack of confidence in raising health issues with GPs are significant factors in this, and a clear example of a social determinant of ill-health and increased mortality as described by Marmot in his 2010 report *Fair Society, Healthy Lives* [35].

While ethnicity and faith are by no means coterminous, faith-based communities often include significant numbers of 'hard to reach' individuals, and they therefore provide a possible setting for interventions aimed at behaviour change. This opportunity may not be recognised by faith groups themselves, since risky behaviours may be seen as culturally normal within the community, but public health bodies may approach faith leaders to engage their members in activities such as screening or behaviour-modification interventions. For other faith communities, informed members may highlight a common health need and seek to address this themselves with lay facilitators and advisors. Campbell et al. note this distinction [36], with the notion of faith-*placed* interventions, where the

instigator and driver of the intervention is from without, versus faith-*based* interventions, which spring from within the faith community itself. They also describe a third model of collaborative partnerships between faith and outside groups.

Faith communities have a number of assets that can be maximised for health interventions. They may have buildings in accessible locations; they often have a strong culture of volunteering and an experienced volunteer base; and they tend to have longevity in a community, developing trusted relationships with community members over a period of years – a characteristic that in the current climate is found less often in other institutions such as workplaces.

In terms of the published literature in this area, there is a substantial body of literature from the US that is mostly focused on interventions in Black American churches. For the UK and Europe, the literature is more limited. Studies are of varying quality, ranging from well-resourced randomised control trials (RCTs) and thorough qualitative studies, to studies with less rigorous scientific methodologies or descriptions of processes. The following section provides an overview of these studies, bringing together lessons learned, highlighting common themes for success and identifying some of the common barriers to successful programmes.

The US literature

The literature from the US deals mostly, but not exclusively, with interventions in Black American churches. The reasons for this are twofold: this group reports high affiliation and attendance at places of worship [37] and, since ethnicity is a strong social determinant of ill-health in the US, interventions that target Black Americans have the potential for reducing health inequalities. These interventions are primarily aimed at behaviour change for prevention and management of behaviour-modifiable diseases such as diabetes and cardiovascular diseases, and uptake of screening programmes. Because this body of literature is relatively large, to review each study is beyond the scope of this report. However, there are a number of existing reviews of these interventions, with recommendations for future programme design and evaluation, and these reviews are examined in more detail below. In addition, some examples of current studies with robust study designs are included.

Reviews of interventions in Black American churches, 2004 to 2012

Four reviews carried out over the last ten years are discussed briefly here, with a summary table (Table 5) highlighting the range of interventions reviewed, key findings, lessons learnt from the studies and recommendations from the reviews.

Review of health promoting activity in FBOs

Dehaven and colleagues (2004) carried out a comprehensive review of US-based literature on any health-promoting activity in FBOs from 1990 to 2000 [38].[22] They recommend that attention is paid by public health bodies to establish relationships with faith communities representing underserved populations, leading to collaborative partnerships for health interventions. They emphasise the importance of such partnerships, particularly for evaluating programmes and disseminating findings, and encourage evaluation methods that are sensitive to what is practical in real-life situations, ensuring more realistic replication.

Review of church-based health programmes

In their 2007 systematic review of church-based health programmes, Campbell and colleagues [36][23] stress the need for understanding the cultural/social context of the FBO through extensive formative research and the importance of culturally competent staff; they argue that only by so doing would assumptions of a 'one size fits all' approach be avoided and relationships of trust established. They note that most studies used culturally appropriate material and volunteers from the church community to deliver the intervention, and overall showed evidence of the effectiveness of church-based health programmes.

Based on their review and their own work with FBOs, Campbell et al. propose five key elements that are necessary for creating the conditions in which effective church-based health promotion can be conducted:

- Careful attention to partnership development and building trust
- Involving churches in recruitment of participants
- Efforts to understand the cultural/social context through formative research and involvement of key informants/advisors
- An intervention strategy that incorporates the sociocultural environment and can be delivered at least in part by the community
- Ongoing plans for ensuring programme sustainability (leaving something behind)

Review of church-based health education interventions

In 2009, Thompson and colleagues [39] conducted a review of the literature addressing specifically church-based health education interventions for diabetes and cardiovascular

[22] Of the 58 studies that were eligible for the review, 28 presented outcome measures, and it was found that those that were faith-based (initiated and run by the faith organisation) were less likely to be adequately evaluated or indeed reported at all in the public sphere. The authors acknowledge that the results are subject to publication bias: there are many health-related activities run by faith organisations that are never evaluated or documented; and they stress the need for more rigorous research methods if this model is to be recognised, developed or replicated.

[23] Campbell et al. identified 60 documented health programmes in FBOs, of which 13 reported an experimental or quasi-experimental study design with outcome data and statistics. Seven of these were included in Dehaven's 2004 review, and eight were carried out subsequently.

disease prevention in Black Americans.[24] Due to the poor quality of research methods and evaluations, they recommend more rigorously researched interventions which are culturally appropriate and include post-intervention support and long term follow-up.

Review of church-based diabetes self-management education

In 2012, Newlin and colleagues [40] conducted a review of literature specifically addressing church-based diabetes self-management education (DSME)[25] in African-American churches. Many Black Americans do not benefit from this effective intervention, and the authors suggest a number of provider and patient barriers that are responsible for this.[26] The authors emphasise sustainability as a key feature of interventions that target diseases such as diabetes, which require life-long adherence to healthy behaviours, and therefore identify that collaborative and participatory working between faith communities and the public health community is an essential component of their success in sustaining an intervention beyond the initial research phase. This collaboration includes making use of community assets such as adequately trained and supported volunteers, and the importance of financial planning for sustained implementation. Additionally, an important factor for these programmes was that religious content was integral to them, including spiritual concepts such as love, peace, faith, self-control, and godliness, and religious activity such as prayer, Bible study and telling inspirational stories, alongside the specifically health-related content. Despite various limitations,[27] Newlin concludes that the faith-based interventions are promising for DSME, and therefore for the improvement of outcomes for Black Americans with type 2 diabetes.

[24] Of the 16 primary studies identified in this review, six met the review's inclusion criteria; four of these were not included in either of the reviews above. All of these studies targeted behaviour change by running sessions on nutrition, physical activity education or both, and overall demonstrated weight loss in Black Americans. However, of those six, the majority were methodologically inadequate with small samples, weak study design, and varying intervention designs, making it difficult to draw conclusions. Only one randomised controlled study was identified but the randomisation procedure was not reported.

[25] Diabetes self-management may involve adhering to meal and exercise plans, monitoring glucose levels and managing medications accordingly, and treating wider diabetes symptoms, including foot care. With DSME, the health worker works collaboratively to empower patients individually or in a group setting to self-manage their diabetes more effectively, with a strong recognition of the psychological, social and cultural factors that can affect success.

[26] The studies were similar in terms of research approaches, sampling plans, and recruitment and retention strategies. They delivered distinct interventions with varying levels of religious content, and resulted in overall positive health outcomes. The interventions followed conventional, collaborative, or participatory research approaches, with 12 following a collaborative approach, where researchers had chief control in the research process with church and/or community stakeholders having varying levels of responsibility in developing and running the health promotion programmes. Two studies followed a more participatory approach, with the research process being controlled by the church community, with input from researchers in an advisory role.

[27] A total of 19 studies addressing aspects of DSME in Black American populations were reviewed (eight of which had not been included in the above reviews); methods employed to affect outcomes were primarily components of DSME. In common with other reviewers, Newlin found that most of the studies used limited study designs. As very few of the studies proposed theoretical explanations for the outcomes, there was consistent lack of clarity about which components of the intervention (e.g. social support, cultural sensitivity, learning coping skills) were responsible for the positive outcomes; they recommend that further research focuses on qualitative methods, shedding light on how and why faith-based interventions affect healthy behaviour change.

Table 5 - Summary of US-based reviews of health interventions in FBOs

Review and Studies covered	• Range of interventions • Significant effects • Conclusion	Lessons learned / Recommendations
Dehaven et al. 2004 [38] [41-68]	• primary prevention and general health maintenance, cardiovascular health, cancer awareness, mental health • reductions in cholesterol and blood pressure levels, weight, and disease symptoms and increases in the use of mammography and breast self-examination • faith-based programmes can improve health outcomes	• more rigorous research methods need to be employed • public health bodies need to establish relationships with faith communities representing under-served populations • suggests 'middle ground' approach of collaborative partnerships, particularly to evaluate programmes and disseminate findings • emphasises evaluation methods that are sensitive to what is practical in real-life situations, ensuring more realistic replication
Campbell et al. 2007 [36] [41, 44, 47, 48, 51, 57, 69-75]	• primary prevention, smoking cessation, breast cancer awareness • greater consumption of fruit and vegetables, increase in: physical activity, smoking cessation, cancer screening • community-based health promotion programmes have produced significant impacts on a variety of health behaviours	• importance of building relationships of trust with churches, and involving them in programme development including the recruitment of participants • need for understanding the cultural/social context of the FBO through extensive formative research • the importance of culturally competent staff
Thompson et al. 2009 [39] [56, 57, 76-79]	• weight management in Black Americans (nutrition, physical activity, or both) • reduction in blood pressure, weight and BMI • the majority of the studies were methodologically inadequate with small samples, weak study design and varying intervention designs, making it difficult to draw conclusions across the studies	• more rigorously researched interventions are needed • interventions should be culturally appropriate • interventions should include post-intervention support and long term follow-up
Newlin et al. 2012	• diabetes education with Black	• by involving church leaders in

[40] [41, 46, 47, 56, 57, 64, 66, 67, 72, 74, 75, 77-84]	Americans • increases in fruit and vegetable intake • studies reviewed reported significant health outcomes. However, interpretation of these findings is problematic • qualitative findings show promising role for FBOs in DSME	recruitment and retention of participants, health programmes are seen as more credible • most studies reviewed were undertaken without guiding theoretical frameworks; therefore relational explanations between interventions and outcomes were not provided • further research should focus on qualitative methods, shedding light on how and why faith-based interventions affect healthy behaviour change • spiritual content can render a programme more acceptable to Black Americans • importance of financial planning for sustained implementation • importance of an asset-based approach to sustainability, making use of community assets such as volunteers

A recent church-based intervention

In addition to these reviews, an individual intervention that is currently running in the US merits inclusion due to its size and the relevance of its approaches, which apply recommendations from previous studies.

