

Places of Worship as Minority Ethnic Public Health Settings in Leeds

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Executive Summary

The aim of the research was to undertake a scoping study to help Public Health Leeds better engage with BME communities in order to achieve the coordinated delivery of public health activity through a network of places of worship (PWs) across the city, working closely with religious leaders and congregations. The research will also contribute towards developing guidance on practical steps that PWs can take to become public health settings.

We had 9 objectives:

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 prevalent health concerns within certain religious and/or ethnic groups in order to explore whether places of worship could play an important role in dealing with those specific health issues.
3. To begin to identify, scope and utilise relevant data sets suggesting correlations between the quality of health in different locations across the city and people's religion and ethnicity to support objective 2.
4. To find out what 'religious leaders' (RLs) know the about the health and well-being needs of their members and/or local communities.
5. To discover the attitudes of local 'religious leaders' (RLs), 'congregations' and public health (PH) staff in Leeds with regard to PH practice in places of worship.
6. To record PH activity at PWs in order to document successful and innovative practice.
7. To explore the potential of working with PWs to inform the development of a local network and eventual guidance document for PWs that wish to become public health settings.
8. To generate interest and ownership from relevant stakeholders including RLs and relevant staff in PH.
9. To make a series of recommendations, including PH responsibilities (see section 5.4).

Highlights from the recommendations are that PH Leeds should consider:

1. Exploring a variety of PH opportunities for PW and how existing commissioning arrangements could encourage and enable third sector organisations to engage with PWs where appropriate.
2. Co-coordinating a local 'faith and health' network and a consultation process to develop guidance on practical steps that PWs can take to become public health settings.
3. Collaboratively designing and delivering a 'religious health asset mapping' tool and 'health needs analysis' tool for use by PWs.
4. With Leeds Faith Forum initiating a process of consultation to identify interested and capacitated PWs that are willing to engage in a pilot process, supported by PH Leeds. The process will involve work at theological and practical levels.

Preface

The collaboration between the Centre for Religion and Public Life (CRPL), at the University of Leeds, and Public Health Leeds, that gave rise to this report, began towards the end of 2013. Roxana Summers, BME Health Improvement Specialist, Leeds City Council, was put into contact with Dr. Emma Tomalin, Director of the CRPL, to undertake a scoping study to help Public Health Leeds better engage with BME communities in order to achieve the coordinated delivery of public health activity through a network of places of worship. PH Leeds had already begun to discuss this project with the other key partner in the research, Leeds Faith Forum.

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 PH Leeds and also supported by an *Ignite* grant from the University of Leeds, Cultural and Creative Industries Exchange Hub.

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Introduction

1.1 The aim of this research was to undertake a scoping study to help Public Health Leeds better engage with BME communities in order to achieve the coordinated delivery of public health activity through a network of places of worship (PWs) across the city, working closely with religious leaders and congregations. The research will also contribute towards developing guidance on practical steps that PWs can take to become public health settings.

1.2 Objectives

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 prevalent health concerns within certain religious and/or ethnic groups in order to explore whether places of worship could play an important role in dealing with those specific health issues.
3. To begin to identify, scope and utilise relevant data sets suggesting correlations between the quality of health in different locations across the city and people's religion and ethnicity to support objective 2.
4. To find out what 'religious leaders' (RLs) know about the health and well-being needs of their members and/or the local communities.
5. To discover the attitudes of local 'religious leaders' (RLs), 'congregations' and public health (PH) staff in Leeds with regard to PH practice in places of worship.
6. To record PH activity at PWs in order to document successful and innovative practice.
7. To explore the potential of working with PWs to inform the development of a local network and guidance on practical steps that PWs can take to become public health settings.
8. To generate interest and ownership from relevant stakeholders including RLs and relevant staff in PH.
9. To make a series of recommendations.

1.3 Background

Leeds is an ethnically diverse city and is becoming more so. According to a document produced by Leeds City Council, drawing on 2011 Census Data:

- In 2001 the city's BME population totalled 77,530 (10.8% of the resident population), by 2011 the number had increased to 141,771 (18.9%).
- The Census data shows that there are at least 90 ethnic groups in the city (but there will be more given the number of people not allocated to specific groups).
- The Pakistani community is the largest "single" BME community in the city (with 22,492 people) but there are 22,055 people in the category of Other White (which includes people from Poland).
- Analysis of the small area data shows that the Harehills ward has become the first in the city where the BME population comprises the majority.
- Different ethnic groups have very different age profiles, with median ages ranging from 18 (Black Caribbean / White) to 52 (White Irish) (Leeds City Council 'a' no date, p. 6).

BME communities in Leeds, and beyond, experience unfavourable and unequal outcomes in health conditions such as obesity, depression, diabetes and smoking related illnesses, as well as conditions linked to ethnic groups such as sickle cell anaemia, which is more prevalent in people with an African or Caribbean heritage.¹ People of South Asian, African and Caribbean heritage are also at greater risk for developing diabetes (Department of Health, 2001). However, the prevalence of these conditions cannot be linked to ethnicity alone and reflects structural issues 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 recognise and respond to the specific needs of diverse communities.

This scoping research, and the eventual guidance document for PWs, seeks to address this situation by examining places of worship (PWs) as suitable settings for public health work. An earlier pilot survey (2011), as well as a Hyde Park Faith Leaders Event (Dec. 2012), suggested that there is interest from PWs in working more closely with PH around the development of a guidance document for PWs wishing to become public health settings. The current study reached the same conclusion, but with some caveats and recommendations (see section 5). In 2011 the West North West Health Improvement Manager, in the Hyde Park area of Leeds, carried out a survey - the Hyde Park Health and Wellbeing Community Consultation Questionnaire - (with Makkah Mosque, the Hindu Temple and All Hallows Church, as well as some other organizations). This suggested that religious leaders believe it would be appropriate and desirable to deliver suitable PH interventions at PWs as a way of contributing 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 PWs already use.

The aim of this research project was to extend and expand this earlier study and to create a knowledge base for future research concerning the engagement of places of worship for BME public health activity 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 activity. Additionally, following decades of neglect of the role of religious organisations in the UK public sector, Central Government has been carrying out work on religion (e.g. see Christians in Parliament reports; the All Party Parliamentary Group (APPG) on 'Faith and Society'), as has Leeds City Council (see Lindsay et al. 2014).

Leeds City Council recently became a signatory to the 'Faith Covenant', on March 5th 2015, when members of LCC, Leeds Faith Forum and FaithAction met at Leeds Civic Hall. The Faith Covenant is an initiative of the All-Party Parliamentary Group on Faith and Society, headed by MP Stephen Timms, for which FaithAction is the secretariat.² The predicted impact of the Covenant is that it will support faith communities in working with local authorities, guide engagement and promote open, practical working. LCC was the second Local Authority in the UK to sign the Covenant, following Birmingham in December 2014.

Although there has been the emergence of a new climate where the significance of religion is increasingly taken more seriously by actors in the public sphere, and where PWs are recognised as potential settings for public health activities, little is known about the best ways to engage and involve those individuals who attend PWs, or the drivers and barriers to such engagement. To approach them 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 begin to identify, scope and utilize relevant 'big data' sets suggesting correlations between the quality of health in different locations across the city and people's religion and ethnicity (this is outlined in section 3).
- To carry out a series of interviews with religious leaders and PH staff across Leeds, and focus groups with members of PWs (details are outlined in section 4).

1.5 Research questions to be addressed in the qualitative research:

RQ1: Who uses the PWs visited: what is their age, gender, ethnicity and how far do they travel?

RQ2: What are the characteristics of the PWs visited? What general activities do they engage in beyond purely religious activities; how are they organised and who makes the decisions; and what is the role of the 'religious leader'?

RQ3: What are the main health issues facing congregations/members of PWs according to our interviewees/focus group participants?

RQ4: What activities have been undertaken around health, including how these are funded/supported, and the nature of any previous engagement with PH professionals and third sector organisations?

RQ5: What is the role of religious teachings and practices in health promoting activities?

RQ6: What are the drivers and barriers to the promotion of health in the PW, including barriers to engaging with PH bodies, barriers that people face in accessing health services and how might these barriers be overcome?

RQ7: What are the attitudes of public health staff with regard to public health practice in places of worship?

RQ8: To what extent are participants from PWs interested in the development of a local network and eventual guidance document for PWs wishing to become public health settings? Would they like to be part of this?

1.6 Structure of report

Having outlined the aims, objectives and background to the research, the next section 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; religion and public life in the UK; religion and health research globally and in the UK. Section 3 will outline the work that we have begun on identifying and scoping relevant 'big data' sets. Section 4 gives an overview of the findings from the interviews and focus groups. The report concludes in section 5, which provides a series of recommendations.

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

2.1 Introduction

What follows is not a comprehensive literature review, but instead aims to contextualise the work that we have undertaken in Leeds 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. Winslow³ 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'⁴

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 PW 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. 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. 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 or 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.⁵

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.⁶

Interest also began to grow in the USA about how the mobilisation of ‘religious health assets’ 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 Consortium⁷ 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."⁸

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'.⁹ 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."¹⁰

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' (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

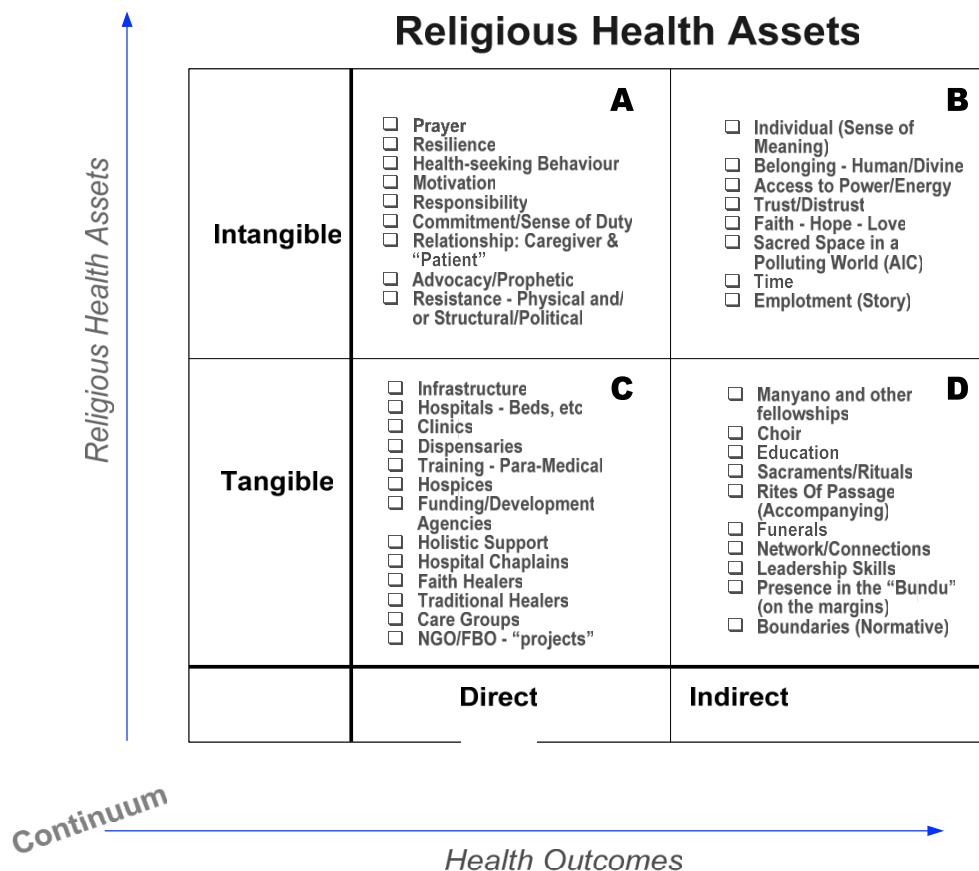
PIRHANA

“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?”¹¹

Figure 1: The “ARHAP Theory Matrix”¹²



Thus, a key feature of the work of ARHAP is supporting communities to carry out assessments of their 'religious health assets'. As Figure 1 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. **A next step for our project could be the development of a similar tool for PWs to document their RHAs as a basis for establishing naturally occurring opportunities for PH activity (see appendix 1 for a practical exercise that can be undertaken in PWs to assess RHAs). Eventually this could help establish developmental needs as well as the support needed from PH and other quarters.**

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 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 the curative moment. This was an issue that was highlighted in the focus groups that we carried out in Christian settings in Leeds (see section 4.6).

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.'¹³ In particular, PWs contributed markedly to people's ability to connect with others and to engage in activities that require them to 'give'.¹⁴

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' (2013, 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; Dinham and Jackson 2012; Woodhead and Catto 2012; Lambie-Mumford and Jarvis 2012 and Green, Barton and Johns 2012).

Lindsay et al. (2013: 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 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. (2013: 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 are due to be made public during 2015. 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.¹⁵

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 recognizes 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' (2014: 27) is important (see also 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 utilised 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 *Faith Action Enables Government and Faith Groups to Work Together for Good* report identifies how many faith and community groups share four common attributes which contribute to their unique value (no date, 3):

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 represent 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’ (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 towards particular health concerns. Wild et al. (2007) point to an increased risk of cardio vascular 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. 2007).

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 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).¹⁶

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 Leeds, an activity that could be led by a Leeds network in partnership with relevant partners such as the LCC Informatics Team.

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' (2001: 197). Baker and Murdoch (2008) examined the role that PWs could play in improving 'awareness and health-seeking behaviour for glaucoma' (2018: 1).
- **Smoking:** Bush et al. (2005) 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' (2005: 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 9).

- **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 workshop 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:** See Box 7 for an outline of research on *Leeds Let's Get Active and BME Faith Communities in Leeds* (Corbishley 2014 and Horne 2014).

Box 7 Leeds Let's Get Active and BME Faith Communities in Leeds

Leeds Let's Get Active and BME Faith Communities in Leeds

Background

This account is based on research undertaken by undergraduate students in Theology and Religious Studies at the University of Leeds as part of a work placement module with 'Leeds Let's Get Active' (LLGA), an initiative 'which was launched in September 2013, with the intention of increasing the amount of physical activity within Leeds' (Corbishley 2014: 3). It was a £1million programme targeting 'people who currently do little physical activity to do at least thirty minutes once a week' through the 'provision of free gym facilities, swimming sessions and access to leisure centres in a supportive environment' (2014: 3).

The aim of the research was to better understand the relationship between sports and religion in Leeds and aimed to produce data and recommendations that would be useful for LLGA in engaging with different communities across the city.

One focus of the research was upon Sikhs and Muslims from South Asian backgrounds, where many experience higher levels of diabetes and coronary heart disease than the population at large. Barriers to engaging with sporting facilities in the city are important to understand in order to improve health outcomes amongst these groups.

Sikh Communities in Leeds and Sport

The Sikh community in Leeds has its own purpose built sports facilities the 'Ramgarhia Sikh Sports Centre'

(RSC) on Chapeltown Road: offering indoor football, basketball, cricket and hockey, squash and badminton courts, a gym and male and female changing rooms. This is a large centre that attracts Sikhs from across the city and although it is open to anyone to use, regardless of their background or religion, the researcher noted that 'there was hardly anyone there and according to the participants, this was not unusual' (Corbishley 2014: 9) In addition the centre was largely funded by the Sikh community and did not receive 'the same financial support from the Council' (2014: 9) as other sports facilities in the city: 'many classes for the older generations and women have had to stop for this very reason. The gym equipment is outdated and there are no gym instructors to provide supervision as they cost too much to employ' (2014: 9). While some funds are given by Sikh Sport UK and the centre is hired out for community activities such as weddings, it is not in a healthy financial state.

Participants in a focus group told the researcher that there are barriers to members of the Sikh community accessing gym and swimming facilities. This included the fact that the 'five K's' worn by Sikhs as a sign of their respect for God can prevent them from participating in sporting activities. For instance, in some cases staff have asked Sikhs to remove their Kirpan [dagger] or leave the pool' (2014: 10). In addition some 'women have felt uneasy about entering these sports centres in the first place' (2014: 10) and 'the majority do not like the public show of nudity within the changing rooms' (2014: 10) The participants also stressed that 'the vast majority of the Sikhs prefer to put their trust in their own sports coaches rather than send their children to other clubs around the city. This is due to the relationships they have built with these representatives over recent years. When new faces of non-South Asian heritage appear with no knowledge of Sikh culture, they do not appreciate the specific needs of these people.... The general impression given was that the Sikhs would prefer for LLGA to support activities at the RSC' (2014: 10-11).

Muslim Communities in Beeston and Sport

The participants told the researcher that there were 'boys football teams and taekwondo classes, but little available to older generations' (Horne 2014: 5) and that 'generally speaking, older members of the Islamic community feel uncomfortable and embarrassed when facing physical activity, with the general opinion that sport is for the young' (2014: 5). While it appeared that the facilities offered by LLGA were not well known to all the participants, some 'felt hesitant in trusting such an alien organisation, especially concerning their children' (Horne 2014: 6). Also experiences of racism could get in the way of people 'stepping outside of their own community in order to find the facilities available to them' and 'women especially, feel uncomfortable exercising anywhere in the presence of the opposite sex' (2014: 6). In addition 'many Muslim women feel more comfortable exercising in their traditional clothing and Muslim men have an obligation of covering their legs at all times, including when swimming'. (2014: 6). Finally, the obligation to pray five times a day and also fasting during Ramadan could get in the way of physical exercise.

Recommendations

Drawing on the findings from the research a series of recommendations were made in the report:

- LLGA could improve sports facilities used by the Sikh community that cater to its needs
- LLGA sports centres across the city could make more effort to run gender specific events
- LLGA could retrain current staff to be more sensitive to cultural traditions (e.g. Sikhs wearing of the '5 K's' and Islamic dress codes)
- Friday prayers in the mosque could be used to promote LLGA, but this might not reach women
- Another method of promotion could be phone and door-to-door advertising. 'Especially within the female Muslim community, literary and language skills is poor, meaning that leaflets and posters would be less effective' (Horne 2014: 6).
- LLGA could train coaches who are members of the Sikh and Muslim communities.

