Evaluation of the Tower Hamlets Faith Health Action Partnership Project 2022-2023

Final Report

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Introduction

This report provides an evaluation of FaithAction's Tower Hamlets Faith Health Action Partnership (FHAP) project. The first focus on the evaluation is to provide a summative assessment which looks at the extent to which the FHAP project has delivered as per the expectations of the funder. To this end, the evaluation approach has looked to capture good practice and areas of learning from FHAP which can be used by other programmes and projects.

The second focus is on trust: the evaluation aims to build an understanding of the relationship between FHAP's approach and activities and the trust between participants, places of worship and the local authority. With a faith sector agent leading delivery, rather than the local authority or public health bodies themselves, the research presents an opportunity to explore the role of the faith sector in local health action through the lens of organisational trust. This second focus is designed to provide insights to inform future delivery models.

FHAP

The FHAP project is funded by Public Health at Tower Hamlets Council and led and coordinated by FaithAction, a national network of faith-based and community organisations. In delivering the project, FaithAction work in partnership with East London Mosque and is supported by Tower Hamlets Inter Faith Forum. The project supports 8 local faith settings and faith-based organisations to deliver 10 different health focused projects to the local communities. This work builds on the work of the Faith COVID Assistance Partnership, which provided support and COVID-19 infection prevention supplies to many places of worship in Tower Hamlets throughout the pandemic.

The projects offer a wide range of health-based projects, including activities for young people, healthy eating guidance, fitness sessions and blood pressure checks. These projects were co-developed with the local faith leaders to ensure that they address real, local, community need in Tower Hamlets.

The 8 faith-based groups funded to run projects in the borough through FHAP are; Cycle Sisters, Christ Apostolic Church, Shahporan Masjid & Islamic Centre Trust, Globe Community Project, Dorset Community Association, Newark Youth London, East London Mosque and Wapping Noorani Masjid & Cultural Centre.

Evaluation Objectives

This evaluation has three clear objectives, requested and agreed at inception by FaithAction and Public Health at Tower Hamlets Council. These are:

A. Evaluating the delivery of FHAP against funded deliverables.
B. Capturing best practice and areas of learning to inform future faith sector led delivery.
C. Developing an understanding of how faith sector delivery impacted on participant's organisational trust towards the FHAP project itself, the local authority and local public health bodies.

Methodology

The research team has taken a mixed-methods approach to the evaluation, bringing together a range of data types in order to produce a breadth and depth of findings on the programme's progress and impact.

Evaluation and monitoring have been built into the programme from inception, with each project lead having reporting requirements and evaluation data collection responsibility which relate to the interests of both the funder and FaithAction. In particular, projects have provided data on beneficiaries' trust in different stakeholder groups and institutions and demographic data. On top of quantitative reporting data, FaithAction have also collated a range of case studies to which the evaluation team have also had access.

The evaluation team have sought to supplement this with additional qualitative data from three main sources:

1. Semi-structured interviews with Project Representatives (n=5);
2. A semi-structured interview with a Funder Representative (n=1)
3. Semi-structured interviews with FaithAction team members working directly on the programme (n=3).
4. In-depth site visits and observations with two projects, including focus groups with participants from two projects (n=24).

The qualitative data collection focused on people's perceptions, personal experiences and views of the programme, aiming to complement the quantitative data which focuses on more comparable and measurable progress indicators around trust. Collected solely by the evaluation team, the qualitative data also add independence and rigour to the evaluation overall.

Data from across these methods has been synthesised, using analysis which allows themes to be drawn from the data. Findings are, where applicable, triangulated between datasets, meaning that quantitative data, observation data and interview/focus group data are brought together to support or discuss key points throughout.

The data collection process has prioritised the avoidance of detriment to participants and projects, working around the delivery of project. This does mean, however, that qualitative data collection relied on convenience sampling – involving those who were taking part in activities during fieldwork visits and prioritising two sites which were available for visits – meaning that data collected is not chosen through random selection and may be less-than-fully representative of the whole population of programme beneficiaries. Despite these concerns, researchers found a good degree of saturation in the findings from the data, meaning that very similar themes and ideas were raised across focus groups and interviews and, towards the end, no new themes were raised. This is not to say that the views and experiences of all individuals are represented in this limited dataset but that there can be a good degree of confidence in the validity of findings and broad themes in this report.

Project Data and Findings

This section splits into 3 subsections to present analysis and discussion of data and findings around the demographics of those engaged by FHAP, the outcomes of the work around well-being (comprising physical health and mental health outcomes) and finally trust in people and organisations. This allows for a rounded review of delivery according to both the original aims and desired outcomes and the externalities and outcomes that emerged as the work was undertaken.

FHAP was purposefully designed to not be output and deliverable focused with the emphasis instead being on allowing for community-led interventions and understanding the impacts and dynamics of those involved. This sits in stark, positive contrast with the evaluation team's experiences of almost all other similarly funded programmes, which are often preoccupied by targets and numbers to the detriment of understanding and documenting the meaningful change which can be achieved through these interventions.

> *"It is better to involve local stakeholders rather than just doing to them."*
> - Commissioning body interviewee

> *"There were no minimum numbers to engage with and this really helped. TH understood the approach and that all the projects would be different and have different levels and numbers of engagement."*- FaithAction interviewee

Whilst it is important to note the numbers engaged with and the reach of the programme, this evaluation, like the programme itself focuses on the more experiences and perspectives of those involved in FHAP, as providers and beneficiaries, and what these experiences mean for the future delivery of similar pieces of work.

As discussed in the Methodology section of this report, the quantitative data used is drawn from that collected by FaithAction from the 10 projects and is the latest and represents a complete dataset for the programme and thus gives a reliable and useful reflection of the work undertaken and the perceptions and outcomes for those involved.

The 10 Projects and their Demographic Reach

The section below gives details of the 10 FHAP projects and the numbers engaged in them and presents the demographic data of those engaged alongside contextual analyses of these.

The table below outlines the 10 projects with a brief description of each and their activities alongside the total number of participants who registered as being engaged with the project. The numbers here show distinct engagements, with each individual counted once per project regardless of how many sessions they attend. This means that the total number of project sessions attended over the course of FHAP will be far higher than the total number of participants engaged.

It is recognised that the 10 projects are very different in their aims, approaches, cohorts and scalability. Therefore, direct comparisons between the number of participants engaged by each project are unlikely to be analytically fruitful; in particular, those with higher numbers should not automatically be regarded as "better" or "more impactful" than those with a smaller number of registered participants. The less-than-prescriptive, open nature of the funding – advertised widely to groups who are not ordinarily engaged in this work – and the fact that it was not target driven in the same way that many other similar schemes are, enabled and empowered local people and groups to design interventions that they felt addressed distinct, local need. This approach is, in the evaluators and project stakeholders' views, a positive one and should not be marred by a reductive assessment at project end.