Diabetes prevention translational programme

A robust cluster-randomised control trial by Williams and colleagues [85] is the first to include a sizeable number of Black Americans (n=604) in a community-based, randomised control diabetes prevention translational programme. In this study design, health professionals who are already members of congregations are trained to deliver an adapted version of a secular evidence-based intervention for weight loss and increased physical activity, as protective factors for type 2 diabetes. Requested by a group of church pastors, the project was developed within the framework of community based participatory research with a team of health and academic professionals alongside church communities. The secular version of the intervention was adapted by adding scriptural motivational content, and individualised motivational interviewing interactions. The programme specifies its theoretical model as the socio-ecological model, seeking to integrate the message within multiple layers of church life. These include health messages during Sunday services, prayers for participants

and announcements of the total group weight loss. In addition each church has agreed to one policy change: examples include setting guidelines about the types of food served at church functions and adding healthy choices in the church vending machines. The comparison groups receive a 12-week class using relevant health information and participant hand-outs. The results of this study are yet to be published; however, the study design appears to take account of lessons learned from the reviews discussed above, and as such will add significantly to the scientific evidence base for health promotion in FBOs. In addition, this study contains a cost-benefit analysis that will allow for roll-out consideration should the results prove significant.

Interventions involving other faiths

There is very little in US literature about faith communities or organisations other than Black American churches as settings for health interventions. However, there is currently an RCT underway that tests a strategy of using community health workers (CHWs) among Bangladeshis with type 2 diabetes living in New York. The treatment group in this predominantly Muslim community receives a six-month CHW-led intervention consisting of five monthly group educational sessions, two one-on-one visits, and follow-up phone calls as needed [86]. The control group receives an introductory educational session only. Outcome measures will include clinical measures such as HbA1c (long-term blood sugar) and weight change, behavioural measures such as access to and utilisation of care (i.e. appointment keeping and use of specialist care), and knowledge and practice of physical activity and healthy eating. Additionally, the qualitative aspect of the study will look at CHW characteristics, and the processes by which their interventions lead to behaviour changes. This study has an estimated completion date of January 2015.

The UK literature

While most US studies focus on Black Americans because of the health inequalities faced by this group, most UK studies on health promotion interventions within minority ethnic groups focus on South Asians for similar reasons. At present, there is a relative paucity of UK-based studies, possibly due to the fact that many South Asians are still first and second generation immigrants, whereas the Black American population, with its associated health disparities, is a long-established population group in the US. The UK literature therefore deals with individual studies, and lacks the longer term perspective of lessons to be learned and recommendations made that is gained when several programmes over many years are reviewed.

The current UK literature dealing with health interventions around 'lifestyle' diseases in faith-based communities is summarised and discussed below, organised by theme and with reference to some of the lessons learnt and recommendations from the US-based literature.

Smoking

Smoking is much more common among Bangladeshi men (40%) than among men in the general population [8]. Cancers of the trachea, lung, and bronchus are the highest cause of death from cancer in South Asian men, with smoking being the principal risk factor. Smoking is also a significant risk factor for a range of other diseases including diabetes and vascular diseases. The majority of Pakistanis and Bangladeshis in England are self-reported Muslims, and therefore several studies have examined the feasibility of reaching these groups through connections with their faith community.

Study of smoking among the Bangladeshi and Pakistani communities
A qualitative study by Bush et al. in 2005 sought to understand the influences on smoking behaviour in Bangladeshi and Pakistani communities in the UK, in order for effective and culturally acceptable smoking cessation interventions to be developed [87]. The study used purposive sampling for 37 interviews and 24 focus groups, with a grounded theory approach to data generation and analysis. The unique aspect of this study was the commitment to participatory methods: 13 bilingual 'community researchers' were recruited from the local South Asian population and attended a 14-week, accredited training programme in qualitative research. They were thereafter responsible, with supervision, for all aspects of organisation, recruitment and implementation of the study, with involvement in data analysis. Regarding religious themes, the authors found that there was some confusion about the Islamic position on smoking, with most people believing that it was *mukrooh* (discouraged) but not *haram* (forbidden), and many feeling that as long as the smoker was not addicted, smoking was acceptable. Smoking was universally felt to be taboo for women, with associated underreporting.

Commentary
This study of smoking behaviours by Bush et al. is very reminiscent of a study [64] cited in the review by Newlin et al. [40], in which Black American church leaders developed, marketed and implemented a programme to reduce the risk of CVD, and in its empowering approach comprises most elements of Campbell et al.'s keys to success, by building respectful relationships, building capacity, and therefore 'leaving something behind' [36]. This kind of qualitative study is invaluable before a health-behaviour intervention is implemented, and a clear example of how assets of knowledge and volunteerism can be mobilised for successful outcomes.

Studies on chewing tobacco

It has been found that 49% of the female UK Bangladeshi population chew tobacco [88], while in contrast only 2% report smoking (although this may be underreported). Clearly this situation calls for a nuanced understanding of the cultural and social aspects of this type of tobacco use, and in 2002, a study using nicotine replacement therapy (NRT) was the first to show that this method is useful for chewing tobacco cessation [89]. This study used Sylheti speaking community workers to recruit participants and, although no mention is made of accessing faith leaders or communities as such, the authors stress the need for further research into alternative methods of recruitment and support for these women if successful cessation is to be achieved.

Commentary

We have already noted the importance of public bodies taking into account issues specific to diverse groups when planning public health campaigns or services, and the findings relating to chewing tobacco illustrate this well. The potential for engaging Muslim faith groups in this research is significant. Newlin's review found that among Black American church-goers, health messages were more readily received when they acknowledged the faith position of the participants by including spiritual or religious content and references. It would appear that the same principle is true for interventions in other faith settings. In a study in Pakistan [90], Imams used Friday sermons to encourage smoking restrictions in homes, with positive effect, suggesting that a similar strategy in British Bangladeshi and Pakistani Muslim communities could play an important role in affecting smoking behaviours.

'Smoke free homes' intervention with Bangladeshi and Pakistani communities

Ainsworth and colleagues at the University of Leeds are carrying out a cluster RCT of an educational intervention, 'Smoke free homes', which has been adapted in collaboration with Muslim faith leaders for them to deliver in different faith settings such as at mosques, in faith schools and madrassas, and in women's forums [91]. This pilot programme aims to discourage smoking within the home, thereby reducing the harmful effects of second hand smoke in the local Bangladeshi and Pakistani communities; the content is grounded in Koranic teaching about not harming the body and not harming others. As well as gathering quantitative data about compliance and effectiveness, this pilot trial comprises a significant qualitative element to elicit attitudes and opinions from lay people and leaders about the acceptability of the programme, including any barriers or facilitating factors, and will provide

information to inform the design of a future definitive study. It is anticipated that its results will be published in summer 2014.

Ramadan-focused smoking cessation initiatives

The 2004 NHS document *Heart Disease in South Asians* [5] also refers to a number of projects that intersect with faith communities, for which evaluations are not published, but which use strategies that merit inclusion in this report. For example, Manchester Smoking Cessation Service has worked together with Salford and Trafford Smoking Cessation Service and partners – including the Muslim Council of Britain and the Islamic Society of Britain – to run an initiative around smoking during Ramadan. This aimed to raise awareness about the health benefits of quitting smoking and to provide accessible, appropriate cessation services. Religious and community leaders were offered training to run awareness-raising talks and signpost people into services. One-to-one appointments for those wanting help with tobacco cessation were offered at mosques and community centres before and during Ramadan. Every year QUIT runs a National Smoke Free Ramadan Campaign with partners such as the British Heart Foundation, Smoke-Free London, the Muslim Health Network and the Imams of 60 large mosques; the campaign reaches some 1.6 million Muslims in the UK. The campaign communicates its messages by directly linking guidance with Koranic teaching on self-preservation and not wasting resources. Calendars with prayer times are made available which carry health messages and the Asian Quitline phone number. These campaigns are promoted on local Radio Ramadan stations during the daily countdown to breaking the fast, a sociable time when families are likely to be gathered together. QUIT also runs campaigns around Hindu and Sikh religious festivals backed by intensive media, PR, poster campaigns, talks, exhibitions and outreach work by counsellors.

Cardiovascular disease

The increased risk of CVD in the South Asian population is well recognised [4], with various factors given as explanations for the disparity, including language barriers and cultural taboos [5]. A number of community-based interventions for health education specific to these communities have been developed. NHS health checks have been part of public health screening strategy since 2008 [92] and, although there is reference to faith and voluntary sector organisations being well-placed as a platform for checks for those "not in touch with organised health care", this strategy has limited worked examples.