2.5 Conclusion

The aim of this section was to contextualise the work that we have undertaken in Leeds 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 quantitative work that we had done so far, utilising sources of 'big data' to tell us something about the links between religion and health in Leeds.

3. The Role of 'Big Data' and Quantitative Research: towards a better understanding of Religion and Health in Leeds

3.1 Introduction

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: what 'big data' would be useful for meeting the aims of the research; what data sets actually exist; how they can best be worked with in order to provide contextual and analytical support to the research. This part of the report will be shorter and less developed than the following sections where we analyse the interviews and focus groups. However, we have sought out and used some quantitative data in a tentative and exploratory manner.

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 support the suggestion that PWs could play an important role in dealing with those health issues specifically. This is not to say that religious affiliation is itself a causal factor underpinning certain health conditions but instead that these may be linked rather to the ethnicity of those within religious groupings either in terms of genetic links to particular illnesses and/or to lifestyle/cultural practices or marginalisation from mainstream primary health education and services. The identification of such links could be of importance for PH teams in order to be able to allocate funds to tackle particular health issues in PWs. Certain 'big data' sets could provide support for this objective and below we look briefly at two of these: National Census Data and National General Practice Profiles.

3.2 Census Data

3.2.1 Religion, Ethnicity and Health in Leeds

According to figures from the 2011 Census there are 751,485 people living in Leeds of which 65% identified themselves as affiliated to a religious tradition (see Tables 1 and 2). Leeds is also a highly diverse city, 'with increasing numbers of people identifying with minority ethnic groups' (Leeds City Council no date: 6). 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 affiliation. For instance, for the 'Asian/Asian British: Pakistani' group - which totals 22,492 people - 20,522 profess to be Muslim; for 'Asian/Asian British: Bangladeshi' 3,943 out of a total 4,432 claim to be Muslim; and for 'Asian/Asian British: Indian' - from a total of 16,137 - 6,493 see themselves as Hindu and 6,395 as Sikh. There is also quite a high correspondence for some other groups: for 'Black/African/Caribbean/Black British: African' out of 14,894, 11,196 identify as Christian and 'Black/African/Caribbean/Black British: Caribbean' out of 6,728, 5,063 identify as Christian. It is also significant to note that for these groups only a small portion of people claim to follow no religion at all (see Table 1).

Table 1: Ethnic Group by Religion in Leeds¹⁷

Ethnic Group	All categories: Religion	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other religion	No religion	Religion not stated
All categories: Ethnic group	751,485	419,790	2,772	7,048	6,847	40,772	8,914	2,396	212,229	50,717
White: Total	639,487	387,536	1,049	80	6,517	1,693	151	1,964	196,997	43,500
White: English/Welsh/Scottish/Northern Irish/British	609,714	366,649	943	65	6,065	855	127	1,844	191,825	41,341
White: Irish	7,031	5,773	18	2	31	24	5	22	730	426
White: Gypsy or Irish Traveller	687	494	6	2	10	7	0	6	109	53
White: Other White	22,055	14,620	82	11	411	807	19	92	4,333	1,680
Mixed/multiple ethnic group: Total	19,632	8,327	99	85	89	1,563	101	107	7,477	1,784
Mixed/multiple ethnic group: White and Black Caribbean	8,813	4,256	17	10	17	90	8	52	3,628	735
Mixed/multiple ethnic group: White and Black African	2,493	1,342	8	6	7	240	0	8	684	198
Mixed/multiple ethnic group: White and Asian	4,906	1,333	46	59	12	873	79	25	2,002	477
Mixed/multiple ethnic group: Other Mixed	3,420	1,396	28	10	53	360	14	22	1,163	374
Asian/Asian British: Total	58,243	4,191	1,553	6,839	18	29,409	7,550	190	5,321	3,172
Asian/Asian British: Indian	16,130	958	39	6,493	7	884	6,395	120	605	629
Asian/Asian British: Pakistani	22,492	203	3	41	3	20,522	119	9	273	1,319
Asian/Asian British: Bangladeshi	4,432	143	4	47	2	3,943	6	0	80	207
Asian/Asian British: Chinese	5,933	1,049	724	16	0	126	17	20	3,494	487
Asian/Asian British: Other Asian	9,256	1,838	783	242	6	3,934	1,013	41	869	530
Black/African/Caribbean/Black British: Total	25,893	18,954	30	15	17	2,981	20	94	1,941	1,841
Black/African/Caribbean/Black British: African	14,894	11,196	7	5	8	2,516	8	14	361	779
Black/African/Caribbean/Black British: Caribbean	6,728	5,063	10	5	2	66	0	55	916	611

Table 2: Religion in Leeds¹

Religion	Leeds Numbers	Leeds Rates
Buddhist	2,772	0.4%
Christian	419,790	55.9%
Hindu	7,048	0.9%
Jewish	6,847	0.9%
Muslim	40,772	5.4%
Sikh	8,914	1.2%
Other	2,396	0.3%
No religion	212,229	28.2%
Religion not stated	50,717	6.7%

While this could appear to lend support to the view that PWs may be a suitable place for PH activity, we cannot assume that all those who profess to belong to a particular faith actually attend places of worship with any regularity. We are not currently aware of any data that gives levels of attendance at places of worship within Leeds. **This could be a useful project to be carried out, possibly by PWs themselves with support from the research team, PH Leeds and LCC Informatics.**

Nonetheless, it seems likely that given high levels of reported religious affiliation within some communities in Leeds, PWs could play an important role in health education and even delivery.

There is some evidence from our qualitative work that communities with high levels of religious observance and attendance at places of worship are often likely to be deprived and experiencing poor health outcomes. **In order to make this point more strongly it is necessary to identify relevant quantitative data that can demonstrate both religious affiliation and health outcomes for particular groups.** For instance the NHS Leeds Neighbourhood Profiles¹⁸ use data from different sources, including the Census, and provide information on the numbers of religious affiliates from different traditions in each MSOA in Leeds as well as data on health outcomes. It is not clear to us whether these two types of variable (faith affiliation and health outcomes) can be correlated from the data presented in these profiles. In general there is a lack of information stored on clinical systems about religion and therefore inference from ethnicity is a reasonable alternative. Another method focuses on people's names to infer heritage and faith affiliation, using 'origins software':

Origins software analyses forename and surname of every GP registered patient in Leeds and gives what is considered to be an indication of an individual's most likely heritage and faith according to geography. This is not necessarily how they might describe themselves. For more information about Origins software visit:

<http://publicsector.experian.co.uk/Products/Mosaic%20Origins.aspx>¹⁹

These data may be useful in linking religious affiliation to health conditions in particular individuals as they are both derived from GP records and could possibly be correlated more easily and with less error. However, the accuracy of the 'origins software' approach is limited as it takes name as a proxy for religious affiliation. Also LCC has used this in the past to identify religious affiliation, but no longer has access to this software and use of the derived data halted a couple of years ago.

While the Census data in Tables 1 and 2 give the total numbers of religious adherents for each tradition for the whole of Leeds, it is also possible to view these data as disaggregated for the different MSOAs in the city. The data on this in the NHS Leeds

Neighbourhood Profiles are taken from the 2001 Census and although we have located the relevant data set from the 2011 Census, we have only found a version that includes the MSOA codes rather than the names of the different areas.

Before we move onto look at other sources that might help examine the prevalence of particular illnesses within certain religious and/or ethnic groups - in order to support the suggestion that places of worship could play an important role in dealing with those health issues - we first consider if there is any material in the 2011 Census that could do some of this work for us. Leeds City Council has undertaken an analysis of 2011 Census data relating to religious communities in Leeds and one area of correlation explored was with respect to 'health and wellbeing'. This document analysed the answers that people had given about their own understanding of their health condition and correlated this with their professed religious affiliation. Highlights from this analysis are given in Box 8.

Box 8: Health and Wellbeing and Religious Affiliation

Health and Wellbeing and Religious Affiliation (Leeds City Council 'b' no date: 7)

- Across the city 40,652 people (5.4%) feel that their general health is "bad or very bad", with rates ranging from 2.8% for Hindus to 10.6% for those in the category of "other religion"
- The proportion of people who felt their health was "bad or very bad" rises with age from just 0.6% in the 0-15 age band to 16.3% in the 65+ category, with rates ranging from 15.8% for Christians to 33.2% for Muslims
- Across the city 125,678 people (16.8%) feel that they have a limiting long-term illness, with rates ranging from 8.8% for Hindus to over 20% in the Christian and Jewish communities and also for those in the category of "other religion"
- Across religious groups the proportions of people with a limiting long-term illness who feel their general health to be "bad or very bad" ranges from 26.9% in the Jewish community to 38.5% for those in the category of "other religion"
- In 65+ age group, 29% of people who have a limiting long-term illness feel their general health to be "bad or very bad", with rates ranging from 26.8% in the Jewish community to 45.9% in the Muslim community.

Overall the data, and its analysis, are not particularly revealing and it is hard to see any patterns. They are limited in that they do not provide information about specific health issues, may not be able to account for the fact that some groups are more likely to report ill health than others and that some of the cohorts measured only included small numbers of people which means that the findings are less likely to be significant in terms of identifying general trends. The data do suggest though that members of the Hindu community view themselves as significantly healthier than other religious groups, an analysis which could benefit from further probing. The data are not able to give us enough detail and the level of specific illness by BME groups practicing particular religions in the city.

3.3 Using data from The National General Practice Profiles

The second method that we used to attempt to draw some links between the prevalence of certain health conditions in particular areas of Leeds, and the role that PWs might play in addressing them, involved data from the National General Practice Profiles.²⁰ We wanted to explore how we might develop a method for identifying and then potentially targeting PWs (in a sensitive and appropriate manner) in areas where there exists a high incidence of particular priority health conditions impacting upon BME groups. The health issues that we selected to

examine were obesity, depression, diabetes and smoking, data for which can be accessed on the National General Practice Profiles.

Due to time constraints this method was developed at the same time as the interviews with religious leaders and PH professionals were taking place (discussed in section 4), so in this project the method did not determine the choice of PWs where interviews and focus groups took place. However, future work could usefully employ this method to accurately identify and target PWs that are in areas where GP surgeries record high levels of obesity, depression, diabetes and smoking. Lessons were learnt from trialling this method that can be taken into consideration in future research on this topic.

Primary care health provision in Leeds is split into 3 Clinical Commissioning Groups (CCGs), covering Leeds South and East, Leeds West and Leeds North. The National General Practice Profiles outline population trends by CCG. Most values are given by practice and by CCG. The average value for England is also given for comparison. Each CCG represents a large area encompassing a variety of characteristics (rural, urban) and types of housing. For example Leeds North CCG has an average deprivation score of 22.7 (England average 21.5) but this score includes practices in Chapeltown with deprivation scores of 54.7, and practices in Seacroft with scores of 54.5. By contrast Collingham and Shadwell, also in Leeds North, have deprivation scores of 8.55 and 9.3 respectively.

We examined the prevalence of obesity, depression, diabetes and smoking by CCG and then linked the catchment areas of the practices to places of worship within the boundaries of the practices with highest prevalence. The strengths and limitations of this method will be explored below.

3.3.1 Findings and Analysis

Table 3 gives a summary of the CCGs/areas in which the priority health issues have the highest prevalence alongside suggestions of BME PWs in those catchment areas that could be the focus for PH interventions. In identifying which PWs existed in each area, we were unable to locate a source of regularly updated information on the location of places of worship in Leeds. While highly recognisable places like the Sikh Temple in Chapeltown can be clearly identified, smaller community places or worship are often known only to those minorities who attend them and are therefore not necessarily included in Table 3. The places of worship presented in Table 3 were compiled by exploring a series of (mostly) historical directories held by Leeds Libraries, the knowledge of local religious leaders, Internet searches, online directory searches and physical visits to some of the areas.

Correlating ethnicity and BME places of worship with disease prevalence can obscure the fact that nearly all of the places in Table 3 have deprivation scores about the average for England. High levels of BME self-identification are not as closely linked to prevalence of particular illnesses as deprivation (Connely *et al*, 2000; Evans *et al*, 2000). This does not mean that ethnicity does not impact upon the way disease affects people or on health related and help seeking behaviours (Barnard and Turner, 2011), but it highlights the need for a more nuanced understanding of an individual's health which encompasses all aspects of their identity and context.

Table 3: Summary of Data and Places of Worship Results

Priority Health Issue	CCG	Area	% BME population in area (Census data)	Examples of BME PWs in practice catchment areas
Obesity	North	Chapeltown	48.8%	Sikh Temple, Gurdwara Namdhari Sangat Leeds (Sikh), Masjid-e-Shah Jalal Mosque, Our Lady of Czestochowa & St. Stanislaw Kostka (Polish Roman Catholic), St Martin's Church (Anglican; West Indian), Church of God of Prophecy (Pentecostal; Afro-Caribbean), Wesleyan Holiness Church (unknown), New Testament Church of God, (black majority)
		Otley	4.5%	None known
		Seacroft	15.5%	None known
	West	Drighlington	7.5% (Morley S)	None known
		Gildersome	7.5% (Morley S)	None known
		South and East	Cottingley	27.4% (Beeston&)
Hunslet			39.2% (City &)	Church of the Nazarene (International: Evangelical), Gurdwara Gurunanak Nishkam Sewak Jatha (Sikh).
Depression	North	Seacroft	15.5%	See above
		Chapeltown	48.8%	See above
	West	Wortley	10%	Holy Family Catholic Church (Irish Catholic), Sri Guru Nanak Sikh Temple.
		Morley	6.8/7.5%	New Horizons Church (South East Asian minority), Church of the Nazarene (International: Evangelical)
	South and East	York Street	N/A	N/A
		Hunslet	39.2%	See above
		East End Park	34.7%	Deeper Christian Life Ministry (Evangelical: Nigerian)
Diabetes	North	Chapeltown	48.8%	See above
		Chapeltown	48.8%	See above
	West	Gildersome	7.5% (Morley S)	See above
		Morley	6.8/7.5%	See above
	South and East	Harehills	64.2%	Central Jamia Mosque (with Leeds Islamic Centre), Markazi Jamia Masjid Bilal (Harehills Mosque), Quba Mosque, The Church of the Three Hierarchs

				(Greek Orthodox), Church of Jesus Christ Apostolic, New Testament Church of God (used by various Pentecostal and Evangelical African groups including Grace Gospel Church), Muslim Cultural Society at Bilal Mosque.
		Hunslet	39.2%	See above
Smoking	North	Seacroft	15.5%	See above
		Chapeltown	48.8%	See above
	West	Bramley	8.1%	None known
		Bramley	8.1%	See above
	South and East	York Street	N/A	N/A
		Hunslet	39.2%	See above
		Harehills	64.2%	See above

3.3.2 Strengths and Limitations of this Method

Primary care data are reliant on the quality of coding and reporting taking place in each practice. Where a practice has multiple sites, these sites are often very close together but occasionally multi-sited GPs generate significantly extended catchment areas. Some practices will have their data skewed by a high proportion of type-specific accommodation within a catchment area, such as care homes or student housing. Further interrogation of the primary care data would require a prebuilt MIQUEST²¹ search at additional cost to any research project. Any data search that requests ethnicity data from primary care will find highly variable quality in the recording of ethnicity data (Jacobson, 2003). However, the quality of this data is improving steadily (Mathur *et al*, 2013). Ethnicity data still relies upon assumed religious affiliation based on ethnicity, which can often be over assumed in BME populations.

Primary care data describe only the individuals whom actually access primary care resources. Certain populations are known to distrust such services or find they are barred from accessing those services and as such are underrepresented in these data. For example the temporary addresses of some Gypsy's and Travellers have been reported to cause staff at GP practices to turn them away when trying to register (Atterbury, 2010).

Linking practice catchment areas to places of worship within that catchment assumes that people attend a GP within their catchment area. While this is true for most people, a few may move out of area and retain a GP - either because they are happy with the quality of care or through inaction. This link also assumes that people attend PWs in the same area as their GP. The qualitative work explore the extent to which this is true.

PW data that do exist can be unreliable as building usage can change quickly and spaces can be used for multiple purposes. Chain migration can mean that there can be a sudden influx of people from one small area who will live closely together and may also worship together, often in informal settings.

3.4 Conclusion

This discussion has examined the role of 'big data' in helping us to address one of the overarching objectives of the research: to identify prevalent health concerns within certain religious and/or ethnic groups in order to explore whether places of worship could play an important role in dealing with those specific health issues.

We looked briefly at two types of data: National Census Data and National General Practice Profiles, while acknowledging that as qualitative researchers we are not best placed to know what data are needed, what data already exist and how they can be presented so as to support the research. **Future work would require collaboration with quantitative researchers used to working with 'big data' in the relevant areas of health and deprivation, as well as ethnic and religious affiliation.**

The National Census data are invaluable in providing information about ethnic and religious identification in the UK, but cannot speak to questions on religious practice or attendance. Further, the data collected on health are too general to be of much use for our purposes. The discussion of the use of National General Practice Profiles demonstrated that it is appropriate to examine local prevalence data when examining national health priorities. NGPP data justify the focus of the PW research project in Chapeltown, as this area has a high BME population and a high prevalence of multiple illnesses that are priority concerns for PH. The data also indicate a particular concern about high rates of diabetes in the population of Chapeltown. The data justify an intersectional approach to an individual's health by demonstrating that deprivation also affects the overall health of an area and any Public Health approach must consider people in their socio-economic context.

The above discussion justifies a multifaceted approach to the exploration of the question; what is the role of places of worship in improving BME health? It suggests that big data can be used to guide research directions but cannot, without further complex intervention, examine the health concerns of minority populations. This work must be done on a more personal, qualitative basis.

Mapping small congregations practicing their religion in community spaces or private homes can only be identified through embedded community links. This would mean any follow on research project must build into its bid resources to facilitate working with third sector and community groups.