An example of this can be seen in the quote below with a case study of this later in the report:

> *"Also all of the externalities aren't captured. Look at the example of [NAME]. It is important that people like her have been moved from not being able to ride, which wasn't a target but something that we helped with, to actually riding, which was a target. She couldn't ride but we helped her and signposted and now she has a bike and might be a ride leader. She wants to be. She is also now actively involved in the female Somali community."*
> - Cycle Sisters Interviewee

Project Lead	Description	Participants Engaged
Cycle Sisters	The Cycle Sisters Tower Hamlets group hold weekly group rides for local people. Suitable for all levels of ability, with support from Ride Leaders, the rides are a way of getting exercise whilst chatting and enjoying the surroundings. The project seeks to enable local people to make a positive change, open up new possibilities in their lives and boost self-esteem, hoping that these good habits filter through to family life.	51
Christ Apostolic Church	Christ Apostolic Church, in Bow, are holding a diabetes and blood pressure testing service for the local community. Taking place once a month after church service, the church opens its doors to the whole community for these health checks. The checks are carried out by a member of the church that is a nurse and people that get checked out often share tips with each other, on healthy eating, ideal measurements and how to lower blood pressure.	36
Dorset Community Association	The Dorset Community Association Elders' project aims to promote healthy eating and fitness, as leaders of the organisation were aware that levels of diabetes, high blood pressure and obesity were a cause of concern. The project aims to make attendees aware of healthy living choices, as well as providing a space for people to meet and connect. The sessions include a fitness class and advice on healthy food. In addition, people that attend see the session as a social hub, which helps to tackle loneliness and isolation.	17
Dorset Community Association	The Dorset Community Association Women's project has the same aims and approach as the Elders' project above but runs at a distinct time for a cohort of women in the local area.	25
Shahporan Masjid and	Shahporan Masjid & Islamic Centre Trust runs sessions aimed at young men aged 15-25.	29

Islamic Centre Trust	There is a focus on the prevention of a range of linked issues, particularly around getting involved with gangs, crime and drugs. Guidance is given on challenges faced and how to deal with them constructively and make the right choices whilst space is also made for youth-led conversation and discussion.	
East London Mosque and Maryam Centre	The East London Mosque Senior Citizens Group meets weekly and attendees can chat, receive health advice from visiting services and take part in light exercise. There have also been day trips with the group taking them out of London. The project has been vital for tackling loneliness and keeping older people informed of health advice. The group is peer-facilitated, offering vital health awareness tips and activities that can also be provided in community languages.	34
East London Mosque and Maryam Centre	The Maryam Centre Group focusses on exercise and fitness for women. An hour-long exercise session takes place each Wednesday and, as with the East London Mosque Senior Citizens' Group, a day trip has taken place outside of the Borough. Many of the women attending had not been outside of the Borough since before the pandemic. The group is also peer-facilitated and offers vital health awareness tips and activities that can be provided in a range of community-relevant languages.	12
Newark Youth London	Newark Youth London provides support and activities for young people but has identified a need for parents and older people to access sports and physical activities. The organisation is now running a pilot project, offering a mix of indoor activities such as yoga and outdoor activities like walking groups. These activities help to address health problems, boost mental wellbeing and tackle loneliness.	19
Globe Community Project	Globe Community Project is running a project that helps people cope with chronic pain and illness. Take Back Your Life is a pain management programme aimed at people who lack access to help and the team are training up 'Mindfulness Champions'. The project aims to cascade skills and learning gained on the "Take Back Your Life" pain management programme into the local community. Local Champions have been equipped to run mindfulness workshops for the local community, having been trained in motivational interviewing, self-belief, positive psychology and identifying values and strengths.	11

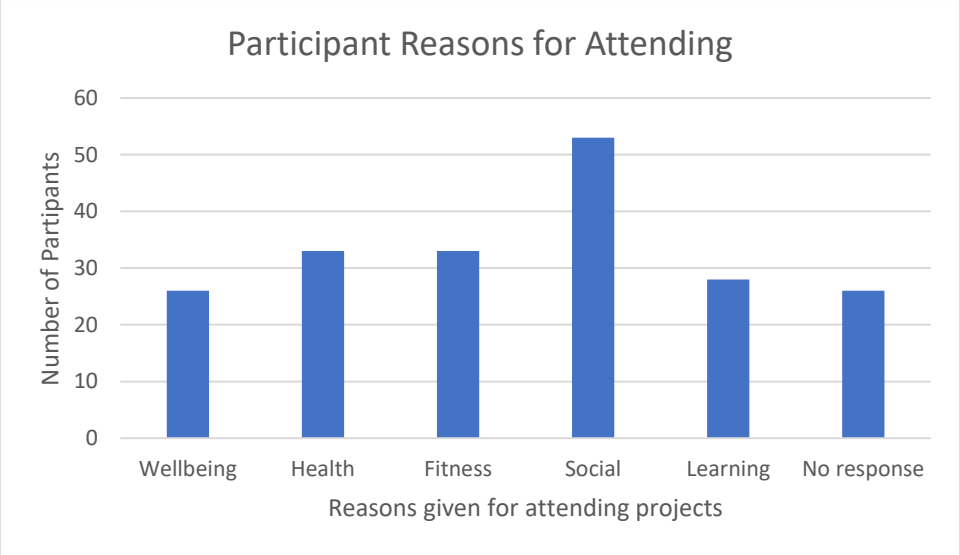
Wapping Noorani Masjid and Cultural Centre	This project is running fitness and health awareness sessions in Wapping for people aged 50 and over. The leaders were aware that a lot of people were extremely isolated, and lacking in exercise, leading to health issued associated with this. They were also aware that older people in Wapping cannot easily access other service in the borough. The sessions also have a part time advice worker to assist people with filling in forms, such as for benefits and offers occasional beneficial activities such as massage	11
	Registered Total	**245**

An indicative estimate of the number of people reached indirectly by FHAP can be arrived at by adding together the number of people who live in the same household as those registered on the programme. The data available at the time of writing gives a total of 651 individuals, though this can be considered a minimum given that 20 respondents did not provide an answer.

Despite this, a direct engagement with at least 245 participants and indirect engagement with at least 651 is an impressive return for the scope and scale of the FHAP work. This is especially the case given that many of those who have been involved in the programme are – anecdotally at least – those who are not engaging with other health or social services. These participants are regarded by some interviewees as *"traditionally hard to reach"* for statutory bodies.