CVD intervention with the Hindu community, Brent

However, one project that has responded to this challenge within the Hindu community is an initiative between the Royal Free Hampstead (RFH) NHS Trust, H.E.A.R.T. UK and two Hindu temples in the London borough of Brent to provide screening for CVD risk factors in the community, reported by Rao et al. [93]. This study recognises that among South Asians, language restrictions or lack of perception of CVD risk factors leaves many disconnected

from primary health services, and that using a faith-based setting may allow people to connect due to the familiar environment and encouragement from respected community leaders.

The programme was a partnership between clinical experts from the RFH, members of the faith community within the medical profession, and interpreters from the faith community, with the service designed and co-ordinated by a team made up of clinical and community leaders. Screening events were advertised in the temples and on their websites, and participants were given a 40 minute appointment for CVD screening and targeted health advice. A number of screening tools were used, with a total of 434 participants being screened. For this population, who had not presented themselves for testing elsewhere, 92% had at least one modifiable CVD risk factor, and Rao and colleagues conclude that "screening UK south Asians in religious settings is a feasible approach to identify a high proportion of individuals with vascular risk factors in this community" (p.266).

Commentary
It is important to note that there are some acknowledged limitations to this study: participants demonstrated intrinsic motivation by agreeing to a health check, so were not necessarily representative of the entire faith community. However, it is also worth noting that almost 60% of participants were from the most deprived quintiles, whereas just fewer than 10% were from the least deprived. This seems to indicate that there was a significant proportion of participants from 'hard to reach' groups, and that there is therefore the potential for using this and similar interventions to reduce health inequalities. A further limitation in this study is that, although individual health advice was given to each participant, it fell outside the remit of the project to demonstrate whether or not the advice was taken and participants reduced their risk of CVD.

In terms of approach, although there are many aspects of this programme in which members of the faith community were involved, the programme lacked a strategy for sustainability. As such, it can be considered a faith-*placed* intervention that is likely to lack long-term effectiveness, except in those individuals who had a health check and were given advice. However, it is reasonable to conclude that if faith settings are feasible platforms for health screening due to familiarity, the encouragement of trusted leaders and the minimising of language and cultural barriers, then the same advantages would render these settings suitable for behavioural interventions.

Khush Dil CVD intervention with the South Asian community, Edinburgh

An intervention to reduce the risk of CVD amongst South Asians in Edinburgh [94] recognised the multi-layered determinants of this disease, such as smoking, diabetes, obesity, lack of exercise, poor diet, low socio-economic status and inequalities in health care. Co-ordinated by health visitors, the intervention, called Khush Dil ('Happy Heart'), offered a range of health-promoting activities in the wider community, including cookery workshops, exercise classes and coronary heart disease (CHD)/diabetes awareness sessions to encourage lifestyle change and reduce CHD risk. Some of these activities were run from mosques; the report on the intervention does not give details of additional involvement of the faith community, although there appears to be a high level of participatory working with voluntary sector groups and other community groups such as the Pakistani Women's Association. In fact, the authors recognise that more collaboration with faith groups might prove useful, as they refer to an increase in outreach work to mosques and temples as a strategy for reaching men.

Commentary
The authors of this paper are clear in pointing out that this is neither an RCT nor a research project, which they acknowledge as a limitation. However, the differences in biometric scores and motivational state reported in the 140 participants who returned for follow-up measures are hard to ascribe to any other factors than the Khush Dil activities, and the authors also point out that this type of 'service evaluation' of a new or innovative service can be a pragmatic choice due to its relative ease and cost-effectiveness; its combination of quantitative and qualitative data serves to inform process as well as outcomes. This is reminiscent of the recommendations by some of the US-based reviewers, such as the suggestion by Dehaven et al. that evaluations "test interventions in a way that is sensitive to what is practical in the real world" (p.1034) [38].

Diabetes

Type 2 diabetes is up to six times more common in people of South Asian descent and up to three times more common among people of African and African-Caribbean origin than in the general population [6]. Among women, diabetes is more than five times as likely among Pakistani women, at least three times as likely in Bangladeshi and Black Caribbean women, and two-and-a-half times as likely in Indian women, compared with women in the general population [2].

BIPOD diabetes prevention initiative with the Bangladeshi community, London
The Bangladeshi Initiative for the Prevention of Diabetes (BIPOD) study [95] sought to explore beliefs and attitudes about diet and physical exercise among the London Bangladeshi community, with a view to informing health promotion efforts to combat the high prevalence of type 2 diabetes in this group. This qualitative study specifically engaged

with Muslim leaders and clerics, as 93% of this population are Sunni Muslims who self-report that their religion is a central part of their identity [96]. Both lay participants and religious leaders stressed the resonance between Islamic teachings and healthy lifestyle choices around diet and physical activity, and faith was linked to personal confidence and motivation for behaviour change. These faith-related beliefs seemed to be in conflict with the influences of cultural social norms. For example, the fear of gossip or ridicule if curries were prepared with less oil was a very strong factor, despite widespread knowledge of what would constitute a more healthy diet. Faith-related education was thought to be an important potential strategy for intervention, and faith leaders were enthusiastic about the possibility of working in partnership with health professionals, both to educate the community and to educate the health professionals in some of the cultural beliefs and traditions around diet and exercise. This element of mutual education was borne out by the findings from the focus groups with lay people, which indicated that there was a mismatch between what health professionals thought were the cultural norms and levels of knowledge about healthy eating, and what the reality was. There is recognition in this study that the approach of 'doing with' is more effective than the 'doing to': there was a genuine desire to share information both ways across the researcher/faith group relationship.

READ Diabetes education programme with the Muslim community, Brent

Regarding initiatives that situate interventions in the heart of the belief system of the faith group, Bravis and colleagues aimed to determine the impact of Ramadan-focused education on weight and hypoglycaemic episodes during Ramadan, in a type 2 diabetic Muslim population taking oral glucose lowering agents [97]. Recent studies show that for individuals who are normally well controlled, neither glycaemic control and lipoprotein levels, nor blood pressure, are negatively affected in Ramadan [98] – but this is not the case for those with less well controlled diabetes. In Brent, where this study was conducted, the standard advice given to diabetics was not to fast. This study used the Ramadan Education and Awareness in Diabetes (READ) programme, developed with national guidelines but made culturally appropriate by an ethnic food specialist dietician and delivered by culturally diverse staff. It was advertised in community venues including mosques, where Imams also encouraged participation. Participants in the programme lost significant amounts of weight and had fewer severe glycaemic incidents.

Commentary

Again, in terms of approach, this faith-placed study appears to use faith communities as convenient sources of recruitment rather than actively to involve them in the design or implementation of the intervention. This has the advantage of having more likely gains in the short term, but in the long term, interventions that work collaboratively with faith leaders and members have more longevity as individual and organisational capacity is increased.

Obesity

Obesity in children is a major public health concern, with its associated risks of type 2 diabetes, heart disease and other chronic conditions in early adulthood [99]. It is established that ethnicity is correlated with obesity, with children and young people of non-White ethnicities being more vulnerable [100], and this trend therefore has implications for the persistence of health inequalities. Though obesity is known to have genetic and non-genetic components, studies comparing migrant populations with those in their countries of origin demonstrate an increased risk of obesity in the former [101]. The Medical Research Council's DASH study [3], described in Chapter 2 above, examined in detail the eating and physical exercise habits of 6000 adolescents and found that ethnic minority adolescents tended towards behaviours associated with obesity when compared with White British peers. It is established in the literature that obesity interventions are most effective when family influence is taken into account; for many ethnic minorities in particular, the faith community provides a platform where different generations in families can be reached and where parental involvement in obesity-reducing strategies can be maximised. The DASH data suggests high weekly attendance at places of worship. For example, over 84% of Nigerian and Ghanaian, 60% of 'other Africans', 43% of Black Caribbean, 53% of Indian and 69% of Pakistani/Bangladeshi 11 to 13-year-olds in the DASH study reported weekly attendance at a place of worship compared with 9% of their White British peers.

DEAL obesity intervention with young people from ethnic minorities

To build on this research, the DEAL (DiEt and Active Living) feasibility study [102] aimed to research ways in which schools and places of worship could be the setting for culturally acceptable family-based interventions to reduce the behavioural risk factors of obesity for children and young people (aged 8 to 13) from ethnic minorities. In their qualitative research, Maynard and colleagues researched the views of young people, parents, grandparents, teachers and religious leaders from a wide range of religious groups: two Pentecostal churches, a mosque, a Sikh gurdwara, a Hindu temple, a Tamil Hindu temple and a Jain community centre. Fifteen focus groups were run in the places of worship, where discussions were guided around perceived barriers and facilitators that influence engagement with healthy food choices and sufficient physical activity, including competing priorities, family life, parental support, access to opportunities, and preferences for activities and dietary patterns.

As part of this study, various interventions were trialled for feasibility in different settings. The school setting had the advantage of allowing reliable access to large numbers of children, easier recruitment and a familiarity for researchers who were used to working within this kind of environment. The advantage of the places of worship, however, was that they allowed greater access to the wider family, with family members talking more freely about

traditional food practices than in the schools. This was significant as the study found that grandmothers and mothers-in-law were particularly strong influencers of family behaviour relating to dietary and physical exercise practices. In discussing the relevance of faith settings, the authors state that "places of worship provide access to the wider family and therefore offer valuable opportunities for family and culturally specific support for the implementation of the intervention", but also point out that due to issues of recruitment and retention of faith leaders and participants, working with places of worship for interventions of this kind also requires the input of additional funded community mechanisms.

