
Places of Worship as Minority Ethnic Public Health Settings in Bradford

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Executive Summary

The aim of this research was to undertake a scoping study to better understand the role that Places of Worship play as Minority Ethnic Public Health Settings in Bradford.

We had 4 objectives:

1. To contextualise the research undertaken on this project within the global literature on religion and health care.
2. To identify the health concerns prevalent within certain religious and/or ethnic groups in order to understand how places of worship could play an important role in dealing with those specific issues.
3. To discover the attitudes of local ‘religious leaders’ (RLs), ‘congregations’ and public health (PH) staff in Bradford with regard to PH practice in places of worship.
4. To make a series of recommendations.

Highlights from the recommendations:

1. Co-coordinating a local ‘faith and public health’ network and a consultation process to develop guidance on practical steps that PoWs can take to become public health settings.
2. Collaboratively designing and delivering, with support from the International Religious Health Assets Programme (IRHAP), a ‘religious health asset mapping’ tool and ‘health needs analysis’ tool for use by PoWs.
3. Initiating a process of consultation to identify interested and capacitated PoWs that are willing to engage in a pilot process. The process will involve work at theological and practical levels.

Preface

Collaboration between the Centre for Religion and Public Life (CRPL), at the University of Leeds, and FaithAction has given rise to this report. The authors of the report had already undertaken research with Leeds City Council in 2013-2014 to undertake a scoping study to help Public Health Leeds better engage with black and minority ethnic (BME) communities in order to achieve the coordinated delivery of public health activity through a network of places of worship. The aim of the research in Bradford was to extend the work already carried out in Leeds.

The Centre for Religion and Public Life is situated within the School of Philosophy, Religion and History of Science at the University of Leeds. The aim of the Centre is to foster research into the immensely important, and increasingly contentious, role of religion in public life in the world today, and to provide a forum in which contemporary research and scholarship can be debated and disseminated.

As the focus for an academic community at the forefront of current research into the nature and role of Christianity, Islam and African and Asian religions in society, politics and culture, the Centre brings together a group of scholars seeking to overturn the neglect or marginalisation of religious factors in many academic and popular debates about public life.

The Centre's interdisciplinary character, signaled by the theological, sociological, anthropological and historical interests of its participants, make it a unique forum for the study of contemporary religion, while its promotion of research into issues such as globalisation, violence, ethics, technology, development studies, ecology, diaspora, race and ethnicity mean it is uniquely placed to make a substantive contribution to serious consideration of some of the most pressing intellectual and practical challenges facing the world today.

The research that underpins this report was commissioned by FaithAction.

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1 Introduction

1.1 The aim of this research was to undertake a scoping study to better understand the role that Places of Worship play as Minority Ethnic Public Health Settings in Bradford.

1.2 The objectives were:

1. To contextualise the research undertaken on this project against the backdrop of a discussion of the global literature on religion and health care.
2. To identify the health concerns prevalent within certain religious and/or ethnic groups in Bradford in order to understand how places of worship could play an important role in dealing with those specific issues.
3. To discover the attitudes of local ‘religious leaders’ (RLs), ‘congregations’ and public health (PH) actors in Bradford with regard to PH practice in places of worship.
4. To make a series of recommendations.

1.3 Background: religion, ethnicity, health and how to research the links

Data gathered in 2012 suggests that Bradford has become more ethnically diverse since the 2001 Census:

- Although the White ethnic group has decreased in size since 2001 (76.1%), the largest proportion of the District’s population (63.9%) identified themselves as White British.
- Bradford District had the largest proportion of people of Pakistani ethnic origin (20.4%) in England; this is an increase of nearly 6% since the 2001 Census (14.5%).
- The following groups also saw an increase in their numbers: Bangladeshi, Mixed multiple ethnic groups, Other Asian, Black/African/Caribbean/Black British and Other ethnic groups. There was a decrease in the proportions of the District’s Indian and White Irish groups (Bradford City Council 2012: 1).

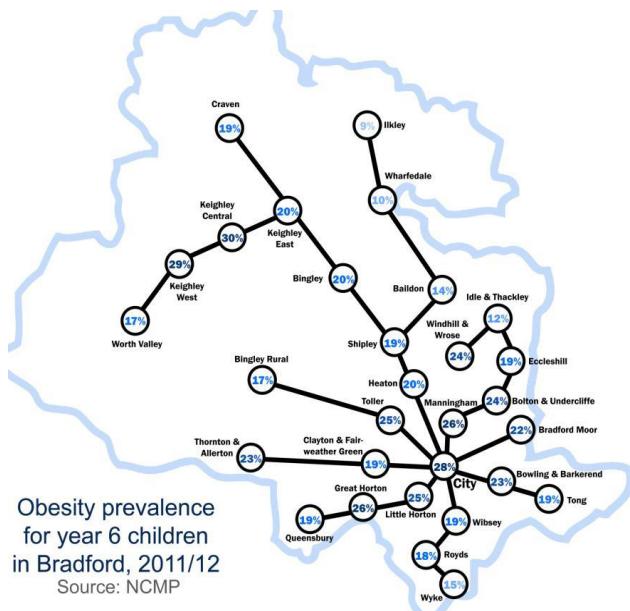
Corresponding to this ethnicity data, Bradford is also a religiously diverse city, with the number of Muslims in particular increasing since 2001 (see also Table 1):

- Although the proportion of the population who identified themselves as Christian has fallen since 2001, they were still the largest religious group in the Bradford District. Between 2001 and 2011 the proportions fell from 60.1% to 45.9%.
- Nearly one quarter of the population identified themselves as Muslim – the second largest group – which has increased from 8% to 24.7% since 2001 Census. Bradford District has the fourth highest proportion of Muslims in England (Bradford City Council 2012: 2).

BME communities in Bradford, and beyond, experience unfavourable and unequal outcomes with regards to a number of health conditions including obesity, depression, diabetes and smoking, as well as conditions linked to ethnic groups such as sickle cell anaemia, which is more prevalent in people with an Asian, African or Caribbean heritage (NHS 2012). People of South Asian, African and Caribbean heritage are also at greater risk for developing diabetes (Department of Health, 2001). In a number of Bradford’s neighbourhoods, high BME occupancy rates correlate with some of the highest national levels of childhood obesity, a complex phenomenon underpinned by poor diet and lack of exercise (see figure 1). Another issue in Bradford, mainly affecting the South Asian Pakistani origin communities, are health problems in children born to couples which are closely related (consanguinity), including cousins (see Born in Bradford research).¹ Finally, there

is some evidence that British Pakistani women experience 'a higher prevalence of depression, suicide and self-harm than White women' (Gater et al: 2010).

Figure 1: Obesity prevalence for year 6 children in Bradford, 2011/12 (national average for 2011/12 was 19.3% (NHS 2012: 7))²



The prevalence of these health conditions cannot be linked to ethnicity alone and also reflects highly complex structural factors such as: poverty and deprivation; the fact that members of BME communities are not always reached by mainstream health services and education; the inability of the mainstream health services to always recognise and respond to the specific needs of diverse communities; and religio-cultural factors.

One overarching objective of the research is to identify whether particular health concerns are prevalent within certain religious and/or ethnic groups in order to understand how places of worship could play an important role in dealing with those specific health issues. One of our interviewees from a Christian background, a 'community worker', was keen to stress that:

Faith isn't the relevant thing in terms of understanding why...the outcomes are so bad in Bradford for so many people but...if you're thinking of interventions or ways of communicating and accessing people, that's where I think it's relevant. There [are] particular ways of understanding things [and] that is where faith comes in, so I don't think it's the reason why things are [as] they are but I think it's a way of getting in there or introducing interventions...you need an understanding of faith to be able to understand that community and develop interventions that will work for that community because without an understanding of faith, it can just go wrong... I suppose if anything is going to change in Bradford, I think [the] public sector and [...] Health...needs to be more religiously literate to do the intervention bit.

It is not the case then that religious affiliation or practice is necessarily a causal factor with regards to bringing about certain health conditions, but certain health conditions correlate with the ethnicity of those who make up particular religious groupings. Such correlations may be explained by: genetic links to particular illnesses; lifestyle/cultural practices; and marginalisation from mainstream primary health education and services. The identification of such links could be of

importance for PH agencies in order to be able to allocate funds or other support mechanisms to tackle particular health issues *via* PoWs. Certain ‘big data’ sets could provide support for this objective.

Despite the fact that religion would seem to be an important factor here, and supporting the concern about a lack of religious literacy in the field of Public Health, another of our interviewees – a dietitian – told us that issues of religious faith and belief rarely get mentioned in health settings and that this could partly be to do with the fact that people felt that it was not politically correct to define groups according to their religion:

I go to a lot of meetings where all the Public Health leads would be and there’s a mix of different backgrounds, religion never really comes up, [we] talk less about religion and more about communities and population groups, so [we] wouldn’t talk about a Muslim population, we talk about the South Asian population so included in that would be other faith groups...[It] just feels a bit politically incorrect possibly sometimes but then I suppose when we think about our South Asian population in Bradford, we are talking about mostly Muslim people, we don’t have many Sikhs, many Hindus.

According to figures from the 2011 Census there are 522,452 people living in Bradford of which around 73% identified themselves as affiliated to a religious tradition (see Table 1). Bradford is a highly ethnically diverse city. Of course ethnicity and religious affiliation are not always neatly aligned but for some communities there is a fairly close correlation between ethnicity and particular religious traditions. For instance, of the ‘Asian/Asian British: Pakistani’ group – which totals 106,614 people – 100,502 profess to be Muslim; for ‘Asian/Asian British: Bangladeshi’ 9,249 out of a total 9,863 claim to be Muslim; and for ‘Asian/Asian British: Indian’ – from a total of 13,555 – 4,364 see themselves as Hindu, 4,152 as Muslim and 3,429 as Sikh. There is also quite a high correspondence for some other groups: for ‘Black/African/Caribbean/Black British: African’ out of 4,993, 3,733 are Christian and ‘Black/African/Caribbean/Black British: Caribbean’ out of 3,581, 2,637 are Christian. It is also significant to note that for these groups only a small proportion of people claim to follow no religion at all (see Table 1).

While this could appear to lend support to the view that PoWs could be suitable places for PH activity, we cannot assume that all those who profess to belong to a particular faith actually attend places of worship to any regular degree. We are not currently aware of any data that gives levels of attendance at places of worship within Bradford. **This could be a useful project to be carried out, possibly by PoWs themselves with support from relevant agencies.**

Nonetheless, it seems likely that, given the high levels of religious identification within some communities in Bradford, PoWs could play an important role in health education and even delivery.³ There is also some evidence from our qualitative work that communities with high levels of religious observance and attendance at places of worship are often likely be deprived and experiencing poor health outcomes. **In order to make this point more strongly it is necessary to identify relevant quantitative data sets that can demonstrate a link between religious affiliation and health outcomes.**

While as qualitative researchers the focus of our work is on interviews and focus groups, we also recognise the importance of quantitative data to the aims of this research. To develop this aspect of the work in the future we will need to collaborate with quantitative researchers who better understand how relevant ‘big data’ sources could be identified and used to meet the aims of the research.

This scoping research, which has so far relied on qualitative methods, seeks to address the notable correlations between poor health outcomes and ethnic and religious identification in Bradford by examining places of worship (PoWs) as suitable settings in which to tackle public health issues. A pilot survey was carried out in Leeds in 2011 in the Hyde Park area, by the West North West Health Improvement Manager, which suggested that religious leaders believed it would be appropriate and desirable to deliver suitable public health interventions at PoWs as a way to contribute to the wider health and wellbeing agenda of their congregations with appropriate support and capacity building. The survey also showed that people felt it relevant to make good use of the 'assets' held by organisations in the area, particularly the communication mechanisms that places of worship already use.

The aim of this current research project was to extend and expand this earlier study and to create a knowledge base for future research on the engagement of places of worship for BME health promotion in Bradford, following a similar project carried out by the research team during 2013 in Leeds. As we outline in more detail below (section 2) the engagement of faith-based groups to support health-based initiatives forms part of a larger agenda of community engagement in health promotion. For instance, research funded by the World Health Organisation (WHO) has suggested PoWs as a setting for PH interventions (ARHAP 2006). Additionally, following decades of neglect of the role of religious organisations in the public sector, work on religion has been carried out in Parliament (e.g. see Christians in Parliament reports;⁴ the All Party Parliamentary Group on 'Faith and Society'⁵), as have some city councils, such as Leeds (see Lindsay et al. 2014).

However, although a new climate seems to be emerging where the significance of religion is increasingly taken seriously by actors in the public sphere, and where PoWs are recognised as potential sites for health promotion activities, little is known about the best ways to engage and involve those individuals who attend or lead a PoW, or the drivers and barriers to such engagement. To approach PoWs in the same as any secular organisation may be a mistake.

1.4 Overview of research methods

- To review of the global literature on religion and health care, with a particular focus on the UK (this is outlined in section 2).
- To carry out a series of interviews with religious leaders and Public Health and third sector actors across Bradford, and focus groups with members of PoWs (this is outlined in section 3).

1.5 Research questions to be addressed in the qualitative research (interviews and focus groups):

- Which health issues are the ones that most affect BME groups in Bradford?
- In what ways could these be addressed within places of worship?
- In what ways do places of worship in Bradford already engage with activities that are aimed at addressing the health of their congregations/members?
- Do they already engage with outside agencies and if so how?
- What are the limitations to addressing health issues via places of worship?

1.6 Structure of report

Having outlined the aims, objectives and background to the research, as well as its main research questions, section 2 will provide a discussion of the context for the project. This will include an overview of the main areas of existing research on the topic of religion and public health: the

global setting for religion and health; religion and public life in the UK; and religion and health research in the UK and beyond. Section 3 will give an overview of the findings from the interviews and focus groups. The report concludes in section 4, which provides a series of recommendations.

Table 1: Ethnic Group by Religion in Bradford⁶

Ethnic Group	All categories: Religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	No religion	Religion not stated
All categories: Ethnic group	522,452	239,843	1,000	4,882	299	129,041	5,125	1,686	108,027	32,549
White: Total	352,317	223,917	460	59	244	1,772	56	1,283	100,917	23,609
White: English/Welsh/Scottish/Northern Irish/British	333,628	209,473	425	43	211	1,165	39	1,204	98,747	22,321
White: Irish	2,541	2,066	9	0	0	10	4	12	273	167
White: Gypsy or Irish Traveller	433	337	2	0	2	7	1	4	48	32
White: Other White	15,715	12,041	24	16	31	590	12	63	1,849	1,089
Mixed/multiple ethnic group: Total	12,979	4,792	41	32	4	2,785	41	44	4,101	1,139
Mixed/multiple ethnic group: White and Black Caribbean	4,663	2,392	7	2	2	122	2	14	1,728	394
Mixed/multiple ethnic group: White and Black African	875	490	2	0	1	118	0	4	183	77
Mixed/multiple ethnic group: White and Asian	5,677	1,188	12	23	0	2,191	34	18	1,731	480
Mixed/multiple ethnic group: Other Mixed	1,764	722	20	7	1	354	5	8	459	188
Asian/Asian British: Total	140,149	2,875	481	4,701	36	118,822	4,183	299	2,051	6,701
Asian/Asian British: Indian	13,555	563	9	4,364	2	4,152	3,429	248	255	533
Asian/Asian British: Pakistani	106,614	340	7	72	29	100,502	143	29	380	5,112
Asian/Asian British: Bangladeshi	9,863	53	2	60	2	9,249	3	0	41	453
Asian/Asian British: Chinese	2,086	400	217	12	0	181	8	6	1,100	162
Asian/Asian British: Other Asian	8,031	1,519	246	193	3	4,738	600	16	275	441
Black/African/Caribbean/Black British: Total	9,267	6,834	8	27	6	1,042	19	50	617	664
Black/African/Caribbean/Black British: African	4,993	3,733	5	8	4	817	5	5	142	274
Black/African/Caribbean/Black British: Caribbean	3,581	2,637	3	16	2	143	13	39	400	328
Black/African/Caribbean/Black British: Other Black	693	464	0	3	0	82	1	6	75	62
Other ethnic group: Total	7,740	1,425	10	63	9	4,620	826	10	341	436
Other ethnic group: Arab	3,714	345	3	16	0	3,086	19	1	79	165
Other ethnic group: Any other ethnic group	4,026	1,080	7	47	9	1,534	807	9	262	271

2 Setting the Context: a discussion of the global literature on religion and health care⁷

2.1 Introduction

What follows is not a comprehensive literature review, but instead aims to contextualise the work that we have undertaken in Bradford within a global setting. It will trace an interest in religion and health activities back to the 18th and 19th century missionaries in Africa, Asia and elsewhere and draws upon two recent key texts in the area of religion and public health (Gunderson and Cochrane 2012; Holman 2015).