The reasons given by participants for attending FHAP projects are shown in the figure below and this goes some way towards explaining why the projects have a greater reach than traditional NHS or Public-Health-led interventions. The main factor that participants gave for attending was for social reasons (53 respondents), some way ahead of health, fitness and well-being (33, 33 and 26 respondents respectively). Here we can perhaps see the first indication of the advantages of the non-traditional offer of the programme which may not be found in regular, NHS and Public Health provision. This was a view also expressed by some research participants and links to the logic of the initial commissioning:

> *"No one goes to the hospital or the GP to have tea and talk to their friends"*
>
> - ELM participant
>
> *"The faith sector is already there and is established, both in terms of physical presence and people's minds and habits, so use them."*
>
> - Commissioning Body Interviewee



In terms of ethnicity, the majority of participants in the projects are from Bangladeshi backgrounds, accounting for 67.8% of the total. Whilst Tower Hamlets has the largest Bangladeshi populations in the UK – for example, 14% of the Boroughs residents' list Bangladesh as their country of birth (Census 2021) – this is still disproportionately high. Furthermore, the third largest ethnic group taking part were people from Pakistani backgrounds (3.8%). This engagement with Bangladeshi and Pakistani beneficiaries points to a success and strength for the approach across the Borough, particularly as it is well documented that South Asian populations are regularly identified as a priority group which faces barriers to NHS and public health engagement nationally (Douglas et al. 2011; Khan, Kerr and Kingston 2016; Woof et al. 2020). Similarly, Black African participants make up the second largest cohort, 14.8% of the total – a further group which the evidence suggests that the NHS has sometimes struggled to reach effectively in physical health (Bamidele et al. 2019) and mental health (Degnan 2022) services. This percentage is significantly higher than the percentage of Black African residents in the Borough which is 5% according to the latest data (Census 2021).

This engagement with people from ethnic minority groups in the Borough, and particularly those ethnic groups with which the NHS has struggled to engage in the past, seems highly positive. It is an approach that has perhaps supported the positive momentum built during the height of the Covid-19 pandemic in the Borough, linking well to a key focus for FHAP:

> *"Covid and lockdowns created a lot of pressing issues and priority areas of working …. A lot of these came down to who wasn't accessing provision but should be or needs to. Hence faith sector involvement."*- FaithAction interviewee

Moving to the faith groups of beneficiaries, the table below adds to the analysis above showing that the largest faith group engaged with by FHAP was Muslim. These participants accounted for 73.2% of all participants with Christians making up the next largest cohort at 15.3%. The data shows a clear overlap between the large Bangladeshi involvement and the high proportion of Muslims engaged and also between Christians and Black African participants, given the demonstrable links between those respective ethnic groups and religious practice (e.g. census data shows that over 90% of the Bangladeshi community in England identify as Muslim (Census 2021)). Whilst it is possible to break the data down further into a combined analysis of ethnicity and religion, this analysis has not been included in this report as the small datasets in some groupings could lead to participants being identifiable.

Linked to this, the data also suggests that engagement via faith-based groups and centres is not a panacea for engaging with all demographic cohorts across the Borough as there are

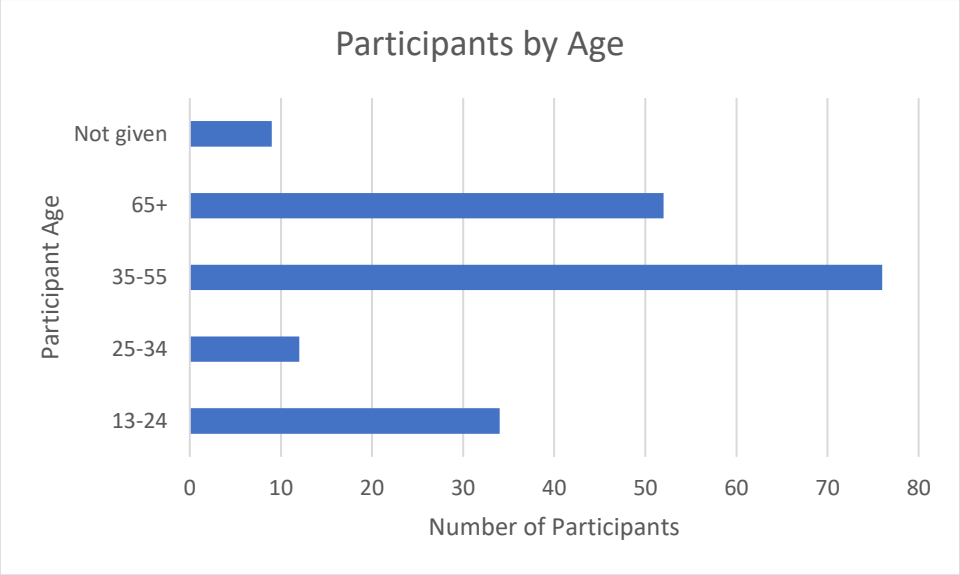
some which are less likely to be accessing any kind of faith centre or place of worship. Only 1.6% of participants said that they did not belong to a faith group, far below the 26.6% of Tower Hamlets residents who stated that they had no religion in the 2021 Census. This is not an issue with the FHAP project or the work that has been undertaken here but a note of caution regarding access and accessibility for those of non-faith backgrounds. It is to be expected that a Faith Health Action Partnership would attract a distinctly low number of people of no religion.

Faith Group of Participants	Number of Participants	Percentage of Participants
Buddhist	1	0.5
Christian	28	15.3
Hindu	1	0.5
Muslim	134	73.2
No religion	3	1.6
Not given	14	7.7
Other	2	1.1
Total	**183**	**100**

Participant data by gender is shown in the table below and highlights a slight majority of male engagement in the FHAP projects. Some of the projects are explicitly gender focused but there are mixed projects and 3 which are aimed at females only. Gender-based engagement was not an explicit aim for the project overall: this table is included largely for information purposes and to demonstrate that there has been an attempt, and partial realisation, of balanced engagement.

Gender of Participants	Number
Female	72
Male	102
Non-binary	1
Not given	8
Total	**183**

Finally, the figure below shows participants engaged by age. Here too there is a good spread across the age bands. This is perhaps to be expected given the focus of different FHAP projects on different age-based cohorts but shows the wide appeal of the projects which has surfaced from the programme.



An important benefit of engaging widely across the age spectrum was highlighted by several different project leads:

> *"Kids have parents and grandparents. We get them involved through the kids"*
> - Dorset Community Association Lead

This process plays out in multiple ways with different, respective projects with some working with younger people with whom they engage regularly as a route in to engaging with their parents or elderly family members whilst others engage primarily with the older generations but are able to leverage these relationships to reach younger people. These known familial pathways are not routes that are easily open to more traditional NHS or Public Health interventions but are an effective means for reaching people who may not engage regularly or effectively with health programmes and public health messaging.