Commentary
With the range of groups involved in the DEAL study, it is unlikely that the research team had culturally sensitive staff for each group, which may have contributed to the difficulty in recruitment. However, the building of trust through cultural and religious sensitivity was a key lesson learnt from the US studies.

Review of research on lifestyle choices among the South Asian community
In their comprehensive review of qualitative research into the beliefs behind the lifestyle choices of South Asians in the UK, Lucas et al. [103] provide a rich resource of insight into a predominantly Muslim group. Two strong themes of this analysis are the role of fatalism and the importance of the social group, not the individual, in making lifestyle choices. As a backdrop to life's circumstances is the belief among members of the community that God rather than the individual is ultimately responsible for an individual's health. However, in this case, this perceived lack of control over health was related to feelings of anxiety and hopelessness about health conditions. Regarding the importance of the social group, the authors point out that contemporary theories of behaviour change tend to focus on individuals, which is at odds with South Asian culture. For example, for a woman with diabetes seeking to lose weight, reducing the amount of oil and sugar used in traditional cooking will affect her entire extended family and she will have to address the difficult balance between making changes for her own health and risking criticism and alienation. Again, cultural norms are powerful factors: in some Bangladeshi dialects there is no word for physical activity or exercise beyond walking, and in this absence of an exercise culture, making a choice to 'take up exercise' is seen as inappropriate and immodest for a woman whose role is defined as meeting the needs of others within the home setting.

Lucas et al. propose that health promotion messages are directed towards groups rather than individuals, and that they should be highly sensitive to the beliefs and world view of the community in question, for whom the advice and wisdom of peers and elders is highly valued.

Commentary
While Lucas et al. suggest family-based educational interventions as a means of building on existing beliefs, attitudes, and behaviours, with a community-based, word-of-mouth approach, they fall short of suggesting that this could be done in partnership with community-embedded faith-based organisations.

Table 6 below summarises the studies reviewed above, and their level of collaboration between the FBO and the academic or health team involved in the intervention. It also gives a summary of further lessons learnt from these studies.

Table 6 - Summary of UK-based interventions addressing disease modifying behaviours in partnership with FBOs

Study Programme Targeted group Faith setting	Type of intervention or study	Level of collaboration Theoretical model, if stated	Results Conclusions, lessons learned, recommendations
Ainsworth et al. 2012 [91] Muslim communities learning about second-hand smoke (MCLASS) Muslims in Leeds Mosques and other Islamic faith settings	Cluster randomised control trial of an educational intervention, 'Smoke free homes', adapted for delivery by Muslim faith leaders. Study gathered quantitative data on effectiveness, and qualitative data about acceptability of programme.	This study represents a high level of collaborative and participatory work, as faith leaders were trained to deliver an intervention which they helped to develop, thereby building individual and organisational capacity.	Results not published at time of writing (due summer 2014), but small feasibility study which preceded it showed that intervention is acceptable and feasible. Element of using religion-specific material (Koranic references) builds on Newlin's 'lessons learned' from US studies in Black American churches [40].
Bush et al. 2005 [87] Community research on smoking habits 87 men and 54 women aged 18-80 years, smokers and non-smokers, from the Bangladeshi and Pakistani communities of Newcastle upon Tyne, during 2000-2	Qualitative study using community participatory methods, purposive sampling, one-to-one interviews and focus groups, and a grounded theory approach to data generation and analysis.	Highly participatory approach; community members participated in study development, implementation, and analysis. Thirteen bilingual "community researchers" recruited and attended 14 week, accredited training in qualitative research and carried out all aspects of recruitment and	Among Bangladeshi men smoking was associated with socialising, sharing, and male identity. Among women, smoking was associated with stigma and shame, and often hidden. Peer pressure was a strong factor for Bangladeshi youth; smoking was often

[Study did not take place in a faith setting]		implementation and analysis with support from lead researcher.	hidden. Confusion around Islamic position on smoking.
Rao et al. 2012 [93] CVD screening Gujarati Indians in Brent Hindu temples	An initiative between the Royal Free Hampstead NHS Trust, H.E.A.R.T. UK and two Hindu temples in the London borough of Brent to provide screening for CVD risk factors in this community. A quantitative study, collecting biometric data on weight, height, waist circumference, BP, body fat composition and blood levels of cholesterol and glucose. Participants were advised regarding culturally specific lifestyle interventions.	Collaborative aspects: • service designed and co-ordinated by a team made up of clinical and community leaders • advertising in temples and on websites • project team included GPs, scientists, nurses and pharmacists who were members of the faith community Less collaborative aspects: • Designed as a one-off intervention for screening purposes; no 'leave behind' element of training or capacity building	434 participants screened who had not been screened elsewhere. 92% had at least one modifiable risk factor (60% from most deprived quintiles, <10% from least deprived). Concluded that screening South Asians in a religious setting is feasible due to familiarity, encouragement of leaders, and minimising of cultural and language barriers.
Mathews et al. 2007 [94] Khush Dil Project South Asians in Edinburgh Community venues including faith settings such as mosques	Pragmatic service evaluation of a range of community-based interventions for CVD prevention. Evaluation approach chosen due to its relative ease and cost-effectiveness; its combination of quantitative and qualitative data serves to inform process as well as outcomes.	High level of collaboration with wider community, but in terms of faith groups, partnership was limited to use of buildings. Used transtheoretical model, a stage model for motivational and behavioural change	This style of evaluation is beneficial for reasons of cost and real-world approach, a factor highlighted by Dehaven et al. [38]. Men were harder to follow up; recommendation made to use mosques and temples in outreach strategy.
Bravis et al. 2009 [97] READ programme (Ramadan Education and Awareness in Diabetes), a two-hour education	Retrospective study of 111 patients. All were invited to programme; 57 attended and the 54 who did not attend were considered the 'control	Mosques and Imams were used for recruitment of participants rather than actively involving members in design or implementation of	Participants who attended the READ programme lost a significant amount of weight and experienced fewer hypoglycaemic events, with some

programme Muslim Type 2 diabetics in Brent who took oral diabetic medication, and who choose to fast for Ramadan Mosques	group', though no randomisation occurred. All patients were followed up by their GP.	intervention: a faith-placed rather than participatory intervention.	outcomes being sustained 12 months later. No inclusion of sustained involvement or capacity building within faith community, so longer terms gains unlikely: an issue raised by Thompson et al. [39].
Lucas et al. 2012 [103] Review of research South Asian Muslims	Systematic review of qualitative research into the beliefs behind the lifestyle choices of South Asians in the UK (included 10 studies).	Seeks to understand the cultural/social context of the FBOs, an important factor also stressed by Campbell et al. [36]. Challenges the validity of individualistic theories of behaviour change, which might promote individual behaviours such as gym membership, and instead advocates for a new theoretical model that focuses on wider family and community.	For many Muslims, fatalism is a strong factor in uptake of behaviours which may reduce risk. The social group has more significance than the individual in risk-modifying behaviour, and advice and wisdom of peers and elders is highly valued. Recommends family-based educational interventions as a means of building on existing beliefs, attitudes and behaviours, with a community-based, word-of-mouth approach.
Maynard et al. 2009 [102] The DEAL (DiEt and Active Living) Study Ethnic minorities from various faith communities Two Pentecostal churches, a mosque, a Sikh gurdwara, a Hindu temple, a Tamil Hindu temple and a Jain community centre	Qualitative feasibility study which aimed to research ways in which schools and places of worship could be the setting for culturally acceptable family-based interventions to reduce the behavioural risk factors for obesity in children and young people (aged 8 to13) from ethnic minorities. Used 17 focus groups in three sequential phases.	Using focus groups with a wide range of participants, including faith leaders, lay adults and adolescent children, this study called for high levels of participation from the faith community. Based on three theoretical models which emphasise that complex, multi-level behaviours require multi-dimensional interventions, and emphasise the family	Found that people are more free to talk about traditional ways of eating in faith than school settings. Grandmothers and mothers in law were particularly strong influencers of family behaviour relating to dietary and physical exercise practices. Additional funded

	The intention was that this data would provide the basis for a pragmatic pilot RCT at a later date. If carried out, this has not yet been published.	and community level over and above the individual level.	community mechanisms need to be factored into faith-based interventions, to recruit faith leaders and participants.
Grace et al. 2011 [95] Bangladeshi Initiative for the Prevention of Diabetes (BIPOD) Study Bangladeshi Muslims in London, their faith leaders and health professionals Mosques and other Islamic faith settings	A qualitative study to explore beliefs and attitudes towards diet and physical exercise, with a view to informing health promotion efforts to combat the high prevalence of type 2 diabetes in this group.	In engaging faith leaders and clerics as well as lay people and health professionals, this qualitative study was formative in that it sought to discover factors pertinent for success of health promotion interventions. Religious leaders and scholars were recruited through mosques, Islamic forums, Islamic schools and Islamic study circles.	All participant groups stressed resonance between Islamic teachings and diet and exercise. Faith was linked to personal confidence and motivation for change; however, other social norms, such as serving oily foods to guests, conflicted with this. Faith leaders were enthusiastic about their possible role in educating the community in partnership with professionals, and highlighted the need for more education for health professionals whose views were outdated.

Summing up: Strand 1

The US has a long history of faith groups working with public health bodies, mostly among Black American churches. The UK literature shows a growing interest in this field, with a range of interventions currently being developed which show promise. These range in the extent to which they are embedded with the faith setting and, as such, the extent to which they 'leave something behind'. It also is worth noting that there are a great number of health-related activities going on in FBOs' premises and/or involving their members that are so well 'embedded' that they are never thought of as interventions or evaluated as such –

such as the slimming club held in a church hall, or the walking group. Nonetheless, such activities can be seen as part of FBOs' contribution to public health.