To improve the quality of data analysis drawing on the National General Practice Profiles a large scale project would require a MIQUEST search to run in all practices in Leeds to explore how ethnicity impacts upon prevalence data. Any search that focuses upon ethnicity data would have to consider the caveats found earlier in this report; that assumptions should not be made that BME identification automatically equates to a particular religious affiliation nor that a religious affiliation entails religious attendance.

A further in-depth study would also be required to map comprehensively places of worship in Leeds given that directories and Internet searching cannot be proved to be conclusive. Annually the Department of Philosophy and Religious Studies at the University of Leeds carries out a mapping of religious practice area by area (Brackenbury, 2001). **This project involves students and takes a full term to map one single ward – illustrating the**

resources needed to accurately map religious sites. If the results of this mapping could be shared digitally, or mapped electronically, this would be an extremely useful resource for further Public Health research and work, potentially replicable in other cities.

4 Places of Worship and Public Health: the qualitative study

4.1 Introduction

In this part of the report we outline and discuss the findings from the interviews and focus groups that we carried out. In total we carried out 9 interviews with key figures at different places of worship in Leeds, 1 interview with a member of a third sector organisation working with asylum seekers, 3 interviews with PH professionals and 2 focus groups in Christian PWs. The 'religious leaders' that we interviewed were selected from a list of contacts provided to us by Leeds Faiths Forum²² alongside some additional recommendations from other individuals we met during the research. We covered a range of religious traditions present in the city with 4 interviews within Christian settings (2 Anglican, 1 Methodist and 1 Pentecostal), and one each within Muslim, Hindu, Sikh, Jewish and Buddhist settings. Although most of the members of the Buddhist centre we visited were ethnically 'white British', Buddhist centres in the city are places that certain BME communities may engage with from time to time. Therefore, we feel it is important for PH Leeds to have some knowledge about the Buddhist community in Leeds and have decided to include Buddhism in the study. We also carried out focus groups within two of the Christian churches (1 Anglican, 1 Methodist). The PH professionals were suggested to us by contacts at PH Leeds and we were directed to the third sector organisation by one of the members of Leeds Faith Forum. These interviews do not comprise a representative sample but instead reflect the interviews we were able to secure in the timescale available.

As outlined in section 1.3 the main research questions to be addressed in this research are as follows, and the findings from each of these will be used to structure the following presentation of the interview and focus group data:

1.5 Research questions to be addressed in the qualitative research:

RQ1: Who uses the PWs visited: what is their age, gender, ethnicity and how far do they travel?

RQ2: What are the characteristics of the PWs visited? What general activities do they engage in beyond purely religious activities; how are they organised and who makes the decisions; and what is the role of the 'religious leader'?

RQ3: What are the main health issues facing congregations/members of PWs according to our interviewees/focus group participants?

RQ4: What activities have been undertaken around health, including how these are funded/supported, and the nature of any previous engagement with PH professionals and third sector organisations?

RQ5: What is the role of religious teachings and practices in health promoting activities?

RQ6: What are the drivers and barriers to the promotion of health in the PW, including barriers to engaging with PH bodies, barriers that people face in accessing health services and how might these barriers be overcome?

RQ7: What are the attitudes of public health staff with regard to public health practice in places of worship?

RQ8: To what extent are participants from PWs interested in the development of a local network and eventual guidance document for PWs wishing to become public health settings? Would they like to be part of this?

4.2 The profile of those using the place of worship: age, gender, ethnicity and how far they travel

4.2.1 Justification of the selection of faith traditions to include in the study

This study focuses on PWs as sites for BME public health settings in Leeds. As outlined below the majority of Sikhs, Hindus and Muslims in the city are from BME communities, although a number of 'white British' also belong to these religious groupings. Therefore, selection of PWs where these groups are represented was fairly straightforward. The situation with Buddhism is more complicated. Although nationally there are more Buddhists from BME communities than 'white British', and this is also the case in Leeds (see below), the Buddhist centres or places of worship in Leeds mainly cater to 'white British' who have converted to Buddhism. We do not know of any Buddhist centres in Leeds catering to BME Buddhists, but because these groups of Asian-origin Buddhists will sometimes attend Buddhist centres catering to converts, we have decided to include Buddhism in the study. We also decided to include Judaism, though we recognise that although classed as a BME community, the Jewish community does not experience the low levels of socio-economic advantage that many other BME groups do. Finally, while the membership of Christian traditions across Leeds is mainly 'white British', there are Christian settings in Leeds with high BME membership levels and this representation dictated our selection of Christian PWs.

4.2.2 Sikhism

Within the Sikh community in Leeds 97% of the population is from the 'Asian/Asian British' ethnicity category in the 2011 Census (See Table 1). There are seven gurdwaras in Leeds:

- Guru Nanak Nishkam Sewak Jatha (Leeds) UK is in Hunslet
- Gurdwara Kalgidhar Sahib Bhatra Sanghat, the Sikh Temple, the Ramgarhia Board, and Namdhari Sikh Sangat are all in Chapeltown
- Guru Nanak Sikh Temple is in Wortley/Armley
- Gurdwara Sri Hargobind Sahib is in Harehills.

Four of these are in Chapeltown, and the others are in Hunslet, Harehills and Wortley. It is notable that all of these wards are identified in Table 4 above as having a high incidence of key health concerns. Of course not all those using these gurdwaras will live in the local area; many Sikhs have moved from areas that are more deprived as their socio-economic situation has improved. Those who have moved out tend to be younger more affluent people while the older generation is still living nearby.

The temple that we visited - Guru Nanak Nishkam Sewak Jatha (Leeds) UK – is in Hunslet and is located in the former Rington's tea factory dating from 1936 which was acquired in 1988 for £80,000: 'there was a need for a gurdwara to serve Sikhs living in the southern part of Leeds, as they had to make a long journey over to the north side of the city to the existing gurdwaras' (Minnis 2008: 53). However, our interviewee explained that they had been a little nervous when they bought the property:

There was a certain degeneration in Beeston, particularly many factories...where people use to work, they closed down, and they lost their jobs. And the youngsters who had already had some Western education, and qualified with degrees and all that, didn't want to live in a deprived area. So they

started to move to North Leeds...And another difficulty...is that we haven't got a good secondary school here, and that is another very strong factor— so as soon as children get up to the age of 12 or 13, and are ready to go to high school, people sell up their homes here and go up to North Leeds.

Nonetheless, the community has grown over the years with people coming in from the local areas of Hunslet, Holbeck, Beeston, Morley, Middleton and Belle Isle but also from further afield including 'Denby Dale, Wakefield, Dewsbury, Batley, and some from Pudsey as well'. The gurdwara attracts about 300 people at the weekend and on larger occasions, including weddings, funerals and special festivals such as Guru Nanak's Birthday up to a 1000 will come. In contrast to the Buddhist centre discussed below, which mainly attracts adults for meditation teachings and classes about Buddhism, the gurdwara attracts families: 'When people come to worship they come with families...And there are slots for women to lead our worship, there is a slot for children to lead a worship, there is a slot for our priests to deliver a sermon and preach - so there is room for everybody.'

4.2.3 Hinduism

Within the Hindu community in Leeds, 97% identified as 'Asian/Asian British' in the 2011 Census. Unlike the Sikh community there has only been one Hindu temple in Leeds (although we have recently heard but have not been able to confirm that a second has recently opened in the Kirkstall area of the city). Understanding the reasons behind this requires further research, but possible explanations might include: people travel outside of Leeds to attend temples elsewhere; for Hindus in Leeds the temple does not have such a focal role as it does for Sikhs (e.g. more Hindus may primarily worship at home with the temple in Hinduism performing a different role); the Hindu temple accommodates more people than the individual gurdwaras; Sikhs prefer to worship in smaller caste related groups which means that they need to develop more premises. Interestingly the Sikh and Hindu communities in Leeds are 8,914 and 7,048, so they are not that differently sized; the difference in size is not large enough to account for the Hindus only having one temple.

The Leeds Hindu Mandir in the Hyde Park area of the city – 'is located in an area known as 'The Harolds', a tightly built up group of streets of back to back houses in Hyde Park. Most of the members live further afield and there is a large car park in what were the grounds of a large Victorian villa, formerly owned by the Salvation Army and bought by the Hindu community in 1968 for use as a temple. It is now used as a community centre' (Minnis 2008: 51). The foundation stone for the temple was laid in August 2000. Part of the temple is a converted building that probably used to be a stable. A community centre has now been built adjacent to the temple. Unlike some Hindu temples that attract people from specific parts of India our interviewee explained that a 'cross-section of the Asian community comes to the temple...We are very lucky in here that we have all four groups— Bengali, Punjabi, South Indians and Gujarati. They all come together in here...They do their own worship in their own way, although they participate. And then it makes a nice integrated congregation.'

4.2.4 Islam

The Muslim community in Leeds totals 40,772 people according to the 2011 Census and reflects a more diverse population than for Sikhs and Hindus, with 72% from the 'Asian/Asian British' grouping and the rest from other groups. According to one Internet source there are 24 mosques in Leeds.²³ Our interviewee was linked to the Makkah Masjid, Brudenell Road, in the Hyde Park Area of Leeds, mainly used by Muslims of Pakistani origin. It opened on 29 August 2003 and has three floors, is able to

accommodate 3000 people: ‘internally, the building is structured around the three large prayer halls, one on each floor’ one of which is for women (Minnis 2008: 64). Our interviewee told us that most of the people who use it come from the local area but that some people come from West Park in particular and other parts of North Leeds as there is no mosque there. During the day the majority of people who come to the mosque to pray are older, and are not working, but for the main prayer on Friday the congregation leaps from between 20-80 people to around 700 people, and includes a range of ages. There is typically a short sermon of about five minutes before the main prayer.

4.2.5 Buddhism

The Buddhist community in the UK stands out from other Asian origin traditions in that it attracts a higher number of ‘white’ converts: 38% of the total Buddhist population in Leeds is white, compared for instance with only 0.1% of the Hindu population in the city and 0.17% of the Sikh population.²⁴ Moreover, our interviewee at the Jamyang Tibetan centre in Leeds²⁵ explained that ‘the majority of people [who attend the centre] are white western, and they are pre-dominantly, but not exclusively...middle-class’ and are therefore less likely to suffer poor health outcomes than those from lower socio-economic groups. There are some Tibetans who attend but ‘they come only occasionally. They usually would come if we have a service – a puja, but they wouldn’t particularly come for teaching, which is the main thing that we do here’. Some members of the Chinese and Korean and communities also use the centre, and are likely to come if there is a special event or talk that attracts them. As far as we know there are no temples or Buddhist centres in Leeds catering to these groups of so-called ‘ethnic Buddhists’. We only know of three centres, all of which are more focused on western converts than ‘ethnic Buddhists’.²⁶ Jamyang Leeds is part of the Foundation for the Preservation of the Mahayana Tradition (FPMT) and is located in central Leeds. Most of those who use it do not live in its catchment area, and instead travel in for weekly and weekend teachings from across Yorkshire, which sometimes draw up to 35 people, particularly for the weekend retreats. Hundreds may attend when a more famous teacher comes to the centre such as Lama Zopa or the Dalia Lama, and other premises may be booked in order to accommodate everyone.

4.2.6 Judaism

The Jewish community in Leeds totals 6,847 and the vast majority, 96%, are from the ‘white: total’ ethnic grouping in the 2011 Census. The Jewish community in Leeds is far older than the minority communities discussed above, dating back to at least the mid eighteenth century. Consequently it is a more settled and better-established community and also has higher levels of socio-economic security than most other minority groups in Leeds. There are 8 synagogues in Leeds, 7 Orthodox and 1 Reform,²⁷ but as our interviewee told us, there is a Representative Council that ‘is overarching for all the communities in Leeds, not just religious organisations but...social welfare, sports, cultural, educational...’ We did not carry out this interview in one of the synagogues so will not provide a description of a faith based setting here.

4.2.7 Christianity

Finally, we come to the interviews and focus groups in the four Christian settings. We carried out interviews in two Anglican settings, one Methodist and one Pentecostal. Out of the 419,790 Christians in Leeds, 92% are in the ‘White: Total’ grouping, with the next largest percentage relating to ‘Black/African/Caribbean/Black British: Total’ at 4.5 %. Our first Anglican interviewee was a representative of the ‘Moor Allerton and Shadwell Team Ministry’²⁸ (this includes 4 parishes: St Barnabas area on Alwoodley Lane, St Stephens in Moortown, St Pauls, Shadwell, and St Johns in Moor Allerton) and the other Anglican

setting was St Martin's in Potternewton.²⁹ Roscoe Methodist Church is just off Chapeltown road³⁰ and the New Testament Church of God, which is Pentecostal, is in Harehills. Unfortunately, we were not able to carry out an interview in a Catholic setting but this should be followed up in future research.

According to our interviewee there are 35,000 people in the Moor Allerton and Shadwell parishes, from the area round St Barnabas, on Alwoodley Lane, one of the wealthiest areas in the country, with very few BME members, down to St Stephens in Moortown, which is one of the poorest areas in the UK and has a higher concentration of BME individuals within its congregation. Most of those who use these PWs live in the local area and for St Barnabas, St Paul's, and St John's the congregations are 'predominantly 98% White British'. St Stephens, by contrast, which describes itself as a 'lifeboat church', to which 'people of all ages come— a great amount of children and young parents', is much more mixed with Caribbean and African members and we will focus just on this setting in the remainder of the discussion.

The second Anglican setting we visited was St Martin's Potternewton, where '80% of the congregation [are] from the Caribbean [and] 80% of those are from St Kitts and Nevis' who came to England in the '50s and 60s.... [settling] in this area mainly because of the hospital'. Interestingly, a good number of female Caribbean immigrants to Leeds were nurses and there would seem to be the potential to involve them in health initiatives within their PWs. These communities are very tight-knit, having experienced together the process of immigrating and establishing themselves in Leeds. Most of the congregation members were of retirement age and 'then there is quite a gap...people from 30 up to 50 don't tend to come', with young children often being brought by their grandmothers rather than their parents. Not everyone who uses the church lives in the local area: 'we do have a few people travelling— mainly it's the white [members]... but it is also the [few] younger families [which] are a bit more far-flung. So, typically, the older generation have stayed here because of their work. But their children might have moved out.'

Our interviewee from Roscoe Methodist Church told us that the congregation totals around 100 people and as with St Martin's, 'the vast majority of those are Caribbean, or of Caribbean heritage...[and]...a lot of those are from St Kitts and Nevis' and some also from Jamaica and Barbados. The church also attracts 'a smaller group of people who are African— Nigerian, Ghanaian, Zimbabwean, Cameroon' and a 'handful' of white European members. Another church linked with Roscoe - Trinity United Church [Methodist/United Reformed, Harehills] – has a similar profile, with around 50-60 members, but is more 'diverse in the sense that there are fewer Kittisians and Nevisians, a lot more Jamaicans, and a lot more Zimbabweans...we have the Methodist Zimbabwean fellowship, that meets in the afternoon in Trinity... There are quite a few Zambians as well.' As with St Martin's, both these congregations are 'massively tilted towards the 60+ age group...At Trinity, there is a higher proportion in their 30s and 40s, but that is because of the Zimbabweans'. Predominantly people live in the local area, 'three quarters of people are within walking distance, and there is only really a small percentage of people that have cars. So probably about 10 or 15% of people...So that reflects very much the local community.'

We also visited a Pentecostal setting: the New Testament Church of God in Harehills. According to our interviewee the congregation is much larger than that at the other Christian settings, totalling nearly 300 'signed up members'. Then there are others [around 50] 'who we would classify as adherents. So, they might come on a regular basis, and they might bring their children to be dedicated – they'll get their weddings here, funerals... But they are not actually church members.' There are around '29 different nationalities, from different places in Europe, many of the African countries, or

the Caribbean countries' and 'demographically speaking, it is the full range from those would be classed as the working class to quite middle-class'. Because the New Testament movement only tends to have one church per city, people do travel some distance to attend.

4.2.8 Key points:

- Sikh: The gurdwara attracts around 300 people at weekends and 1000 on special days and is in a deprived area. Many who use it do not live nearby but have moved away, particularly the young. It attracts families who are of South Asian origin
- Hindu: Until recently there was only one Mandir for the city (whereas there are 7 gurdwaras). It attracts families and people do not necessarily live nearby as it caters for many different Hindu groups.
- Muslim: 20-80 people attend prayer during week and they are mainly older as they are not at work. On Friday prayer up to 700 attend and the ages are more mixed. Most people live nearby but others come from North Leeds where there is no mosque.
- Buddhist: This is a small community centre attracting mainly 'white' converts who are middle class. It mainly attracts adults and people do not tend to live in the catchment area of centre which is in central Leeds
- Jewish: This is an older more settled minority group and is more affluent than the others. There is a stronger Orthodox tradition in Leeds than Reform (7 Orthodox synagogues and 1 Reform).
- Christian:
 - Moor Allerton and Shadwell Parishes: St Barnabas, St Paul's, and St John's, 98% White British. St Stephens is in a more deprived area and is much more mixed with Caribbean and African congregation members.
 - St Martin's in Potternewton: 80% of the congregation from the Caribbean, 80% of those are from St Kitts and Nevis. It has a mainly elderly congregation, with grandparents bringing children but few families or people in 30-50 age group attending. It comprises an older congregation who live nearby, while the younger members have moved away.
 - Roscoe Methodist Church: A congregation of about 100 people with the vast majority of those of Caribbean heritage with many from St Kitts and Nevis. People also come from Nigeria, Ghana, Zimbabwe, Cameroon and Zambia. Trinity [United Church] has 50-60 people and is a bit more diverse with fewer Kittisians and Nevisians, a more Jamaicans, and more Zimbabweans. It has a bigger proportion of younger members in the 20-30 age group due to the Zimbabwean membership. Otherwise, both congregations are mostly older/elderly (60+) and people tend to live near to the churches.
 - New Testament Church of God: A congregation of around 300 with 29 nationalities from different places in Europe, as well as representation from many African and Caribbean countries. People come from a range of socio-economic backgrounds.