Well-Being

All 10 FHAP projects had some element of well-being support or focus planned into them. This focus on well-being was widely interpreted, fitting with the strengths of each project. Activities range from physical interventions, such as measuring blood pressure, exercise classes or cycling, to more psycho-social and emotional foci leading to activities such as encouraging positive conversations amongst young people and re-building older people's social networks. The projects are all very different, tailoring to organisational capabilities and local need, which is undoubtedly a strength of the work and testament to the locally-designed interventions.

Most projects tend to have a focus on improving the physical health of participants but also generate outcomes which are related to improving the mental and emotional health of participants too. The pre-implementation needs assessments made clear that mental health support, including around isolation and social anxiety post-pandemic, were priority areas, but this was not overtly translated into projects with an explicit focus on these.

> *"We go for social and physical benefits. 40% or so of our participants are either disabled or have health issues. Covid isolated the over 50s. We show them that the community cares."*
>
> - Project Lead

Interviews with those commissioning and running the projects suggest that physical health interventions were oftentimes seen as a means to engaging participants around mental health, as well as valuable in their own right. Interviewees suggested that it was likely to be the case that, for many of the communities and cohorts engaged, overt discussions of mental health are seen as taboo and that advertising projects primarily as mental health interventions may prevent people from accessing them. Even where this was not the case, it was felt that participants would be unlikely to be sufficiently motivated or engaged to take part in projects which did not have more physical activities on offer:

> *"Explicitly meeting for mental health support might be a barrier for some people. Plus, people need to have a background activity to get them talking."*- Project Lead

> *"We have a focus on women's health. They check their blood pressure and weight. They also do a self-check in on themselves about how they feel emotionally and how this baseline data changes. We put aside 3hrs for a bike ride but this always fills up with conversation. We don't make people talk but they do."*- Cycle Sisters Lead

This understanding of the relationship between mental health support and physical health offers and the cultural context behind it likely shows a high degree of implicit cultural intelligence offered through the projects.

Though data has been recorded and reported by all projects on the work that they have undertaken, the diverse nature of the projects means that effective and useful comparisons of outcomes between projects is limited. Directly comparing, for example, a member of the congregation having their blood pressure tested after service at Christ Apostolic Church with a woman attending her first bike ride with Cycle Sisters would not yield meaningful findings in relation to programme outcomes because the interventions and people's exposure to them are very different. It would also be reductive to report solely on the number of interventions that have taken place or participants engaged as this does not give any insight into the breadth or depth of the intervention or, in some cases, the outcome of it. This section therefore focusses on participant experience across the programme as a whole with regards to both physical health and mental health outcomes.

Physical Health

There is a large body of evidence in the project data collected by FaithAction that physical health interventions have been offered and undertaken by beneficiaries. Though evidence of an output is not the same as there being evidence of a positive outcome, there can be firm assumptions that activities, such as exercise classes for the elderly, taking place do lead to physical benefits – in the immediate term at least – for beneficiaries.

> *"I've had one lady say she wouldn't exercise at all if she didn't come here. Yeah, she uses a walking stick…like the first week she was just sat by the wall watching because she's got a bad back so she wasn't sure but now look at her!"*- Newark Youth London

> *"I saw a group of 11 men engaged in exercises at the back of the main hall. The session ended by 100 steps run inside the building. 56 years old Ahmed who is living on incapacity benefit told me 'It helps me to keep moving on since I lost my factory job two and a half year ago due to severe arthritis."*- FaithAction visit to Dorset Community Association

Alongside these direct physical interventions, many of the projects also run sessions or have space in sessions dedicated to improving knowledge and awareness of important health issues for beneficiaries. These include learning around strokes, heart disease and diabetes as well as when and how to access primary care services in the borough. Some of these sessions have led to clear behavioural changes in participants. These changes range from small-scale shifts with the potential for longer-term benefits – for example, one participant has

stopped adding extra salt to his food after learning of the health risks of this – to much more acute changes, as seen in the example below:

> *"I had one person, last month, who had stopped taking their high blood pressure medication. When we did the reading and it was through the roof, I told him, you have to start taking your medication again – and he did."*- Nurse, Christ Apostolic Church

In combining a wide range of practical and accessible interventions to get participants physically active and introducing basic health literacy concepts to participants, the outputs undertaken by the FHAP projects can be seen to be highly likely to have achieved positive physical health outcomes for those involved in them. This is particularly likely to be the case where, often elderly, participants have been undertaking no other forms of physical activity.

Mental Health

Whilst well-being outputs related to mental and emotional health were not explicitly designed into the logic of many of the projects, there was an expectation amongst many projects' leads that mental health outcomes would surface organically.

> *"Mental health is an issue for our cohort and we know it. But we don't explicitly lead to discuss it. Conversations are led by the cycle lead but take on their own life. We give space for people to talk. Safe space and trust link here."*- Cycle Sisters lead

Many participants have been isolated from family, friends and the wider community by the Covid-19 pandemic and those with outstanding health conditions have been less keen and able to re-engage fully in previous activities. For many of those taking part in the research, this has taken a significant strain on their mental well-being and the FHAP projects have provided a route to re-engaging and addressing these issues. In this respect, the logic articulated by the project leads has played out in reality.

> *"'So I hadn't cycled for ages and I picked it up again in lockdown. For my wellbeing yeah – God you know, it was such a tough time. I got such bad depression. I couldn't cope with lockdown. I actually requested to be furloughed because I wasn't coping. So yeah I went out riding with my husband and I was so wobbly I was like 'just…stay away! Don't ride so close to me!' And then I heard about Cycle Sisters"*- Cycle Sisters participant

The projects' being designed in this way, actively providing space for participants to talk to one another and develop relationships, has led to significant disclosures from some participants about their own mental health and challenges with well-being, pandemic related and not, and the building of new social networks and support – this was clearly observed during site visits by the evaluation team. This links well to recent research which shows that individuals with low levels of satisfaction with their social relationships have a far greater risk of developing chronic health conditions, including heart disease and depression (Xu et al., 2023).

> *"One lady in her 70s lost her adult children to Covid and really found this as a space to let her issues out and talk. It's more than an exercise class. That gets people through the door then they talk"*- Dorset Community Association

> *"You don't just sit on your mat and then leave – people get to chat, get to know each other – that's the difference between classes here and in the big studios."*- Newark Youth London

This links to findings around trust and the role of the faith sector in the delivery, both of which are discussed in the following sections.