Where interventions are purposely developed, however, the literature identified in this chapter points to the need for projects to be developed which: are designed in collaboration with faith leaders and members, and integrate beliefs into the interventions; use the expertise and volunteerism intrinsic within the group; are based on robust qualitative research; are adequately evaluated, being clear about the theoretical model upon which the intervention is based; and embed organisational capacity building and financial sustainability within the design of the project.

3. FBOs and Social and Spiritual Capital – Evidence from Strand 2

We have explored so far the health issues that are known to affect different communities, some of the approaches that have been taken to address these with FBOs, and the lessons from the results that might inform future work. However, the social and spiritual capital gained by belonging to a faith community can, in itself, confer physical and mental health benefits and mitigate other determinants of health [104]. The evidence for this is summarised in this chapter, with particular reference to the role of wellbeing. In terms of the activities of FBOs which seek to look beyond the walls of the church, mosque, temple or synagogue into the wider community, particular attention will be focused on how these health benefits can be widened, with examples drawn from faith-inspired projects that address issues of injustice and poverty – especially reaching those marginalised by society – and thus seek to have an impact on the wider determinants of health. The chapter concludes with a set of illustrative case studies.

Benefits of wellbeing

In the 2014 DH document, *Wellbeing: Why it matters to health policy* [28], evidence is given for the following effects of wellbeing:

- It adds years to life
- It improves recovery from illness
- It is associated with positive health behaviours in adults and children
- It is associated with broader positive outcomes
- It influences the wellbeing and mental health of those close to us
- It affects how staff and health care providers work

This message is reinforced by the inclusion of measures of wellbeing (such as self-reported wellbeing and social isolation) as indicators in the Public Health Outcomes Framework [1], under the domains of improving the wider determinants of health and of health improvement. These indicators reflect factors that can have a significant impact on health and wellbeing, and their aim is to ensure a focus by local authorities and their partners – including the voluntary sector – on the "causes of the causes" (p.10) of health inequalities.

Measuring wellbeing

Wellbeing is a key indicator of success for many community interventions, and various measures of wellbeing have been developed in recent years. The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS), developed by Warwick and Edinburgh Universities from 2006, has been academically validated as having good psychometric properties and good validity and reliability. It provides the ability to distinguish between population groups and has been used in the Health Survey for England.

It is recognised that different groups will have different capacities and funding for evaluating what they do. The new economics foundation (nef)[28] has produced a useful guide to help community organisations evaluate their work in this area, and recommends a combination of the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), the ONS subjective wellbeing questions and a question on social trust, a known key factor for wellbeing. The SWEMWBS measures 'flourishing', a term used in this context to cover both the feeling and functioning aspects of positive mental wellbeing. The ONS wellbeing questions are intended to capture what people think about their wellbeing, and the single question on social trust is included because of its importance to overall wellbeing.

Faith, wellbeing and mental health

The evidence shows that regular engagement in religious activities is positively related to various aspects of wellbeing, and negatively associated with depressive symptoms [105-115]. Mochon et al. [105] showed that religious attendance across all surveyed religions provided a "small and positive boost" to self-reported wellbeing, suggesting that these regular small boosts contribute to the positive relationship between religiosity and wellbeing. Dehejia et al. [106] present evidence that among Black Americans, religious attendance "insures" against decreases in income as it reduces the effect size of income on happiness, and Myers [107] showed that people with the highest religious involvement are almost twice as likely to report being "very happy" than those with least. Both Clark and Lelkes [108] and Hayo [109] demonstrate that this regular participation is positively related to life satisfaction; Cohen [110] and Ferriss [111] both show a positive relationship with happiness; and Lee et al. [112] show that that regular participation in religious activities is negatively associated with symptoms of depression. In addition, a recent large longitudinal study by Rasic et al. [113] suggests that religious attendance is possibly an independent protective factor against suicide attempts. In the US context at least, frequent maternal participation in religious services was associated with healthy functioning and wellbeing in a sample of young

[28] http://www.neweconomics.org

adolescents, with the association being as important as, or more important than, associations involving other traditional demographic variables, with the exception of family income [114]. The same has been shown to be true in the elderly, with church attendance being shown to be beneficial for maintaining cognitive function in older people, and to be an important factor in moderating the impact of depressive symptoms on cognitive function [115]. Lim and Putnam [116] analysed US data over six to nine months, and found that increased church attendance over that period increased life satisfaction.

There is also evidence to show that volunteering can positively affect the health and wellbeing of volunteers [117, 118]. For elderly volunteers particularly, a positive correlation between volunteering and life satisfaction is found, and international research suggests that the benefits of generous and altruistic behaviour on subjective wellbeing are universal [119]. Faith communities represent a large proportion of national volunteering; the think tank Demos found that in the UK, the proportion of people who have volunteered for local community action is 6% among those who belong to a religious organisation, compared with 1% among those who do not [120].

In addition to the evidence around faith and mental health, published evidence shows a positive correlation between religious spirituality and physical health, reduced mortality, and better recovery from physical illness including surgery, with attendance at religious gatherings being the most strongly associating factor [104]. Danish studies conclude that spiritual wellbeing is associated with less distress and better mental adjustment for cancer survivors, although some aspects of faith were both positively and negatively associated with distress and mental adjustment [121].

Faith and social capital

In addressing the mechanisms involved in these associations, analysis suggests three main mechanisms: more healthy behaviours, more social support, and an increased sense of coherence, or meaning [104]. Referring to their findings about religious attendance and life satisfaction, Lim and Putnam found that it was not factors such as theology and private religious practices that predicted greater life satisfaction, but the social aspect of religion: that religious people regularly attend religious services and build social networks in their faith settings [116]. Putnam and Campbell further explore the idea of social capital with particular reference to religion in the US in their book *American Grace* [126].

Connectedness is inextricably linked to wellbeing. In communities with high levels of social capital, measures of wellbeing and health are higher. Low levels of connectedness and issues of loneliness significantly increase mortality, and people with stronger networks are healthier and happier [122]. There is also strong evidence that social relationships can reduce the risk of depression [123].

In their 2006 research for the Joseph Rowntree Foundation, *Faith as Social Capital* [124], Furbey et al. sought to review the existing evidence for the strength of the assertion that faith groups by default enhance social capital. One of the sources they used was a survey of more than 2,300 faith communities from nine religions, which represented over 5,000 projects and 45,000 volunteers. The issues tackled by these projects were broad in range, with many providing services for older people, children, and socially excluded and other 'hard to reach' individuals. Using this and similar studies, and the perspectives of those involved in these groups, the report seeks to reflect a balanced view of the positives and negatives, the possibilities and limits for the faith/social capital relationship.

The concept of different types of social capital is an important aspect of this discussion and warrants a brief explanation here. A commonly used categorisation is that of Gilchrist's bonding, bridging and linking capital [125]. Bonding capital describes the close-knit 'dense' relationships within families or communities with common value; bridging capital is derived from less dense connections with colleagues or neighbours with whom there may be areas of overlap, and linking capital gives people access to organisations or individuals and their resources that are outside of their normal circle.

While acknowledging that there are some undeniable examples of the negative effects of the social capital conferred by faith groups (for example, exclusivity or fundamentalism), the report by Furbey et al. [124] seeks to look with fresh eyes at the activities of faith-inspired groups in the UK and gain a greater understanding of the obvious and more subtle ways in which they contribute positively to this bonding, bridging and linking capital, and how increased involvement with statutory services may affect this.

Furbey et al. conclude that faith communities contribute substantial and distinctive social capital in a number of ways in urban areas, including the sharing of physical resources such as buildings, the richness of their connections and networks, their involvement in governance, and their collaborative work with others. This echoes Lim and Putnam's [116] finding about the importance of the social connections that individuals find in FBOs, as distinct from any benefits of private religious practice. Furbey et al. also point out ways in which the "latent social capital" in faith organisations can be more effectively harnessed; this is an often under-used resource that needs to be recognised by faith organisations themselves, as well as public bodies such as local government, police and primary care providers seeking to serve the wider community.

For example, a church building, used on Sundays and sporadically during the week, may be situated next door to a polyclinic, where there is a constant pressure for rooms in which to run antenatal classes or baby weighing clinics. By sharing the physical resource of a building, the church could give parents the opportunity to connect with the church community in

other ways such as parent and baby groups, or youth groups, so potentially combating isolation and the mental health issues associated with it. A primarily Bangladeshi mosque congregation in the heart of a community where drug use among teenagers is problematic could provide a wealth of cultural understanding for drug workers and the police, and a source of support for parents. An FBO such as Jewish Care, with a strong history of serving the needs of the elderly Jewish population, can share expertise and skills with other organisations seeking to work with those with dementia, as it does for The Reader Organisation in Brent, which uses facilitated reading in groups for people with mental health problems, including the elderly with dementia.[29]

Faith-based organisations and the wider determinants of public health

In their broadest sense, any programmes that seek to take action against socioeconomic inequalities have an effect on health and wellbeing. Health outcomes have been shown to be closely linked to socioeconomic status [35]; growing up in an impoverished household has been shown to impact directly on the wellbeing of children and young people [127], and credit card and unmanageable debt are associated with lower measures of wellbeing [119]. This identification of poverty as a wider determinant of health is recognised within the Public Health Outcomes Framework [1]. Unemployment is also strongly negatively correlated with various measures of subjective wellbeing [119], and some FBOs have responded by becoming involved independently and through government programmes in the area of job preparedness [131, 132].