4.2 The characteristics of the PW: what general activities does it engage in beyond purely religious activities; how is it organised and who makes the decisions; the role of the religious leader (e.g. in promoting health)

This theme/heading is essentially concerned with *mapping the broad religious 'assets'* possessed by a particular PW and examining the ways in which these could be harnessed towards activities that are focussed on health education or engagement. What are the premises like that the PW uses? What types of activities does the PW engage in beyond those that focus on religion and how is the PW structured and organised?

The gurdwara we visited is located in a former tea factory:

The building is laid out with a dining room for [105] people on the ground floor, the principal prayer hall on the first floor, a secondary prayer hall and teaching rooms on the second with the penthouse used for youth activities. The prayer halls are large rooms with suspended ceilings, carpeted, quite plainly decorated with some pictures on the walls with the focus on the [palki (altar)] holding the scriptures. Much of the large complex is being developed for other community activities and the facilities include [Punjabi classes, Indian music classes], a photographic studio and darkroom, a computer room, space for Sikh martial arts and an archery range, housed in the upper floor of the former stable (Minnis 2008: 54).

As is common in all gurdwaras the free, shared meal – the langar – is a focus in this setting. Our interviewee told us that

The idea of setting up the Gurdwara was not just to make people comfortable with their spiritual needs, but also to give them assistance in every aspect of life...that is what we should be doing. But it also depends on the vision of the leader of a particular Gurdwara to create facilities to serve community's needs. If they have the vision, then of course they will create relevant facilities.

Other community activities have included free legal advice, a council officer visiting the premises to advise people and to help with filling in forms, and a homoeopathic consultant. The gurdwara also used to run a day centre for elderly Sikh people but funding from the local authority was stopped and this is now facilitated by Touchstone, a local third sector organisation. There is also a women's group and a girl's group, music classes, an indoor archery range and a Punjabi school, and there used to be Gatka (a martial arts) classes.

The gurdwara has no management committee but a board of trustees, and the chair and the other co-trustees make the main decisions about how things are organised rather than the Granthis/Ragis (religious specialists), whose role it is to carry out the religious duties. The gurdwara is also registered with the local hospitals for chaplaincy work.

Although we began the research planning to interview 'religious leaders' it soon became clear that this means different things in different religious settings, and the 'religious specialists' may not be the ones directly involved in outreach and any related work on health. A set-up where the religious specialist is more-or-less 'in charge' of the overall running of the PW and all its activities seems to be *more likely* within a Christian setting than the other faith traditions we visited. For instance, the religious specialist in the

gurdwara who recites the texts typically does not get involved in organising non-religious events. Our interviewee explained that

We actually don't have an ordained priesthood. These priests that are here are our employees. But their role is more or less to get on with reading the holy book and preaching a sermon from the holy book, and if there is any teaching, then they can teach how to play the tabla or how to play the harmonium... That's the most popular way of worship, so that's what they will do... They do have a little bit of pastoral responsibilities. But ...the leader, [he/she] will then organise and deputise one of the Minister of Religious to go and provide relevant help or service.

Similarly, in the Hindu tradition, the religious specialist is typically not in charge of the day-to-day running of the temple. As with the gurdwara the temple is organised with a management committee, trustees and the religious specialists – *pujaris* – with elections for the non-religious roles. The priesthood is hereditary and can only be occupied by men of the Brahmin caste. There are currently two *pujaris* (priests) at the Leeds Hindu temple but they do not 'involve themselves with any medically-related issue. So, they also say, yes if you have any problem or anything like that, you need to speak with your GP.' Neither would they include health issues in their teachings, since their primary role is to carry out the religious activities. Our interviewee explained that

From time to time, we have a discussion, so in this one we are getting one big [main] speaker who is going to come down. And he will give a speech on the life of, say, Rama, or something. But, in between, there are so many health issues covered indirectly. So, saying why you are not allowed to eat fish, why are you not allowed to eat eggs, why are you not allowed to have chicken, why are you not allowed to kill.

The Hindu temple in Leeds also runs community events including luncheon clubs, dance classes, women's groups and day trips.

In addition to daily worship, the Leeds Makkah Masjid Mosque runs children's classes, courses/ lectures, organises speakers and has study circles including those for women. In addition to the mosque itself, the community also runs the nearby Woodsley Community Centre, which holds table tennis and boxing classes, English lessons and a food bank during Ramadan. Mosques can be organised in different ways as one of our interviewees explained: 'some mosques have committees. So at the Islamic Centre, [they've] got a committee. But the Imam works very closely with the committee... Some mosques don't have committees. The Imam runs the mosque, so you go directly to the Imam.' As another interviewee told us:

Now within the mosques, right, they have committees. And...the mosques, they have membership. So for example, I am a member of a particular mosque, and I subscribe, right, to that mosque, and I pay a set level amount over the year. So they will have other people. So each mosque might have 4-500 individuals that are members that subscribe. So that will pay for their running of the mosques.

The main focus of the Jamyang Buddhist centre, which is located in a rented office space in central Leeds, is the provision of meditation classes and Buddhist teachings, with most people coming for the lunchtime and evening meditation classes, it runs 'two lunchtime meditations a week, and one evening meditation class.' Those who attend are 'not in any

way required or expected' to be Buddhist or even to be very interested in Buddhism, but come to benefit from the meditations themselves. Jamyang Buddhist Centre Leeds is part of a Tibetan movement called the Foundation for the Preservation of the Mahayana Tradition (FPMT) and was founded in Leeds in 1996, 'under the spiritual direction of Lama Zopa Rinpoche. As a non-residential centre run by volunteers, our aim is to provide a peaceful place for meditation and a community of support for the study and practice of Buddhism.'³¹ Volunteers from there are involved in prison chaplaincy and they regularly host important teachers from the tradition. There is no resident teacher there with classes being taught by senior students. Whilst donations are accepted, the classes are free. The day-to-day running of the centre is carried out by the volunteers, who appear to be mainly western converts to Buddhism.

The Jewish community in Leeds has a Representative Council and a range of community facilities including the Marjorie and Arnold Ziff Community Centre, the Leeds Jewish Welfare Board, the Leeds Jewish Housing Association, Donisthorpe Hall, providing residential, nursing and dementia care, and voluntary associational activities (youth, educational, sporting, social, cultural). Our Jewish interviewee told us that

The structure of a synagogue I think is probably very similar to the structure of mosque, I think, but maybe not similar to the structure of the church...basically they are members clubs. They are members clubs, and you pay an annual fee and you are a member of the synagogue. So we have a lay leadership of the synagogue – with officers, a president, treasurer, another officer who is in charge of social and cultural, and then we have the religious leadership ...So we have a lay leadership and a religious leadership.

For the Jewish community 'the question of whether we would be happy to have a speaker coming and talking about drug abuse or something really isn't a matter for the religious leaders of the community at all. It's the lay...it's the president of the synagogue who will say 'I think that will make a nice evening' or 'we want to be bothered with that' or 'we don't want to be bothered about it'. It's not really for the rabbi to decide' although he may come across needs that people have during his pastoral work and pass on suggestions to the lay leadership.

By contrast, the situation in Christian settings is markedly different and the priest or pastor has more of a leadership and organisational role overall – his or her role extends beyond the provision of strictly religious services.

The Moor Allerton and Shadwell Team Ministry looks after 4 parishes in North Leeds. In addition to catering for the immediate congregation - a pastoral group is responsible for the welfare of the congregation members - it also engages in outreach and mission to the wider community including family fun days, a luncheon club and work in schools.³² The ministry team is comprised of four ordained ministers. Similarly at St Martin's, there is a pastoral group to 'keep an eye on...who is getting visited and who is not'. The church supports the local 'women's aid', which helps victims of domestic violence, and organises transport to get elderly people to church. It is also planning to start a soup kitchen and a service carrying out odd jobs for the elderly. Key members of the church carried out a 'mission action plan– we had a big shopping list...and we did decide that if the resource exists, then we just have to promote that.' In addition to the Church building there is also the St Martin's Institute, a large parish hall, which is available to members of the wider community to rent.

In both the Moor Allerton and Shadwell parishes and St Martin's, people do talk to the clergy about their health problems and how they feel about them, and at St Martin's the religious leaders have also included health topics in their services (see below). However, the RLs we spoke to were quite clear that whilst they can provide support and help to signpost people to relevant experts, they are not medically trained so cannot go much further than this. At Roscoe this reflects the cultural composition of the membership:

(T)he nature of the congregation here, as distinct in my experience any way from most white European congregations... the majority of people would involve the minister in all sorts and everything. So, if there is a family issue...they will ask the minister, either to pray, or if there's things that can be done to help, or whatever...I am asked to bless all sorts of things– not just houses and cars, but anything and everything– all sorts...It is a worldview that all we are is about our faith, in every direction. That is not shared completely by the younger family members, but it certainly is by the [older] generation. That is why...we have a very active prayer group that meets regularly and receive requests for prayer. It's a slightly tricky one that, because we try to encourage people, if they are going to raise issues at prayer, to make sure that they have cleared it with the people... especially on health issues, because people rightly don't want everyone to know

Roscoe Methodist Church 'is situated in a multiracial community. As we serve the community we are continuing the work of Methodists which started 150 years ago in Chapeltown, serving Christians and non-Christians and people of all ages.'³³ The church is presently housed in a modern building, opened in 1974, which also has a community centre, which is widely used by other members of the community. The Chapeltown Citizens' Advice Bureau (CAB) runs its service from the premises. Activities run by the Church include a bereavement support group, a church choir and the 'Roscoe singers', a ladies fellowship, bible study and a 'minister's vestry session' – where people can talk to the minister - a luncheon club and the West Indian Family Counselling Service (WIFCOS). A range of other Christian congregations also uses the Church premises, including Fire International Ministries (French speaking) and Bethel Eritrean Church, and there is support for Iranian Christians.

The New Testament Church of God has a much larger congregation than the other Christian settings we visited, which is not uncommon for Pentecostal churches. As with other Christian settings it is common for the pastor to consider that he has a pastoral responsibility to the wider community as well as the congregation. Congregants discussed health matters with the RLs, but in common with the other Christian settings they would be referred to other services:

The first thing about it is that I'm not an expert on it – I am not a clinician, I'm a minister of religion. But I will listen, and normally when they come to me, it is when they have already got some sort of diagnosis. So, it is appropriate for them to come to me, and it is really to give them focused pastoral care. So, what tends to happen then is that I get plugged into some loop if things progress or they get better.

4.2.1 Summing up

The discussion here has highlighted the broad types of 'assets' that PWs have and how this might vary between and within different faith traditions. **This is the kind of**

assessment that could be carried out by PWs themselves, with support from PH, to contribute towards developing greater opportunities for collaboration.

4.3 The health issues facing those who use the PW

This theme/heading essentially hi-lights the role that PWs could play in carrying out 'health needs analysis' of members or congregations as an important step to being able to better coordinate with PH agencies in Leeds. Questions include: what are the main health issues facing those who use the PW? Do they vary by age and gender? What gives rise to them (e.g. culture, lifestyle, genetics, poverty etc..)?

Our interviewee at the Sikh temple told us that two prevalent problems are heart disease and diabetes. This person believed that a lack of exercise amongst the older generation was a contributing factor. Younger Sikhs were deemed to be 'very aware of these sorts of things, because they are educated and they understand, and they use gyms, and if not they go out running or walking.' Apart from heart disease and diabetes, other health issues include depression, obesity and cancer, with smoking and alcohol being less of a problem in this community. Many Sikhs have been confirmed in the faith – 'having taken 'Amrit' – and vowed not to eat meat, fish or eggs, or to drink alcohol or take drugs. However, not all Sikhs are initiated and these do not follow these rules.

Our interviewee at the Hindu temple told us that in his experience the health issues facing people that came to the temple were mainly obesity, diabetes and high blood pressure. Many tended still to have a diet that was high in sugar – something he suggested was inherited from India – but also correlated unfavourably with a lack of exercise. As with the Sikh interviewee, it was felt that the elderly in the Indian community are not as aware about health issues as younger generations and are more likely to be 'set in their ways'. Similar to the situation in the Sikh community, alcohol and smoking appear not to be major issues. Mental health issues were not reported to be of concern, although other evidence may not support this. Dementia was, however, a problem for elderly.

Our interviewee at the mosque identified high blood pressure, high cholesterol, diabetes and obesity as priority health concerns. He noted that the Asian diet and also a lack of exercise can contribute to poor health. Depression was becoming common and there was also 'stigma attached to it, and therefore people are not open about it, and it just gets worse and worse.' For this community, smoking was a concern amongst Muslim men in particular and the mosque had been involved in a 'smoke free homes' project (Ainsworth et al. 2013; see Box 9). However, our interviewee told us that 'at the moment I think Shisha is a big issue, and some reports say that it's more damaging than smoking. But, it's culturally...you know, a lot of youngsters are now doing it and don't think that it's harmful. And, at the moment, there is some effort being made to raise awareness. But, at the moment, we're not focusing on it, and people are going to get hooked on it.'

Our interviewee felt that for the majority of the Buddhist community that used the Jamyang Centre their socio-economic status meant that their health was relatively good and that they were well informed about how to access support. However, mental health was flagged up as an area of concern within this cohort and this fits well with the emphasis within Jamyang and the wider FPMT on 'mindfulness meditation' as a support for those suffering from mental health problems (see below). **Our interviewee did not know too much about the health needs of those using the centre from Asian ethnic groups but since they are not regular attendees this may not be the best location to reach those groups. Alternatively, working with the Jamyang Centre on health initiatives**

that targeted BME Buddhist communities in Leeds could be a fruitful activity.

Our Jewish interviewee again identified age related health problems as significant, as well as stress and mental health. In common with the Buddhist setting he felt that ‘on the whole perhaps [the Jewish community is] perhaps slightly more affluent than the average’ which has a positive impact on health outcomes.

Moving to the Christian settings, and taking first the interviewee from the Moor Allerton and Shadwell parishes, for the church in the most deprived area of this part of North Leeds, St Stephens, ‘the predominant issue is poverty, and just coping...[and]...everything that comes with age...We have cancer, strokes, heart attacks... a whole range of things. We’ve had mental breakdown [and] Alzheimers.’ Similarly, at St Martin’s age-related conditions were prominent with ‘a lot of diabetes and heart diseases of various kinds.... And then of course stroke as well...And there are cases with the much older man having respiratory diseases– obviously from the industry that they would have been involved in.’

At Roscoe, the impact of an ageing congregation was again drawn attention to and that there ‘are lots of mobility issues for people. That is the primary one. There is a...high percentage– of diabetes...There are...mental health issues– there is quite a big issue there....Dementia, in older members, is pretty significant. In the younger... the sort of grandchildren age, drugs is a bit of an issue, but it is not as big an issue as one might expect in a way...obesity is one of the most [common].’

Finally, at The New Testament Church of God again our interviewee stressed the prominence of age related illnesses: ‘in Leeds, where I said I found the difference, certainly there is an ageing population and dementia is a massive issue. And why that concerns me a lot is that people digress back to their childhood, and their childhood obviously, by and large, is the Caribbean...Or one of the African countries.’ This implies a need for cross-cultural literacy in the treatment and accompaniment of those suffering from dementia.

4.3.1 Summing up

The discussion above highlights the type of health issues that RLs perceive to be the main ones for those congregations. These vary according to a variety of factors as is the case within the rest of the population. It is possible that some of issues mentioned would seem to be age-related; perhaps reflecting the demographics of the congregation.

4.4 What activities have been undertaken to date around health, including how these are funded/supported and previous engagement with PH professionals, third sector organisations and the PW

This theme/heading offers an opportunity to look at examples of best practice and what has worked well, and specifically to begin to collect evidence of the ‘religious health assets’ owned by different PWs.

In the gurdwara there had been some focus on physical health services and health education. A homeopathic consultant had come from India and offered her services for free, with people just paying for the medicine. Some doctors from the congregation had also come to give talks on particular health issues and dentists on how to look after teeth, but on the whole this has been ‘quite an informal sort of thing’ organised by the gurdwara rather than PH actors. One of the local hospitals had consulted them about a new alcohol

based hand cleaner that they wanted to start using and would this be a problem for the Sikh community. At other times consultation has been weak, for example, 'when we get posters and other health related material from the NHS or Health department, because we are strictly vegetarians, and the posters say that you must eat fish, meat or eggs etc, I find it difficult to put them on my notice board because it is totally against our beliefs and practices and show lack of cultural knowledge by health authorities.'

In contrast to the Sikh PW we visited, the Hindu temple had previously engaged with public health in Leeds at an event focussing on diabetes. It was initiated by a member of the temple who is a South Leeds GP concerned about the high rates of diabetes among the congregation. He approached the director of PH in Leeds and a BME Health Improvement Specialist was brought in to co-ordinate the event from the PH side. This was the first ever such event in collaboration with the temple and a range of services were offered including: podiatry, blood checks, glucose checks as well as eye checks. The health professionals were able to make referrals and to give results immediately. It was viewed to be a success, and is a useful example of active engagement of a 'health asset' in the congregation, but would have benefitted from being accompanied by a series of on-going educational activities, for instance, to provide continuity/sustainability. Wider advertising of such event, for instance in the temple newsletter, could attract a larger audience for any future undertaking.

The mosque had been involved in raising awareness about health issues,³⁴ including compiling a 'booklet with the NHS called Islam and Health...that was just about raising general awareness about what Islam says about health, in terms of reinforcing the point from a religious perspective.' Another activity took place in 2013 where the mosque 'ran a class with Co-op, where they brought in their chefs, and people, men and women, made their own dishes...But linked to that, there were Co-op pharmacies, where they had the pharmacist there doing blood pressure and things like that.' Our interviewee felt though that the Co-op were targeting civil society spaces rather than PWs specifically.