2.2 The Global Setting

The history of religion can barely be separated from that of health. Most, if not all, religions are bound up with some comprehensive conception of health and well-being, whether cast in cyclical or linear patterns of redemption, salvation or fullness of life (Gunderson and Cochrane 2012: 21).

Many health services throughout history in both developed and developing contexts have had a strong connection with religious actors. In many settings worldwide, health institutions were primarily implemented by religious actors, and in such contexts faith-based facilities continue to comprise a dominant proportion of national health systems. The imbrication of 'religious' and 'cultural' worldviews in many parts of the world generates concepts of health and wellbeing that differ considerably from the bio-medical model, itself informed by a duality of 'body' and 'soul', each of which requires a different type of treatment. Whilst the bio-medical model perceives 'health' in terms of curing diseases that affect the physical body, illness in many communities is often given a religious meaning in terms of understanding its causes and hence appropriate cures (e.g. a punishment from God that requires prayers; or a curse that requires ritual intervention). Further, approaches to healing within religious settings may be more focused on the 'whole person' (in which the body and soul are recognised as responsive to each other) rather than the elimination of a set of physical symptoms. As with a bio-medical model, there are both strengths and weaknesses to faith-inspired ways of thinking about health. Many commentators are critical of explanations for illness that may discourage the faithful from seeking medical help (e.g. the Pentecostal preacher 'curing' people of HIV and AIDS). A growing body of scholarship recognises the strengths of a faith-inspired approach, where the support provided in faith-based settings and the trust that people place in religious leaders, as well as the tangible resources that religious settings have, can be a great asset in the pursuit of better global health outcomes.

A number of recent publications (e.g. Gunderson and Cochrane 2012; Holman 2015) narrate how faith-based approaches to public health have, over recent decades, come to be more widely recognised within mainstream health systems and by mainstream public health actors at international and national levels. One limb of the story begins in Africa and other developing settings, and the other takes us to the USA. It is relevant for our project that to date there is little reflection or sustained research on public health and faith in the UK, or in Europe more widely. These accounts not only tell us about the increased recognition of the role of religion for public health in some settings, but also that Christianity in particular played an important role in the approaches to health care that moved away from a narrow 'medical' model to one that also focused on a social approach to primary care. In 1923, C.E.A. Winslow⁸ defined public health as 'the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities

and individuals' (cited in Holman 2015: 13). While as Holman tells us "public health" was a term created in the nineteenth century when it was meant to refer to government-funded action related to health within a nation' (2015: 13), it was much later that this became a more dominant international approach to health, and Christian actors appear to have played a significant role in this shift (see Box 1 for the definition of PH of the UK's Faculty of Public Health).

Box 1: Definition of Public Health

Public Health: 'the science and art of promoting and protecting health and well-being, preventing ill-health and prolonging life through the organized efforts of society'¹⁹

Three key domains of public health practice:

Health Improvement

- Inequalities
- Education (including health education and health promotion, which may involve leaflets and talks)
- Housing
- Employment
- Family/community
- Lifestyles (another potential area often addressed through standard leaflets and talks)
- Surveillance and monitoring of specific diseases and risk factors (may be diabetes, TB, HIV or Hep b testing in a PoW for example)

Improving Services

- Clinical effectiveness
- Efficiency
- Service planning
- Audit and evaluation
- Clinical governance
- Equity

Health Protection

- Infectious diseases (may be encouraging pilgrims to take immunisations before setting off)
- Chemicals and poisons
- Radiation
- Emergency response
- Environmental health hazards (may be a church encouraging people to car share)

To begin in the Global South, Gunderson and Cochrane (2012) recount how many hospitals in the 18th and 19th centuries in Africa and Asia developed as part of the Christian missionary enterprise, but that by the post-World War II period these missions began to look at their engagement more reflexively to ask why their health services were not having as great an impact as they would have liked. They argue that following the Second World War, the World Council of Churches (WCC) – an international ecumenical movement established in Geneva in 1936 – 'and its affiliates around the world provided exactly the right forum for a rethink of medical missions in the post-war decades...[from which]...emerged ideas that helped inaugurate long-term structural shifts in health care, and not only in the context of Christianity or religion in general' (2012: 28).

In 1964 the WCC and the Lutheran Federation held a consultation in Tübingen, Germany, and then another in 1967 again in Tübingen. As Gunderson and Cochrane explain, an argument emerging out of the debates stimulated at these was that:

Medicine...had to be located within a wider, holistic paradigm of health, including its social dimensions, attentive to the quality of life of all, and governed by the principles of love (esteem for the other) and justice (acting in accordance with the dignity of all) (2012: 30).

Inspired by this, in 1968 the WCC founded the Christian Medical Commission (CMC), which aimed to establish links with the UN agencies, in particular the WHO. A number of religious health associations were also set up in African settings around this time to co-ordinate faith-based health care in newly independent nations and today these remain 'a highly significant part' of African health systems. This was part of a 'trend toward community health that had other, related roots, deep with the WCC, of even wider significance for public health' (2012: 29) and called for a model of medicine that treated the whole person rather than just disease or physical symptoms while the individual was in the medical setting.

In 1973 the deputy director general of the WHO approached the CMC to 'explore closer cooperation' (2012: 32), a collaboration that can be seen reflected within the influential 1975 WHO publication *Health by the People*. As Gunderson and Cochrane write:

The concepts thrashed out in Tübingen and at the CMC were now global property, reaching audiences far beyond the confines of Christian agencies and denominations. The key principles were gathered under a new nomenclature for primary health care' eventually enshrined in the famous Alma-Ata declaration [see Box 2] in 1978, its slogan being 'Health for All by the Year 2000' (2012: 33).

Box 2 The Alma-Ata Declaration

The Alma-Ata Declaration

"The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All. The following are excerpts from the Declaration:

- The Conference strongly reaffirms that health, which is a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.
- The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.
- The people have a right and duty to participate individually and collectively in the planning and implementation of their health care.
- Primary health care is essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family, and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first elements of a continuing health care process.
- An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts. A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share."¹⁰

According to an article on the WHO website, the emergence of the 'primary health movement' has a strong connection to Christian health systems:

The concept of primary health care did not appear overnight. Some trace it back to an intergovernmental conference in Bandoeng, Indonesia, in 1937. That conference was held by the health organization of the League of Nations – a predecessor to WHO – that recommended that ‘the greatest benefit to the health of the rural populations, at the smallest cost, can be obtained through some process of decentralization’.

This recommendation was in line with the vision of missionaries working in community health care in developing countries. Notably, the Christian Medical Commission (CMC), which was part of the World Council of Churches, encouraged the training of village workers at grassroots level, equipped with essential drugs and simple methods. In an article published in the American Journal of Public Health in November 2004, historian Marcos Cueto writes that the CMC created a journal called Contact that may have used the term ‘primary health care’ for the first time.

In 1974, WHO director-general Dr Halfdan Mahler, one of the driving forces behind primary health care, invited the CMC to present its community health work in developing countries to WHO directors.¹¹

Interest also began to grow in the USA about how the mobilisation of ‘religious health assets’ (RHAs) could transform health care there too, and in 1988 an event was held at the Carter Centre in Atlanta attracting over 300 religious leaders. In 1992 the Carter Centre established the Interfaith Health Programme (IHP) and it subsequently established a number of faith health consortia across the US (see Box 3).

Box 3 Interfaith Health Programme

Interfaith Health Programme

“The Interfaith Health Program (IHP) was launched in 1992 at The Carter Center following major national studies that identified the key role of faith groups in advancing the health of individuals and communities, particularly through prevention and health promotion. Since its inception, IHP and our “boundary partners” have worked to build the capacity for collaboration among faith groups and other community assets such as religious health systems and public health entities. In our first years, IHP staff held meetings in more than 20 U.S. cities identifying opportunities and barriers to mobilizing faith groups into effective partnerships. IHP has conducted hundreds of workshops and training events throughout the United States in collaboration with professional organizations, major religious denominations, and local initiatives. In the Fall of 1999, IHP moved into its permanent home at Emory University as a program of the Rollins School of Public Health and in close relationship to the schools of theology and nursing. While much of the interest in this arena reflects a concern for problems of violence, teen pregnancy, elder issues, HIV, or cancer, the IHP strategy is always to build on the enduring strategic strengths and assets of faith structures.

IHP has worked with colleagues in the Faith and Health Consortium¹² to create interdisciplinary academic working groups developing curriculum, research, and service models. We see a vast body of learning, testing, and research needed by the burgeoning faith and health movement. IHP also focuses on a small set of “Whole Community Collaboratives” where front line leaders are learning how to align the assets and strengths of faith and health at the community level. These initiatives link government, religious organizations, academic institutions, foundations, and a wide variety of community partners. While our early years have focused within the United States, this opportunity is global and our work is continuing to grow around the world. Because health is global in its challenges and opportunities for advancement, IHP staff and colleagues speak and consult with professional and leadership events in the U.S. and around the world.”¹³

In 2002 at another Carter Centre event the ‘significant and now widely known international collaboration of the African Religious Health Assets Programme (ARHAP) was born’ (Gunderson

and Cochrane 2012: 38), which ‘expanded the reach of IHP...internationally to address pressing global health concerns such as HIV/AIDS and the role of religion’.¹⁴ See Box 4.

Box 4 ARHAP/IRHAP

ARHAP/IRHAP

“The African Religious Health Assets Programme was established in 2002 when a working group met at the Carter Center, in Atlanta USA, under the auspices of the Interfaith Health Program to consider a proposal for a global religious health assets initiative. The initiative recognized the general paucity of studies on faith-based organizations working in health, both in respect of knowing what is there, and in extensively, intensively and intelligently assessing what faith-based initiatives do best, and how they do this, in the face of growing public health crises in many parts of the world.

Africa became the first regional focus because it was seen to offer the possibility of [having] a great deal of relevance globally, given major public health challenges, a complex mix of religious traditions in varying contexts, and a wide variety of actors in the field of health. It was also ethically and epistemologically significant to consider Africa as the appropriate initial learning ground for a global initiative. ARHAP was therefore formally launched in December 2002, at a meeting in Geneva....

Reflecting better its unfolding work, its name also [changed] to the International Religious Health Assets Programme (IRHAP). The original vision of ARHAP was to ground its primary research in Africa. Based in several African institutions with Northern participation, its goal was to generate knowledge in and from Africa that would be of global significance elsewhere – a reversal of the usual flow of knowledge....

This move fits well with the growing international attention among public health agencies and leaders to the role and potential contribution to health of religious entities and activities, providing an enhanced focal point for research in this field. It also fits very well with the way in which the Programme has been developing in recent times.”¹⁵

2.2.1 The Religious Health Assets Approach

The WHO became interested in the work of ARHAP and its commitment to evidence based research including the evaluation of projects, often ‘missing in health-funded research, especially faith-based projects’ (Holman 2015: 135). ARHAP researchers soon carried out detailed research in Zambia and Lesotho, funded by WHO, which led to the document ‘Appreciating Assets: the Contribution to Universal Access in Africa’ (ARHAP 2006) which made use of their asset-based participatory research model ‘participatory inquiry into religious health assets, networks and agency’ (PIRHANA; see Box 5).

Box 5 PIRHANA

PIRHANA

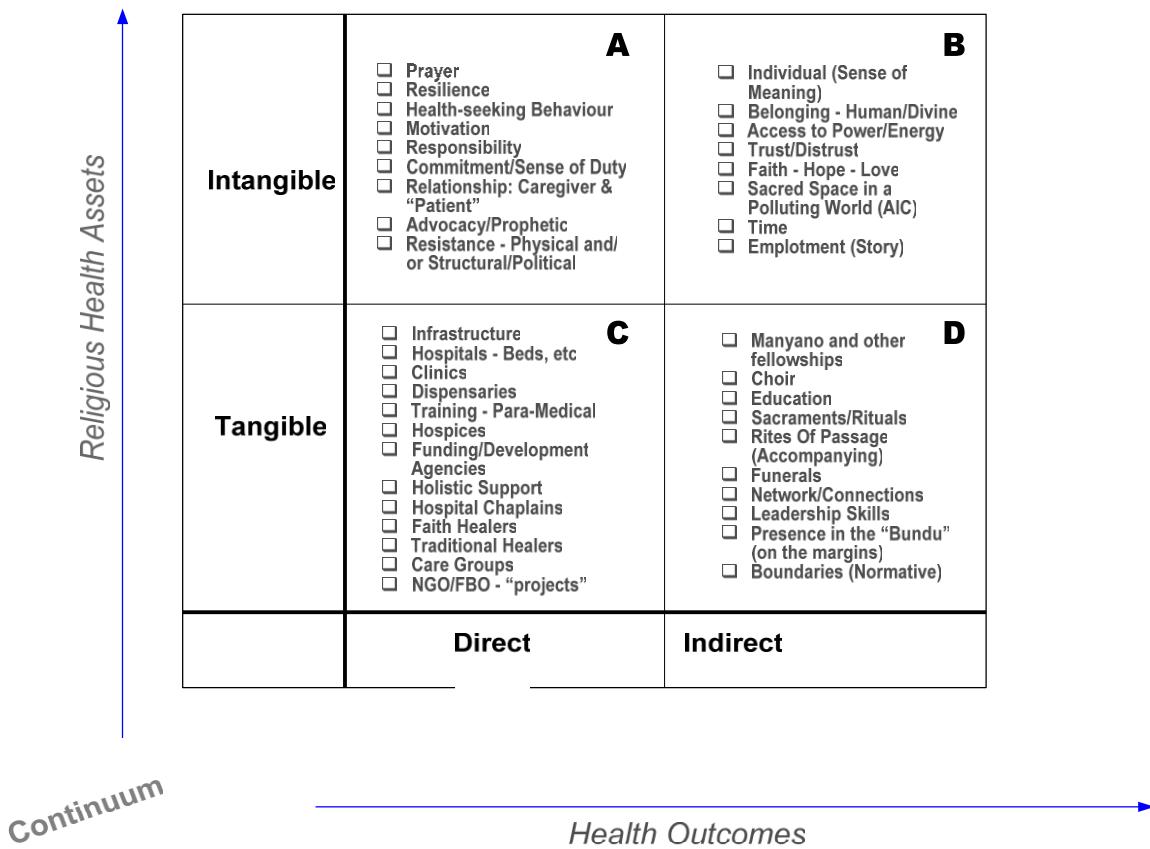
“The PIRHANA approach honors, articulates and “calls out” specific religious health assets of both a tangible nature (church buildings, health ministries, leaders who hold both faith & health leadership roles) and intangible nature (blessings, relational ties to other programs and organizations)....

Specifically, the inquiries focus on these key questions:

- What is the context for religion and health in this community?
- What are the key factors in this context that work for and against health and well-being?
- What are the key public and private entities/organizations that influence health and well-being in your area? What are their relative contributions to health?
- What are the most important ways that religion and religious entities contribute to health in your area and specifically to a targeted health condition’s treatment, care and prevention? What are their relative contributions?
- What are the “best”/ “most effective” religious entities/programs? Of which are you “most proud”? What are their characteristics and locations?

- What can you do to help religious organizations and entities in your area make a greater contribution to health?"¹⁶

Figure 2: The “ARHAP Theory Matrix”¹⁷
Religious Health Assets



Thus, a key feature of the work of ARHAP is supporting communities to carry out assessments of their ‘religious health assets’. As Figure 2 shows, the so-called “ARHAP Theory Matrix” requires respondents to document their Religious Health Assets (RHAs) according to their different types – whether they are tangible or intangible and whether they have a direct or an indirect impact on health. It is feasible that a next step for our project could be to develop this tool in collaboration with IRHAP for use in the UK, to enable PoWs to document their RHAs as a basis for communicating with public health actors about the assets they have and where capacity needs to be developed.

2.2.2 Congregational Studies

Public health professionals are often surprised at how ubiquitously and actively congregations already engage in work relevant to the health of communities. Congregational leaders are equally as often surprised to learn how much of what they do “naturally” do is relevant to the health of the public (Gunderson and Cochrane 2012: 99).