Networks and interventions that support couple relationships and promote positive parenting will also have direct impacts on health outcomes. Research has found that the impacts of separation on adults include ill health, depression, stress, financial difficulties and unemployment [129]. Specifically, couple relationship dissatisfaction has been shown to be linked to increased heart disease [129], and an extensive review of evidence found associations between couple relationship breakdown and poor child outcomes, including poverty, behavioural problems, distress and unhappiness, educational achievement, substance misuse, and physical and emotional health problems [130].

Some brief examples of interventions that aim to address some of these wider determinants of public health are given below as an illustration of just some of the approaches being taken by FBOs. More detailed examples are provided in the case studies section later in this chapter.

Initiatives to address debt and poverty

[29] http://www.thereader.org.uk/what-we-do-and-why/older-people-dementia.aspx

In the area of debt relief, Christians Against Poverty (CAP)[30] provides one-to-one support for debt management and, by liaising with creditors, sets up individual repayment plans, while at the same time giving clients the option of accessing the social and spiritual capital of a local church. This reproducible model has proved popular as a tool for churches, and CAP has seen a huge growth in its eighteen years, with 260 centres operating across the country, and CAP organisations springing up in Australia, New Zealand and Canada.

Similarly, this model of franchising has made the Christian charity The Trussel Trust[31] and its food banks a household name, with local Christian, and more recently, Muslim groups using this tried and trusted formula to serve economically deprived people who have been referred by statutory services.

Other organisations seek to operate further 'upstream' on the issue of poverty, putting their faith into action from a social justice perspective, by organised lobbying of government for more just approaches to poverty alleviation. For example, Church Action on Poverty[32] was one of the drivers in the 'Make Poverty History' campaign to protest the effects of welfare cuts on the most vulnerable.

Initiatives to address homelessness

Poor or overcrowded housing conditions have been shown negatively to affect wellbeing and mental health. A large number of FBOs work with marginalised groups to lobby for or provide solutions for issues of homelessness and housing. For example, the Catholic charity Emmaus[33] combines sustainable housing solutions with social enterprise; Aquila Way[34] provides supported housing for young people and vulnerable families, and the National Zakat Foundation[35] runs shelters for destitute Muslim women and their children. The Sikh Welfare Awareness Team[36] is a volunteer-run charity providing food, bedding and other support to the homeless in Southall, London, and is one example of a local faith-inspired solution to a local problem of social exclusion.

Initiatives working with young people

Faith organisations have traditionally run activities in their communities for young people, whether in the form of uniformed organisations (Scouts and Guides, Girls' and Boys' Brigades, etc.), through more informal youth clubs or through sports teams. This continues to be a strong emphasis across the UK, particularly in areas of deprivation. Projects such as

[30] https://www.capuk.org
[31] http://www.trusselltrust.org
[32] http://www.church-poverty.org.uk
[33] http://www.emmaus.org.uk
[34] http://www.oasisaquilahousing.org
[35] http://www.nzf.org.uk
[36] http://www.swatuk.org.uk

XLP[37] deal with a wide variety of issues including drug awareness, anger management and gun and knife crime and are making a significant contribution to the public health outcomes indicators around pupil attendance (1.03), violent crime (1.2), and first time offending (1.04) and reoffending (1.13).

Initiatives to support couple relationships

Many faith organisations have traditionally sought to prepare couples within their communities for marriage, with some, such as the Catholic Church, requiring this preparation as a precondition for the marriage to be conducted. In recent years, however, in response to worsening issues of family breakdown, organisations such as the Christian charity Prepare Enrich UK[38] have sought to apply this same level of preparation and support for marriages and relationships in the community as a whole. It must also be acknowledged that the involvement of FBOs in personal relationships is an extremely complex area, with the potential for harmful as well as beneficial impacts on individuals – for example where organisations have encouraged individuals to stay in violent marriages, or taken a strong anti-homosexuality line. This is therefore an area that requires careful consideration and handling. Simply expecting faith agencies – or any other agency – to change attitudes does not work. Enabling faith communities to integrate the best information on science and social science with theological principles to understand the potential for harmful impacts, and understand what their faith is really saying in today's culture is crucial. All faiths spoken of here affirm the dignity of the human person, and that is usually an important starting point for understanding potential harmful impacts.

FBOs and mental health interventions

Although most interventions that address mental health do so by addressing the wider determinants of mental health discussed above, there is a small body of literature that examines the role of religious settings in directly affecting issues of mental health and illness. Again, these studies predominantly address the experience in the Black American church, and the relationship between mental health services with churches and church clergy [133]. One large study in Hawaii [134] showed clergy to be under-confident in their recognition of mental illness, but even when they did recognise it, they tended to provide counselling without referral to mental health services. There is a general recognition in the US literature for the need for more partnership working between the church and mental health services, for example in preventing and treating depression in the elderly [135], and in the older immigrant Korean population [136]. The potential gains of such a partnership are that because churches are trusted institutions to which members and non-members turn for help, a respectful, two-way relationship can mean not only that faith leaders can be confident to

[37] http://www.xlp.org.uk
[38] http://www.prepare-enrich.co.uk

make referrals for those who are more unwell, but the mental health interventions themselves can be adapted with the input of faith leaders to be more culturally relevant. This work ranges from faith-placed delivery of culturally and spiritually adapted counselling by mental health workers [137] to more participatory programmes which train clergy in incorporating psychological approaches to mental health support into the traditional spiritual support offered by Black American churches [133]. The broad issue of a lack of knowledge among clergy – but a willingness to learn – was also found in a study of churches on the Australian island of Vanuatu [138]. Among users of services commissioned from UK faith organisations, isolation and the poor mental health that results from this is a key concern, particularly among women [16].

FaithAction's Friendly Places initiative encourages faith-based organisations and places of worship to make an organisational commitment to recognising the important role they can play in supporting those struggling with mental health issues. Groups signing the Friendly Places Pledge also commit to taking small, practical steps that will help them become places of welcome for all people. www.faithaction.net/friendlyplaces

An initiative addressing mental health: Jewish Care

As an example of an FBO serving those with mental health problems, Jewish Care is the largest health and social care organisation serving the Jewish community in London and the South East of England. It runs over 70 centres and services, with 1,500 dedicated staff and 3,000 volunteers, caring for more than 7,000 people every week. Its staff believe Jewish people should have access to specialist services that are designed to meet their needs; the care the organisation provides recognises traditions, beliefs and cultures that are frequently shared by Jewish people, thereby respecting its clients' Jewish identity.

The range of care services includes all ages, but particularly addresses the needs of the ageing Jewish population, 40% of whom are over 60 – a figure that is twice as high as in the general population. Although a recent report [139] based on extensive qualitative research in the Jewish community has stressed that the needs of the 'well elderly' must be included in care and support, Jewish Care provides extensive services for the elderly Jewish population who suffer with dementia and other mental health disorders. These range from care in individuals' own homes and special day care centres to full-time residential care, as well as advice and respite to carers. The organisation's ethos of addressing spiritual needs, working collaboratively, initiating debate and change in the sector, and sharing its expertise with other agencies reflects a number of the themes brought out in this report.

Case studies

This section contains more detailed examples of how some FBOs, known to FaithAction through its networks, are addressing some of the wider determinants of health and wellbeing. They illustrate how FBOs are making a difference in their communities and to the lives of individuals, whether beneficiaries or project workers. Some names have been changed.

Open Doors – combating isolation and depression

Open Doors[39] is a church-based project in East London, whose vision is to combat isolation and fight poverty by offering one-to-one support for vulnerable families, usually referred by statutory services. Support can be practical in nature, but the ethos of the project is to give access to a caring community where families can find a sense of belonging; in essence, building social networks and gaining the benefits of so doing. The project has been running for eight years and in that time has supported over 200 families. External funding has been a very recent development, and Open Doors continues to be an almost exclusively volunteer-powered programme. Open Doors describes itself as a church-based project for people of any faith or no faith.

Open Doors founder, Sally Dixon, explains:

"*We don't see ourselves providing services as such; we walk people's journeys with them, facing issues that arise together. So for one person, that might be fleeing domestic violence, but we would not box ourselves into a 'domestic violence support project'. For another, providing a place of belonging in an outward-looking friendship group will combat the crippling effects of their previous isolation. Our 'conversation classes' have been a key tool in bringing people together to experience community, but we do not class ourselves as an ESOL provider as such. We just 'do life' with people*."

Open Doors has built up strong relationships with the statutory sector over the years, and works in partnership with social services, the perinatal parent-infant mental health service (PPIMHS), and the teenage pregnancy midwifery team, among others. The workers see themselves as 'adding value' to the work of these statutory services, and referrals or informal advice-seeking is a reciprocal aspect of these partnerships. Open Doors volunteers have tapped into statutory training through these links, and referring health and social care professionals acknowledge that Open Doors can provide the social networks and sense of belonging that statutory services are unable to.

Dr Amanda Jones, parent-infant psychotherapist, North East London NHS Foundation Trust, describes the nature of this partnership:

"The care and support that the Open Doors volunteers have provided for many mothers and babies referred by our service has been exemplary. Often the mothers have been asylum seekers, impoverished emotionally and economically, and with psychiatric diagnoses of post-traumatic stress disorder. They have also been suicidal at times and isolated. The combination of psychotherapy treatment from our service and support in the community

[39] http://www.opendoorsproject.org.uk

from Open Doors has enabled these mothers to transform a breakdown into a breakthrough and enabled the relationships with their babies to flourish."