Trust

Trust is a word that is in the common vernacular but is not a term frequently interrogated or explored in great detail. However, as a desired change from the FHAP work was to build trust in the local authority, Public Health and NHS in the London Borough of Tower Hamlets, it is important in this evaluation to clearly define trust and to understand more about how and why it may, or may not, be built in these bodies by FHAP.

It is generally accepted that trust is *"the willingness of an individual to make themselves vulnerable to the action of another party based on positive expectations of the motivation and behaviour of that party"* (Rousseau et al. 1998, Mayer et al. 1995). This definition fits with the majority of trust literature across respective fields of interpersonal and organisational trust and so will be the definition used in this evaluation.

The data in this section covers interpersonal trust and organisational trust. Interpersonal trust is individuals making other individuals a referent of their trust (the entity to which their trust refers or is directed – e.g. 'I trust my friend', 'I trust my GP'). Organisational trust covers the trust that individuals feel towards an organisation (Mollering, Bachmann & Lee 2004: 557), such as the NHS, a local authority or Public Health department.

Both interpersonal and organisational trust models align well with the trust-related data that FHAP has collected from participants and allow for comparison between the two. The OECD Trust in Public Institutions methodology was used in the FHAP Project Registration Form. This gives indicators of participants' levels of trust in both public institutions and other people. The OECD methodology is an established and validated scale with good reliability.

Data was collected by the FHAP projects when they registered new participants and as such only shows their perceptions at the time of the intervention, and not afterwards. Therefore it is not possible to quantitively demonstrate any changes in trust over the course of the participant's time with FHAP. Participant trust perceptions were not collected pre and post involvement with FHAP because of the different natures and depth of the 10 projects and the fact that some (such as the work at Christ Apostolic Church) are one-off involvements for most participants. This would have generated a patchy paired dataset and one that was not comparable between projects.

The quantitative data is good for showing how participants perceive other people and the institutions involved in FHAP though, and this does generate interesting findings. The table below shows both the mean and the median levels of trust for participants who completed the registration form. What is most striking and pertinent for the FHAP model of delivery is that the median and mean levels of participant trust towards most people and the 3 'organisations' involved are broadly similar. In fact, participants have slightly higher mean levels of trust in Tower Hamlets Council generally, local NHS services and their local Public Health Department than they do most other people.

Question	Median	Mean
How much do you trust most people?	6	6.2
How much do you trust most people that you know personally?	8	7.2
How much do you trust Tower Hamlets Council?	6	6.3
How much do you trust local NHS services?	6	6.5
How much do you trust your local Public Health department?	6	6.3

The outlier in the data is that participants, perhaps understandably, trust those they know personally significantly more than they do "most people" or the 3 organisations. Given that

FHAP uses well known and established local agents, via the faith sector, to engage with participants, this means that participants are being approached by individuals with whom they are more likely to have trusting relationships. The qualitative data supports this line of analysis, as explored further below.

It is well-established in the academic trust literature that trust can act as a "lubricant" in interactions and transactions and, as such, it is clear to see how the FHAP model is likely to be appropriate for engaging with participants who have low trust in organisations and have higher trust in key individuals, some of whom may be categorised colloquially by public bodies as *'harder to reach'.*

> *"We can reach people that the statutory can't because we've been here since 1984 and are trusted."* - Dorset Community Association Lead

> *"We come here because we know the people. If [name] says that this will be a good thing for me, then I will believe him and try it."* - ELM participant

> *"I don't know my GP. If I get an appointment it is never the same person. Who are they? They don't know me"* - ELM participant

It is challenging to assess how much the FHAP work has changed perceptions of participant trust towards the 3 organisations. In part this is because of the lack of post intervention data but in large part too it is due to FHAP's being run in a way that was not overtly statutory-body led. Whilst this has been clearly beneficial in engaging the cohorts at whom the work is aimed, it is also the case that for trust to be conferred upon a local authority or public health body, the participants need to be aware that the local authority generally or public health department specifically have been involved in the programme. Although registration forms and much of the promotional materials did have the Council logo on this, this may not have been overt enough for many participants and may represent a missed opportunity.

Project Leads tend to feel that FaithAction have been a close partner in the work but that this would be the extent of "outside" involvement of which participants would be aware. This was corroborated by participants involved in the fieldwork.

> *"How can they (the participants) start to trust the Council when they are never here? I'm here and FaithAction are here. But the Council aren't."* - Project Lead

> *"Is trust passed on to the Council? I'm less sure here. There is a clear partnership with FaithAction and FaithAction invite the council to local faith events and sessions. If the Council do benefit then it is as a friend of a friend."* - Interviewee

> *"I don't know who funded this work or why. I thought it was just here."* - Participant

This challenge in determining how trust is conferred or how participant perceptions change as a result of FHAP is made more difficult by three other factors. Firstly, many of the participants with whom the evaluation team met and spoke were unsure of what the difference is between the NHS and their local Public Health department. Here there have been assumptions made in the design of FHAP (and this evaluation) that this distinction would be common knowledge. It is difficult to build trust in one or both when participants are unable to accurately distinguish between the two. Typically, participants tended to articulate all health interventions as being NHS-led or related to the NHS. When this happened, the work of Public Health here was either credited to the NHS or participants were unaware of it.

Secondly, organisational trust was quite an abstract concept for many participants. Particularly when discussing Tower Hamlets Council, many participants regarded their perceptions of the Mayor of Tower Hamlets as their point of reference. This was a commonality across age and other demographic groups.

> *"I don't want to say too much at this stage as he is quite new and not had a chance to do much yet but, yes, I trust the Council. The Mayor is good"*- Participant

The reference to the Mayor of Tower Hamlets here shows how lines can be blurred between an organisation as a structure and the individuals who represent the organisation and the values it seeks to project (Ashforth, Schinoff & Brickson 2020). This, in turn, makes the distinction between interpersonal and organisational trust harder for individuals to recognise and distinguish. When assessing the role that a participant's trust towards an organisation plays in the outcomes of a project, it is clear that the organisation must be the referent of trust. There are clear parallels here with interpersonal trust, though Zaheer et al. (1998: 142) warn against the dangers of anthropomorphizing and this does make us question the value of trust indicators around Tower Hamlets Council as they may be more of an opinion poll towards the Mayor of Tower Hamlets than an assessment of the work of the Council. It would not be reasonable to expect FHAP, or indeed any programme or project, to have much impact here.

It is, though, common for people to assess trust in organisations in this way and when contacting organisations, individuals are likely to encounter representatives (or internal stakeholders) of the organisation and use these individuals as being representative of the wider organisation (Inkpen & Currall 1998). Giddens (1990) proposes similar when discussing 'facework'. Here trust must be placed in experts, or those representing systems, before they can be placed in the system itself. This potentially blurs the lines between interpersonal and organisational trust, however Fombrun (1996) presents the case that the actions of internal stakeholders form a reputational umbrella under which both the individual and collective actions of those representing the organisation sit together.