Unlike the UK, the USA has a widespread system of religiously based healthcare, which in some settings also partners with congregations. For instance, in Memphis, Tennessee and the mid-

South there are over 500 congregations partnering with the Methodists Le Bonheur Healthcare (MLH) ‘to build a system of caring that incorporates but extends beyond the hospital’ (Gunderson and Cochrane 2012: 100) called the Congregational Health Network (CHN).

The kind of support that is provided by congregations involves aftercare for people who leave hospital, which can mean that they are less likely to be readmitted. The congregations are often in a position to fill the gaps left by a mainstream health system that is more focused on curing disease when it presents itself, rather than what happens before and after.

Work undertaken at the IHP at the Carter Centre proposed an eightfold model of congregational strengths. Whilst Gunderson and Cochrane suggest that these are not ‘specific to American congregations, nor indeed to any one religious or faith traditions’ (2012: 103) we think this probably needs probing further, since it is likely that the concepts included reflect a Christian setting and than some strengths may not appear that are relevant to other faith groups. The 8 strengths are given as follows:

1. Accompanying – ‘gathered people accompany each other through their journey of life’ (2012: 104).
2. Convening – ‘being able to convene people is frequently important to the practice of public health’ (2012: 106).
3. Connecting – ‘they connect...to other existing pools of social capacity in other networks and organisations’ (2012: 107).
4. Storying – ‘people make choices in the context of a larger, multiply-storied narrative that gives coherence to their world’ (2012: 109).
5. Giving sanctuary – ‘FFE’s [faith forming entities] usually have spaces we may call sanctuaries’ (2012: 111);
6. Blessing – ‘the strength of blessing is found not in disembodied, abstract faith, but faith mediated through the physical human relationships found in a faith-forming entity’ (2012: 113).
7. Praying.
8. Enduring – ‘among the most remarkable strengths of congregations is that they last’ (2012: 115).

These strengths of congregations are likely to bring about health and wellbeing benefits. One popular approach to thinking about wellbeing has been developed by the New Economics Foundation and comprises ‘Five Ways to Wellbeing...a set of evidence-based actions [published in 2008] which promote people’s wellbeing. They are: Connect, Be Active, Take Notice, Keep Learning and Give. These activities are simple things individuals can do in their everyday lives.’¹⁸ In particular, PoWs contributed markedly to people’s ability to connect with others and to engage in activities that require them to ‘give’.¹⁹

2.2.3 Summing up

The aim of this section has been to look briefly at the ways in which faith-based actors have become more widely recognised in formal healthcare programmes, particularly in the developing world and the USA. By contrast, there has been much less of a ‘turn towards religion’ in public health activity in the UK. In the following section we will explore the role of religion in public life in the UK and will examine some of the literature that does exist on the topic of religion and health in the UK.

2.3 Religion and Public Life in the UK

A number of publically funded agencies in the UK are now beginning to take issues of religious affiliation more seriously. They have begun to consider the ways in which religious faith and practice might help or hinder their work and how religious actors can best be engaged to ensure better socio-economic outcomes. In contrast to previous decades, where both social scientists and public servants viewed religion as largely irrelevant for their work and tended to avoid working with religious actors, the 2000s have witnessed a slow but steady ‘turn to religion’ in these sectors. As Lindsay et al. write, ‘It has become increasingly common for academics and policy makers to refer to the current era as ‘post-secular’.... in which interest in ‘religion’ is increasing even in sectors that have traditionally marginalized or ignored it... [It] generally describes a global context in which the theory that social modernization inevitably leads to secularization has been brought into question’ (2014, p. 3; Beckford 2012).

The realisation that predictions about the decline of the public role of religion were flawed came to the fore following key religio-political events and shifts from the late twentieth century. This included the 1979 Iranian revolution, where the secular western-backed Shah was overthrown by the religiously conservative Islamic Ayatollah Khomeini, the rise of the Christian ‘religious right’ in the USA, and the atrocities of 9/11 and 7/7 carried out in the name of a distorted Islamic framework (Tomalin 2013). It was no longer possible to view religion as something of private relevance, largely insignificant to broader geo-political dynamics and welfare regimes. In the UK the government increasingly viewed an understanding of religious dynamics and engagement with religious actors as critical for generating social cohesion, particularly after 9/11 and 7/7.

However, it was also the case that this shift to the ‘post-secular’ was joined by a period of austerity measures in the government’s economic policies from 2008 onwards. Declining public sector budgets generated a context in which religious, along with other civil society actors, were increasingly called upon to support a ‘big society’ where the resources of the voluntary sector became ever more important for service provision and support structures (Chapman 2008; Jawad 2012; Dinhm and Jackson 2012; Woodhead and Catto 2012; Lambie-Mumford and Jarvis 2012 and Green, Barton and Johns 2012).

Lindsay et al. (2014: 10) suggest that there have been two main themes to emerge in the increasing body of literature around religion and public policy in the UK: ‘on the one hand, there is the question of the *capacity and potential* of religious groups to achieve public policy goals; and on the other, there is the matter of *potential challenges to be overcome* in partnering with religious groups’:

In the first case, there is discussion of the claims made by both [government] ministers and religious groups themselves regarding the wealth of resources at the disposal of religious groups. This is both in terms of material assets (e.g. finances, equipment, buildings and property) and non-material assets (e.g. expertise and information, especially at a local level)....

In the second case, concerning possible challenges to be overcome, there is debate about how much to expect from religious groups, given the need to maintain standards of service delivery, as well as where to focus partnerships (e.g. whether to pursue community-level projects or larger-scale engagement) (Lindsay et al. (2014: 10).

There does seem to be some evidence that public bodies are engaging more with religious issues and faith-based organisations than perhaps they have in the past. To better understand the place and role of religion and belief in the contemporary UK the Woolf Institute, University of Cambridge, instigated the ‘Commission on Religion and Belief in British Public Life: community, diversity and the common good’, headed by Rt Hon Baroness Butler-Sloss. The findings were made public in

December 2015.²⁰ We were invited in October 2014 to give evidence to the commission at Civic Hall in Leeds and talked about this current project. The aims of the commission are to:

- a) consider the place and role of religion and belief in contemporary Britain, and the significance of emerging trends and identities
- b) examine how ideas of Britishness and national identity may be inclusive of a range of religions and beliefs, and may in turn influence people's self-understanding
- c) explore how shared understandings of the common good may contribute to greater levels of mutual trust and collective action, and to a more harmonious society
- d) make recommendations for public life and policy.²¹

In line with the increasing acknowledgement of the significance of religion for public life, the role of religious affiliation and faith communities with respect to individual and public health is becoming a topic of interest to health bodies in the UK, such as Public Health England and the NHS. A report prepared by FaithAction, however, suggests that 'the degree to which government has recognised the potential of faith groups as agents for improved health and wellbeing is varied' (November 2014: 26). For instance, 'the 2009 DH guidance *Faith communities and pandemic flu* shows a strong acknowledgement and awareness by government of the potential influence of faith groups and faith leaders in reinforcing health promotion messages' but for many other areas of public health the link is less strongly acknowledged, if at all (2014: 26).

Government documents that do encourage FBOs as partners for public health are few and far between, but include Swanton and Frost (2007), where faith groups are 'listed as partners in preventing overweight and obesity' (November 2014: 27); the Department of Health Vascular Programme which recognises the faith sector as a way of accessing those who may not use organized health care (2009); and Gate and Burton (2011) and Counsell (2011) which note that the 'use of the voluntary, community and faith sector as a bridge between services and community based structures' (November 2014: 27) is important (see also UK Drug Policy Commission 2012; Department of Health 2012; 2014).

However, to date there has been little robust and sustained academic research documenting the links between 'health and faith' in the UK. We will examine the nature and scope of this emergent body of literature below and will contextualise it within religion and health research that has been undertaken in other settings.

2.4 Religion and Health Research Globally and in the UK

The role that faith groups and places of worship more specifically could play in reaching and changing the behaviour of hard to reach groups has received some attention in the wider literature on this topic, mostly from the USA or the developing world. As noted above much of this literature focuses on the 'assets' that religious settings have that could be leveraged to inform health interventions:

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 (November 2014: 32).

UK-based FaithAction in its *FaithAction Enables Government and Faith Groups to Work Together for Good* report identifies that many faith and community groups share four common attributes

which contribute to their unique value (2014: 3, box 6):

Box 6: Common attributes of many faith and community groups

Common attributes of many faith and community groups	
Passion – people of faith are passionate about being compassionate and faith groups attract highly motivated volunteers who will go the extra mile to serve their communities.	Trust – when they face difficulties, many people are drawn towards the local group that represents the faith they are most familiar with, rather than towards state-provided solutions. Places of faith are trusted places.
Bespoke Solutions – faith groups are embedded in the community and focus on the holistic wellbeing of the individual. So they are willing and able to develop creative bespoke solutions that result in satisfactory and permanent outcomes for the individuals and groups that they serve. This is specially important for the most vulnerable with complex needs.	Stability – governments and policies come and go, but faith groups are stable, established and enduring and extend beyond country borders. Their stable, universal nature means that often new migrants from other countries will turn to their local faith group for support and advice in preference to state-run institutions.

A literature review produced by ARHAP (the African Religious Health Assets Programme, now known as IRHAP, the International Religious Health Assets Programme) in 2006 outlines several areas that have received attention in the global literature on religion and health. First, we find a focus on studies that look at ‘religion as an explanatory variable in individual health outcomes’ (Olivier et al. 2006: 18; see Koenig, King and Carson 2012) and that look at the ‘impact of religion on individual mental health’ in particular (Olivier et al. 2006: 18; see Koenig 1998). The second area relates to ‘congregational studies’ ‘primarily seen in the work emerging from the United States’ (Olivier et al. 2006: 19). This area of research examines the contribution that predominantly Christian congregations in the USA make to public health (e.g. see section 2.2.2 above on ‘congregational studies’). Third, there are studies that focus on religion, international development and public health, a subset within development studies and mainly having relevance for the Global South. Finally, there is a body of literature on ‘social capital’ which can be seen as has ‘the glue that holds people together in groups and societies through shared experiences, ideas, ideals, beliefs and practices’ (2006: 20) where religious affiliation and structures often play an important role.

November notes that in contrast to studies from the USA:

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 (2014: 38).

One area of research in the UK relates to studies demonstrating the ways in which different ethnic groups have a tendency to experience particular health concerns. Wild et al. (2007) point to an increased risk of cardiovascular disease in South Asian communities in the UK, with NHS (2004) pointing towards language and culture barriers as possible explanations. A Department of Health report (2001) notes that type 2 diabetes is up to six times more common in people of South Asian descent than the general population. Smoking has a higher prevalence amongst Bangladeshi men

(Lifestyle Statistics, Health and Social Care Information Centre, 2013) and Scarborough et al. (2010) found that hypertension had 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%). Prevalence for women in all South Asian populations is lower than the general population' (November 2014: 24). Marriage to a blood relative – which is common in South Asian communities amongst some Muslim families in particular – is also a health concern with increased rates of congenital deafness and heart disease (Gatrad and Sheikh 2005; Yunis et al. 2006).

The higher prevalence of some diseases amongst South Asians in Britain – who are mainly Hindu, Sikh or Muslim – could lend support to the idea that places of worship linked to these traditions are appropriate locations for the delivery of health interventions. Of course it cannot be guaranteed the degree to which members of these religions attend places of worship. However, 'The Determinants of Adolescent Social Wellbeing and Health (DASH) Study gives some useful information about engagement with faith settings' (November 2014: 22; Harding et al. 2007).

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 (November 2014: 45).²²

Although these figures appear quite high, we do not know if the same patterns of attendance are found in other age groups or areas of the country. It would be helpful to carry out attendance studies more widely in places of worship in Bradford. While research on religion and public health remains relatively slim in the UK, areas that have received some attention include:

- **The role of religious beliefs in shaping behaviour and attitudes towards health:** Lucas et al. (2013) undertook a review of research into beliefs associated with lifestyle choices in UK South Asian groups – highlighting fatalistic beliefs and the role of the group, suggesting that individualistic approaches to behaviour change are less likely to be successful in this group.
- **Raising health awareness generally:** A paper by Ghouri (2005) examines a health fair in a mosque in Edinburgh organised by 'the Minority Ethnic Health Inclusion Project, in collaboration with the Local Health Care Co-operative, and in cooperation with Edinburgh Central Mosque' (2005: 197). Baker and Murdoch (2008) examined the role that PoWs could play in improving 'awareness and health-seeking behaviour for glaucoma' (2008: 1).
- **Smoking:** Bush et al. (2003) aimed to gain a 'detailed understanding of influences on smoking behaviour in Bangladeshi and Pakistani communities in the United Kingdom to inform the development of effective and culturally acceptable smoking cessation interventions' (2003: 1). Another study in this area is discussed in Ainsworth et al. (2013) and looks at a 'smoke free homes' intervention in Bangladeshi and Pakistani communities (see section 4, Box 7).
- **Cardiovascular disease (CVD):** A study by Rao et al. (2012) discusses a CVD intervention with the Hindu community in Brent where two Hindu temples in London were used to provide screening services. Mathews et al. (2007) looks at a CVD intervention with the South Asian community in Edinburgh, with some activities run from mosques.
- **Diabetes:** Grace (2011) discusses a project that engaged with Muslim leaders and clerics 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' (November 2014: 43). Bravis et al. (2010)

examine the 'effect of 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' (November 2014: 44). In addition, 2011 NICE (National Institute for Health and Care Excellence) guidelines specifically note places of worship as important settings for the dissemination of information about diabetes (NICE 2011).

- **Diet and obesity:** Maynard et al. (2009) examine the ways in which schools and places of worship could be sites for intervention with respect to childhood obesity.
- **Organ donation:** A *Faith Engagement and Organ Donation Action Plan* (Randhawa, 2013) for the UK has been produced. It discusses the experience and research evidence from across the world showing that the role of faith has been known to play an important part in the decision to donate organs. The action plan is concerned specifically with faith communities and as these comprise followers and worshippers from a wide range of ethnic backgrounds, it is not exclusively targeting the BME communities. However this is the predominant audience given the urgent need for more Black and Asian donors.
- **Physical exercise:** Research was carried out on *Leeds Let's Get Active* and engagement with BME Faith Communities in Leeds (Corbishley 2014; Horne 2014).

Box 7 Muslim Communities Learning About Second-hand Smoke (MCCLASS)

Muslim Communities Learning About Second-hand Smoke (MCCLASS)

The 'smoke free homes' (SFH) project is based at the University of York and has been adapted for use in mosques:

Muslim Communities Learning About Second-hand Smoke (MCCLASS) is a cluster, randomised, controlled pilot trial of 'Smoke Free Homes' delivered in Islamic religious settings (mosques hosting communal prayers, study circles for women and Qur'an classes for children) with embedded preliminary health economic and qualitative analyses.

The research objectives include: establishing the number of clusters (mosques) and the size of each cluster (participants) required for the main trial, ascertaining recruitment and loss to follow-up rates, and other statistical requirements; establishing feasibility, acceptability and resource requirements for delivering the intervention and assessing outcomes; and understanding the extent to which 'Smoke Free Homes' can be integrated into mosques' routines.²³

The SFH project had been originally carried out in Pakistan (Siddqi et. al. 2010) and one of the findings of the focus groups there was that potential drivers of change could be 'community leaders (including imams) supporting this initiative in religious and community gatherings' (2010: 1338). The Pakistan project was then used as the basis for a similar one in the UK and a 'guide on tobacco control for imams for the United Kingdom' was prepared 'based on the experience of imams in the implementation of SFH in Pakistan and a literature review. This guide will be piloted both in Pakistan and in the United Kingdom' (2010: 1340):

Religion is an important determinant of beliefs and attitudes towards smoking in Bangladeshi and Pakistani-origin Muslim communities [28,29] and influences decision-making about health behaviour. Many believe that smoking is in conflict with Islamic teaching, even if not strictly prohibited. In a study in Pakistan, Imams used Friday sermons to encourage people to implement smoking restrictions at home with a positive effect. This suggests that mosques using their influential status in the Bangladeshi- and Pakistani-origin Muslim communities in the UK could play an important role in shifting social norms around smoking behaviours.

With this in mind, we developed a 'Smoke Free Homes' (SFH) package to be used by faith leaders for the benefit of Bangladeshi- and Pakistani-origin Muslim communities. The package was developed in collaboration with faith leaders and mosques, and a feasibility study was conducted in five mosques in Leeds (Ainsworth et al 2013: 2-3).