Ioana came from Romania with her husband and small child, and found herself to be isolated and depressed. She was referred to Open Doors and introduced to Jenny, a volunteer who encouraged her to attend the conversation class. Ioana talks about her journey out of isolation:

"For me, before, I cried because I couldn't speak, and I stayed all the time all day in the home by myself, and cried. I live with a friend of ours - she's friends with me for ten years, from Romania. She was here before I coming. Now, my friend tells me 'How? You meet all London!' All this community, because I meet them at the shop, in a park, on the street…'Hello, how are you?' – something like that. She say me 'You meet all the people from here'. [sic]

The benefit of volunteering is also a key aspect of what Open Doors does. This retired volunteer describes the impact volunteering has had on her personally:

"When I lost my mum last year, there was a big void left in my life and obviously I had a rest period because I was a bit weary. But gradually I started off in the conversation class, and that was a lifeline to me, and just coming here cheered me up because we do have some laughs with those women. I don't know, it just lifts you, I don't know why."

These benefits of volunteering are not restricted to the church volunteers. There is a strong culture of giving back at Open Doors, and many of the current volunteers started off as those being referred for help. This Moroccan Muslim woman describes this journey for herself:

"Why I volunteer? I don't know …. I eat in here, I cry in here, I smile in here, everything!" [sic]

Route 18 – contributing solutions for homelessness

Route 18 Winter Shelter[40] started in 2008 when the Anglican clergy from South Brent were sharing their experiences of a growing number of homeless people arriving at vicarage doors, and discussing ways to help in an empowering and sustainable way. They approached Cricklewood Homeless Concern (CHC) to work in partnership: the churches offered buildings and volunteers, and CHC their experience and expertise. The resulting partnership was Route 18 winter shelter, so called because in the first two years, all the churches involved were on the number 18 bus route. In the second year, the fruitful partnership continued, and the number of participating churches grew to 11, expanding geographically into the north side of the borough. In its third year, this expanded to 14 church centres and one mosque. Of the 82 guests who accessed the winter shelter, 60% were helped to find accommodation. What makes this project so effective is the constructive partnership between the volunteers and CHC staff.

Felicity Scroggie, part of leadership team at the project, explains the 'value added' by the faith-based ethos of Route 18:

"*This is not simply a night shelter that feeds people and then sends them back out onto the streets. Nor is it simply a professional charity that addresses complex life problems of many guests. It is an integral partnership between the volunteers who offer themselves and their resources to brothers and sisters who are equally within the love and compassion of God, and the expert staff who are able to help guests address their complex issues and so begin to rebuild their lives. Guests this year affirmed just how life-giving this combination is. As one guest said, "I came with nothing and you gave me everything. You didn't ask for anything in return. I found a family". The ethos of human dignity, compassion and friendship is at the core of this project. "*

Roman tells the story of his experience with Route 18:

"When I first came to Route 18 Winter Shelter, I had a number of issues I needed to deal with. After spending the last five years in and out of prison and with a bad drug problem, I really needed a lot of help. I found the staff at the Route 18 Winter Shelter were very understanding and really supported me with changing and dealing with the problems that had built up over many years. The staff really helped me to stay focused with the life-changing moves that I needed to make for me to live a productive life in the community. I now live in a one-bedroom flat, and am going to college. I have to give a lot of credit to the staff at CHC as they helped to get me my flat and put me in touch with the different agencies in London that have made a big difference to my life. I am now studying to become a drug reduction worker and in the

[40] http://www.route18.org.uk

meantime I am volunteering."

Maslaha – addressing mental health

Maslaha[41] is a web-based resource that tackles the immediate social issues affecting Muslim communities, and creates a greater understanding of Islam from a cultural and historical perspective.

The rise of mental health issues in Muslim communities and lack of practical resources is a commonly raised concern among medical professionals. Frequently, minority communities are not accessing or receiving effective support, as the stigma of 'mental illness' often means that those who are suffering fear being isolated and ostracised from their community. In partnership with AT Medics,[42] London's largest group of NHS GP practices, Maslaha has produced the 'Talking From The Heart'[43] films focusing on mental health and depression. The films and website were released during Mental Health Awareness week 2013 and combine the advice of medical professionals and religious leaders to address stigma and demystify support and therapy.

Working with doctors, nurses, patients, psychotherapists, Islamic scholars and Imams, from the Somali, Pakistani and Bangladeshi communities, the films address some of the common concerns about depression and anxiety, such as: 'I will bring shame to my family and community.'

The resource is endorsed by the Royal College of General Practitioners, and is designed to be used by GPs and primary care practitioners with their clients. It can also be used by community organisations and mosques, to raise awareness, change attitudes and signpost support.

The short films in three languages (Somali, Urdu and Bengali/Sylheti) with English subtitles can be viewed online at talkingfromtheheart.org, where there is also further information about the project and links to support services. Maslaha also supplies free DVDs as further support, and these can be ordered by emailing info@maslaha.org

[41] http://www.maslaha.org
[42] http://maslaha.org/about/whos-involved/funders-supporters/medics
[43] http://www.talkingfromtheheart.org

Safehaven Women – supporting people to take their place in society

Safehaven Women[44] is a weekly drop-in, purposefully designed as a safe environment for women who have experienced poor mental health, substance or other addictions, homelessness or being a sex worker. It started in response to the request of women attending a Saturday night meal for homeless people at St Peter's church, Brighton.

The project aims to see vulnerable women living confidently, with restored dignity, hope and a sense of their unique value and contribution to society. It provides a safe, homely environment where women can relax and unwind, take a shower and enjoy a hot meal, homemade cakes and fresh tea and coffee and a friendly chat with a volunteer, engaging with healthy social codes of conduct conducive to living confidently in a wider community. There is a range of activities: card and jewellery making, sewing and mosaic art, as well as manicures, pedicures, facials and haircuts. Safehaven works in partnership with statutory providers, signposting to other services as appropriate, and providing support such as transport and escort to hospital appointments, home visits, meals, mini-breaks, and clothing and toiletries if needed. In supporting women to move on, Safehaven can also provide an opportunity to volunteer and where appropriate, references for employers.

Elena's Story

Paula Turton, a Safehaven Women's volunteer, shares Elena's story:

"*Elena came to Safehaven women four years ago when, addicted to alcohol and drugs, she was living in a mutually abusive relationship with her partner in Brighton. She started out attending the Saturday night meal for the homeless community and was one of the original women who helped define what Safehaven women should look like. She found a place of kindness, care and an offer of prayer. She attended sporadically as the ups and downs of her life permitted.*

Her life had involved abuse, prostitution, prison and addiction with the consequences of her children being taken into care. For the past 11 years she had been in and out of rehab, always relapsing during her treatment. However, the hospitalisation of a controlling and abusive partner gave her the window she needed to try rehab once more, and here she encountered a Christian sponsor who challenged her on her concept of a higher power; she returned to St Peter's church this time to do the Alpha course … With support from the church, in the past year she has made new friends, been baptised, and found suitable accommodation within a family from the church, removing her from old potentially negative contacts. She has worked as an intern for Brighton Housing Trust and obtained her first full time, tax-paying job as a support worker for Stopover, a local charity supporting vulnerable young women. She is also

[44] http://www.stpetersbrighton.org/safehaven-ministries

slowly rebuilding the relationships with her family.

Elena readily shares her strength and hope with old contacts in 12-step groups and with new friends. She lives each day with integrity and deep gratitude for the ongoing transformation in her life and it's a pleasure to have her as a friend."

Khalsa Aid – mobilisers of faith-inspired giving and volunteering

Established in 1999, Khalsa Aid[45] is an international non-profit aid and relief organisation founded on the Sikh principles of selfless service and universal love. Khalsa Aid is a UK Registered Charity run exclusively by volunteers, and also has volunteers in North America and Asia. It has provided relief assistance to victims of disasters and wars around the world and provides an important volunteering opportunity for Sikhs and others who share their ethos and values.

Ravinder Singh Sidhu, the Chairman/Founder of Khalsa Aid, explains how he came to set up the organisation:

"At the time of the celebrations across the UK (of the Khalsa tri-centenary) there was a very bloody war in Kosovo and every news bulletin carried the terrible pictures of the refugees struggling to cross the cold and mountainous border to reach a safer and peaceful Albania. The tide of refugees was a never ending tale of suffering and hardship. There was so much food at the Khalsa celebrations yet only 1700 miles away there were people fighting for a loaf of bread! I read about a small group who were organising an aid convoy to Albania. The inspiration from Bhai Ghaniya Ji and Sarbat the Bhalla (wellbeing of all) came rushing into my mind, and at that moment Khalsa Aid was born. The Sangat was extremely generous in donating food and money, and within two weeks we were on our way with two trucks and a van load of aid to Albania. The rest is history!! Since 1999 Khalsa Aid has provided relief to many people. The unpaid volunteers have helped to make Khalsa Aid a global relief agency and from the whole committee we thank them for their input and dedication."

Khalsa Aid has taken up the role of mobilising the potential among UK Sikhs for volunteering and charitable giving. During the 2014 floods, Khalsa Aid was the first charity to send volunteers and supplies to affected areas. An annual event that Khalsa Aid supports with volunteers is a sponsored Snowdon walk. In 2014, funds will be donated to the Jaskomal Foundation's 'Give Hope a Future'[46] campaign, which aims to raise awareness of the need for stem cell donors from Black and minority ethnic communities. Volunteers will be given the opportunity to become registered donors and be screened in a mobile screening unit at the base of Snowdon.