The mosque does receive leaflets from health agencies but those that contain images of people can be inappropriate as the depiction of humans is strongly discouraged in the mosque prayer space. The mosque had organised a few activities over the past years around health including 'events during the day, sometimes specifically just about women, because there's a woman's group that comes...[or]...it has been specifically to a target group like the elderly, people with diabetes, things like that.' A larger piece of work with PH Leeds had also been carried out that involved a range of services. Many of the Leeds taxi drivers are Pakistani males involved in a sedentary occupation who work late shifts, eat takeaways and have a high prevalence of smoking. PH agencies contacted the taxi firms and agreed with the Hyde Park mosque to collaborate in the running of an event at the community centre which was promoted at Friday prayers at the mosque. Two additional PH colleagues who worshiped there distributed the flyers designed in style that proved culturally sensitive and attractive to taxi drivers. The main aim was to access the taxi drivers and to train them up as smoking cessation advisers (this was prior to the ban on smoking in taxis). Leaflets were made available to help them and maybe help their clients too if they asked for advice. Overall 7 men were trained up but the project was not followed up so there is no data available about how effective it was. More recently, the mosque has also been involved in a 'smoke free homes' project (Siddiqi et al 2010; Ainsworth et al 2013; see Box 9).

Box 9 Muslim Communities Learning About Second-hand Smoke (MCLASS)

Muslim Communities Learning About Second-hand Smoke (MCLASS)

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 (MCLASS) 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.³⁵

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*)³⁶ 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.' She 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.'

The Buddhist community we visited has an emphasis upon 'mindfulness meditation' as a way of supporting people with mental health problems. Mindfulness has been popularised in western settings via the writing and courses of John Kabat Zinn, and the technique of 'mindfulness based stress reduction' is now routinely taught in non-religious settings, from schools to the private sector. Jamyang Leeds teaches meditation at its centre but has also been involved in 'various outreach things in the past' including teaching meditation to staff at the annual well-being week run by Leeds City Council, and our interviewee felt that there was scope for running a mindfulness course at LCC in the future. They had also taught meditation in Armley Prison. **Given the over-representation of people from minority ethnic groups within the prison system, this might be worth exploring.**

In addition to this, the centre had a 'Tibetan doctor come here and give talks about Tibetan medicine, and also treatment...she was excellent...We rented space at the 'good health centre' on one occasion...and set up appointments for people to go and see her. And that was very well received. And people were very interested in the talks, which were incredibly interesting.' Our interviewee explained that as with the meditation this offering was not confined to the Buddhist community; a broader cohort of people took advantage of it.

Our Jewish interviewee stressed that the synagogues in Leeds tended to be less directly involved in social welfare and health activities due to the existence of the very active 'Leeds Jewish Welfare Board'³⁷ which provides a comprehensive range of high quality, professionally delivered, culturally sensitive, social, residential and community care services, primarily to the Jewish Community.³⁸ However, 'obviously if we know somebody in our congregation is ill, then the rabbi and the clergy will obviously visit...That's not to say that the synagogues don't care about...pastoral matters as it were. Because they do.' The Jewish community in Leeds also runs an old people's home, just off Shadwell Lane.

Our interviewee was not aware of having seen leaflets and posters from health bodies in synagogues in Leeds but 'I don't think that would be particularly against the idea, certainly, and I'm sure that it's the same with all the main religions. There is an overriding precept to look after your body, without a shadow of a doubt. And I'm sure that any rabbi worth his salt could speak for hours and hours, pulling out all sorts of texts just on that basis, you know.' At a local synagogue there had been a recent after dinner speaker who happened to be a heart specialist and there is also a forum for parents who are concerned about drugs and their children. Also 'there used to be... I don't think there is any more... a Leeds Jewish medical society, where all the Jewish doctors in Leeds – And they used to be quite a lot...used to get together socially to discuss things. I don't think it really exists any more.'

Moving onto the Christian settings, the Moor Allerton and Shadwell parishes interviewee told us that none of the four churches have held any health services or initiatives and neither had anyone come in from PH or the NHS. However, other activities in the Church might engage health issues: the 'luncheon club might touch on it, or the Mothers' Union in

one of its meetings might have someone talking on a subject like that. But not in a sustained way– they'd just come in as a speaker.' Moreover, the pastoral aspect of the work across the parishes, involves 'a strong pastoral network of members of the congregation going to visit and help, both formally and informally. And clergy come into it where there is a more serious case', and this will often bring these volunteers into contact with people who need support because of health problems. They did approach health issues directly during the SARS concerns when it 'suddenly became an issue with the communion wine... We had the disinfecting your hands as you come in, disinfect your hands as you go out. We had the option of dipping the bread in your wine. And you had to make sure that it wasn't the wine that people were drinking from...and I had to, obviously, wash my clothes and disinfect my hands before.'

Our interviewee at St Martin's emphasised work that they had been doing around dementia and mental health more broadly:

As a pastoral team, [we are] focusing on dementia, because obviously quite a lot of our members who are of an older age... that is the mental health condition that predominates there really. We did a special service for dementia awareness week, where we had familiar hymns, a shorter sermon– which went down very well with everybody... We did shake it up a little bit. We didn't have the hymnbooks and the service sheets. We did produce just one service sheets to avoid confusion of flitting between sheets.

While this had been integrated into the Church's religious activities there had also been outside support where 'a lady from Touchstone... came in to talk to that pastoral team as well– to give them some information about dementia and recognising the signs and how to signpost people on, and support people.' The pastoral support that the church provides involves the congregation being divided into groups of about 8 or 10, and then a pastoral visitor is assigned to each group: it is not 'so much a medical thing, but rather a general health and well-being service. Which is a key issue really, because it keeps people, even if they are not attending church or whatever– it keeps them connected, and involved on one level or another.' They aim to get people to recognise the signs of dementia and to support people suffering from it and 'after that dementia service, lots of people talked about it, and their fears about it, and if we are guessing that awareness, and that sharing of fears, then maybe people who did start to recognise the signs would recognise that they are still welcome in church, and that they shouldn't withdraw.'

Raising awareness and removing stigma about mental health issues was also a focus of a project run by Touchstone called 'New View' (see Box 10) that involved many of the Churches in Leeds, including St Martin's, Roscoe and The New Testament Church of God. For instance, a representative from New View came to talk to the St Martin's congregation about 'mental illness more generally, and acceptance of it. And she actually brought along a lady who both had experience of mental illness herself and her daughter. And her mother had had dementia, and it was so brave of her to give a testimony really. So again, we're trying to raise awareness.' One of the focus group discussions we carried out also discussed New View with one participant telling us that it 'was very interesting and very informative regarding our mental health. She did an address and got people to talk, there was an event in the hall at first and leaflets, there was a package, and I read all the information in the leaflet. Which I was very impressed [by] because I have an idea about mental health, and it was in the language where the lay person can pick up and read and understand what depression is.' However, another participant wanted to know what had happened to the project and if there would be any follow up as this had not been clear or forthcoming.

Additionally, another organisation - the 'Black Health Initiative' – had been to the church to carry out screening for diabetes and glaucoma and someone came from women's aid to talk about domestic violence. More broadly, as with other places of worship in Leeds, agencies leave health related materials in the Church. The premises of the Church have been used by the next-door GP surgery to run a 'health and wellbeing event' in the St Martin's Institute, but it was also stated that no active relationship exists between the church and the neighbouring GP surgery beyond the use of the church space.

Box 10: New View Project

New View Project³⁹

"It has been recognised and acknowledged that spirituality and faith play a major part in the lives of people within BME communities, who live with mental health issues, to support their pathways to recovery.

The Time to Change campaign has demonstrated its commitment to supporting this process by commissioning the New View project and thereby, aiming to increase the number of people from BME communities who are able to access appropriate and timely care through their faith.

Project Purpose:

- To change attitudes towards black people with mental health problems.
- To recruit and work with volunteers to enable them to gain confidence, information and support to talk openly about their mental health experiences.
- To enable volunteers to facilitate meaningful one-to-one and group conversations with members of Black Majority Churches and communities to challenge myths and stigma.
- To work with artists from Inkwell (creative mental health project in Leeds) and partner churches, their congregations and volunteers to create art tackling mental health stigma, to be displayed in churches.
- Embrace the values of Time to Change campaign to help achieve its aims of:
 - Improving public attitudes of people with mental health problems.
 - Reduce discrimination.
 - Reduce number of areas of life in which people are discriminated.
 - Increase confidence and abilities of people with mental health problems to address discrimination.
 - Increase social capital of people with mental health problems.

Expected Outcomes:

- Improve public attitudes and behaviour among African and African Caribbean communities towards mental health issues.
- Decrease the level of discrimination faced by BME people in relation to their mental health.
- Improve the confidence and ability of BME people with mental health problems to take action to tackle stigma and discrimination.
- Embrace the values of the Time to Change campaign and enhance its public profile."
-

Similarly, at Roscoe Methodist Church, 'the GP practices, a few years ago now, had a sort of health/medical open day, with lots of different things. But primarily, we were really just the host venue...there aren't many big spaces directly in the community here that are cheap'. The Church also has a space for health related materials, including a community noticeboard and the clergy at St Martin's also has involvement with St Gemma's Hospice, taking services there and supporting the families. As already mentioned the Roscoe Methodist church has a project called 'the West Indian family counselling service', which is 15-20 years old. The aim of this has been to support members of the Caribbean community facing difficulty and distress and to address issues of loneliness and isolation.

It runs a club two days a week for elders at which they cook fresh Caribbean food, do exercises, bingo and crafts, 'and then we have various groups coming to talk about things, such as Diabetes UK and all sorts of different health things – strokes, and falls. And then practical things about home – having devices in your home– all variety of different sorts of things.'

Roscoe and Trinity are well connected with local third sector organisations and initiatives. This includes the 'Feel-Good Factor'⁴⁰ 'they do stuff directly on diabetes and those sorts of issues.' For instance, at Trinity there is a drop-in café – Oasis Café - 'on a Wednesday morning and this is supported by a 'Feel-Good Factor' initiative called 'healthy lives, healthy homes'. This project is also 'encouraged through the Alzheimer's Society. They don't give us any funding directly, and we staff it, but they advertise it. So they often provide some musicians to play some music, or they have resources that they input.' Other local initiatives include the Chapeltown health and wellbeing group, which also works with faith groups, the Black Health Initiative and the Faithful Advice Signposting Service, started by Hyde Park Methodist Church. Roscoe has not been directly involved in that 'partly because the CAB is here...It came out of CAB...' The idea was 'that you would train people from churches, not in giving advice, but in signposting people. And then you'd give people a laptop with some of the basic CAB stuff on, so that people could come, and you could show them and say 'you need to go to so and so'. So that was like, benefits, housing, health, those sorts of things.'

The New Testament Church of God interviewee stressed that

One of the things that we have been blessed with...[are]...numbers of individuals who...have worked in the health sector themselves. From GPs..[and]...including in mental health as well. So, we draw on their expertise from time to time. We work in different departments, and what you will find is that during the course of the year, the men's group will have a health focus at some point. And then, in a similar way, the woman's group...We have looked at different forms of cancer and health. Organised days like MOT days where we get the clinicians to come in and do different tests, or get experts to talk about different things.

The Church has done some work around sickle cell anaemia and someone from the national Sickle Cell Anaemia society, who was based in Manchester, came to the church. The interviewee had, as pastor in a previous church, also received some Home Office funding to run training on prostate cancer:

African Caribbean men were at risk of [prostate cancer], and were late presenters...So we devised a roadshow. I wasn't an expert – We just recognised it as a need, and made some applications and got some Home Office funding, and then we realised [that it would be best to] take that to the various churches [...] because the churches [are not] going to go somewhere else. So, we did that and... at that time, one of the other hats that I had was [related] to something called the West Yorkshire African Caribbean Council of churches...So I used that vehicle because I realised that [...] other churches, would have similar needs...

Our interviewee felt that the church's 'deep roots' and the fact that it had been in Leeds for 55 years meant that it was an ideal location for 'activity that incorporated the local community health providers. Even at the level of making the introduction, so...if they've got

an issue, they will think ‘Oh I remember that I met so-and-so’ linked to that church.’

4.4.1 Summing up

This section has demonstrated some of the ways in which PWs in Leeds have already engaged with activities that have a health component. However, overall these events are more likely to have been initiated by the PWs themselves, and direct engagement with PH could be stronger and better coordinated. **In terms of the RHA that a PW has these may also be made available to the wider community and not limited to the members of the congregation alone. This was a topic discussed in one of the focus groups: ‘So if something is a public, a service is set up here and people are aware of it, whether they’re a member of the church or not they will be able to access it. And members of the church also will be able to.’ We recommend that this is worth exploring in the next stage of work.**

4.5 The role of religious teachings/theologies and practices in shaping understandings of health and encouraging behaviour change

This theme/heading is an opportunity to focus in on a particular type of RHA (religious health asset): namely, specifically religious teachings/theologies and practices. These are often more intangible than those RHAs discussed in section 4.5 yet nonetheless play an important role and ways of capturing their impact should be put in place.

Our interviewee at the gurdwara explained that for the Sikh community health is more than just healing the body:

The spiritual angle is very, very important. Their body being free of illness is one thing, but for the body to be really wholesome... It has got three elements– the soul, the mind and the body. Each one of them needs its own food, and a proper balance. So, this ritual teaching is also very, very important. And practice is very, very important.

Our Sikh interviewee explained also that the community do ‘hold prayers and all that to support the families and to support the person’ when someone is suffering from ill health.

Both our Sikh and Hindu interviewees spoke about alternative systems of medicine and the fact that these tend to be seen as secondary to ‘western’ medicine by mainstream health services. Our Hindu interviewee drew our attention to the Indian tradition of Ayurvedic medicine⁴¹ found within the Hindu texts

The Ayurveda...is full of knowledge of the plants, vegetation etc. so, in the religion, we believe in good health. One of the off-shoots of the religion is Jain[ism], and they are very strict... not to drink water without boiling. There are so many things very close to what the doctor did.

This interviewee also drew attention to the role that meditation can play for those with mental health problems and also ‘with the woman, when she is going through the change of life...You cannot explain what is going on, because they are not medical experts. When they go to the doctor, they put them on a hormone therapy or whatever. But the other way is to do the meditation—to have the control over your mind—concentration on anything

good. Some will come and tell you, what is concentration? You concentrate your mind on this spot.'

There is also scope, according to our Muslim interviewee, in the mosque to intertwine Islamic teaching and health:

When we have another guest speaker, let's say if it's a seminar... [the] Imam will open the floor with introductory remarks saying why we actually are doing this—because Islam encourages us to look after our health... And then we've got a guest—someone who can talk about it—and after that, sometimes we have people giving blood tests and things like that—so that there is a material benefit.

However, the interviewee from the MCLASS project (see Box 9) emphasised that with respect to smoking, for instance, although the religious texts did not adopt a clear position about it, many did feel that it was against Islam:

There are such differing views... about the role of tobacco... and how it's viewed. And, as to whether it's viewed as being forbidden, or whether it's viewed as being kind of acceptable; and you'll get those, you know, you'll get those scholars who will turn around and say, "Ah, well, tobacco wasn't around at the time when the Quran was written, so therefore, it's not applicable." You'll get other scholars who will turn around and say: "Well, the Quran says that you can't use anything that's going to be detrimental to your health, and you know you shouldn't, you know..." And there are others that say, you know: "It says in the Quran that you should not take your own life and smoking tobacco is taking your own life." You know, so there's a real differing view across, you know, sort of across Islam as a whole, it would appear.'

Nonetheless, just because the texts can be interpreted to support a particular view that suggests people should change their behaviour that does not mean the message will be taken on board, there is frequently a gap between values and actions.

While for the Buddhist centre we visited, meditation has a clear link to mental health support our interviewee felt less sure that an approach to health that used the PW to promote behaviour change in terms of religious teachings was appropriate for the audience there. By contrast, the use of 'moral injunctions' or 'preaching' is perhaps more acceptable in some other religious settings.

Our Jewish respondent spoke in a very direct way about linking religious teachings to health in terms of 'scriptural reasoning evenings'. These involve people from different traditions going 'through their scriptures looking at particular topics.' They are lay people rather than professionals who get together to 'go through the text and discuss it and learn about other people's texts'.

The Christian interviewees were open to linking religious teachings with health messages in a direct way to achieve behaviour change and also viewed health as something more than just a physical issue. The Moor Allerton and Shadwell parishes interviewee told us one area where a religious account of health may in fact clash with a biomedical one is around 'some kind of occult problem— possession' and that while it is dangerous only to view this as a religious issue, neither was it helpful to view this as purely a physical concern, it 'seemed that there was a need for medicine and faith to be working together'.

There was also sometimes a view that mental health more broadly is often seen as a stigma as 'possibly a punishment by God, or some sort of thing that we must accept from God' and this was something that needed to be tackled.

In each of the four parishes our interviewee explained that they have 'different activities of healing' and this is particularly strong at St Barnabas [which is more evangelical, in a more affluent area of Shadwell and with fewer BME members], after every service there is what we call a prayer team who will come together and pray with anyone who wants you to pray with them. They lay hands on them, the person tells them what to pray about, who they want praying for... And they lay hands on them and pray for them...'

You go along, and you lay your hands on them, and there are two people that I remember lay hands on and praying for. One had eczema, and wrote back later on to say that my prayer healed them, because the eczema didn't just follow its cycle and go... it stopped. And the other, was a woman who was a singer, and she had a dreadful cold, and she couldn't get out a word, and we prayed for her— and she had to do some singing—and we prayed for her, and laid hands on her, and next thing we knew, there she was singing like a bird, and off she went. And all the time, there is this terribly loud voice in my mind, saying "it's all psychological". And, a little bit later, I thought, well so what if it's psychological? It doesn't make any difference.

Our interviewee also drew attention to a broader understanding of health that could also include the idea that 'we may be growing through illness, and through some quite disabling things, one is actually experiencing the hugeness of God'. Illness can also be a way of 'learning that, actually, life isn't actually designed for my personal convenience, and that the experience can benefit others, can enlarge one's own vision.' He did not intend this to be understood in a fatalistic sense, but that 'as we engage with these things, the presence of God is there. I suppose one would be saying, as Jesus said in one case, this illness was not designed to end in death, but so that the glory of God could be seen.'