This has particular implications for analysis of the FHAP work where participants are being asked for their trust-related perceptions of health professionals. Here we can reasonably expect perceptions of experts representing systems, such as GPs and nurses, to be mapped onto wider perceptions of the systems themselves. This is possibly why participants were more able to relate to the NHS than their local Public Health department when questioned; they will simply have had more face-to-face contact (or be better able to visualise contact) with those representing the NHS.

Lastly, some participants questioned why they were being asked about their level of trust in other people and organisations, including London Borough of Tower Hamlets and the NHS, when they registered for the programme. A number completed the registration forms but did so largely because they were asked to by a person or institution which they personally knew and trusted. Many were not comfortable with being asked directly about their level of trust towards organisations that may play key roles in their lives, including as landlords and health care providers.

> *"[Name] told me that he noticed most people who have filled in forms, complained that they were not sure about the second page of this survey (Trust survey) but did it anyway."*- FaithAction

This may go some way towards explaining both the generic nature of the quantitative data collected through the registration forms but also why some projects reported challenges in ensuring that all participants completed and returned registration forms. A subtler approach to gathering perceptions around trust may have been more beneficial to participants whilst also generating better data.

Overall, it is hard to determine how successful FHAP has been in building trust towards Tower Hamlets Council, local NHS services and the local Public Health department. The relationships involved are complex and intertwined and, for participants, the interaction has often been a combination of fleeting and opaque. It is not clear how or why participant trust should be conferred upon the 3 local bodies through FHAP.

There are possible benefits in terms of trusting relationship over time though via the leads at projects and the organisations which hosted FHAP projects. These leads and organisations are demonstrably trusted by participants and have now built better relationships with Tower Hamlets Council, local NHS services and the local Public Health department. These relationships can grow and become more visible to participants and the wider public if they are maintained. Public Health were mindful not to impose themselves on the projects but were available, and did, present certificates at the end of project celebration. A less cautious approach going forward may be more beneficial.

The statistical data very much supports FHAP's logic: much of the engagement of participants and subsequent work that took place was only possible because these trusted faces at local faith institutions, and the institutions themselves, are already trusted by beneficiaries and trusted more than public authorities.

> *"The council couldn't run these because they don't have the grassroots contacts, local expertise or the capability to connect with people. That isn't what they do. They are a bureaucracy. They do want to do good but aren't best placed to do it directly here as there is mistrust."*- Project Lead

This should be the core finding and takeaway of this report with regards to participant trust and is explored in more detail in the next section which discusses the role played by the faith sector.

The Role of the Faith Sector

The trust data in the previous section makes clear that participants in FHAP projects trust those people that they know from the 10 projects more than they trust other people in general and Tower Hamlets Council, local NHS services and their local Public Health department. This serves to justify the approach used by FHAP in engaging participants through the local faith sector and trusted, known local agents who represent faith organisations and groups in the Borough.

> *"They (mosques) are often more trusted than government institutions. Really, they are an interlocutor and trust is massive here."* - Interviewee

In part, employing the faith sector to engage with people who otherwise would be unlikely to take part in public health interventions works in Tower Hamlets because faith spaces are physically present in participant's immediate localities and, often, are buildings with which participants are familiar and comfortable. There is a trust in both the people representing the organisations as they are known but also in the space itself and this also serves to reduce situational anxiety (Smith & Ellsworth 1985) or *"nerves"* around taking part. Where trust is related to positive expectations, anxiety is related to negative or uncertain expectations.

Anxiety is one of the main moderators of effective project engagement (Stephan & Stephan 2005) and at its root is an uncertainty on the part of the participant as to what will happen and how. Knowing what to expect in a scenario can remove this uncertainty and also mitigate risk of social embarrassment, as it would allow beneficiaries to rehearse or think through their actions beforehand. The ability to mentally rehearse scenarios has been demonstrated to increase self-efficacy and in turn reduce pre-engagement anxiety (Crisp & Turner 2012: 160-164, Stathi et al. 2012: 243). A participant engaging with the perception that the project is backed by organisational values that protect them, and in a place that they know and have positive prior experience of, is key to getting them through the door and involved (Yarrow, Campbell & Yarrow 1958). This then enables a further leveraging of trust:

> *"We've been here and doing this sort of work for longer than most people have lived in the Borough. They come to us because we are a constant"* - Project Lead

> *"It is a trusted space. We can talk here in a way that we can't at school or the youth clubs"* - Participant at Shahporan Masjid and Islamic Centre

It is also the case for many participants that faith buildings and spaces are the only locations outside of their own home which they regularly enter and participate in activities. This means that advertising interventions at faith spaces or even actively recruiting participants when they come in for worship is a powerful, and in some cases the only, way of engaging some people in early interventions and before physical or mental health issues become acute and require urgent, more costly intervention.

> *"If people are only venturing out to mosque, it makes sense to hold a project there"*- Interviewee

> *"The mosque is very central, a lot of people come here to pray so it's convenient for them, and the social aspect is important. Once you enjoy a session you come back for more, see and feel the benefit and good habits never stop….it's a win-win."*- East London Mosque and Maryam Centre Trust

The faith spaces and the trusted representatives of these are able to create a space for discussion and dialogue in which participants are willing and able to disclose and discuss issues and topics that they would not typically do so elsewhere. The most striking example of this observed by the evaluation team was elderly Bangladeshi men discussing mental health and the strain of Covid-19 lockdowns on them. The data from this focus group shows that it is very likely that a process of "facework" (Giddens 1990, Kroeger 2017) takes place, a process which allows participants to draw from their well-established trust in individuals and organisations and project these onto the FHAP activities and fellow beneficiaries:

> *"We know that what we say here (in the mosque) won't go any further and that we won't be judged outside of here"*- ELM participant

> *"We create a safe space for discussion. This requires a high level of trust. There is a huge WhatsApp group but no gossip or backbiting. People trust to be engaged at a personal level."*- Project Lead

It was a recurring theme that participants and project leads, independently of one another and across different projects, referred to the projects as being "safe spaces" for the participants to talk. This introduces the idea that the project, by using trusted faith spaces, are becoming dialogic spaces. Savin-Baden (2008, 52) defines these as *"spaces in which critical conversations occur and ones where change and challenge take place".*

> *"I am sometimes worried about my wellbeing, but seeing everyone take this test and sharing thoughts happily has encouraged me and restored my confidence."*- Participant at Christ Apostolic Church

When defining dialogic spatiality, Su (2018) posits that a place becomes a 'space' when "purposeful activities" occur there, and that this includes conversational encounters with others in a manner that is structured to produce insight and depth. By this definition, many of the FHAP projects which overtly aim at encouraging dialogue and which promote physical health as a vehicle to starting conversations around wider wellbeing, loneliness and isolation can certainly be regarded as dialogic spaces in this light.