It is worth outlining the three research questions within the project that related to the role of Islamic religious settings:

1. What are the facilitators and barriers for integration of 'SFH' into Islamic religious settings' practice and how might facilitators be enhanced / barriers be addressed?
2. What are the views and experiences of faith leaders and participants regarding the intervention?
3. What are people's (that is, men's, women's and children's) views and attitudes on the appropriateness of religious leaders taking on a health promotion role? (2013: 3)

A 'smoke free homes' package (*Smoke Free Homes: a resource for Muslim religious teachers*)²⁴ was to be offered to mosques and training provided on how to deliver it. This trial was completed in August 2014 but has not yet resulted in a publication.

However, we did interview someone who had been involved in the project who explained that while the project had worked really well in Pakistan it had proved much more difficult to engage the mosques in Leeds: 'the interesting thing about the Pakistan side, though, is that in actual fact, the Imam became pretty much the spokesman for the village. Absolutely took the role on and he...not only did he, you know, talk about it in his Friday prayers, he did one-to-one work with fathers and grandfathers, and on all.'

Our interviewee told us that in the UK 'We did get a bit of [buy-in], but I suspect it was probably quite a difficult time though, within the area, because of it wasn't long after the London bombings ... So I suspect it wasn't the most ideal time.' Also 'probably they didn't think it was their role to do that...I think the problem was that at the time, there were a lot of people trying to do stuff through the mosques, and there was probably a sense of suspicion, or...you know, it was just...it was a really...and I'm not sure that we ever really made good progress.' It therefore 'depends on whether the mosque sees itself as responsible for the health and well-being of the community.' It was suggested that one of the reasons why it worked better in Pakistan 'is that a lot of this was new information. And so, rather than it being, "yeah, we know smoking's bad for us and we know that, you know, second-hand smoke is bad for people," which a lot of people do know in the UK...Whereas in Pakistan it was new information, and the interesting thing about Pakistan, is that within the village itself, a lot of people actually stopped smoking...That was an unintended positive consequence of the project.'

2.5 Conclusion

The aim of this section was to contextualise the work that we have undertaken in Bradford within a global context of religion and health research. While there is now a significant body of literature examining religion and health related issues in both developing settings and the USA, this has hardly been touched upon in the UK. In the following section of the report we outline the findings from the interviews and focus group carried out in Bradford.

3 Places of Worship and Public Health in Bradford

3.1 Introduction

In this section we present the findings from the research that we have carried out in Bradford. We have done one focus group with Muslim women and ten interviews (three with third sector organisations, two with public sector actors, one with an academic and four with representatives of places of worship). These interviews do not comprise a representative sample but instead reflect those that we were able to secure in the timescale available.

The research that we carried out in Bradford differed from that carried out in Leeds during the first phase of the research (see Tomalin et al, 2015). In Leeds the research was initiated and driven by a particular individual in Public Health Leeds whereas in Bradford we initiated contact with Public Health actors in the City Council. In Bradford we did not find anyone who had (yet) made considerations of health and PoWs a priority and was driving the agenda forward. The championing of particular causes by individuals and the impact that this can have suggests that even in large bureaucratic public sector settings individuals can drive forward issues and approaches that they feel are particularly significant. Support from PH Leeds made it easier to find PH employees to interview for the research. We hope that we may be able to get 'buy in' from PH Bradford with this report. Also in Leeds, many of our contacts in PoWs were made by Leeds Faith Forum (LFF) and there had already been some discussion within LFF to initiate some work on PH and PoWs. The situation was very different in Bradford where currently there is no active city-wide faith forum and we were starting from scratch.²⁵

Before we began the research in Bradford, a couple of early meetings that we arranged with key individuals had an impact on shaping how we might focus the work. In particular, one direction that several individuals felt could be a useful one to pursue was to examine how childhood obesity could be approached in PoWs. We initially intended to make this the focus of our research, but in the time that we had it proved challenging to focus on this alone and at such an early state of research we did not want to ignore other leads and avenues.

Four areas emerged from the work in Bradford: food poverty, diet and exercise (including of children); Muslim women; dementia; and culturally appropriate mental health support. We begin with a discussion of general health issues facing BME communities in Bradford based on the information that we received from the interviews and focus groups.

3.2 General health issues facing BME communities in Bradford

In Bradford a number of our interviewees drew attention to high levels of poverty and deprivation amongst the BME communities there (see also box 8). A dietitian that we spoke to explained that 'in Bradford we've got a great food poverty/child poverty issue so a lot of faltering growth, where we might not see that elsewhere' which can lead to obesity, diabetes and high blood pressure and that 'even in children we're seeing that being diagnosed now'. The upsurge in takeaway restaurants in the city was also deemed to be a potential problem by this interviewee: 'in areas of Bradford that are quite densely populated with South Asian communities, there are rows and rows of takeaways and I walk up Manchester Road going home and at 4 o'clock or half past 4, there's somebody in every single one of them'. This food is cheap yet unhealthy, and was mentioned by a number of our interviewees as a possible contributing factor to the high levels of childhood obesity in the city:

There's a big row of shops on Lilly Croft, takeaway food shops, probably 10 of them, you stand outside there at half past 5 any day of the week and watch the families going

in and coming out with their really unhealthy food. Why? It's convenient, because they're busy and they've got loads of kids and...it's really cheap, £2.50 for fish and chips. You wouldn't get a bag of chips in Leeds for that would you? I'm not saying that's their fault, if you're stressed and harassed, for £10 you can almost feed a family.

However, research carried out by the Born in Bradford Project (see Box 8 below) did not demonstrate a straightforward link between the number of fast food outlets and obesity in children. According to Fraser et al. (2012) a connection was found between the number of fast food outlets and deprivation but not with levels of obesity in mothers (normally a good indication of obesity in children).

Another interviewee drew attention to studies that had been done around acrylamide in Bradford:

It's a product found in deep fried products, chips, samosas, crisps, anything deep fried, [...] whatever it is, we know that in Bradford, particularly in the inner city, in poorer communities [of] white and Pakistan heritage, the levels of acrylamide...[are] much higher than elsewhere in the country and they know that one of the impacts is a smaller head circumference [at birth and also birth weight].

Some food related health issues may become even more marked during Ramadan, although this is not yet evidence based one way or the other. This same respondent suggested that:

Even though they're fasting, that's a massive problem in weight gain terms because they're fasting all day and then they tend to over-eat and they don't eat the foods that they'd eat during the day, tends to be more of a celebration type meal, so there's more fried foods. So we would address it and especially for things like diabetes, we have to address it because of the risk ...

This respondent also spoke to us about another likely factor in the childhood obesity problem:

Typically, South Asian babies will be born at a lighter weight than a typical white British baby...so a typical baby's born at 7½ lb, that isn't typical for a South Asian baby, that's for a white British baby, so the feeding charts and the amount of weight that your child should put on and the amount of feeds you have a day are all based on a white British baby.

It has been suggested that some families may over-feed 'South Asian babies' in order that they should catch up with the norms promoted by the weight charts. Another respondent told us:

If you're Pakistani in Bradford and have got a baby and the baby looks relatively small – which Pakistani babies ought to – [...they] are born smaller and they ought to grow slightly more smaller, it's a metabolic feature of Pakistanis, what you don't want is Grandma, whose house you're living in, to say "this baby's too small, supplement its diet" and Grandma will say that in part because the [...] family wisdom in a country like Pakistan is that [...] small babies are more vulnerable.

However, this can cause problems later on: 'if they gain faster in the first year of life, it is so dangerous for children, really, really dangerous and is absolutely a precursor for obesity'. Another interviewee told us that if these babies look 'relatively small, it doesn't mean they need to be weaned early and have their breastfeeding supplementing.'

Another factor contributing to poor health outcomes for children, mentioned by interviewees, is the fact that levels of breastfeeding in Bradford are lower than national levels, although the rates are slightly higher amongst South Asian than white mothers (see Box 8 below). With respect to South Asian mothers one of our interviewees explained that:

If you're a breastfeeding mother, you've got to have privacy to be able to establish breastfeeding, if you're living in an extended family and you don't get any time to yourself, do you feel confident about breastfeeding? Who supports you to breastfeed well? We know that people don't get enough support for breastfeeding. Is breastfeeding encouraged? We've got still quite poor rates within the South Asian community for breastfeeding, which you wouldn't necessarily expect, that you'd almost go "oh well, the South Asian community, they're going to breastfeed." Mothers-in-law [are] anecdotally a factor, that if a mother-in-law discourages you to breastfeed, you don't know any better or don't stand up to her or the extended family, you need support and if you're not getting that support because actually someone else gets to feed the baby then, [...] it could be such hard work, breastfeeding and actually people aren't encouraging you to keep going with it and you don't understand the health benefits, then you will just give up. We know people will give up for lots of reasons and a lack of support for breastfeeding – because breastfeeding will make a massive difference for the health of those babies, we know that.

Health problems that were flagged for the communities at large included diabetes, heart disease, obesity, blood pressure, kidney problems, health issues associated with the menopause, recessive disorders associated with consanguineous marriages, and mental health, including dementia. Smoking, chewing tobacco and shisha were also mentioned as crucial factors in the deteriorating health of many.

Box 8 Born In Bradford

Born in Bradford

Born in Bradford is one of the biggest and most important medical research studies undertaken in the UK.

The project started in 2007 and is looking to answer questions about our health by tracking the lives of 13,500 babies and their families and will provide information for studies across the UK and around the world.

The aim of Born in Bradford is to find out more about the causes of childhood illness by studying children from all cultures and backgrounds as their lives unfold.²⁶

About half of the people in this study are Muslims and when we saw a talk advertised at Bradford Cathedral sharing findings from Born in Bradford (BiB) research and examining 'the contribution made to social capital from religious beliefs and religious affiliation' we decided that it would be relevant for this project to arrange an interview.

Our interviewee told us that one area of interest in the BiB project was whether there is 'something that's about being Pakistani in Bradford as opposed to being poor in Bradford, that shapes your experience of being engaged with your community?' He explained that they had found that there is a difference 'in the sense that Pakistani groups are more likely to be linked to faith-based activities [although the significantly smaller Hindu groups even more so] and white British groups are more likely to be based in neighbourhood type sport and leisure activities [rather than faith activities]. But levels of engagement in both are pretty low.' However, when it came to thinking about 'social capital', even amongst the Muslim cohort faith did not appear to have a particular impact, but this could be because they were mostly 'asking the mums here and I think that the engagement with faith organisations in Muslim communities would be different if you asked the men' (see also Uphoff et al. 2013; Uphoff et al. 2015).

He explained that 'being poor in the first place is the determinant really and one's ethnicity shapes something of the experience that you're having around you and it certainly shapes some health outcomes that we're interested in. It has an impact on infant growth and obesity and it's got a genetic impact and genetics are a big deal in Pakistani communities in Bradford because of the continuing practice of cousin marriage, so those things are important. More generally, it's deprivation.'²⁷

Our interviewee told us that they 'do a fair amount of outreach things with the Council of Mosques' but don't do 'any direct work in the mosques, we do a bit of information about sharing research findings and particularly in areas where it's sensitive to the community'. In particular, before findings from the project's research on the genetic implications of consanguine marriage were made public a member of the team visited a mosque 'after prayers, in the announcements that are made...around the time that we were publishing the main paper on genetics which we thought was going to create quite a stir, which it did.' However, the project has engaged with 'community groups, rather than faith groups' but in any case these tend to be 'pretty uniformly of one faith or of no particular religious observance'. They tend to do work through 'children's centres and established community groups, as opposed to specifically faith groups because it's, the children's centres and community groups are pretty well accessed by all communities and they're the route to get in.'

He continued: 'What we found was that the community were keen to hear about genetic risk, if it was presented in such a way that didn't sound like we were just criticising a community habit, so you've got to pitch this in a way that's around genetic risk as opposed to community practice as such, start from the genetics. Faith-based organisations are really useful for that because the context in which people will be making marriage choices is linked to faith. So we've certainly found that a useful direction.'

Echoing our own findings, this interviewee drew attention to the health challenge in Bradford of 'obesity and diabetes and one of the ways of dealing with that is around early infant feeding, what you feed children and the process of weaning children and that involves educating or helping members of the Pakistani community to realise that babies grow at a particular pace. If they look relatively small, it doesn't mean they need to be weaned early and have their breastfeeding supplementing. Levels of breastfeeding in Bradford are lower than the national average, they're lower in both Pakistani and the white community, slightly lower in the white community than Pakistani but in general, very low and what we've got to do and we could use faith organisations for this, is help them in terms of thinking about diet and what's appropriate and the real challenge to get over is that what might have been appropriate to Pakistan, is not necessarily appropriate in the calorie rich environment of a Bradford diet.'

There are marked health inequalities between the three Clinical Commissioning Groups (CCGs) in the city where according to an interviewee:

City CCG which covers the inner city has got some of the worst health outcomes for the country, we have the lowest healthy life expectancy for men and women in the country...The life expectancy rate is so low because of diabetes and heart disease. We also have one of the highest infant mortality rates in the country. Now the people who are suffering from those issues are majority Pakistani community who would be Muslim, or poor white.

Our study is interested in BME communities specifically, so in Bradford the largest cohort within this sector are Pakistani Muslims. Islam will therefore feature more strongly in the case studies outlined below. One of our interviewees stressed that there were some very good examples of broad community provision now taking place in Bradford mosques, specifically mentioning the Madni Mosque on Leeds Road, the Al Markaz ul Islami on Becksides Road and the Salafi Mosque on Long Lane. The 'Tile Street Mosque' (Jamia Masjid Naqshbandia Aslamia) has a 'deaf Islam' project 'a deaf group where they support deaf people, and they do [...] Christmas presents into the hospital'. Also mentioned was the Al Mahdi Mosque on Leeds Road which is 'quite engaged in the different social settings', as well as the Al Mustafa Cultural and Educational Centre²⁸ and a group called Clements Gate, whose chair is a female Muslim:

We are a Bradford based charity that aims to provide Islamic learning material to the youth of Bradford. As part of our programme of activities at Clements Gate we have

developed a range of relevant and essential services that cater for the varying needs of the Muslim community. Our aim is to serve the needs of the community in a proactive and responsive manner [...] guided by Islamic principles. The services we offer are confidential and we aim to adhere to good practice models of pastoral care, support and professionalism. Our aim in providing these services is to enable Muslims living in Bradford [...] to remain attached to their Islamic norms and values while at the same time enabling them to become better citizens of Bradford and a force for good.²⁹

However, this interviewee stressed that it was important to remember that first and foremost a mosque is a place of worship but they do also often have spaces outside the prayer area that can be used for broader community activities. For instance, at the Madni Mosque:

downstairs they have a community venue which is not considered to be part of the mosque, [it is not] in the prayer area. So in that space a lot of things can be done. They have Jiu jitsu classes for women for example. So they have made that kind of separate distinction and it's open. Upstairs is prayer, but the prayer is also linked into the physical daily life.

Having outlined general health issues facing BME communities in Bradford, based on the information that we received from the interviews and focus groups (rather than the literature on the topic alone), we now present four case studies emerging from our research: food poverty, diet and exercise (including of children); Muslim women; dementia; and culturally appropriate mental health support.

3.3 Case Study 1: Food Poverty, Diet and Exercise (including children)

In this case study we look at issues around food poverty, diet and exercise and the ways in which some faith communities in the city have addressed these. As already noted, poverty and deprivation can contribute to low levels of exercise and poor diet and a number of the projects that we came across were linked to these issues.

3.3.1 Food banks

One of our interviewees from an Anglican setting told us that:

The thing we're doing at the moment where most churches have got engaged...[is]...around food poverty because so many have got food banks or hot food projects... the majority are run by churches, there are a few, there is one [foodbank] run by Bradford Lions which is Muslim led and there are two hot food projects that are Muslim led, of the ones that have been recent, so of this kind of new wave of welfare reform that's taken place, in a response to welfare reform, the majority are Christian food banks and the historical ones, our oldest food bank was set up by a Sikh but is not faith-based and it has involvement from people of different faiths but is not a faith oriented organisation.