The extent to which 'healing' is a feature of Christian settings can depend on the make up of the clergy there and those who attend the particular setting. At St Martin's our interviewee told us that they have had healing services - 'we did a few... probably about half a dozen, and then discontinued them. We weren't getting that many people, but I know that [the minister] is quite keen to bring some of that element in. Perhaps, at the occasional Sunday, to have communion then have healing.' While healing might not be so popular here, there are other ways that religious teachings and practices are combined with health messages in ways that aim to encourage behaviour change. For instance,

We do talk about fasting at Lent— about giving things up— that it is good for the body, but that it is also good for the soul. That would be in sermons, and in Lent groups—we would have discussion groups, and also in magazine articles— that's another way to talk about these things. ...We had tips about dementia in the [parish] magazine didn't we? Tips about how to spot people, both in church and at home...And it does go along with the spiritual journey as well, because you give up some of the pleasurable things and take up moral issues— so we will have some Lent groups, or an extra service, or something, but also encourage people that they should be reading more and that they should be studying the bible and praying more, and becoming more aware during Lent. And it does work— people talk about it, and are committed to it.

As with many other religious settings, health here is seen in ways that go beyond the physical:

It figures in our teaching that God is for all aspects of life, and that God wants our well-being, and that therefore we should support the well-being of other people and those in need. And a certain amount of preaching perhaps to combat the prevalent idea that somehow illness is god's punishment or god's will. So I guess that the theology [we] would put forward in our preaching is that it is not God's will— God is not inflicting this upon you. God wants people's well-being. It is common to also hear at the back of church conversations along the line of 'how are you?', 'oh, you know, I have got a bad leg/ I've got diabetes and I'm struggling, but God is good'. That is a very familiar statement. And people do testify— you know, praying, when they have been up in the middle of the night, and they are really suffering— they will pray. Probably that rather than getting up and taking their tablets!

The role of the pastoral visitors and of the priest when people are sick and close to death is critical to health and wellbeing where 'even people either with dementia or who are dying, and you think that they are so far gone, but you start to say the Lord's prayer, and they start to mumble along. It's like something that they never lose.'

As with St Martin's, Roscoe also has a 'healing ministry' but 'we have not really done it big style, because a lot of people are anxious about it. We have done it in a sort of fairly informal...[way].' Some Methodist churches do go in for this more 'but the focus is very much on the healing and wholeness, rather than on the Pentecostal sense of...deliverance...Because we are a Methodist tradition, we are not in the situation in which some other Pentecostal churches are... as a kind of spiritual battle. It's really demon possession, and that's really the only thing that matters.'

However, our interviewee also drew attention to the range of different views that people have on this matter. For instance, 'people that have been brought up in the Caribbean in a British Methodist tradition...whilst they would have a definite role for the spiritual dimension of things, and the devil would definitely be an element of understanding of how that expresses, it wouldn't be to the extent that— in most people's cases anyway—they wouldn't put that over and above obvious health and medical issues'. However, for those coming from African backgrounds he suggested that the influence of spirits was stronger. So for 'a lot of the Zimbabweans, they manage to live in both worlds...They live in the sort of African understanding of spirits and how that impacts and affects everything, and they live with a sort of contemporary Western understanding of health.... And a lot of them are in their health profession as well. And they sort of live in both worlds.'

As with St Martin's our interviewee also noted that some congregation members view sickness and death in terms of 'fatalism' or 'God's Providence' and also sometimes hold the view that illness is a result of sin: 'people have said that, well, God will do what God will do, so there is nothing you can do really...You have just got to pray about it...there are occasions where I have said to people— families and individuals— that you need to pray about this, but you also need to do something that involves some medical support... Although prayer is very PWERful, it is not meant to be an exclusive... And we have a lot of these discussions in relation to mental health issues.'

Our interviewee strongly felt that theology played a role in the Churches' responsibility to health:

Jesus's understanding of salvation was as a whole thing. It was about a person's, as you call it 'soul' – about their eternal destiny, for sure – but it was also about who they were, and where they lived, and how they lived, and the experiences they had, and all those things, which are really the context of health and wholeness and that sense of well-being. There is no point in being saved in an eternal sense, and living in a way that doesn't get a glimpse at least of what that wholeness is meant to be. Given the fall and the sinfulness of the world, theologically, you are going to have all these things all the time, but really our context of salvation is working at health, and healing, and wholeness in the fullness of our person.

The New Testament Church of God interviewee also drew attention of the fact that members of the church interpret health issues in ways that are influenced by their culture and religion and that such understandings tend not to be reflected in mainstream health care services:

Some years ago, we had one of the church members sectioned under the mental health act, and I went to see them, and...they were classed as being delusional because they were praying – in tongues as we call it in our sort of churches, which is normal behaviour for us.

While an emphasis on prayer and healing in Christian settings is clearly beneficial to many, there is what others would consider to be a less positive side to this approach, which requires understanding and sensitivity in addressing it. One of our interviewees expressed some concern with the 'irresponsible' way in which some Christian churches approach HIV and AIDS with respect to beliefs about healing:

I'm sometimes very concerned about some of the messages that are coming out of churches about health. For example, a good friend of mine who's a refugee invited me to her church service. And I went along...It was in a warehouse. It was an African church...I think it was Pentecostal, and it was a healing service...It was about being healed and...basically, if you were ill, then it's because you've said 'yes' to the devil. So, "You've got to say 'no' to him. You've got to fight him."

Our interviewee described a very dramatic performance from the pastor who was wearing a 3-piece white suit and saying

All these people have been healed because they've believed in God. So it's your fault if you're ill"... And then afterwards, "Who's been healed? Who's been healed?" And...then...the pastor saying, "God can cure you of HIV. Anyone who's HIV positive and has been cured...step forward, step forward." This is in front of their whole community. So all these people are stepping forward, actually saying publically then that they're HIV positive....I knew the woman who was sitting beside me was HIV positive, had been to a previous service like this, and had gone forward, and was 'cured'; so therefore didn't need to take her medication anymore. She didn't. She then got another boyfriend, who she slept with. And she actually got so ill, she ended up in [hospital] with pneumonia...I'm a Christian myself, but, you know, there's the story of the lepers and the lepers go to Jesus, and he says, "Show yourself to the doctors." And there's none of that message coming. It was actually...nearly like, testing God. Because if

you're saying you're not healed, you're saying you're doubting he can do it, you know?

That this is a delicate issue was clearly recognised by the interviewee, but it was also recognised that such views did need to be challenged, and education provided to church leaders who act and interpret in this way. This was not the first time this situation had been encountered by our interviewee. Another example involved a pregnant refugee who was HIV positive and when she visited the consultant who advised her that with appropriate medication her child could be born HIV free she explained that "Ah, it's okay, 'cause I've been told at church that God's cured me. So I don't need any of this."

4.5.1 Summing up

Religious understandings of health can often differ from bio-medical ones and sometimes this can actually put people's health and well-being in danger. Finding ways of dealing with such tensions in a sensitive manner is critical if PH Leeds is to engage more closely with PWs around health education and delivery. However, religious teachings and practices can also be highly constructive in supporting people with health concerns, for instance through the practice of meditation and prayer as well as the role that religious teachings could play in behaviour change. However, it is important not to overestimate the role of religious teachings however they might relate to health (positively or negatively) and to recognise that there is frequently a gap between values and action.

4.6 Drivers and barriers to the promotion of health in the PW, including barriers to engaging with PH bodies, barriers that people face in accessing health services and overcoming barriers

One of the strengths of PWs is that they rely primarily on volunteer labour, often willing to offer their services for free. They are typically embedded within communities and provide a safe and trusted space for people to use for both religious and other purposes. One of our Christian respondents felt the clergy has 'a certain amount of weight. And sometimes, people will say to us, 'so-and-so needs to see the doctor. Will you have a word?'' Another talked about the position of trust that RLs occupy in certain communities (e.g. Caribbean) where there is a level of uncertainty about:

External services, and whether you can trust them and...So that is one side of it: whether you really trust people coming from the outside, and what they are going to be like et cetera...People still have the sense that we should be taking care of ourselves really– that it is a family thing; we should be able to deal with these issues.

This can be particularly challenging for elderly people who 'really struggle with the thought of nursing homes or even sometimes with people coming into their homes.' Thus, PWs can provide a way of reaching groups and individuals that may not access conventional health care services by providing a location for PH interventions ('faith-placed') as well as those generated within the PW as part of their normal activities ('faith-based') (Campbell et al. 2007). One of our interviewees drew attention to the possible benefit of this:

The Bangladeshi community, for instance, has been difficult to engage with and to get them to access health care in Leeds They are a very insular community and it could be difficult for women in particular to go out. However, places of worship...maybe a place that they're allowed to go to. So [by] having things

there, maybe [you're] going to reach people who aren't going to access health in other places.

Approaching health in a religious setting can be advantageous in a number of ways. Another of our Christian respondents told us that this is particularly the case for 'people from non-European faith groups, faith is the whole life... You wouldn't really make any distinction... actually it is not that obvious when you are used to living in a white European framework.' Another interviewee told us about when she teaches ante-natal classes to white middle class women, religion is never mentioned. But for the refugee communities she works with this is not the case:

I always do introductions. And I started off one session, and I thought, "Right. I'll do your name and something you do to relax." And I'm thinking of going on to pain relief for birth, okay? One woman started, she was a Christian, and she said, "Uugh. My baby's late and I'm really fed up. So on the way here, I prayed and now I feel much better." And then the next woman said, she said, "Well, I read the Quran everyday, and that helps me." And then another woman said, she said, "Don't laugh at me," she said, "but my mother's died and I talk to her everyday and that helps me." And suddenly...I think I had every major religion in the room...And they all knew exactly what each other was talking about, and respected it. And it was brilliant. So, but, all the time with women who have been seeking asylum, I don't think I've come across one yet who hasn't had a religion. I don't think I have. You know, it's been something really, really important for them.

However, faith can also get in the way of health if, for instance, people are influenced by their religion to view poor health as a punishment or the result of sin or *karma*, or in a way that suggests it is stigmatised. Religious explanations for poor health can also mean that some people view this as 'god's will' or that they should 'suffer their lot'. For instance, our participant from the mosque suggested that some members of the Muslim community are difficult to motivate to take their health seriously 'even though they might not be feeling well. It's just that it's not really in their culture to go to seek help, and as a result they just carry on until it's unworkable.' One of our Christian respondents told us also that 'The danger is that people can spiritualise it, and say well I don't want to go because I've prayed about it, or I've got my minister to pray for it already, and if I go that means I'm demonstrating a lack of faith...But that's not something that we encourage. We will pray, but we will encourage people to go just to verify that they have been healed'. In such cases PWs can play a role in helping people see beyond these explanations.

In some other ways, though, PWs may not be the ideal location to address health issues, particularly when they relate to sex, women or LGBT groups. As one interviewee told us:

What we found with the women we were supporting, [was that nearly] half of them were going through domestic abuse. And it was only because the volunteers I had formed trusting relationships with them that lots of things came out that would have stayed hidden otherwise. And quite a number of the women were from Christian churches, African Christian churches here.... And talking to one...she knew that if the pastor came around, [he would say] that, "You are married, so you should stay."

We asked all our interviewees about health topics that it might not be appropriate to discuss in a PW or topics that would be sensitive for their faith community. **Whilst it is**

true that some faith/religious groups may never feel able to bring sensitive issues to the fore, one Muslim respondent told us that ‘reproduction—that would be difficult to discuss...[But] we tackle over the years all sorts of taboo issues, such as cousin marriages, and things like that, even though that’s very sensitive. But it needs to be discussed.’ There are likely to be other settings perhaps linked to the mosque – e.g. community centres – where women’s groups meet and such issues can be more comfortably discussed. In the mosque men and women pray separately and there are some mosques where there is no prayer space for women, thereby rendering the PW itself as a site that is not welcoming to women and poorly suited to addressing their needs. Women tend to attend the mosque less than men, and commonly articulate understandings about their own prayer space being located in the home. One of our Christian respondents felt that gay marriage would be difficult to discuss but that health issues relating to sex and reproduction would not be relevant to much of the congregation, presumably because of their ages. Another Christian respondent felt that topics like sexual health and drugs might be difficult to discuss but also less relevant to the congregation as there were not so many young people. Another suggested that abortion is a complex and emotive subject.

We asked our interviewees about possible barriers to engaging with health issues in PWs in terms of practical considerations. The issue of when to have events is crucial and according to a Muslim participant:

one barrier is getting people to come along – timing!...Over the years, I guess that what I’ve learnt is that if you call people, and say ‘we’re going to have a health-related seminar’, people are not interested. So we tried tagging it along with something else, where people already come to that event. And then, you can use that to sort of plug-in other messages...So, for instance, Ramadan is coming up, and we have about 70 to 80 to 100 people who would come to break their fast. And, before that, you’re raising awareness about the long days that you going to fast and, as a result, you have to be careful about your diet that you choose. And also, it’s all linked into if you eat fatty stuff, or oily stuff... all that. So, they’re just general messages, and people are in a way more interested at this time of year to understand what they should eat and what they shouldn’t.

However, the timing of the breaking of the fast does not fit with the normal working day, taking place at 9.30 pm when most NHS and PH staff are off duty. Therefore the imams do this work rather than anyone from NHS. It is important to stress that this point assumes that someone from PH might always be needed in situ which is not always the case. Indeed it is more sustainable to promote work that PWs can do themselves with some input from PH and other players.

This interviewee summed up that in addition to questions of timing, it is important to tag health related events onto things that are already happening at the PW. This was also mentioned in other PWs.

Another barrier is lack of funding and capacity, and it is not always guaranteed that support from the local authority will be continuous. Our Hindu respondent told us that:

The thing is—I’ll be honest with you...the cost involved is very important. Because most of our donations come to the temple for religious purposes. But then, you’ll have to convince my committee—look if you are going to spend a

few hundred pounds for this reason, although it came for religious purposes, we don't blindly follow the religion... this is for a good cause.

In addition, some initiatives that have been started in the past have not continued, leaving people with a sense of abandonment. One of our participants suggested that rather than expecting people to an event for one day:

If an organisation is coming to a new area, and they are going to do something for ten or twelve weeks, or something like that—it's a long-lasting and carrying on project—people feel more a part of that. Even though you may have less people attend that over the course of the weeks, there's more trust—it's a relationship building exercise... in order to engage the community and to engage anyone, that you need to build that trust relationship and carry on with those projects.

It would seem desirable to coordinate and set up long term initiatives potentially under the auspices of the proposed network between PH teams, third sector organisations and PWs, ideally linked to a calendar of yearly activities, relevant training/materials, long term commitment from relevant agencies and an associated evaluation procedure.

Barriers that prevent ethnic minorities from engaging with health services can also include:

[T]he location of where the centres are... the times of it... and it doesn't take a lot for someone to get put off... Any hint of racism and...that message will get communicated within the community like wildfire.

And as already mentioned materials produced by health professionals not only need to be translated into relevant languages but also to take on board cultural sensitivities (e.g. no meat or fish on posters sent to Sikh or Hindu temples and no images of people on material for use in mosques).

Some participants were critical of the NHS for not giving enough time for consultations with GPs, for the long time it could take to actually get an appointment with a doctor and for the waiting times for tests and results. **While it is important to take such critiques of the NHS seriously, it may also be the case that some training could be done with PWs about how the health system works and the various constraints it faces so that expectations are realistic.** Nonetheless, people's frustrations with the NHS can result in making them anxious and even less likely to go to their doctor. A number of the Christian settings that we visited in Leeds have 'pastoral teams', members of which visit people from the congregation who are sick, elderly and housebound. During these visits pastoral workers play a critical role in keeping people connected to the churches and social networks and providing psycho-social support, listening to anxieties caused by their illness or worries about the health system, and praying with people. As one of the focus group participants told us:

I think, it's about being proactive, because quite often you're made aware when it reaches the crisis point when someone has got an illness and is in hospital. Whereas, if you can back track and prevent it at an earlier stage, and I think the thing about churches is... you're en mass really, whereas if you got to the GPs it's one to one isn't it and you do feel very much in the spotlight and it is you.

Whereas, if it's, if part of a bigger number of people then the information might get across without feeling too much like it's you in the spotlight.

Existing pastoral support systems could provide a useful site of interaction and intervention for PH to provide capacity building.

4.6.1 Summing up

The aim of this section was to examine both drivers and barriers to the promotion of health in PWs, which builds on the eightfold model of congregational strengths discussed in section 2.2.2. However, although it is important to stress features that make PWs good places to address health, there are also limitations or barriers, including the fact they are often hierarchically arranged in ways that marginalise women's experiences and voices and may not be good locations in which to address issues around sexual and reproductive health. We also discussed barriers to engaging with PH bodies and barriers that people face in accessing health services.

4.7 The attitudes of public health staff with regard to religion and public health practice in places of worship

We were only able to scratch the surface of this area of research and it deserves further attention. An issue that emerged in the focus groups concerned the ways in which PH actors responded to people's faith commitment. One participant told us that when they:

went to the new surgery, and the nurse was asking me questions, I did mention to her that I feel that I'm helped by my faith. She didn't say, "Well what are you talking about?" But I had to let her know that because for me it's a blessing that I don't have to actually run to the doctor often. So for my age, I mean how do I manage to do that because they always say, "are you on tablets, are you on this are you on that?" So I just mentioned well of course sometimes I might get pain, but I pray about it and I'm open and God... You know that sort of thing, so I just said that to her that I do pray sometimes and I don't know whether to come. So what she would have reflected upon that I don't know, she didn't say to me.

Another participant talked about 'a brief encounter with...paramedics. I was surprised because this just happened a few years ago, and I couldn't believe she was praying with me...And I was surprised, and she said, "don't worry God is looking after us." I've never forgotten that day, which was good, so that's why I said you don't know who is walking with god within them and who's not.'

Two other respondents talked about the reassurance that small indications of the faith of hospital staff provided:

I had surgery many years ago, and I remember the one who came before I was to be taken down, one of them in the blue, I don't know what you call them came. But he was whistling Rock of Ages for me, and that really reassured me, I think well if he has anything to do with it, I will get through. You know he had some faith, he was whistling it you know, and I thought that was very good. He did something to me to help me to feel...[Uplifted]...make me trust him yeah.