[45] http://www.khalsaaid.org/index.htm
[46] http://jaskomalfoundation.org

Jami – supporting recovery from mental illness

Jami (Jewish Association for Mental Illness)[47] was founded in 1989 by parents, relatives and friends of people with mental illness. It offers a range of culturally specific services for Jewish people who have a severe and enduring mental illness by using a variety of outreach and befriending services. The charity is recovery-orientated and is committed to working alongside statutory services to provide a high quality community-based service that enables people to maximise their potential and take control of their own recovery.

One of Jami's activities is a hospital visiting service, for people who are in psychiatric hospitals or residential care homes, or who are too unwell to leave their own home. Jami has a Hospital Visiting Co-ordinator who liaises with the chaplaincy departments of psychiatric hospitals and hostels to see who would welcome the support that Jami's volunteers can offer.

When the team visit people in hospital they provide encouragement and support and a link to the outside world that might not otherwise be accessible. The hospital visiting team also organises social events for isolated patients at their hospitals – these can be to celebrate the Jewish festivals or provide social interaction with other Jewish patients.

One patient has described the help she received from Jami's hospital visiting team:

"The interest you took in me through your visits at this stage of my illness was a lifeline. I cannot thank you enough."

She is now successfully managing her illness with help from the Jami team.

[47] http://jamiuk.org

Breathing Space – mindfulness based approaches to promoting health and wellbeing

Mindfulness is a Buddhism-derived, secular health intervention that is used within the NHS – for example, it is a recognised treatment for prevention of recurrent depression.

Breathing Space[48] is run by the London Buddhist Centre, based in Bethnal Green, East London. It teaches Mindfulness Based Approaches (MBAs) to help people look after their mental health, focusing particularly on preventing relapse into depression and addiction, and helping to manage stress and anxiety, as well as on stress reduction for carers. The centre's clinical director, who trains and supervises the teachers, is an NHS consultant psychiatrist.

Breathing Space works with and accepts referrals from local professionals, such as those in Community Mental Health teams and addiction and substance misuse teams. The centre currently provides services to the London Boroughs of Tower Hamlets and Hackney, which fund set numbers of free places on some of its courses and retreats, including Mindfulness Based Cognitive Therapy, Mindfulness Based Stress Reduction and Mindfulness Based Addiction Recovery, as well as support for local carers.

The centre has hosted a number of PhD research projects investigating the health effects of mindfulness, looking at, for example, how meditation practice has affected men's lives; what the NHS could learn from Mindfulness Based Cognitive Therapy run in a non-statutory setting; and the health benefits of meditation.

[48] http://www.breathingspacelondon.org.uk

Summing up: Strand 2

Self-reported wellbeing is recognised as having important associations with physical and mental health and, along with other wider determinants of health such as poverty, housing and debt, is a key indicator in public health policy. Social and spiritual capital have also been shown to be significant in contributing to wellbeing, and physical and mental health.

As an ethnically and religiously diverse society, the UK has a vast network of faith-based groups and organisations which embody a rich source of social and spiritual capital. Many who belong to faith communities enjoy the benefits to their physical and mental health that such belonging confers. For others, contact with faith organisations and their compassionate outreach and care has been the thread which has kept them connected with society and has supported them through times of family or financial hardship which might otherwise have tipped them into mental illness or deprivation.

For FBOs, the challenge is to take up a more asset-based approach to their work, recognising and facilitating the development of individual members for building organisational capacity, and wider engagement with community governance and activity. For other agencies such as community and mental health services, the police and local government, the challenge is to develop greater understanding and recognition of these groups and their potential contribution to bonding, bridging and linking capital to service users: the 'value added' which connections in the wider community bring to their professional provision. As wider definitions of health and health indicators are embraced, the contribution of faith organisations – both actual and potential – is an exciting area for the development of partnerships that is yet to be fully maximised.

4. Conclusion and Recommendations

This report has examined a wide range of public health issues and interventions, exploring the role that FBOs have had, and have the potential to have, in contributing to physical and mental health, wellbeing and the wider determinants of health. It has illustrated how FBOs are conduits for action, important builders of social capital, providers of charitable assistance for those who need it and, often, advocates for a fairer society. We have seen how the familiar, culturally appropriate environments of faith settings and the encouragement of respected community leaders can make a significant contribution to addressing determinants of mental and physical health in many communities, as they allow people to connect both with an intervention and with others.

Nonetheless, we must recognise that there are currently gaps in the evidence, particularly with regard to a lack of robust evidence from interventions taking place in FBOs in the UK. We hope that by highlighting this need alongside the enormous potential of FBOs as partners in improving health and wellbeing, we can encourage the building of the evidence base. Neither can we dismiss the finding that there can be negative as well as positive impacts associated with belonging to a faith organisation. However, the strength of the positive evidence points to faith being a factor that is too significant to ignore.

It is vital that the diverse faith sector – the tens of thousands of organisations and communities with their unique position of trust and access to some of the most disadvantaged, as well as willing volunteers – is a central contributor to strategies for tackling the pressing issues in public health, such as rising levels of diabetes, obesity and coronary heart disease. Indeed, innovative strategies for prevention and treatment are already being considered, involving NHS hospital and community provision, as well as voluntary and community sector organisations, including the faith sector. Expanding on this will require public health bodies and commissioners to broaden their thinking to encompass faith groups, and the huge potential gains of partnering with them, in a spirit of two-way learning and collaboration. FBOs themselves will need to recognise this potential, and to step up as willing partners with a 'can do', problem-solving attitude to addressing pertinent health issues within their communities.

Collating the lessons learned from published reviews from the US, and research projects, evaluations and case studies from the UK, there are a number of recommendations that can be made to those working in FBOs, and for those commissioning and managing statutory public health provision. We hope that these will help to build partnerships that make a real difference in communities, and particularly in tackling health inequalities.

We recommend that FBOs should:

- Review the assets of their organisation, including physical assets such as buildings or vehicles, and the time, skills and strengths of their staff and volunteers. By developing this asset-based approach, an environment will be fostered for those accessing the FBO's projects also to recognise their strengths, skills and ideas, and make a contribution, rather than focusing exclusively on their needs. This 'doing with' rather than 'doing to' approach challenges the dependency culture in which people can become entrenched. A useful resource for developing an asset-based approach is the IDeA's *A glass half-full: how an asset approach can improve community health and wellbeing* [140].

- Are proactive in developing relationships with statutory sector providers, bringing to the table their unique flavour and contribution of assets. For example, projects that seek to address issues of deprivation will invariably include individuals with mental health problems, for whom specialist help is required. Building trusted relationships with mental health practitioners is a key to ensuring safe and joined-up care. These practitioners may also be able to provide training for staff and volunteers. The example of 'Open Doors' in the case study section is a good working example of this.

- Recognise that their work, which may seem 'everyday' to them, has often given the organisation and the individuals within it expertise that can be shared. Part of their work may be to share this expertise with others, including statutory agencies, and all relationships across the agencies should be viewed as two-way in terms of referrals and expertise. This will include contributing to the 'faith literacy' of statutory providers. To this end, involvement in governance and taking opportunities to contribute to local government strategy and decision making should all be valued as important means of sharing assets.

- Evaluate their work. Despite the wide range of projects being run by FBOs, there is little evidence of effectiveness for these projects. By evaluating a project, the organisation can understand what is working well and what needs to change, and the difference the project makes in real lives; being able to evidence the effectiveness of their work will also open up sources of funding. A helpful resource for community groups looking to evaluate their work is the new economics foundation's *Measuring Wellbeing: A short handbook for voluntary organisations and community groups* [141]. The Inspiring Impact programme,[49] New Philanthropy Capital (NPC)[50] and Charities Evaluation Services[51] are further sources of support. FaithAction also provides resources and training to help FBOs evidence their work.

[49] http://inspiringimpact.org
[50] http://www.thinknpc.org
[51] http://www.ces-vol.org.uk

We recommend that public health bodies, as they seek to engage with diverse communities and diverse needs, should:

- Become familiar with local FBOs and the work they are doing. Invariably, faith groups that have been working in an area for some years will have strong and trusted relationships with residents and may be a source of information, expertise or other community assets. When carrying out community development activities for health, these assets embodied in the faith sector may help avoid costly replication of resources, and provide a 'foot in the door' with hard to reach groups.

- Recognise the potential inherent in faith groups as partners in addressing particular health issues such as diabetes, CVD, obesity and smoking, alongside other community-based interventions.

- Appreciate that FBOs can provide nuanced insight into the cultural spaces that at-risk groups inhabit. Accessing this insight through genuine joint working can avoid common pitfalls and misunderstanding of social norms, being the difference between success and failure for an intervention.

- Collaborate with faith groups in a participatory fashion, using formative qualitative research with group members to ensure a programme that is culturally sensitive, with the inclusion of spiritual content alongside traditional health content. They should take the lead in always including a robust evaluation as part of the project, and evaluate the work together with the FBO to ensure the growth of the evidence base for such interventions.

- See FBOs that offer support to those who are marginalised as partners. Many mental health and social care practitioners struggle with the fact that their role is limited by time and professional boundaries, and by partnering with FBOs, they can help their clients to access the added value of grassroots support and social connections that is not bound by these constraints.

- **'**Leave something behind' when the project comes to the end of a cycle, or research is completed, by taking opportunities to develop organisational capacity in the FBO, training volunteers, and sharing responsibility for programme development and recruitment of participants. This should include working with the faith groups to ensure financial sustainability after the programme period.

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