This interviewee was involved undertaking a survey of who uses food banks in the city:

We went to three major ones, Trussle Trust Central Food Bank, the Bradford Met Food Bank [which only take referrals]...and then the Salvation Army in Keighley, which is dropping in. They're not all giving the same food and access isn't the same but we got

them to fill in this survey, we had about 80 odd respondents, we think there was a peculiarity about when we did it, so a lot of people said that wasn't a typical week...so it's not a robust methodology by any sense but we had all white people, nearly all white men. There's a sense that the Pakistani Muslim heritage community are not, not that they're not experiencing poverty, statistics would say they are amongst the poorest communities but actually not accessing food in that way.

This interviewee also explained that while 'there is some evidence that the food parcels are accessed by the women's refuges and so there is probably some Pakistani heritage Muslim women using food parcels through different routes' overall 'it feels like it is the single white men are the ones that are coping least well.' This respondent drew attention to the fact that there could be cultural issues that prevented the Pakistani origin communities from accessing food banks or concerns over food not being Halal:

Bradford Met Food Bank were...the ones that in a typical week said "Yes, we would give out some Halal food parcels", so we know that there's demand from Muslim community in some places. But I suppose the sense was that for the most part and I know this because of the hot food projects are similar, they're not seeing ethnic minorities full stop. To a certain degree, some Eastern European and particularly the Roma community will be accessing some of the hot food projects but again...is it that they don't know about them? Or is it again that thing of, to use a food parcel, they're not even at the stage of being able to use a food parcel and it's of no use to them, or have they still retained the ability to cook a meal with cheaper ingredients?

3.3.2 'Soup Kitchens'

Two of the groups we visited also run hot food projects in the city. St Paul's Church in Manningham, with its dwindling congregation, and situated in a now largely Pakistani origin Muslim area runs one of the many 'soup kitchens' across the city. Another – the 'curry circle' – is run by the Muslim Women's Council in the city (see below)

St Paul's is an Anglican Church in the Manningham area of the city and according to our interviewee this parish is 'in the bottom half a per cent...child poverty is around 40% here, adults with no qualifications, not even one NVQ, that's 40%, so it gives you a feel of the area...'³⁰ The congregation had steadily shrunk over the years and now only amounted to around between 30-40 members, with a shifting demographic in that area of Bradford to a mainly Pakistani origin Muslim population, comprising around 85% of the parish. A good number of parish churches in that area had already closed, reflecting a broader trend in the city as a whole. Another interviewee told us that 'church numbers are falling in Bradford...we had 20 [Anglican] parishes up to a few years ago, Dioceses did a big restructure and we [now] have 10'.

Only around one third of the congregation of St Paul's were estimated to still live in that area, and the projects run by the Church were therefore not directed at congregation members.

The soup kitchen at St Paul's is run on a Friday and is called the 'drop in café'. It was started with homeless people in mind

people who are really on the edge and can't afford food, so they come on a Friday, they get a three course meal free and when we get our food donated from other churches and some charities give us food, so they get a soup, a hot two or three choices for a main course and then a pudding, rice pudding, a cake, something simple.

The organisers try to keep the food healthy and get about 60 people attending each week, many of whom are overweight. The Church also keeps an emergency food supply for people who call at the door, which is regularly, and they give food parcels, but the main aim is to provide the café on Fridays.

3.3.3 Other projects – healthy eating, elderly support and youth work

Related to food and diet, St Paul's Church also runs a 'scones and samosas' group, which a public health actor from the local council has visited and for which they have received local authority funding:

It started out [...] talking to mums outside the school and they wanted to learn how to cook traditional English food like lasagne and pasta! So we do that, that's on a Tuesday, they're doing it now. So that also helps their language skills because they didn't know about measurements and all those sorts of things...But the focus on that is healthy cooking...We have a worker funded by a charity, "Sharakat" – an Urdu word for "communion"– so she's the Sharakat worker, so she runs that. They get about 14-20 mums, mainly mums go to school first and then come here...They're mainly Mirpuri Pakistanis around here, so that's scones and samosas, although it's cooking and scones are not very healthy, but they do have a lot of focus on healthy eating, healthy menus. There's an ESOL class here on a Wednesday and a lot of that is based on food and also again it's healthy food, like vegetables, is pushed in that.

Rather than catering for the immediate congregation, these projects reach out to those in the wider community via the Sharakat project which according to its website,

...has grown from the church's vision to serve the local community in a way that fosters well being, includes the marginalised and encourages cross cultural and cross-faith relationships. It seeks to be a practical witness to the love of God in the community.

Sharakat's initiatives are varied, reflecting the needs and desires of our community members, including:

- Conversation Cafe
- Drop In Cafe
- English Speaking Classes (ESOL)
- Scones and Samosas³¹

This Church also runs a

'silver club' [funded through Near Neighbours, run by the Church Urban Fund] as well for the elderly on a Monday...that's just again a safe place to be warm and chat and read and knit and play draughts and things. We sometimes, every other week, we have a fitness lady comes along who does exercise in chairs and that sort of thing, they love that.

And an Afro-Caribbean café is run on a Wednesday each month, but not by the Church itself: 'they come here, they run it, a wellbeing café, their food is always healthy but they have a lot of speakers on health and public safety, crime prevention stuff and they also have fitness, it's the same lady comes along and does armchair fitness.'

A number of our interviewees also worked with young people, including initiatives that aimed to have an impact upon improving diet and exercise for younger people. St Paul's Church runs a 'Beaver colony' and also an after school club, from 3.30 till 5pm on Tuesdays, for predominantly Muslim children, who attend until 5pm when they go to the mosque, and includes a snack. The aim was not to convert people to Christianity, however:

Yes, I'd love everybody to be a Christian but that's not our aim at all, it's sharing the gifts that God has given us, it's like the after school club with the cubs, they're all Muslim kids, bar probably one or two. It's never going to affect our church congregation but that's not what, inner city churches, that's not what we're here for, I don't think so, some people would disagree with me but we're not here, we are growing slowly, two or three new people come along and they like the engagement we have with the community particularly.

Another interviewee talked about work undertaken in Early Childhood Services in Bradford around children's play, which is important for health and development. We were told that

It's well recognised that in particular for 8 to 13 year olds, there is always a kind of gap in provision, the demise of what was extended services provision nationally, not just locally, much of that money went into schools and schools then, some carried on and did it as a non-curricular activities but a lot of them didn't, so there's a kind of lack of provision for that particular age group.

Play teams were set up across the city with different activities including afterschool activities:

It's kind of child-led, there's no adult oriented direction and part of that is about enhancing a child's cognitive skills, brain development, as well as experience risk in a managed way, can develop resilience in children. So we're about developing that self-confidence, self-esteem and resilience, obviously being active, there's an additional benefit then in relation to public health agenda.

This interviewee explained that staff began to realise that some children were going straight to the mosque from school rather than attending afterschool sessions they had arranged and they began to think of ways to reach those children. One idea is to work with those local mosques to deliver play services in the mosques while the children are there and discussions are currently underway about whether this is feasible, 'it would be about trying to get access to mosques to put that provision on, to increase our reach and ability to make contact with children in that age group'.

The dietician that we interviewed suggested that children's diet and ability to exercise might also suffer when they go the mosque after school:

They [girls and boys] come home from school and then they go to mosque between 4 and half past, till about 6 or half past...which really limits the amount of time that's available for activity and from what I've seen, what parents do is the child gets home at half past 3, it's a long time to go with nothing until 7, so they give them, I don't know, fish finger sandwich or something that they would class as more of an English type tea generally, or a chapatti with small portion rice and then they come home and have their second tea...So in theory, they're having two evening meals. Now, there's never any mention of any food being given at mosque, usually I don't think that happens but it isn't helping us then trying to get that child more active because five nights a week, they're unavailable to do anything, so you'll say "Can they attend anything after

school?" "No, because they've got mosque." So then [there are] Saturdays and Sundays, [but] there's other things that families have to do on Saturdays and Sundays and I appreciate that, so getting them to go to all these clubs and things or even getting them to the park and that, it's not possible.

We asked the Children's Services interviewee if it was felt that PoWs could offer some 'added value' in approaching diet and exercise behaviour change, other than the provision of a setting. Our interviewee told us that the focus was on the PoW as a place to access children who could benefit from their play schemes rather than because they felt that a faith-based environment provided particular advantages as a setting for engagement.

This question of whether or not PoWs offer comparative advantages over secular settings with relation to health interventions is one that is frequently raised in discussions. The empirical data do not lead to any strong conclusions. We argue that it is less important to focus on the question of whether faith settings do things better than non-faith settings and more important to emphasise that there is evidence that they are relevant and may have particular potential impact for some individuals and communities. The point is that they need to be taken into consideration in broader assessments of health systems.

Our respondent from St Pauls' told us that:

There's loads of emphasis of the link between spiritual wellbeing, whatever faith it is and health, there's loads of research that shows that, so this place is offered as a safe place for many people for that. You realise, particularly some of the women we're told, come here because they just want to be out of the house, so they can do what they want just for an hour. There's probably things here most days they could come to, so we offer that space.

Our dietician interviewee felt that there could be advantages to using PoWs as settings for PH, but that some people may not want their health condition to become public knowledge:

If we go back to Islam, Islam is all about protecting life, well how can you protect life if you're carrying extra weight, you've got high blood pressure, you've got diabetes, you smoke? And it's all about that, that's what Islam is, about protecting life to the very end and maintaining life. Similarly probably, your Christian type, it's all about trying to ... spread your message and how can you spread your message if you're dead?...

I think they're good as venues because people know them, people feel safe getting to them, there might also be a bit of a problem with them in that it might be, they might go for something that they've kept quite secret from other people possibly ... so you're publicly acknowledging that you've got something that needs sorting, so I'm not sure if that [...] might stop some people.

Another disadvantage or barrier that came up across our interviews was the extent to which the mosque is a suitable setting to access Muslim women around PH since they are less likely to use the mosque than men. We explore this in our second case study.

3.4 Case Study 2: Muslim Women

A significant limitation of engagement with mosques around women and children's health is that women are less likely to attend the mosque than men. According to the dietitian we spoke to: 'not many ladies go to the mosque, so it tends to be quite a male environment, whereas if you think about your Christian churches, that might be [a] more female led congregation as opposed to male.' Women are not obliged by their religion to pray in the mosque, sometimes there are no separate prayer facilities for women, many women feel that it is too male dominated as a space for them to feel welcome and they prefer to pray at home. This was discussed in our focus group, where Muslim women confirmed that they are less likely to go to the mosque to pray than men, even when there are facilities for them, but that they take part in social activities there as well as to attend religious learning classes in madrasas, sometimes located on the mosque premises:³²

I personally don't have any contact with the mosque, I don't go pray there; I pray at home. The only contact I do have is if there's somebody passed away and they usually have the gatherings there. But I do know that all the local mosques that I know of now do have facilities for women don't they?...To come in and learn, to learn Arabic, Koran....?

Yeah there's classes and they can even pray now....

Yeah if it's time for prayer, but men do it in congregation, we don't really....

It's like my local mosque...as well, they've actually extended the mosque now, they've made two or three more rooms for women to gather, to have gatherings there. Or if they want to have fun days and things like that they can, and if they want to do any charity work and stuff. Like [X] was saying, you know if there's a few women they all gather there, they've got rooms for women and men. So they're beginning to involve the community as well as men and women...But now because the women are getting more involved, women are contributing to the financial side, helping the mosque in bringing in money and stuff. Because the Hilton Mosque it was all very small wasn't it at the beginning. Now all the community pulled in together, they put money in and built it into a bigger mosque for the community. So the women have some role in that as well now.

There was some disagreement about whether men would like women attending the mosque more frequently 'because the men like to rule. You know the mosque is like the men are always in charge of it.' Another disagreed 'because more women are using mosques now' and another drew attention to the fact that there was great variety across the city, and that the madrasa she attended (which was not actually in a mosque) was run by a husband and wife team who were quite 'equal'. There are different types of mosque – some of which are more traditional and less welcoming to women and others that appear to be more progressive. One female interviewee in a Christian setting told us that:

This isn't true of every Muslim community in Bradford, [but] women are not part of the mosque structure so they won't be part of the committee which is typical of elsewhere, but they will not go to mosques which is typical [of] some places in the UK and not typical of everywhere. You've got a very male domain that doesn't particularly bring together young people, doesn't particularly bring together women, so it's also not a functional way into the Muslim community.

Another interviewee, who took part in the Muslim women's focus group, drew attention to work done in community centres, that had some appeal for women. These include the Khidmat centre on Spencer Road run by Bradford Council of Mosques which runs a women's group, as well as an

advice centre, day care, drop-in, classes, health activities, sports and a youth group every Friday.³³ Also mentioned was the Karmand Centre³⁴ on Leeds Road offering a similar range of services to the Khidmat centre but with no obvious link to a faith-based network.

However, on the whole there was a perception of mosques as relatively unwelcoming to women and for holding quite conservative views about gender issues and women's health. As one female interviewee from a Christian setting told us, 'my worry is that there is a hierarchy and a patriarchy in the religious structures, the social structures and the family life that...until male religious and community leaders are going to start recognising and saying this stuff, it won't change in Bradford.'

For instance, a Muslim focus group member also told us that she:

[...]approached a Mufti once and there was this issue between me and my husband that I wanted to put my children [into nursery], as soon as they hit two; I've had enough, my depression's really kicked in, I've got no agenda for myself, I'm just living the life of the kids....So I was really happy in sending my kids to child care, but my husband would say money issues, you don't need to go. Islam says you should be with the kids as long as you can in the first few years, part of their life. I felt as though the nurseries were actually giving my children more structure and routine for me and my kids, and it was more of a healthier partnership. When I approached a Mufti and he was saying, "No you should be bringing them up by yourself at home."

A number of the focus group participants also felt that any health issues dealt with in the mosque or other religious settings would need to be appear uncontroversial in relation to accepted gender norms, such as diabetes:

It's quite a mild topic, it's not that controversial is it... we're not telling them to allow women to start going out more or something...And I think when we're talking about health it can't be anything personal. I don't think that would go down well don't you think? I don't know something off the top of my head like testicular cancer or something like that...Something about genitals or something like that, something like gynaecology or breast feeding in the mosque...I think it's got to be things like diabetes...

It was also suggested that a religious framing of health issues might mean that such issues not receive adequate attention by public health actors, who want to avoid being culturally insensitive, leading to outcomes that disadvantage women and their families. Regarding the impact of consanguineous marriages, a female interviewee from a Christian setting suggested that there is a need for genetic counselling and testing to be offered before marriage so that families can be discouraged from entering into close family marriages if there is a risk of genetic problems for offspring. She explained that currently the genetic counselling

that's offered in Bradford is offered once you're married and I just think within a Islamic framework, you can know [the risks] but the choice to not have children is not going to be well supported; the blame always rests with the woman, even if factually it isn't the woman's fault, she'll often bear the burden of the blame. Adoption and fostering and surrogacy and IVF and all these things actually are publically frowned upon, they happen but they're not massively commonplace within the Muslim community, so if you say to a couple, "You shouldn't have children because you've got a 1 in 4 risk of your child being born with a congenital condition", what do they do with that? All it offers is that their younger siblings might make a different choice, it doesn't really do anything for them.

According to the same interviewee, another example of the religious framing of health issues is a tendency to sometimes view a child who is born with a life limiting condition or a severe disability as:

Allah's will, it's pre-destined...I can understand that that must be quite a comfort, to be able to go "well, it's Allah's will, it's pre-destined, it's a gift to us" and so then you've packaged it up quite neatly, that you don't ever need to change that practice, it would be really good to get some leaders, religious leaders or people who have respect in religious communities, who were able to say "Do we want this for our children?"

However, the Muslim women's focus group participants did feel that the mosque could be a good venue for addressing men and children in particular:

I think it would be effective in maybe attracting like children, because they already go there. I remember when I used to teach the children, anything new said to them they soaked up really well. Because they have a lot of respect for you, anything you say they'd probably go home and tell their parents as well.

They also felt that men might listen to the Imam if he were to give health messages:

They could put it as part of their sermon, you know when people are sat there and they're listening...If somebody gives a talk on it I think they will listen then, because they won't be able to move and go anywhere. Even if they wanted to leave because...it's part of their whatever they say every day, particularly on Fridays...Especially on a Friday because there's a lot of people go to mosque on a Friday...And during the fasting month as well, they tend to... They've started to wean people before Ramadan starts, about a couple of weeks, that it's not all about eating fried food....And especially during Ramadan as well, like a stop smoking campaign [...] they do in Ramadan. Now's your chance to stop smoking....Because a lot of men on a Friday, you won't get any more during the week than you get on a Friday. You have young people there as well....think if the Imam is doing the sermon and he starts talking about health and then they said, "we've got some leaflets there so make sure that you pick one of them up, and if you want to speak to somebody," I think that would be a good idea.