Su also argues that faith institutions are well placed to become dialogic spaces because of the perceived values behind and inherent in them. This links to participants having high levels of trust in spaces with which they are familiar but also with the work of Oldenburg (1989) whereby faith buildings and places are categorised as "third places". These third places are outside of the home and work environments and are local, inclusive venues which serve as a

“mixer” in which people are known to one another and interact in way that supports community life while fostering a sense of belonging.

This sense of community life and belonging and the ensuing dialogue in a “safe space” was evident to the evaluation at visits to projects at both the East London Mosque and Maryam Centre and Shahporan Masjid and Islamic Centre Trust, as well as in interviews with those involved with the Cycle Sisters project. Here activities, some of which may appear unrelated to deep discussions around personal vulnerabilities and concerns were able to take place because they occurred in third places in which people were comfortable and because they were in these places with people with whom they had commonalities with and were thus more comfortable.

All participants at one session attended by the evaluation team were adamant that they would not discuss their social isolation and loneliness with family or friends outside of the venue or group that they were in, and none felt that these were matters that they would discuss with health professionals either. They were only willing and able to discuss these vulnerabilities in the faith space that they were in, with the people that they were there with and felt commonality with.

A clear benefit of these conversations and disclosures taking place in well-established faith settings is that these settings are well connected to other services in the borough and so are able to refer and signpost FHAP participants towards formal health interventions. Here the partners act as a gateway to the statutory sector and are able to use their system’s literacy to supplement that of participants.

> *“We can reach people that the statutory services can't because we've been here since 1984 and are trusted. We run a lot and it is for the whole community. Did Jubilee work etc. Once we know that they’ve got a problem, we can help them by telling them where to go and who to see about it”*- Dorset Community Association Lead
>
> *“We help beyond our remit and can signpost.”*- Cycle Sisters Lead
>
> *“We're about to connect with GPs, housing associations, community groups etc to get participants to them.”*- East London Mosque and Maryam Centre Lead

There were no formal targets for the projects and signposting and referring to other partners was not an output that was systematically recorded by projects. It does appear though to be a major part of the work that has taken place and is one that is likely to have had significant impacts on participants once they have secured access to the relevant bodies via their faith centre referral.

A logic has emerged showing that many participants engaged with FHAP projects on the basis of either their faith or the projects being run through a faith centre which is familiar to them, or a combination of both. Trust in people and institutions underpins this involvement. This then appears to have allowed many participants to overcome barriers in proactively managing their physical and/or mental health and talking about these in an open forum. The focus of many projects on physical health, which is often more comfortable territory for participants, appears to have acted as a gateway for them to talk about mental health with others in ways that they haven’t before.

This provides evidence and opens up the scope for health interventions in Tower Hamlets, and the UK more generally, to be designed in a way that can leverage the participant trust in the faith sector to encourage those who do not engage in public health interventions to do so. Once “in the system” other interventions are opened up to participants as faith institutions and those who they work with can address participant needs:

> *“Faith can play a part in the health system. This is seen in other areas of the world. Challenge the idea that health has to be secular because that is how we do it in the UK. It is an open access conduit and doesn’t turn people away.”*- Interviewee

Discussions with participants also throw up a challenge to the assumption that people feel empowered to ask for and to access the provisions that they are both entitled to and need.

> *“If people aren’t accessing things that they need there is probably a reason why. We need to know that and tackle it or find another way. Business as usual isn’t good enough if it isn’t working”*- Interviewee

Many people do not feel confident in approaching or challenging an expert representing systems, such as GPs or receptionists at hospitals or surgeries. This is a basic tenet of health literacy whereby literacy is measured by the ability of a participant (or patient) to understand and make decisions about their health, healthcare and access to health systems (Lui et al 2020). Nuttbeam (2008) evidences that writing and reading skills, oral literacy, and numeracy are inextricable from the most fundamental form of health literacy. This ties into previous research which found that lower levels of health literacy lead to worse health inequalities and outcomes (Haun, et al., 2015, Bostock & Steptoe 2012). Recent public health research in Birmingham has suggested that those in the city with low levels of English language proficiency are more likely to suffer from health inequalities and there is no reason to suggest that this experience is not generalisable to Tower Hamlets.

That many beneficiaries in the FHAP projects do not feel comfortable or able to access healthcare in the borough is suggestive of low levels of health literacy in the borough which may be an area of future interest for local health bodies. Participants were more proactive in attempting to address their health needs through their local faith centres which may be an in road to promoting greater health literacy.

> *"People can ask for things that they need that they can't ask for elsewhere"*
>
> - Project Lead

Conclusion and Recommendations

This evaluation finds that the FHAP project has successfully enabled and overseen the delivery of 10 community designed public health interventions in the London Borough of Tower Hamlets. These projects have directly engaged at least 245 participants and indirectly reached at least 651, with this latter figure likely representing a considerable under-estimate. There has been a wide diversity of different projects reaching an equally diverse number of cohorts, likely enabling some of the momentum built by the Faith COVID Assistance Partnership to be maintained or at least supported.

The data shows that FHAP is a well-designed and run programme that allows community groups to design localised interventions that address self-identified, observed need. The logic of the programme is both coherent in meeting unmet need and is designed in a way which is supported by a large body of literature around both interpersonal and organisational trust. That people known to participants, such as local faith sector leads involved in FHAP projects, are more trusted by participants than other people in general and all 3 of Tower Hamlets Council, local NHS services and the local Public Health department is an important finding of this evaluation. This finding can contribute to furthering the understanding of these dynamics and how they can better be harnessed to plan public health interventions in the borough.

Many participants in the projects have seen tangible physical health benefits from activities such as undertaking exercise and increased awareness of blood pressure issues but also have seen equally important outcomes which were not overtly targeted at participants. These include participation in participant-led discussions around issues such as mental health and the menopause and these, in turn, allow the project representatives to signpost participants towards formal and more traditional interventions.

As a result of this, the data shows that there is a group of people in the Borough with health-related needs who were not accessing services and provision and now are. This is partly as a result of both improved knowledge of services available and increased ability and confidence in accessing them. That discussions and disclosures around mental health and wider well-being have also taken place is a further, important benefit.

It is important to note though that whilst the evidence base for where trust lies in the Borough and how people trust each other and local statutory services has grown, that participant trust in the local statutory services has not necessarily done so.