I myself personally if I'm ill, or admitted to the hospital, it's a special blessing for me if one of the medical staff is, I shouldn't say Christian, but have a faith like I do. And most of the time you can tell, the signs are there.

This may suggest the need for staff from relevant organisations to become familiar with the locally agreed 'Faith Covenant' (see section 1.3) recognising the RHA that PWs can offer and seeking to find a common ground as a way to reduce health inequalities in the city.

We were also interested more broadly in whether our public health interviewees felt that PWs could be appropriate settings for health promotion activities. One question that arose in these interviews was whether PWs are an appropriate location for the delivery of health messages in the UK:

I suppose the other thing is what do people expect to get? You know, is it the right place? And...are people going to expect to hear public health messages, you know, if they go to church, or to synagogue, or to a mosque? Is that what's expected?...If you go to the doctor's, you expect them to talk about [good] health and smoking and weight and all that kind of stuff. But would you expect that within...[a place of worship]?

This interviewee questioned whether people expect health topics to be brought into religious teachings but did feel that PWs can be seen as 'settings' for health interventions where groups can be used opportunistically to talk about health issues (e.g. men's groups to talk about health eating). This need not involve PH professionals, but instead draw upon support from PH to set up systems or to commission work from third sector organisations. Also are PWs necessarily the best place for PH to direct its resources? This interviewee also told us:

I read an interesting thing...[in] one of the Sunday papers. And it was actually saying that Methodists have the greatest life expectancy and tend to be the healthiest...So, is that the best place to put your resource?... If you do go to a place of worship, is it the groups who suffer the worst health that go? Does that vary from area to area...? Thus a decision about whether to engage with PWs probably needs to be done on a case-by-case basis.

In response to this concern, however, one of our suggestions is that there is scope to examine the role that PWs can play in relation to the health of the wider community and not just to those who attend the PW on a regular basis.

The suggestion that engagement with PWs 'probably needs to be done on a case-by-case basis' was also borne out by the MCLASS research (see Box 9). One of the findings here was that while engaging with the mosque and religious leaders in Pakistan around making homes smoke free, this did not work so well in the UK. This does not mean that the mosque is not a relevant setting in the UK for this work but that perhaps a different approach adapted for the UK context needs to be employed.

Our third PH interviewee has had a more successful experience of working with faith groups in Leeds, mosques in particular. However, this has been over many years and with respect to a number of initiatives. Also a follower of Islam, this interviewee had built up a relationship with communities over a longer period of time, going back to the 1990s:

Coming to Leeds back in the 90s [I] worked on a very unique project...joint-financed between the health authority and Leeds Social Services. The rationale for the project was to research inequalities in health of the BME communities (of) that time, and to work very closely with BME communities and the...third and faith sector organizations as part of the overall strategy for Leeds health authority...We actually undertook consultations with some of the Leeds faith community organizations such as the Leeds Islamic Centre, the Hindu centre, the gurdwara, the Leeds Jewish community, the Christian community, et cetera...From the research, we actually produced the then Leeds Health Strategy, looking particularly at...prevalence of diabetes, for example, within a South Asian community; prevalence of sickle-cell thalassemia within the African, Caribbean, Asian communities; the prevalence of higher mental health issues with the black African Caribbean communities; looking at issues on sectioning; looking at...issues around care, et cetera. And the elderly.

This interviewee drew attention to the importance not only of spending time building relationships with communities but also on working with people that were part of minority communities to bridge any gaps between them and public health. The elderly, for instance, in South Asian communities often do not

want people from the outside to come in to look after their loved one...Because it was embarrassing. And also, looking after somebody is part of people's faith...So there's an honour issue there as well, yeah? So that's why people looked after their loved ones at home, as opposed to seeking advice, information, yeah, et cetera. So again, we know, we worked with different religious groups and organizations to ensure that that level of messages went out at that time.

Another example given was of a diabetes working group:

...there was some research done by public health at that time, saying, "What we will do is we will recruit people from our community. We will train them in terms of giving out messages around public health, yeah?" And those people will go back into the community and will then make the communities aware of diabetes, and prevalence of diabetes, yeah? If you look at say, for example, prevalence of diabetes within South Asian communities, type 2, it's higher than (our?) national average. And that's because of lack of information, lack of awareness...there were six individuals that went out into the community...worked with the local mosques; did a lot of seminars, yeah, and [awareness] sessions. And...in terms of gender... there [were] 3 men and 3 women...And the women worked...with the women's group. The men worked with the local mosques.

Another project in particular was noted as a success:

During that time, there were a lot of incidences around drugs [sic] abuse within south Leeds community. And we actually held a seminar within the old mosque...on Stratford Street [Beeston], and we actually got well over a hundred young people attending the actual conference. And the conference was in two parts. One in terms of bringing in professionals [that could] give information, such as myself...But also...[the youngsters had] an opportunity within workshops to actually have their say.

At first it had been difficult to get the mosque involved and the interviewee explained that:

What I did was when I came into Leeds, I did a huge mapping and scoping exercise...and basically went along, spoke to [some of the] so-called leaders and representatives and said, "this is the level and type of work I'm doing"... Some of the mosques have committees, sort of committees that are responsible for allowing that level of research on what... the case may be. So you have to prove the business benefit of the research, what the benefits would be, not just [for] the health perspective, but to the community, and to the individuals. So, I had to present a business case and say, "Look, you know, after this particular research, you can use the analysis to evidence base, yeah, and put business planning in place if you ever want to go...for any kind of grants from [the] local authority."... Plus, obviously, the mosques...for me... being a Muslim, I used to go...for Friday prayers...so they were more accepting. I think I...built up a trusting relationship over time. That, I think for me, that was the main thing. Plus, I met with the committee members, I met with the congregation. I was doing a lot of work with young people there at that time, and they saw that this person is genuine...And (obviously) when we held (the) conference in the mosque, it was through the (committee). It was the committee, I think, some of the committee members were affected by some of their own children being affected by either... [by] drugs.

One project that had benefited from this approach was a day centre for Sikh elders

with the (Gurdwara) in South Leeds and the Gurdwaras in Leeds as well, the (Ramgharia Board)...they identified need (of) the elderly within their community. Again, they got a grant from Leeds City Council to provide that service...20 years now...they provided the service for all 20 years. 'Cause there was...at that time, you'd need (a) pot of money available. Not many people at that time, not many organizations were familiar with the health and social services funding structure.

For this respondent, it was felt that that there were not any barriers to engagement as long as the message and the messenger are the right ones for the context:

The messenger should be somebody that people trust, yeah? The messenger should also [come]... with an open view...The messenger should also look at individuals from that same community and look at public health messages that impact on men, women, young people, people coming into that area as well...if you look at some of the work that I'm doing now, especially the accident and emergency focus groups...at the Leeds Islamic Centre....what I did was...as an introduction, went to the committee, spoke to the secretary. He invited me to meet the Chair of committee of members. I had to present a business plan to them...The secretary...himself had gone through 9 different [episodes] of [taking his daughter] to [A and E]. So he fully understood the problems... and why the South Asian communities were reporting disappointment at [A and E]. In fact, he sold the project to the committee.... And on Friday, after the Friday prayers, yeah, the Imam, right, announced that [there was going to be] two focus groups, and if you have any problems...had any problems with A and E, then by all means come along... So that was really good. We also produced some posters as well... And also, I said that when the report was made available, I would give you a summary of the report.

4.7.1 Summing Up

One issue that generated considerable discussion in the focus groups was the response of PH actors to patients' faith commitments. It was also clear that engagement with PWs 'probably needs to be done on a case-by-case basis'. This was borne out by the MCLASS research (see Box 9) which found that whilst engaging with the mosque and religious leaders in Pakistan around making homes smoke free proved effective, this engagement did not work so well in the UK. This does not mean that the mosque is not a relevant setting in the UK for this work but that the approach needs to be tailored for the UK setting. One of our interviewees had very positive experiences of engaging with PWs in Leeds, but had spent many years cultivating relationships and was also a Muslim community member, which aided engagement.

4.8 To what extent are participants from PWs interested in the development of a local network and eventual guidance document for PWs wishing to become public health settings? Would they like to be part of this?

One of the key objectives of the research was to ascertain the extent to which members of PWs are interested in the development of a local network and eventual guidance document for PWs wishing to become 'health promoting'. We only visited 9 PWs but in each there was support for exploring engagement with PH Leeds further. We did not discuss the content of a guidance document in the interviews as we felt the discussions were at a too much of a preliminary stage. However, this is to be one of the key areas discussed at the event on May 12th 2015, where this report will be 'launched' and a 'faith and health' network initiated. **This points to the need to begin a discussion on RHAs and potential areas of PH activity within PWs. Eventually and depending on a number of factors like need or the demographics of their congregation, PWs will be in a position to determine the exact type health interventions that they can/wish/need to deliver as well as how this could be achieved.**

In the Sikh setting there was a fair amount of activity going on already but there is scope for developing better links with PH. Our interviewee was interested to take this further and particularly emphasised raising the profile of traditional medicine, arguing 'that thing has never been explored properly, and if those things were of any value, I think that they need to be discussed properly and used'. Our interviewee felt that there was also scope for engaging more widely with other gurdwaras in the city on these issues as well as their broader memberships, but that if a consultation was carried out via email or using the Internet this might limit success as levels of Internet use are still relatively low amongst some members of the community.

In the Hindu setting we asked about whether the PW would be interested in taking this further, including the development of an eventual guidance document for PWs wishing to become public health settings. As our PH colleague explained, who was also present at this interview, it would be 'a set of guidelines for all places of worship on how we can work together'. Our interviewee replied that:

Yes, I can do that. We're, as a temple—not only me—even if I'm not here in five years, somebody else will be... The whole idea is that if you work with connection with the health authorities, it's going to effect or help, directly or indirectly, the members of the congregation anyway. So that is the general guideline and philosophy in which I believe. Yes, we can certainly do that, yes.

The thing is—I'll be honest with you. A number of times, the cost involved is very important. Because most of our donations come to the temple for religious purposes. But then, you'll have to convince my committee—look if you are going to spend a few hundred pounds for this reason, although it came for religious purposes, we don't blindly follow the religion... this is for a good cause.

Also in terms of wider consultation with members of the temple, a survey could be circulated to people in various ways – in the newsletter, via email or the Internet, or printed off in different languages and given to people in the temple.

Our mosque representative felt that the mosque could play a role in bridging the gap between local people and Public Health and that future engagement was a positive step:

Yes, absolutely. And also...if you have a captivated congregation, then at least people are dropping in at some point. So, going back to that point... if events were linked into other events that the mosque was already organising...So you have it...a captured audience, and it was appropriate, linked to that, you can plug in these messages, and then people can see material benefit. People can see that they're actually getting something out of it, and then sometimes it catches on. So someone says 'I've been, and found out', and they talk about it, and as a result you hope that other people will get interested.

Regarding finding out attitudes of the wider membership of the mosque this interviewee suggested that the Woodsley road community centre, linked to the mosque, could be a good place to contact people and also to run focus groups to get a community perspective on these issues – about whether or not people think that this is something that they think places of worship should be doing or not.

As already discussed, we gave some thought as to whether to include Buddhism in this study since most of the Buddhist centres and groups in Leeds cater predominantly for 'white British' Buddhists. According to our interviewee 'we identified that there were nine Buddhist groups...I don't think that there were any from the BME Buddhist communities. There aren't Buddhist groups like that, so these were all Western converts, as you say.' The interviewee admitted that when they 'came across this proposal in...[Leeds Faith Forum they]...thought that there isn't very much that we could do' because most of the members of the Buddhist centre are not from BME communities. However, 'when you think about it in another way, who else is going to provide these services to those [BME] communities?...It's a really strong point. That's something that we ought to think about.' While we cannot assume that faith representatives are going to be the best people to serve their needs, there could be a role for Buddhist PWs here. As our interviewee suggested 'for some types of problems, they would probably want to talk to someone who understands what Buddhism is.'

For the Jewish interviewee it was felt that the Synagogues may not be the best place to engage because the Jewish Welfare Board in Leeds is so active, and in any case this BME community is probably not one of the most needy.

Moving onto the Anglican settings, both were interested in exploring engagement with PH further. Our interviewee at St Martin's suggested that Churches would be a good place to trial any initiatives since there were 'lots of willing pairs of hands, especially making food and... hospitality et cetera...' but that if it involved attending activities taking place elsewhere time constraints might make that difficult: 'If you set something up and invited us, then we might be able to go but, on the other hand, I am not sure that I could commit

us to any regular participation'. This echoes similar feelings across the PWs we visited, that initiatives are more likely to be successful if they take place at times when people are already at the PW.

Our interviewee at Roscoe told us that there would be interest in working with public health in the future, stressing 'I think it's quite key stuff, as I said, because theologically, it's just the other side of what we are about really in terms of wholeness. It's the practicalities of what we could do. I would say that fairly significant proportions of my time are given to that sort of dimension.' And also in the Pentecostal setting, there was interest in taking things further. However, our interviewee did say 'the answer is yes, with a caveat...because my primary role is being a spiritual leader here. But that takes on many dimensions, including this one – and it is important. There's competing priorities. So, yes – if it's at an appropriate level, I'll say yes.'

4.8.1 Summing up

Overall the RL's we spoke to were interested in pursuing the possibility of engagement with PH further but with a few caveats that mainly drew attention to funding, time constraints and the fact that running health activities could get in the way of the 'core' business of the PW.

4.9 Conclusion

The above discussion has presented the analysis of the interviews and focus groups we carried out and was organised into different sections in order to address our main research questions:

1.5 Research questions to be addressed in the qualitative research:

RQ1: Who uses the PWs visited: what is their age, gender, ethnicity and how far do they travel?

RQ2: What are the characteristics of the PWs visited? What general activities do they engage in beyond purely religious activities; how are they organised and who makes the decisions; and what is the role of the 'religious leader'?

RQ3: What are the main health issues facing congregations/members of PWs according to our interviewees/focus group participants?

RQ4: What activities have been undertaken around health, including how these are funded/supported, and the nature of any previous engagement with PH professionals and third sector organisations?

RQ5: What is the role of religious teachings and practices in health promoting activities?

RQ6: What are the drivers and barriers to the promotion of health in the PW, including barriers to engaging with PH bodies, barriers that people face in accessing health services and how might these barriers be overcome?

RQ7: What are the attitudes of public health staff with regard to public health practice in places of worship?

RQ8: To what extent are participants from PWs interested in the development of a local network and eventual guidance document for PWs wishing to become public health settings? Would they like to be part of this?

In the following section of the report we present our conclusions and recommendations.

5 Moving forward: conclusions and recommendations

5.1 Introduction

The aim of the research was to understand the ways in which PWs could play, or already do play, an important role in dealing with health issues that face BME community members in Leeds. In order to do this we undertook a scoping study to help Public Health Leeds better engage with BME communities in order to achieve the coordinated delivery of public health activity through a network of places of worship (PWs) across the city, working closely with religious leaders and congregations. The research will also contribute towards developing guidance on practical steps that PWs can take to become public health settings. The need for this research emerged out of the recognition that BME communities in Leeds, 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 settings for public health activity, 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, as well as in Europe more broadly, has to date been little developed. This project has sought to address this lack by initiating a process that explores the feasibility of PH Leeds engaging more closely with places of worship in the city and by developing 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.

5.2 Conclusions

As outlined at the start of this report, the main objectives of this research 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 prevalent health concerns within certain religious and/or ethnic groups in order to explore whether places of worship could play an important role in dealing with those specific health issues.
3. To begin to identify, scope and utilise relevant data sets suggesting correlations between the quality of health in different locations across the city and people's religion and ethnicity to support objective 2.
4. To find out what RLs they know the about the health and well-being needs of their members and/or the local communities.
5. To discover the attitudes of local 'religious leaders' (RLs), 'congregations' and public health (PH) staff in Leeds with regard to PH practice in places of worship.

6. To record PH activity at PWs in order to document successful and innovative practice.
7. To explore the potential of working with PWs to inform the development of a local network and eventual document for PWs that wish to become public health settings.
8. To generate interest and ownership from relevant stakeholders including RLs and relevant staff in PH.
9. To make a series of recommendations.

Objective 1 (to contextualise the research undertaken on this project against the backdrop of 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), are tools for identifying and capturing 'religious health assets' in the development of an asset-based participatory research model - 'participatory inquiry into religious health assets, networks and agency' (PIRHANA; see Box 6). **It is feasible that a next step for our project might involve the development of a tool similar to this one that could be used within PWs to map their RHAs as a basis for communicating with PH about what assets they have and where capacity needs to be developed.**

We looked 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 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. 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 prevalent health concerns within certain religious and/or ethnic groups in order to explore whether places of worship could play an important role in dealing with those health issues specifically) and **objective 3** (to begin to identify, scope and utilise relevant data sets suggesting correlations between the quality of health in different locations across the city and people's religion and ethnicity to support objective 2) are both addressed in section 3 of the report. While here we explored how 'big data' might be used to address objective 2, in section 3 we explored this by asking people's views during interviews and focus groups.

First we examined Census data from 2011, which indicates a fairly close correlation between ethnicity and particular religious traditions within some BME groups. This could suggest that if certain BME groups experience a high prevalence of key health issues then PWs may be a suitable place to address them. While this could appear to lend support to the view that PWs might be a suitable place 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 Leeds. **This could be a useful project to be carried out,**

possibly by PWs themselves with support from the research team, PH Leeds and Informatics at Leeds City Council.