In attempting to find out whether or not the mosque was appropriate as a location for women's health a number of interviewees instead suggested that they are more likely to attend community centres that are not linked to mosques, reflecting the fact that some religious spaces can be difficult for women. As a female interviewee from a Christian setting told us

I think there is another set of spaces that bring together Muslim women, not because they're Muslim but because they're women, the Children's Centre network in Bradford, huge, brings together a lot of women, there's quite a few women's centres or women's groups running out of community centres. So there are networks where Muslim women are brought tighter, they're just not explicitly connected to the places of worship. Some are. So the Hindu temple up the road from here, they bring together Hindu women regularly and it's a social club, it's not about practising their faith but it is at their place of worship...[the]...Gurdwara does the same but... I don't see the mosque doing that the same and in a way, it now exists already so I don't know that women would start going to something that was setup by the mosque.

We carried out an interview at Keighley Women and Children's Centre, which caters for

women and children, it's predominantly with South Asian community...it provides provision for education, work experience, needlework, creative arts, for women we do exercise, health and wellbeing, that's a regular provision that has been available for the last 15 years for this centre. There's provision such as IT, ESOL classes, English classes, then there's creative art classes. There's other classes we put on for cohesion work, at this current moment we're doing a project to bring three schools together, which is called Our Future, Our Keighley because there's been a lot of racial tension within the schools and the young people...We do not have any core funding, we look for funding ourselves and we've been established for 27 years...there was a need in '84/85, there was no provision in the area, there wasn't anything in the vicinity for childcare or any provision other than nurseries.

Women come to the centre during the day and after school they work with young people:

We do all sorts of activities...it's just raising awareness and giving those young people a platform to raise their confidence, self-esteem, a safe environment where they can come in, chill out, talk about issues, things that are happening at home, things that are happening in Keighley and sometimes there's issues like the CSE [child sexual exploitation] that's been in the papers and the media.

The centre staff have also done work on controversial areas that it might be difficult to approach in some mosques, such as sex education and forced marriage. Over the years the centre has run events where they have invited 'different people in from different areas of health and wellbeing, to come in and deliver awareness sessions... we're here as a first point of call and then we signpost them or bring people here to raise awareness and plus most of our staff are trained, they've had nutrition training so we're able to deliver sessions ourselves.'

When we do a health and wellbeing project, we always plan that within the project, that there will be a session raising awareness around nutrition...There's actually an exercise class from 11 till 12 here [currently funded by Community First]....Exercise and then we do a nutritional element of it, maybe two weeks they'll exercise full-on one hour and then third week, we'll talk about some things but a lot of times when they arrive early, we do have a little bit of a session and within that it's talking about the weekend, how it's been, has it been beneficial for them to come in and exercise...

We teach the women to look after themselves and then we'll say, "Can you do this type of cooking for your children?", so we talked a lot about the nutritional value of foods, the protein, carbohydrates... I have to translate all this into Punjabi for them so that they've got better understanding and for young people, I do lots and lots of work with them, recently because that is what our focus has been for this quarter, is looking at health and wellbeing, about nutrition, about them understanding.

We've taken them to Asda for a shop to see what do they see, from a child's perspective, what is healthy, it might be a packet of crisps for them, so teaching them and making them aware of what is good and then also we've done lots of nice dishes we cook here for them, which they participate in, in preparation. We prepare fruit salads, we do lots of brown bread, wheat things, we make lots of things around health and wellbeing, so we're looking at nutritional stuff like proteins.

The interviewee told us that they had done some youth work in the local mosque with young people but that recently this had come to a halt and it was not clear if it would be feasible to start it

up again. As a result of this work there is now a group of young girls who access the same service at the women and children's centre:

At that time, there was one of the councillors on the management committee [of the mosque] and I approached him and said, "I'd like to come into the mosque and do some work with the young girls because you do have a young girls session", where they do the Koran, they do the reading, then they do the *fikr* and then there's a little bit of time left afterwards and I thought if I could get in there, the last maybe three quarters of an hour or maybe half an hour, just to raise awareness about things that they're not aware of, a lot of young girls are not aware of like you've got Childline, if things are happening at home, who do you talk to, to give them that confidence to be able to talk...We were going in because I was going to do the project first with the girls and then I was going to work with the boys because that is my speciality anyway, I've got a lot of experience...so I thought "Let's go in this way and we'll approach the boys because I need to work with some of the boys about attitudes, respect", there's a lot of values that need to be addressed and talked about and a lot of times it doesn't matter where you are but you've got to give that opportunity to young people to speak out.

However, it was made clear that although religion comes up in the work done at the women and children's centre

We don't practise anything, we don't preach anything here but women do come with faith....They talk a lot about religion when they come in, when we're doing a health and wellbeing session and I always say that even religion tells you to look after yourself, not to let go of yourself but a lot of the women when they're sitting in groups, like our health and wellbeing group that we have on a Monday morning, they will talk about death, they will talk about illnesses, they'll talk about...the Koran, they might just reflect on something, they might just want to share it with the other group. Sometimes some of them accept it, sometimes they don't because they're from different sects, so you can't impose anything, so you have to be very neutral in what they do. But if they want to talk about it, we don't stop them. This is again a safe environment for them to discuss what they want to.

Another organisation that caters for women outside the mosque/madrassa setting is the Muslim Women's Council (MWC) in Bradford, which was

established in 2010 as a small outfit to start with, initially the reason we established this was we found quite clearly, through scoping exercises, through feasibility studies, that there was a huge gap in service provision, when it came to an advocacy organisation, advocating on behalf of Muslim women. A lot of male-led patriarchal structures out there but no specific women led structures, faith-based. So a small group of us came together, managed to secure a small pot of funding and initially we set it up not as a delivery organisation, more as a representative advocacy organisation, to kind of do a bit of the challenging work and look at where the gaps were.

The MWC do a lot of sign-posting and their events attract women from different socio-economic backgrounds as well as those who have come over from the Indian sub-continent so do not have English as a first language. While to date they have not done any work on health, it is something that they are interested in and they have been meeting with the local health NHS trust boards/CCGs, particularly with respect to mental health. However, our interviewee stressed that people often needed additional motivation to attend events around health and that such initiatives need to be linked to other events. The MWC works with a local organisation – Bevan Health Care

– to bring health care professionals to the ‘curry circle’ hot food programme, which they run on one evening during the week.

The main finding from this case study about Muslim women is that many places of worship are gendered and any potential engagement must be cognisant of the fact that a PoW may not be used in the same way and to the same extent by women as by men. From our research this appears to be particularly the case with mosques. However, while there are mosques where women do not have relatively equal access compared to men, many others are much more welcoming to women. Our interviewee at the MWC told us that

It's actually been quite recent that mosques have started to ensure that there is space for women, I think 15 years ago it was unheard of pretty much so, for women to go into the mosques, especially in northern cities. I'm sure that wasn't the case in places like London or Manchester, maybe Birmingham but Bradford seems to be lagging behind a little bit, which goes against the original rulings of Islam whereby the mosques in our prophet's time were congregations where women were given adequate space in the mosques as men.

She explained that the MWC was ‘carrying out quite a detailed audit of all the local mosques to look at provision for women in the mosques’ (there are just under 90 mosques in Bradford):

There's a claim out there that there's adequate provision but when you talk to the women on the ground, there isn't, if you go to the mosques, the women are either ushered into the cellars or they've got a small little room with no windows, they're almost pushed to one side and what we're saying is that if you look at the demographics, why is there not, why is this need not being met within the mosques?

The level of detail we've been asking is quite generic at the moment...to look at what space there is in the mosques, how the women can actually access the mosque, whether they're coming in through a back door, whether they can access the mosque through the front door, who they can speak to at the mosques, what the committee structure is made up of and what we're finding is it's predominantly the sub-committees have got women on them but the main committees across the piece are made up of men. Where women can go to if they've got problems, who they can speak to at the mosque, so it's those kinds of questions at the moment.

I think more work needs to be done definitely to open doors with mosques, it shocked us going round the mosque, looking at the level of access which was pretty dire so it's no wonder that women don't access mosques to the degree that they should be doing....

So yes, I think that's the first question, access to the mosques...We're looking to complete the audit by the end of this year, we started it last year with a view to building the first mosque in Bradford for women only, it's an ambitious project, we're already in conversations, trying to secure the land for it, if successful it will be the first of its kind in the UK.³⁵

The plan for us is obviously once that's up and running, we're not just looking at a mosque, we're looking at a bespoke centre that's got everything in there, including hopefully a GP surgery etc....And open up the doors as well because if you look at the political climate, the level of Islamophobia out there it's important that you have a place where people from different faiths can come together and have those conversations.

3.5 Case Study 3: The Dementia Friendly Gurdwara

One of the settings where we carried out an interview was the Ramgarhia Gurdwara³⁶ on Bolton Road in Bradford, one of six Sikh temples (Gurdwaras) in the city. People travel from quite some distance to use this Gurdwara, including from Huddersfield and Leeds, and it attracts members of the Ramgarhia community of Sikhs, traditionally comprising people involved in technical occupations. It was opened in 1981 in a building that used to be a Methodist hall, Victoria Hall, and was bought for £45,000 in 1980 by the community. In 1982 a Punjabi School was set up which can teach up to A Level and there is also a community centre used for weddings, social and cultural events. There are two weekly congregations, one on Thursday evening and one Sunday morning. Our interviewee explained that ideally they would meet every evening but because so many of the members were in employment, this meant that they found it difficult to fit it in.

The interviewee at the Gurdwara outlined how there was a basis in Sikh history and religious teachings for engaging in health care:

...because in India...every Gurdwara has a clinic of their own, the first guru started the clinic outside the Gurdwara...it used to be herbalism and then homeopathy and I don't know if you've travelled, how many religious places like Golden Temple, they all have a *sala*, a place where you can spend your nights before you go and visit the guru and those were used as hospitals, the people who can't travel, they used to treat them, they used to go and sleep there....

The seventh guru, Guru Har Rai was one of the best herbalists who saved the life of Akbar's son, Akbar the Great. His son was so ill and the only medicine, the herb was with Guru Har Rai so he sent it to him to save him...In India, our tenth guru, Gobind Singh, fought many battles and he had one Sikh who was a water carrier, so when he was giving water, he will not see, is he an enemy or is he a Sikh or is he a Muslim or a Hindu, we give the water to everyone and some Sikhs got mad and called him a traitor, they went to Gobind Singh and said "this person is a traitor, we fight hard, he falls down tired and this guy gives him water, they start fighting again" and guru knew what his Sikh was doing but just to prove others, he called him to court, he said "Bring him in", and he said, "These people are saying you're a traitor, you're giving water to enemy" and he said, "Guru, I don't see no enemy, in every person I see your face, I'm only feeding you" and then Guru knew that already but he says, "Here's the ointment, here's the bandage, now do rest of it as well, don't give them water", so that's where the first...Red Cross, according to us, has started.

Our interviewee also told us that the third Guru had his own leprosy clinic and every morning he used to wash people suffering from the disease. Interestingly though, today the 'priests' in the temple would not get involved in delivering health messages or talking to people about health, their role is quite different:

Their role is a Holy role because the biggest disease is mankind, the world, the karma effect and that we have separated from the Spark, we've got to go and join, the only way you can join, yes we have got a Karma, they've given the destiny but as per Sikh, you can change your destiny by serving the poor because they will bless you and all your sins will go away with their blessing.

In line with this long tradition of health care practice the Gurdwara had been involved in raising money for a ‘cataracts camp’ in India and ‘we had a day in here, in Leeds as well, we had checking of the sugar level and blood pressure and telling them why exercise is very important.’ Out interviewee told us that: ‘We haven’t done work as such [with Public Health Bradford] but we do inform people because Asians are suffering with cardiology problems...Heart problems, diabetes and now dementia, well we never knew about dementia before, it’s just the last 5-10 years it’s come up as a disease, we just used to think it was a mental condition, you know?’

There have also been ladies keep fit classes organised by the Gurdwara in a nearby hall that the community owns but have since leased out for other uses. One of the local Gurdwaras, Guru Nanak Dev Ji Gurdwara, runs a gym for Sikh families – Khalsa Fitness, ‘the whole ideology..was the Gurdwaras to create an area where our kids go in the evening and play instead of going outside and throwing stones.’

Our interviewee said that there were three main areas where the ‘Gurdwaras wouldn’t mind to have some sort of training or some sort of workshops once or twice a year, regarding heart problems, diabetes, dementia, these sorts of things.’ However, in terms of work around dementia this Gurdwara is pioneering. It is the first ‘dementia friendly Gurdwara’³⁷ winning first place in the voluntary sector category of the 2014 Alzheimer Society’s Dementia Friendly Awards.³⁸

They [the doctors who run it] come every Sunday and anybody who wants to talk to them, they can talk to them.... Just explaining to people what dementia is, the signs and symptoms and they want to talk more about it, they can talk to [them] as well...It was their idea to make the Gurdwara ‘dementia friendly’ because Asians are suffering more on the dementia side lately, quite a bit. In this Gurdwara we had about 10-15 people going that way so that was their project...[they]...put signs [all] over as well and...had quite a few workshops here as well, regarding that.

We also carried out an interview with a representative from the project who explained that it was started in 2012 by a wife and husband who are both training to become doctors and are members of the Gurdwara:

Dementia friendly is a term that’s used by both the Alzheimer’s Society and the Dementia Action Alliance and it’s kind of come from David Cameron and the government, trying to push more money into dementia research and dementia awareness and dementia friendly communities and dementia friendly buildings. The team in Bradford are especially good in helping local communities, libraries, places of worship, schools, all that kind of thing, to run their own kind of dementia awareness initiatives so that they can get this dementia friendly status if you like and they give you a sticker and you can put it on the window, when you’ve done all that kind of stuff.

The project was based on an awareness that

the Bradford Sikh community didn’t have a good enough awareness of dementia, so that they could be on the lookout for signs and get relatives and family members the support that they needed, early on. So the project was started on that kind of basis and the aims were to try and raise awareness, promote education by the Gurdwara being a hub for little dementia awareness sessions and providing leaflets, educational material, that kind of thing and a place really where people could talk about dementia in a safe environment, without the stigma attached to it which is still quite prevalent because it’s not widely known about....

Our interviewee stressed that the Gurdwara is:

quite a social hub for the community so everybody knows everybody and it's difficult to find any other place, where everybody meets on such a regular basis and gets to know each other quite so well and also do activities because the Gurdwara itself provides ... there's musical activities, there's the worship part of it, there's the community part of it, there's the food part of it, the free meals that you get at the Gurdwara and that kind of thing and in all those areas, it was really the best place...

The other thing is that a Gurdwara is supposed to be somewhere where anybody can come, regardless of their religion, their caste, their sexual affiliation, anything. It's supposed to be somewhere where you can come and feel accepted and wanted and welcome, regardless of the baggage that you bring. And so if we're not making the Gurdwara a dementia friendly place for people with dementia and if we're not making it a place where dementia can be discussed, then [...] the Gurdwara is not fulfilling its purpose and keeping up with the ages because the population is getting older, dementia is much more prevalent or perhaps we're just much more aware of it and if we just keep doing what we've been doing for a very long time without updating ourselves and things, then we're going to die out really.

The organisers of the initiative undertook a 'dementia training champions course...run by the Alzheimer's Society, ...[to] learn about dementia and then you can go on one of the training courses to become a mentor, so that you can then deliver sessions in your local community.' A representative from the Alzheimer's Society then visited the Gurdwara and

looked at the environment through the eyes of someone who has dementia, to see what can be improved. A lot of Gurdwaras are not purpose built....So it can be quite confusing, even for people who don't have dementia, it can be confusing trying to figure out where everything is and just things like signage and making things clear and easy to navigate, that kind of thing they helped us with....In the Gurdwara, we've put a little information portal where people can pick up leaflets on their way in and on their way out and we've designed our website, which has got podcasts and stuff like that, so that people can logon and read things in Punjabi and in English because the language barrier is sometimes quite difficult. So it's basically a tailor based approach to raise awareness in the Sikh community and we've piloted it at the Gurdwara on Bolton road in Bradford ...at the moment we're in the process of getting the other four or five Gurdwaras in Bradford involved.