Faith organisations, and their representatives, are able to engage with participants because they are trusted and embedded in local communities, and often in close physical proximity to where participants live and operate. By getting participants through the door and creating “safe spaces” for participants to engage and to talk about issues that they wouldn’t do elsewhere, positive health interventions with these groups have become possible. The data strongly suggests that this is not work that Tower Hamlets Council, local NHS services and the local Public Health department can do as effectively on their own.

With this in mind, this report makes the following recommendations:

1. Funding options be explored for continuing the work and scaling it up if viable.

The FHAP project and the previous Faith Covid Assistance Partnership have demonstrated proof of concept and have enabled FaithAction and local faith-based partners in the Borough to generate goodwill and engagement amongst participants. If momentum is not maintained then re-starting similar works is likely to be far less efficient and more resource intensive than continuing current, shown-to-be-effective ones.

2. Tower Hamlets Council, local NHS services and the local Public Health department make concerted attempts to involve the faith sector in consultations and the delivery of public health works.

This is crucial in enabling the organisations to reach cohorts that the organisations may not otherwise be able to reach and to maximise the value of the faith sector's position in the public health sector.

3. Tower Hamlets Council, local NHS services and the local Public Health department be more overt in their engagement and involvement of the faith sector in their interventions.

Trust between participants and these organisations can only be built if the participants are aware of the organisational involvement. There appears to be a ready conduit for conferring trust onto these organisations via faith sector representatives but this will require both time and meaningful, consistent engagement at the grassroots level by statutory representatives.

4. Any future projects or research in the Borough with a focus on participant trust use softer indicators of trust to gather subtler, more detailed baseline and end-line data.

Suggestions here include either the short-form Organisational Trust Inventory (Cummings and Bromiley, 1996) or qualitative approaches.

5. Research around health literacy in the Borough be considered and links between health literacy and English language proficiency be explored.

Appendices

Appendix 1 – Bibliography

Ashforth, B. (2020) 'Identity and Identification During and After the Pandemic: How Might COVID-19 Change the Research Questions we Ask?' Journal of Management Studies, 57, 8

Bamidele, O. O., E. McGarvey, H., Lagan, B. M., Chinegwundoh, F., Ali, N., & McCaughan, E. (2019). "Hard to reach, but not out of reach": Barriers and facilitators to recruiting Black African and Black Caribbean men with prostate cancer and their partners into qualitative research. *European Journal of Cancer Care*, *28*(2), e12977.

Crisp, R. and Turner, R. (2012) 'The Imagined Contact Hypothesis' Advances in Experimental Social Psychology (46), 125-182

Cummings, L.L. and Bromiley, P. (1996), "The Organizational trust inventory (OTI): development and validation", in Kramer, R.M. and Tyler, T.R. (Eds), Trust in Organisations: Frontiers of Theory and Research, Sage, Thousand Oaks, CA, pp. 302-31.

Currall, S.C., A. Inkpen. (2002). 'A Multilevel Approach to Trust in Joint Ventures. Journal of International Business Studies 33

Degnan, A., Berry, K., Vaughan, M., Crossley, N., & Edge, D. (2022). Engagement with services in Black African and Caribbean people with psychosis: The role of social networks, illness perceptions, internalized stigma, and perceived discrimination. *British Journal of Clinical Psychology*, *61*(4), 1134-1153.

Douglas, A., Bhopal, R. S., Bhopal, R., Forbes, J. F., Gill, J. M., Lawton, J., ... & Sheikh, A. (2011). Recruiting South Asians to a lifestyle intervention trial: experiences and lessons from PODOSA (Prevention of Diabetes & Obesity in South Asians). *Trials*, *12*(1), 1-10.

Fombrun, C. (1996) Reputation: Realizing Value from the Corporate Image. Harvard Business School Press

Giddens, A. 1990. Modernity and Self - Identity: Self and Society in the Late Modern Age. Polity Press, Cambridge

Khan, N., Kerr, G., & Kingston, H. (2016). Community engagement and education: addressing the needs of South Asian families with genetic disorders. *Journal of community genetics*, *7*(4), 317-323.

Inkpen, A., S.C. Currall. 1998. The nature, antecedents, and consequences of joint venture trust. Journal of International Management 1 1-20

Mayer, R.C., J.H. Davis, F.D. Schoorman. (1995). 'An integrative model of organizational trust'. Academy of Management Review

Mollering, G., Bachmann. R. and Lee, S. (2004) 'Introduction: Understanding organizational trust- foundations, constellations and issues of operationalisation' Journal of Managerial Psychology. 19 (6) 556-570

Rousseau, D.M., S.B. Sitkin, R.S. Burt, C. Camerer. (1998) 'Not so different after all: A cross-discipline view of trust'. Academy of Management Review, 23 (3), 393-405

Oldenburg, R. 1989. *The Great Good Place* . Cambridge, MA: Da Capo Press.

Savin-Baden, M. 2008. Learning Spaces: Creating Opportunities for Knowledge Creation in Academic Life . Maidenhead: Open University Press & McGraw-Hill Education.

Su, F. (2018) 'Place', 'space' and 'dialogue': conceptualising dialogic spaciality in English faith-based universities, Journal of Beliefs & Values, 39:3, 330-343,

Smith, C. A., & Ellsworth, P. C. (1985). Patterns of cognitive appraisal in emotion. Journal of Personality and Social Psychology, 48(4), 813–838.

Stathi, S., Crisp, R., Turner, R., West, K. and Birtel, M. (2012) 'Using Mental Imagery to Promote Positive Intergroup Relations' in The Psychology of Prejudice: Interdisciplinary perspectives on contemporary issues. ed by Russel, D. and Russel, C. Nova, 235-250

Stephan, W., and Stephan, C. (2005) 'Intergroup Relations Program Evaluation' in On the Nature of Prejudice: 50 Years After Allport ed. By Dovidio, J., Glick, P. and Rudman, L. 431-447 Blackwell UK

Woof, V. G., Ruane, H., Ulph, F., French, D. P., Qureshi, N., Khan, N., ... & Donnelly, L. S. (2020). Engagement barriers and service inequities in the NHS Breast Screening Programme: Views from British-Pakistani women. *Journal of medical screening*, *27*(3), 130-137.

Xu X, Mishra GD, Holt-Lunstad J, et alSocial relationship satisfaction and accumulation of chronic conditions and multimorbidity: a national cohort of Australian women General Psychiatry 2023;36:e100925. doi: 10.1136/gpsych-2022-100925

Yarrow, M. Campbell, J. and Yarrow, L. (1958) 'Acquisition of new norms: A study of racial desegregation' Journal of Social Issues. 14 8-28