The project is 'the first in the UK, in fact in the world, of dementia awareness targeted specifically at the Sikh community in a Gurdwara' and their 'ideal for the future would be that every Gurdwara in every city has a group of people running a dementia awareness initiative'. We asked if other faith groups had been working in this area and our interviewee told us that:

I think the churches are quite proactive, so we were invited to a recent Dementia Action Alliance meeting a few months ago, where there was St Mary's Church I think is the name, so again run by volunteers who are basically doing exactly the same thing as we're doing and tailoring it to the needs of that particular community. I haven't heard yet in Bradford of any other faith groups, I've only heard from the Christians but I'm sure it will come, if it's not there already.

Our interviewee also added that 'I think our project was particularly, I don't know, welcomed because it was an ethnic minority project, of which there are very few at the moment or certainly

maybe they're there but no-one knows about them, could be either'. After winning the Alzheimer's Society award they received a fair amount of media attention and 'as a consequence of that...we got a couple of emails from the south of England and we were contacted by people in India, people in Australia wanted to do similar things'. Our interviewee was not aware of any dementia specific initiatives that have been successfully launched as yet, but was quite clear that their role was not to replicate the project themselves in other places. Instead, 'our website then, we designed a blueprint so that's like a six page document just step by step, "this is what we've done, this is what worked for us and what didn't, if you have any questions then get in touch with us and we can talk about it more":

What we feel is that if [...] a couple of people or a handful of people, dedicated individuals who are regular congregation members at the Gurdwara, take on a project like this, it works much better which is why we didn't go in...the communities are built up over a number of years, you'll find several generations of one family have been going to one particular Gurdwara for many decades, someone new can't really go in and start saying, "This is what you should be doing and this is how you should be thinking about dementia", it's just not going to work, you won't get the same reception. It's much better if people who are already integrated into the community, can work with people because it often has to be done on a very informal basis, even we found that you can't just go and set up a dementia session and expect people to come because people might be a bit apprehensive, might be a bit confused, might not know what you're talking about. It can be quite an insular community, you have to break barriers, you have to make people comfortable with the whole concept and start the conversation going, so we found that because we knew people, it's easier to talk to them on a one to one basis just like when you're eating, having a chat with them, that breaks down the barriers and then you can start doing more formal structured things and then it works quite well, but you can't do it the other way round.

They had also made contact with an organisation called the British Sikh Doctors Organisation which runs healthcare screening sessions at Gurdwaras to see if they could incorporate any of what they have been doing with dementia awareness.

The role of the doctors in the Gurdwara is not directly to treat people, but instead to advise them and to suggest that they visit their GP, 'we're basically trying to make dementia a talked about issue so that people can learn more about it, so that they can help themselves, their friends, their families to contact medical services and healthcare services, carers, support, that kind of stuff. So we see our role as being sign-posters in a way, rather than doctors.'

To date they have had no direct engagement with Public Health Bradford or the NHS, and have received no funding:

We were thinking of applying for funding but the advantages of doing things at the Gurdwara is that the Gurdwara is self-sufficient. You've got basically a free place to eat, the kitchen's all free because it's run by volunteers, you've got a free place to do your sessions because it's usually got a couple of rooms space where they do kids classes and that kind of thing and what else do you need really? We print off the leaflets from the internet, so I guess printing costs but that's [it].

We were interested to ask about the extent to which Sikhism added something apart from the material venue and free labour to the project. Did people think about their dementia in terms of Sikh teachings or Sikh philosophy or stories? Did they do any work around that? Our interviewee explained that they had not done this yet, partly because there was so much variety in

understandings about basic Sikh teachings. One common misunderstanding was regarding karma, that people often say “I've got dementia so I must have done something bad in one of my previous lives.”... “I must deserve it”....You can't change the way that people think about a religion when they've thought it that way for many, many years because someone's understanding of their faith can be very individual to them. There are many, many Sikhs out there who feel that their way is the only way of understanding.’ Our interviewee said that it would be important to try and correct this kind of understanding but that:

I would do it gently and I would do it in a way that perhaps is not so religiously slanted because that can sometimes put people off. It can sometimes be better to talk about dementia in a non-religious way because people feel, religion can be very associated with guilt sometimes, you can say to someone “That's not the way to think about it, that's not what ...Sikhism [says] about dementia”, they can feel like they're being told that they're ignorant or, it's very complicated. The layers of complexity are, you have to pick up on cues, you have to be able to empathise with people, you have to think about how these people have been brought up....we have to be careful I think because sometimes we don't want our religious beliefs to influence what we're doing in the Gurdwara in a way that impacts upon other people in a negative sense. We want people to be able to approach us regardless of whether they agree with our views or not.

3.6 Case Study 4: Culturally Appropriate Mental Health Services

One issue that came up in our research in Leeds and Bradford was the extent to which mainstream mental health services in the UK catered for the diverse needs of BME communities, members of which may have different experiences and interpretations of mental health problems. These differing experiences relate both to the causes of mental health distress medically and also to the religio-cultural explanations that people give to their experiences. We spoke to a representative of an organisation called Sharing Voices Bradford (SVB). According to the SVB website:

Sharing Voices recognises that for all people, but especially those from BME communities, understanding and coping with mental distress, culture, faith, values and spiritual traditions play a central role.

We encourage people to talk about these issues and enable them to engage with them in a meaningful manner.

SVB recognises that there are differences within communities and spiritual traditions, so we do not assume anything and we work with people on their own terms and definitions.

SVB firmly believes that it is these values, beliefs and traditions of people that enable them in times of crises to give sense, meaning and direction, and therefore we aim to support the development of diversity and spirituality agendas in service developments as well as everyday life.

We also recognise the importance for mutual understanding that occurs when people from different faith traditions are brought together.³⁹

Our interviewee explained that SBV is

...a community development health organisation. We were one of the first pioneering organisations in terms of community development and mental health, exploring some of the principles and values of that work and what that might entail. In a nutshell from a community development perspective, the people that we work with are experts by experience...[and realise] that approaches to mental health, wellbeing, from a medical model won't necessarily be meeting the needs of BME communities...

Well first of all it's the conceptualisation of what mental distress is. So the use of spiritual and religious frameworks within that context. For example a person might be saying, "I'm possessed," or, "I'm afflicted by," in people's words, "black magic." In my words adverse magic. So that's quite a stark contrast between a medical model, so the medical model would define that as problematic, and [reflecting] symptoms of underlying mental health conditions....

[For] BME communities from a whole range of perspectives, whether it be Pentecostal or whether it be South Asian, or Muslim, whichever perspective [...] there's a view of the hidden reality, which has interplay with the human world. So in that respect there's a clear contrast there. Plus [...] each cultural, spiritual religious framework [...] has its own view of what mental health is, and how it shapes a human being. Also in terms of their self, the understandings [of] their self is different. There's clear contrast of the difference between say an African Caribbean outlook of the world, contextualising the experience of slavery, racism, oppression etc, all that type of stuff. Plus the religious framework into that dynamic, you know it's a completely different contrast. Similarly from a Muslim perspective, the understanding of the self and it's the nature of the self and the mind and the brain, and all that type of stuff, it's again different. I'm no expert in those areas, I just have a rudimentary understanding of those, but happy to listen to somebody who wants to articulate that.

While SVB engages with religious perspectives it is 'an overtly secular organisation with representatives from different community backgrounds, both on the board and in the staff team....the point is that we are workers to interface with people who are in distress and they have their needs and we cannot transpose our values onto them.' One of its commissioned projects has been the Listening Imam Project, involving the training of local Islamic religious leaders about mental health services.

3.7 Conclusion

The above discussion has presented the analysis of the interviews and focus groups we carried out and we presented four case studies:

- Case Study 1: Food Poverty, Diet and Exercise (including children)
- Case Study 2: Muslim Women
- Case Study 3: The Dementia Friendly Gurdwara
- Case Study 4: Culturally Appropriate Mental Health Services

Although there might be some broadly identifiable trends that relate to particular traditions as well as others that are relevant across traditions, we stress that the research focus on PoWs has revealed the need for **contextual analysis** ahead of any PH engagement to understand what assets a particular PoW might have, what challenges engagement might face and how effective they might be in the area of PH. The PoWs considered within both this study and the one from Leeds (Tomalin et al. 2015) vary widely from faith to faith, tradition to tradition and institution to institution in ways that impact on their efficacy and suitability in the field of PH. More generally, a

contextual evaluation to assess the suitability of the fit between a PoW and PH needs to take account of the following findings:

- I. **Leadership** – Religious specialists do not always have same role in PoWs. Whilst there are many religious traditions where understandings of leadership entail work that goes beyond the ritual functions involved – care for the physical and social as well as spiritual wellbeing of congregants – in other traditions (e.g. Sikhism and Hinduism) religious specialists normally focus solely on ritual aspects. Even within traditions where we might assume that the figure of the leader entails both sacramental and pastoral responsibilities (Christianity and Islam), the focus on one aspect or another varies from individual leader to individual leader, dependent in many cases on personal preference and comfort. A leader who is primarily concerned with the ritual/spiritual rather than social aspects is unlikely to engage comfortably in PH work. Likewise, a leader who by their volition/character takes a more institutionally facing role is likely to require considerable assistance in navigating the requirements of a focus on PH. Whilst we have encountered religious leaders who are outward facing, heavily engaged in the local community and well positioned to signpost congregants to relevant PH care providers, others are far less able or comfortable to perceive their role in such a way.
- II. **Intentionality and capacity** – Collaboration between PH and PoWs requires intentionality on the part of a PoW's leader and congregation. It cannot be assumed that PoWs *should* be involved in PH work. Any response needs to be *intentional* on the part of the PoW and the public health message must fit into priorities of ministry, rather than vice-versa. A theological and pastoral case needs to be made by a PoW as to why PH work is a relevant and important area for engagement. Given that much of the everyday work of PoWs is done by volunteers and lay people, there needs to be recognition and interest by ordinary congregants.
- III. **Appropriateness** – There is a wide diversity between both different faith traditions and different PoWs within any one tradition regarding the range of PH discussions/interventions that might be approached. In the situational analysis of a PoW's suitability to host particular discussions/activities a number of factors must be taken into account:
 - a. How is the PoW positioned in relation to particular structural understandings that might impact on constructions of health/illness or dictate which concerns are recognised, which receive attention and response? Different traditions/denominations engage differently with structural aspects that implicate 'health'. Such structural aspects to be considered include gender/sexual orientation/age/socio-economics/ethnicity/culture/education. Any analysis needs to explore the relationship between structural biases and the wider community health needs. For example, given the ageing profile of the mainline Christian Churches in the UK, they may be well placed to engage around issues of old age, elderly care, dementia etc. Equally, a PoW which explicitly or implicitly does not challenge patriarchal gender structures is likely to be limited in its impact on discussions of the health needs of women and children, so a better community based space should be found for such activities. Given that our research supports the widely recognised fact that concern around health care issues tends to be a female concern, the importance of a gender analysis and methods that seek to engage women cannot be underestimated. The ways in which any structural biases relate to community health needs must be taken into account in any site specific analysis.

- b. A related issue concerns how PoW activities are organised and for whom they cater. A PoW that does not easily create discussion space for its particular constituent groups – particularly women and young people – is going to be limited in its utility to address particular health issues facing those groups. However, where there are regular constituent group meetings, progress can be made. Examples mentioned in the research include work in men's groups around prostate awareness. By utilising existing group meeting structures, PH agencies can capitalise on the convening power of PoWs.
- c. Our research suggests that there are likely to be taboo issues that many places of worship are not comfortable addressing. It is important to note that the appropriateness or otherwise of any PH issue is likely to reflect not only the values of the PoW but the constituent congregation so taboo issues may differ from PoW to PoW even within one faith tradition. For example, it is widely recognised that many PoWs in the UK find it difficult to engage discussion/interventions about sexual behaviour and sexuality. Another area that was mentioned in our research in Leeds (Tomalin et al. 2015) as a cultural taboo in the Afro-Caribbean community was that of menopausal advice, where, it was felt, useful peer health work through the constituency group meetings in the church could be useful.

In the following section of the report we present our final summing up followed by a series of recommendations.

4 Moving forward: conclusions and recommendations

4.1 Introduction

The aim of this research was to undertake a scoping study to better understand the role that places of worship play as minority ethnic public health settings in Bradford. The need for this research emerged from the recognition that BME communities in Bradford, and elsewhere, often experience poor health outcomes yet also have higher levels of religious observance than many communities in the majority ‘white British’ ethnic group. The value of approaching places of worship as sites for health promotion activities has been gaining saliency at a global level, particularly in developing settings and the USA. As Gunderson and Cochrane write:

If the situation of public health is much more critical than might have been anticipated, and the potential role of religion in the health of the public insufficiently grasped by most health and religious leaders, then the question of shifting the paradigm to allow for aligning religion and public health is worth posing (2012: 18).

Health practice and research in this area in the UK has to date been little developed. This project aims to scope the feasibility of a closer engagement between PH and places of worship in the city, and also to begin to develop a research agenda in this area.

In this section we outline our main conclusions first, demonstrating how the objectives of the research have been met. We then move on to make some recommendations about how practical engagement and a research agenda could be further developed.

4.2 Summing up

As outlined at the start of this report, the ***main objectives of this research were***:

1. To contextualise the research undertaken on this project within a discussion of the global literature on religion and health care.
2. To identify the health concerns prevalent within certain religious and/or ethnic groups in order to understand how places of worship could play an important role in dealing with those specific issues.
3. To discover the attitudes of local ‘religious leaders’ (RLs), ‘congregations’ and public health (PH) staff in Bradford with regard to PH practice in places of worship.
4. To make a series of recommendations.

Objective 1 (*to contextualise the research undertaken on this project within a discussion of the global literature on religion and health care*) was addressed in section 2, where we first traced an interest in religion and health activities back to the 18th and 19th century missionaries in Africa, Asia and elsewhere, drawing mainly upon two recent key texts in the area of religion and public health (Gunderson and Cochrane 2012; Holman 2015). One area that has been developed in African settings, by the African Religious Health Assets Programme (ARHAP is now known as IRHAP), are tools for identifying and capturing ‘religious health assets’ (RHAs) in the development of an asset-based participatory research model – ‘participatory inquiry into religious health assets, networks and agency’ (PIRHANA; see Box 4). **It is feasible that a next step for our project could be to develop this tool in collaboration with IRHAP for use in the UK, to enable PoWs to document their RHAs as a basis for communicating with PH actors about the assets they have and where capacity needs to be developed.**

After looking briefly at the ways in which faith-based actors have become more widely recognised in formal healthcare programmes, particularly in the developing world and the USA, we then explored the role of religion in public life in the UK and examined some of the literature that does exist on the topic of religion and health in the UK. In line with the increasing acknowledgement of the significance of religion for public life in the UK, the role of religious affiliation and faith communities regarding individual and public health is becoming a topic of interest to health bodies in the UK, such as Public Health England and the NHS. However, to date there has been little robust and sustained academic research documenting the links between 'health and faith' in the UK. While there is now a significant body of literature examining religion and health related issues in both developing settings and the USA, this has hardly been touched upon in the UK.

Objective 2 (*to identify the health concerns prevalent within certain religious and/or ethnic groups in Bradford in order to understand how places of worship could play an important role in dealing with those specific health issues*) was approached through the interviews and focus groups and the findings are presented in section 3.2. In future research we need to supplement this with quantitative work and **identify, scope and utilise relevant 'big data' sets depicting relationships between quality of health in different locations across the city and people's religion and ethnicity.**

Objectives 3 (*to discover the attitudes of local 'religious leaders' (RLs), 'congregations' and public health (PH) staff in Bradford with regard to PH practice in places of worship*) was addressed in section 3 of this report where we outline the findings from our interviews and focus groups.

Our 4th and final objective (*to make a series of recommendations*) is taken up in the following section.

4.3 Recommendations

4.3.1 Improved coordination between PH, third sector agencies and PoWs: Overall our research has revealed a **limited engagement** between PoWs and PH in Bradford City Council. Where there exist examples of collaboration between PoWs and external organisations around issues of health, these tend to have been facilitated by third sector organisations (rather than public health agencies) already working within the community, although many of these initiatives are commissioned by PH in the local authority. In the context of their community work, these third sector agencies have engaged local PoWs to capitalise on their various 'health assets', including their: convening capacity, ownership of public halls/space; and access to particular audiences.

The issue of coordination between different agencies and PoWs is critical to successful learning and collaboration. This could also include the development of a local 'health and religion' network and the development of guidance for engagement between different agencies and PoWs.

4.3.2 PoWs need to take ownership of any PH work that they engage in: Enabling PoWs/RLs to recognise the significance/value of engaging in collaborations around PH could usefully involve work by PH agencies in the city amongst faith leaders and the facilitation of encounters between PH agencies and PoWs. It is by no means self-evident to all religious leaders that PoWs have a responsibility to the public health needs of their constituent members. **It is important to mobilise and sensitise RLs about the value of public health work. In the longer term, a coalition of PH actors and engaged religious leaders could intentionally lead training and sensitisation work with religious leaders/congregations.**

4.3.3 There is a need for sustainability: Any commitment to facilitating/coordinating work in PoWs by PH Bradford needs to be strategic around issues of **sustainability** so communities and

PoWs can take ownership of any public health work that they embark upon with some degree of on-going support where necessary. Some communities consulted expressed concern about short-term partner/agency programmes coming and going without real care for the **long-term wellbeing of/in the community**. The fact that PoWs are consistent presences in communities makes them particularly valuable as sites/agents of public health work, yet resources/commitment by public health actors need to be long term enough to facilitate community ownership and longer term sustainability.

4.3.4 Useful supporting research and data gathering:

- a. **Mapping of PH activities in Bradford and their current or potential engagement with PoWs:** Given the scope of the research work, we recognise a number of gaps that a coordinating presence could usefully address. The first is that of a systematic mapping of PH initiatives and activities in any one neighbourhood in Bradford. Once identified, these activities need to be evaluated for potential application in or engagement with local PoWs. It may also be the case that some identified activities already engage with PoWs. Such an evaluation will need to take into account: relevance for the PoW audience based on membership/congregation profile; fit with the existing priorities of the PoW; and appropriateness of subject matter for engagement within the PoW as opposed to another community venue. Given that many third sector agencies are at the forefront of PoW/PH engagement, further research to better understand their experiences in both programme/intervention delivery in PoWs and in interpreting/managing the relationships between communities and PoWs would be highly valuable.
- b. **Audit of third sector activities that are faith-based, which have been supported by PH Bradford.**
- c. **Gathering data on who attends PoWs in Bradford and where they live:** In order to be able to conclude that one way of addressing BME health problems is via PoWs it would be useful to have data that told us who attends PoWs and where they live. It may, however, be difficult to collect this data and people may view it as a form of surveillance.
- d. **Getting a better understanding of how health initiatives in PoWs could also benefit the wider community:** Even if BME attendance at PoWs is not as high as might be expected, health initiatives that are run in PoWs could also benefit local people who do not attend that particular PoW. We recommend that this is worth exploring in future work.
- e. **Carrying out ‘health needs assessments’ in PoWs:** Generally, congregant leaders and members recognised many of the specific health issues facing their congregations. **‘Religious leaders’ could benefit from support in carrying out ‘health needs assessments’.**
- f. **Identifying ‘religious health assets’ (RHAs) in PoWs:** We identified a number of ‘religious health assets’ across the PoWs. These include: pastoral networks; wellbeing ministries (healing, meditation, fellowship, bereavement befriending); buildings to host events; long term presence and accompaniment over time; trust; cultural sensitivity; convening capacity to bring closeted issues into the public domain and to host encounters between PH agents and congregations. Another asset mentioned by many congregations is the membership of health care

professionals and social workers. **It is feasible that a next step for our project could be to develop a tool in collaboration with IRHAP for use in the UK, to enable PoWs to document their RHAs as a basis for communicating with PH about the assets they have and where capacity needs to be developed.**
'Religious leaders' could benefit from support in identifying the 'religious health assets' present in their communities.

4.3.5 Facilitation of collaboration between PH and PoWs: The PoWs consulted in the research in both Leeds and Bradford reflected a range of interest in and capacity for PH work. Taking this into account, we recommend a pilot engagement between PH agencies and those PoWs that already see the value of the collaboration to model and document case studies of best practice. **There should be a consultation process that involves a more detailed look at the type of health interventions PoWs would value, how they would like to be involved and what a potential framework for engagement might look like. At present, the interviews and focus groups give the impression that currently health promotion is seen in terms of 'talks' and leaflets. Instead, we need to think carefully about the evidence base for the effectiveness of a range of interventions that are more engaging than talks and more likely to lead to behaviour change and long term sustainability.**

It is critical that any intentional, coordinated collaboration between PH agencies in the local authority and PoWs entails a situational analysis (of PoW and neighbourhood) that maps out where and how any PoW might be best engaged in PH work to maximise potential impact. To this end, we recommend a process of consultation between PH experts/agencies and faith leaders/congregants which enables the development of a pilot process to develop the evidence base and generate best practice.

Such a process would delineate distinct actions to PH agencies and PoWs.

4.4 Public Health Bradford's actions could include

1. **Resources:** Assuming that the allocation of capital resources to support particular interventions is not feasible given budget constraints, PH Bradford should ensure that adequate existing staff time is directed towards work on faith and health in Bradford. In addition, existing commissioning arrangements could be tweaked so as to encourage and enable third sectors organisations to engage with PoWs where appropriate. One possible mechanism for achieving this is the Faith Covenant,

drafted by the All-Party Parliamentary Group on Faith and Society...to support faith groups/organisations and local authorities in working together. It is a joint commitment between the two to a set of principles which will guide engagement.⁴⁰

2. **Facilitation/support/training:**
 - i) Facilitation of dialogue and engagement between religious leaders and PH professionals, creating space for discourse that presents and models different approaches and generates shared concerns;
 - ii) Supporting engagement between PoWs and third sector organisations where appropriate and providing advice and capacity building on applying for grants;
 - iii) The provision of basic orientation/sensitisation training for religious leaders around recognising when health needs are being expressed in pastoral conversations;
 - iv) Providing some training with PoWs about how the health system works and the various constraints it faces;

- v) The generation of neighbourhood ‘health asset maps’ identifying relevant agencies to which RLs/congregants can signpost;
- vi) When developing leaflets/messages pertaining to relevant health concerns, to be made available in PoWs, to ensure that these are culturally appropriate.

3. Co-ordination:

- i) Of a local ‘faith and health’ network;
- ii) Of a consultation process about the design of a framework for engagement between PoWs and PH;
- iii) Through a consultative process we recommend the identification of interested and capacitated PoWs that are willing to engage in a pilot process. The process will involve work at theological and practical levels.

4. Supporting research and data collection:

- i) Carrying out mapping of neighbourhood PH activities in Bradford and their current or potential engagement with PoWs;
- ii) An audit of third sector activities that are faith-based and have been supported by PH Bradford;
- iii) Work with PoWs to gather data on who attends PoWs in Bradford and where they live;
- iv) The collaborative design and delivery of a ‘religious health asset mapping’ tool and ‘health needs analysis’ tool for use by PoWs;
- v) Getting a better understanding of how health initiatives in PoWs could also benefit the wider community.

4.5 PoW actions could include

1. The development of a ‘theology of wellbeing’ (RLs) that focuses on questions of health from physical/spiritual/social perspectives. This exercise might map out particular seasonal opportunities/challenges in relation to PH such as the use of Lent or Ramadan to encourage people to think about healthy lifestyles and nutrition. This conceptual work might also entail the recognition of any tensions around the relationship between spiritual and pastoral care and formal health services, where different understandings/worldviews might lead to distinct interpretations of health/wellbeing/prevention/cure. Such tensions need to be explored by faith leaders in conversation with congregations/members and GPs/local PH agencies.
2. Once the ‘theological’ case has been made to congregants/members, and health recognised as a priority area for the PoW, the congregation/membership can contribute relevant aspects/experiences/thoughts/concerns so that collaboration is fostered between leadership and congregation/membership. Work needs to be done to identify relevant capacity and expertise within the congregation/PoW to lead the process of identification of health assets. A health asset is: “any factor or resource which enhances the ability of individuals, communities and populations to maintain and sustain health and well-being. These assets can operate at the level of the individual, family or community as protective and promoting factors to buffer against life’s stresses.” (Foot and Hopkins 2010). Other assets include the following:
 - The practical skills, capacity and knowledge of local residents
 - The passions and interests of local residents that give them energy for change
 - The networks and connections – known as ‘social capital’ – in a community, including friendships and neighbourliness

- The effectiveness of local community and voluntary associations
 - The resources of public, private and third sector organisations that are available to support a community
 - The physical and economic resources of a place that enhance well-being.
- (Foot and Hopkins, 2010, p7)
3. A simple demographic ‘health needs analysis’ of the congregation/membership can also be undertaken to evaluate relevant PH issues that might be addressed. This needs analysis must be cognisant of the seasonal health/wellbeing challenges throughout the year. Such challenges might include the difficulties of Ramadan with regards to regulating diet (evidence suggests that Ramadan can encourage over-eating in the evenings); winter also poses particular problems, particularly in ageing congregations with particular challenges of seasonal diseases and mobility. Facilitation/PH guidance/information may be required to stimulate the asset/needs analysis.
 4. Neighbourhood familiarisation must be undertaken to locate relevant third sector/PH agencies and assess the level of social support in the community/neighbourhood to ensure adequate knowledge for signposting. PH Bradford can provide information about relevant local agencies. Work might also need to be done by the PoW on the relationship between the profile of the congregation/membership who regularly attend the PoW and that of the neighbourhood in which the PoW is situated to ensure that PH initiatives target the relevant constituencies. Whilst we have relied on neighbourhood profiling in this research, it is clear that a neighbourhood analysis cannot account for a possible disjuncture between the congregation/membership attending a PoW and the demographic profile of the surrounding community. There currently exists no data on who actually *attends* PoWs in the UK (and whether attendants reflect the characteristics of the neighbourhood profile). This is a gap that work by PoWs could usefully do to improve the understandings of PH agencies about the relationship between a congregation/membership and the community in which it is situated.
 5. Once the analysis and assessment has taken place, an invitation/introduction of relevant PH agencies into the PoW space might enable the sensitisation and awareness raising of congregations about relevant work/resources/support in the locale. Regular interactions with such agencies would enable them to become trusted partners to the PoW and would open up possibilities for deeper collaborative work and the mobilisation of individual, congregational and community health assets in a coordinated way. However, we need to bear in mind that this unlikely to be successful without at least one ‘champion’ within the faith group who really understands why this is worth doing. This consideration is captured in the difference between ‘faith-placed’ and ‘faith-based’ interventions (November 2014) – pointing to the observation that PH work will only take root when there are people within the faith group driving it forward.

4.6 Conclusion

The aim of this section has been to outline our main conclusions, demonstrating how the objectives of the research have been met, and also to make some recommendations about how practical engagement and a research agenda could be further developed.

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6 Endnotes

¹ <http://www.borninbradford.nhs.uk/parents-families/Our-Findings-in-a-Nutshell/Babies-Born-with-Serious-Conditions/> (accessed 03/01/16).

² Reproduced from 'Bradford and District: The Current Population', Public Health Analysis Team, City of Bradford Metropolitan District Council (no date given).

³ However, there are also limitations. As we discuss later in this section, the opportunity for mosques in particular to engage women is limited, particularly where proper provision is not made for them to use these settings.

⁴ <http://www.christiansinparliament.org.uk/resources/> (accessed 1/3/16).

⁵ <http://www.faithandsociety.org> (accessed 1/3/16).

⁶ DC2201EW , Ethnic Group by Religion, 2011 National Census (<https://www.nomisweb.co.uk/census/2011/dc2201ew>, accessed 21/09/15).

⁷ This section of the report also appears in our Leeds research report, *Places of Worship as Minority Ethnic Public Health Settings in Leeds* (Tomalin, Russell and Sadgrove 2015).

⁸ Charles-Edward Amory Winslow (4 February 1877 – 8 January 1957) was an American bacteriologist and public health expert who was, according to the Encyclopedia of Public Health, "a seminal figure in public health, not only in his own country, the United States, but in the wider

Western world'" (http://en.wikipedia.org/wiki/Charles_Edward_Amory_Winslow accessed 21/09/15).).

⁹ http://www.fph.org.uk/what_is_public_health (accessed 21/09/15).

¹⁰ http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/ (accessed 21/09/15).

¹¹ <http://www.who.int/bulletin/volumes/86/10/08-031008/en/> (accessed 21/09/15).

¹² Formed in 1997 between the IHP and five US universities -

<http://www.cartercenter.org/news/documents/doc782.html> (accessed 21/09/15).

¹³ <http://interfaithhealth.emory.edu/about/index.html> (accessed 21/09/15).

¹⁴ <http://interfaithhealth.emory.edu/about/History.html> (accessed 21/09/15)

¹⁵ http://www.irhap.uct.ac.za/about_history.php (accessed 21/09/15).

¹⁶ <http://stakeholderhealth.org/promising-practices-mapping/> (accessed 21/09/15).

¹⁷ If this matrix were to be used in Bradford, it would need to be adapted in consultation with local faith communities and PH professionals. For instance, some obvious elements many be missing and there may be alternative views about whether particular assets are tangible or intangible.

This image is reproduced from Gunderson and Cochrane (2012: 49).

¹⁸ <http://www.neweconomics.org/projects/entry/five-ways-to-well-being> (accessed 21/09/15).

¹⁹ http://b.3cdn.net/nefoundation/8984c5089d5c2285ee_t4m6bhqq5.pdf (accessed 21/09/15).

²⁰ <https://corablivingwithdifference.files.wordpress.com/2015/12/living-with-difference-online.pdf> (accessed 03/01/16).

²¹ <http://www.corab.org.uk/background-information> (accessed 21/09/15).

²² <http://dash.sphsu.mrc.ac.uk> (accessed 21/09/15).

²³ <http://www.york.ac.uk/healthsciences/research/public-health/projects/mclass/#tab-1> (accessed 21/09/15).

²⁴

<http://www.leedsouthandeastccg.nhs.uk/Downloads/Your%20health/Smoke%20free%20homes%20imams%20resource%20pack/Smoke%20Free%20Homes%20guide%20for%20Muslim%20religious%20teachers.pdf> (accessed 21/09/15).

²⁵ One of our interviewees told us that there was a faiths forum in Bradford that was mainly funded by Bradford Council, 'set up by Bradford Vision, which was kind of a quasi-governmental body, it was the Local Strategic Partnerships, when they existed, post the riots [in 2011].'

²⁶ <http://www.borninbradford.nhs.uk> (accessed 21/09/15).

²⁷ <http://www.borninbradford.nhs.uk/research-scientific/bib-scientific-publications/> (accessed 21/09/15).

²⁸ <http://www.almustafa.org.uk/default.aspx> (accessed 21/09/15).

²⁹ <http://www.clementsgate.co.uk/> (accessed 21/09/15).

³⁰ Church Urban Fund website (<http://www.cuf.org.uk/parish/460299> accessed 21/09/15).

³¹ http://manningham.church/wp/?page_id=205 (accessed 03/01/16).

³² "The Muslim Council of Britain has suggested that three main types of madrassa currently exist in the UK (Hayer 2009):

- the largest group are madrassas attached to mosques, with one survey suggesting that as many as 94 per cent of mosques in England and Wales are currently providing some kind of education for young people (Charity Commission 2009)
- those run by volunteers who teach Islamic classes in hired-out community centres or school halls
- informal classes held in people's homes."

http://www.thecordobafoundation.com/attach/inside-madrassas_Nov2011_8301.pdf
p. 18 (accessed 21/09/15).

³³ <http://divabradford.org.uk/Organisation.aspx?ID=2500> (accessed 21/09/15).

³⁴ <http://www.karmand.org.uk> (accessed 21/09/15).

³⁵ <http://www.muslimwomenscouncil.org.uk/public-consultation-on-first-all-women-managed-mosque-in-the-uk/>; <http://www.theguardian.com/lifeandstyle/2015/jul/31/bana-gora-muslim-womens-council-bradford-mosque> (accessed 21/09/15).

³⁶ <http://www.ramgarhiagurdwara.co.uk> (accessed 21/09/15).

³⁷ <http://dementiafriendlygurudwaras.com/> (accessed 21/09/15).

³⁸

http://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=2647&pageNumber=5 (accessed 21/09/15).

³⁹ <http://www.sharingvoices.org.uk/diversity.htm> (accessed 21/09/15).

⁴⁰ www.faithaction.net/work/faith-covenant (accessed 19/03/16).