The second data set we looked at to attempt to draw some links between the prevalence of certain health conditions in particular areas of Leeds, and the role that PWs might play in addressing them, involved data from the National General Practice Profiles. We wanted to explore how we might develop a method for identifying and then potentially targeting PWs (in a sensitive and appropriate manner) in areas where there exists a high incidence of particular priority health conditions. The plan was to use this data to identify GP surgeries in Leeds in areas with large BME populations and with high incidences of obesity, depression, diabetes and smoking and then to locate nearby PWs that could be targeted and where health initiatives could be delivered. A limit of this approach is that we cannot be sure that those who attend the GP surgeries are those who attend the local PWs or indeed that they are the ones living with higher rates of those conditions identified. We concluded that **future work would need collaboration with quantitative researchers used to working with 'big data' in the relevant areas of health and deprivation, as well as ethnic and religious affiliation.**

Objectives 4 (to find out what RLS know about the health and well-being needs of their members and/or the local communities), **5** (to discover the attitudes of local 'religious leaders' (RLs), 'congregations' and public health (PH) staff in Leeds with regard to PH practice in places of worship), **6** (to record PH activity at PWs in order to document successful and innovative practice), **7** (to explore the potential of working with PWs to inform the development of a local network and an eventual guidance document for PWs that wish to become public health settings) and **8** (to generate interest and ownership from relevant stakeholders including RLS and relevant staff in PH) are all addressed in section 4 where we present the findings from the interviews and focus groups. The qualitative research was designed so as to answer a series of research questions (RQ 1-8).

RQ1: Who uses the places of worship that we visited: what is their age, gender, ethnicity and how far they travel?

- **Sikh:** gurdwara attracts around 300 people at weekends and 1000 on special days and like other gurdwaras in Leeds it is in a deprived area. Many who use it do not live nearby but have moved away, particularly the young. It attracts families who are of South Asian origin
- **Hindu:** Until recently there was only one Mandir for the city (whereas there are 7 gurdwaras). It attracts families and people do not necessarily live nearby as it caters for many different Hindu groups.
- **Muslim:** 20-80 people attend prayer during week and they are mainly older as they are not at work. On Friday prayer up to 700 attend and the ages are more mixed. Most people live nearby but others come from North Leeds where there is no mosque.
- **Buddhist:** This is a small community centre attracting mainly 'white' converts who are middle class. It mainly attracts adults and people do not tend to live in the catchment area of centre which is in central Leeds
- **Jewish:** This is an older more settled minority group and is more affluent than the others. There is a stronger Orthodox tradition in Leeds than Reform (7 Orthodox synagogues and 1 Reform).

- **Christian:**

- Moor Allerton and Shadwell Parishes: St Barnabas, St Paul's, and St John's, 98% White British. St Stephens is in a more deprived area and is much more mixed with Caribbean and African congregation members.
- St Martin's in Potternewton: 80% of the congregation from the Caribbean, 80% of those are from St Kitts and Nevis. It has a mainly elderly congregation, with grandparents bringing children but few families or people in 30-50 age group attending. It comprises a older congregation who live nearby, while the younger members have moved away.
- Roscoe Methodist Church: It has a congregation of about 100 people with the vast majority of those of Caribbean heritage with many from St Kitts and Nevis. People also come from Nigeria, Ghana, Zimbabwe, Cameroon and Zambia. Trinity [United Church] has 50-60 people and is a bit more diverse with fewer Kittisians and Nevisians, a lot more Jamaicans, and a lot more Zimbabweans. It has more younger members in the 20-30 age group due to the Zimbabweans. Otherwise, both congregations are mostly older/elderly (60+) and people tend to live near to the churches.
- New Testament Church of God: It has a congregation of around 300 with 29 nationalities from different places in Europe, as well as many of the African and Caribbean countries. People come from a range of socio-economic backgrounds.

RQ2: What are the characteristics of PWs we visited? What general activities do they engage in beyond purely religious activities; how are they organised and who makes the decisions; and what is the role of the 'religious leader'?

This theme/heading is essentially concerned with the *mapping of broad religious 'assets'* possessed by a particular PW and the ways in which these could be harnessed towards activities that are focussed on health education or engagement. What are the premises like that the PW uses? What types of activities does the PW engage in beyond those that focus on religion and how is the PW structured and organised? Although we began the research planning to interview 'religious leaders' it soon became clear that this means different things in different religious settings, and the 'religious specialists' may not be the ones directly involved in outreach and any related work on health. A set-up where the religious specialist is more-or-less 'in charge' of the overall running of the PW and all its activities seems to be *more likely* within a Christian setting than the other faith traditions we visited. For instance, the religious specialist in the gurdwara who recites the texts typically does not get involved in organising non-religious events. The discussion highlighted the broad types of 'assets' that PWs have and how this might vary between and within different faith traditions. **An exercise where the broad religious assets possessed by a PW are assessed, could be carried out by PWs themselves, with support from PH, to contribute towards developing greater opportunities for collaboration.**

RQ3: What are the main health issues facing congregations/members of PWs according to our interviewees/focus group participants (Which health issues are highlighted by the statistics as those most affecting particular communities)?

This theme/heading drew attention to the role that PWs could play in carrying out a 'health needs analysis' of members or congregations as an important step to being

able to better coordinate with PH agencies in Leeds. Questions included: What are the main health issues facing those who use the PW? Do they vary by age and gender? What gives rise to them (e.g. culture, lifestyle, genetics, poverty etc.)? The discussion highlighted that the kinds of illnesses that PWs' members or congregations suffer from may vary between different ethnic and religious communities, linked to lifestyle and sometimes genetics. Most of the conditions raised, however, were age-related partly because more elderly people attend PWs but at the same time are more likely than younger generations to suffer ill health.

RQ4: What activities have been undertaken around health, including how these are funded/supported, and the nature of any previous engagement with PH professionals?

This theme/heading offered an opportunity to look at examples of best practice and what has worked well, and specifically to begin to collect evidence of the 'religious health assets' (RHAs) owned by different PWs. We demonstrated some in which PWs in Leeds already engage with health related activities, but noted that these events are more likely to have been initiated by the PWs themselves, and direct engagement with PH has to-date could be stronger and better coordinated. In terms of the RHAs that a PW has these may also be available for the wider community and not the members or the congregation alone. This was a topic discussed in one of the focus groups: 'So if something is public, a service is set up here and people are aware of it, whether they're a member of the church or not they will be able to access it. And members of the church also will be able to.' **We recommend that this is worth exploring later in the next stage of work.**

RQ5: What is the role of religious teachings and practices in health promoting activities?

This theme/heading was an opportunity to focus in on a particular type of RHA (religious health asset): namely, religious teachings/theologies and practices. These are often more intangible than those RHAs above yet nonetheless play an important role and ways of capturing their impact should be put in place. Religious understandings of health can often differ from bio-medical ones and sometimes this can actually put people's health and well-being in danger. Finding ways of dealing with this in a sensitive manner is important if PH Leeds is to engage more closely with PWs around health education and delivery. However, religious teachings and practices can also be highly constructive in supporting people with health concerns, for instance through the practice of meditation and prayer as well as the role that religious teachings could play in behaviour change. It is important though not to overestimate the role of religious teachings. Often they do not clearly provide support to particular health practices (e.g. not smoking). Moreover, it should be recognised that there is frequently a gap between values and action.

RQ6: What are the drivers and barriers to the promotion of health in the PW, including barriers to engaging with PH bodies, barriers that people face in accessing health services and how might those barriers be overcome?

The aim of this section was to examine both drivers and barriers to the promotion of health in PWs, which builds on the eightfold model of congregational strengths discussed in section 2.2.2. However, although it is important to stress features that make PWs good places to address health, there are also limitations or barriers, including the fact they are often hierarchically arranged in ways that marginalise women's experiences and voices and may not be good locations in which to address issues around sexual and reproductive health.

RQ7: What are the attitudes of public health staff with regard to religion and public health practice in places of worship?

We were only able to engage superficially with this area of the research and it deserves further attention in the future. One issue that generated interest and discussion in the focus groups was the ways in which PH actors responded to people's faith commitments. **This points to some useful research that could be done around PH attitudes towards and engagement with personal religiosity, either the PH actors' own or those of the patients.** It was also clear that engagement with PWs 'probably needs to be done on a case-by-case basis', as borne out by the MCLASS research (see Box 9). This research found that whilst engaging with the mosque and religious leaders in Pakistan around making homes smoke free proved effective, this engagement did not work so well in the UK. This does not mean that the mosque is not a relevant setting in the UK for this work but that the approach needs to be tailored for the UK setting. One of our interviewees had very positive experiences of engaging with PWs in Leeds, but had spent many years cultivating relationships and was also a Muslim community member, which aided engagement.

RQ8: To what extent are participants from PWs interested in the development of a local network and eventual document for PWs that wish to become public health settings?

One of the key objectives of the research was to ascertain the extent to which members of PWs are interested in the development of a local network and eventual guidance document for PWs that wish to become public health settings. We concluded that **there should be a consultation process that involves a more detailed look at the type of health interventions PWs would value and could feasibly become involved in, how they would like to be involved and what a potential guidance document might look like.** All the RLs we spoke to were interested in exploring engagement further albeit with some caveats: it is important for PH to recognise that health is not and cannot be the primary business of a PW. This has implications for the funds and time that PWs can themselves dedicate to health work. However, they all stressed that in important ways public health was fundamental to the broader aims of the religious traditions they represented.

Our **9th and final objective** (*to make a series of recommendations*) is taken up in the following section.

5.3 Recommendations

1.3.1 There is a need for better coordination: Overall our research has revealed a **limited engagement** between PWs and public health teams in Leeds. Where there exist examples of collaboration between PWs and external organisations around issues of health, these tend to have been facilitated by third sector organisations (rather than public health teams) already working within the community, although many of these initiatives are commissioned by PH. In the context of their community work, these third sector agencies have engaged local PWs to capitalise on their various 'health assets', including their: convening capacity, ownership of public halls/space; and access to particular audiences. Whilst there is evidence of activities (for example the Touchstone/New View work around mental health, see Box 10), very few formal PH activities have been initiated by the PWs themselves

(an exception would include the prostate rallies organised by the NTCG (New Testament Church of God), the Dementia services at St. Martin's or the Diabetes event at the Hindu Temple). There is little, if any, coordination between public health providers, third sector agencies and PWs. **The issue of coordination between different agencies and PWs is critical to successful learning and collaboration. This could also include the development of a local 'health and religion' network and a guidance document for PWs that wish to become public health settings. This is an area where PH Leeds could play a valuable role.**

- 1.3.2 PWs need to take ownership of any PH work in which they engage:** Enabling PWs/RLs to recognise the significance/value of engaging in collaborations around PH requires work by PH agencies with faith leaders and the facilitation of encounters between PH agencies and PWs. It is by no means self-evident to all religious leaders that PWs have a responsibility to the PH needs of their constituent members. **Mobilising and sensitising RLs about the value of PH work is another area where PH Leeds has a role to play. In the longer term, a coalition of PH and engaged religious leaders could intentionally lead training and sensitisation work with religious leaders/congregations.**
- 1.3.3 There is a need for sustainability:** Any commitment by PH Leeds to facilitating/coordinating work in PWs needs to be strategic around issues of **sustainability** so communities and PWs can take ownership of any PH work that they embark upon but 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 PWs are consistent presences in communities makes them particularly valuable as settings for PH work, yet resources/commitment by PH Leeds need to be long term enough to facilitate community ownership and longer term sustainability. The Black Health Initiative was suggested as a good example of working practice.
- 1.3.4 Supporting research/data gathering that needs to be done:**
- i. Mapping of PH activities in Leeds and their current or potential engagement with PWs:** 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 Leeds. Once identified, these activities need to be evaluated for potential application in or engagement with local PWs. It may also be the case that some identified activities already engage with PWs. Such an evaluation will need to take into account: relevance for the PW audience based on membership/congregation profile; fit with the existing priorities of the PW; appropriateness of any topic for engagement within the PW (as opposed to another community venue. See point 1.3.5 (3) below). Given that many third sector agencies are at the forefront of PW/PH engagement, further research to better understand their experiences in both programme/intervention delivery in PWs and in interpreting/managing the relationships between communities and PWs would be highly valuable.
 - ii. Audit of third sector activities that are faith based and have been supported by PH Leeds.**

- iii. **Gathering data on the demographics of who attends PWs in Leeds:** In order to be able to conclude that one way of addressing BME health problems is via PWs it would be useful to have data that told us who attends PWs and where they live. PWs could gather this information themselves with support; a possible partner for this could be LCC Informatics.
- iv. **Gaining a better understanding of how health initiatives in PWs could also benefit the wider community:** Even if BME attendance at PWs is not as high as might be expected, health initiatives that are run in PWs could also benefit local people who do not attend that particular PW. We recommend that this is worth exploring in the next stage of the work.
- v. **Carrying out 'health needs assessments' in PWs:** Generally, congregant leaders and members recognised many of the specific health issues facing their congregations. **'Religious leaders' could benefit from support in carrying out a systematic Health Needs Assessment (HNA). This is one of the areas where Public Health Leeds could make a contribution.**
- vi. **Identifying 'religious health assets' in PWs:** We identified a number of 'religious health assets' across the PWs. 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 (a good example is that of St Martin's Anglican Church which worked with Touchstone to facilitate a more open dialogue around mental health). Another asset mentioned by many congregations was 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 similar to this one that could be used within PWs to document their RHAs as a basis for communicating with PH about what 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. This is another area where Public Health Leeds could offer support.**
- vii. **There is also a need for some reflect on whether the work undertaken at the IHP at the Carter Centre on the eightfold model of congregational strengthens is actually specific to Christian American Congregations and whether it could be adapted for other settings and faith traditions would be very valuable.**
- 1.3.5 Site specific analysis for PWs:** Our research suggests that there are a number of broadly recognisable trends that relate to particular traditions but also others that are relevant across traditions. Within most of the PWs we visited, the age profile means that there is often awareness of and focus on the health needs of the elderly (e.g. including a dementia friendly café run by Trinity or the Sikh Elders Service). Also, as we have outlined in our section 2.4, particular ethnic minority congregations are adversely affected by a number of diseases including diabetes, heart disease and prostate cancer. Some work has been done in PWs in neighbourhoods with particular disease profiles to raise awareness in relevant areas.

However, whilst there are identifiable broad trends, we stress that the research focus on PWs has revealed the need for **contextual analysis** ahead of any PH

engagement to understand what assets a PW might have and how effective they might be in the area of PH. The PWs considered within this study vary widely from faith to faith, tradition to tradition and institution to institution in ways that impact on their efficacy and interest in the field of PH. The diversity from PW to PW requires a site - specific analysis.

More generally, a contextual evaluation to assess the suitability of the fit between a PW and PH needs to take account of the following findings:

- 1) Leadership - Religious specialists do not always occupy the same roles in PWs. 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 focus solely on ritual aspects. Even within traditions where formation assumes 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, dependant 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 institution-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 of their role in such a way.
- 2) Intentionality and capacity – collaboration between PH and PWs requires intentionality on the part of a PW's leader and congregation. It cannot be assumed that PWs should be involved in PH work. Any response needs to be *intentional* on the part of the PW 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 PW as to why PH work is a relevant and important area for engagement. Given that much of the everyday work of PWs is done by volunteers and lay people, there needs to be recognition and interest by ordinary congregants and it would be useful for the PH network to highlight, evidence and demonstrate the potential benefits of this approach.
- 3) Appropriateness – There is a wide diversity between both different faith traditions and different PWs within any one tradition regarding the range of PH discussions/interventions that might be approached. In the situational analysis of a PWs suitedness to host particular discussions/activities a number of factors must be taken into account:
 - a. How is the PW 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 aging 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 PW 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 understated. 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 PW activities are organised and for whom they cater. A PW 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 the 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 in the NTCG. By utilising existing group meeting structures, PH agencies can capitalise on the convening power of PWs.
- 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 PW but also the constituent congregation, so taboo issues may differ from PW to PW even within one faith tradition. For example, it is widely recognised that many (though not all) PWs in the UK find it difficult to engage discussion/interventions about sexual behaviour and sexuality. Another area that was mentioned in this research 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.

1.3.6 Facilitation of collaboration between PH and PWs: The PWs consulted in this research 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 PWs 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 types of health interventions that PWs would value, how they would like to be involved and what a potential guidance document might look like. At present, the interviews and focus groups give the impression that currently public health is understood in terms of 'talks'. 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 longer term sustainability.**

It is critical that any intentional, coordinated collaboration between PH agencies and PWs entails a situational analysis (of PW and neighbourhood) that maps out where and how any PW 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 responsibilities to PH and PWs, and would require coordination and resourcing by PH Leeds.

5.4 PH responsibilities might include:

1. **Resources:** Exploring a variety of PH opportunities for PW and how existing commissioning arrangements could encourage and enable third sector organisations to engage with PWs where appropriate.
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 PWs 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 training with PWs 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) Ensuring that leaflets/messages pertaining to relevant health concerns which are targeting PWs are culturally appropriate.
3. **Co-ordination:** i) of a local 'faith and health' network; ii) of a consultation process about the design of a guidance document for PWs that wish to become public health settings; iii) through a consultative process facilitated by Leeds Faith Forum and PH Leeds, we recommend the identification of interested and capacitated PWs that are willing to engage in a pilot process, supported by PH Leeds. 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 Leeds and their current or potential engagement with PWs; ii) An audit of third sector activities that are faith based and have been supported by PH Leeds; iii) Work with PWs to gather data on who attends PWs in Leeds 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 PWs; v) Getting a better understanding of how health initiatives in PWs could also benefit the wider community.

5.5 PW responsibilities might 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. PH coordination can facilitate this engagement between sectors (PH).

2. Once the 'theological' case has been made to congregants/members, and health recognised as a priority area for the PW, 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/PW 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 be undertaken to identify 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 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 Leeds can provide information about relevant local agencies. Work might also need to be done by the PW on the relationship between the profile of the congregation/membership who regularly attend the PW and that of the neighbourhood in which the PW 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 PW and the demographic profile of the surrounding community. There currently exists no data on who actually *attends* PWs in the UK (and whether attendants reflect the characteristics of the neighbourhood profile). This is a gap that work by PWs 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 PW space might facilitate 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 PW and would open up possibilities for deeper collaborative work and the mobilisation of individual, congregational and community health assets in a coordinated way.

5.6 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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7 Appendix 1 Identifying Religious Health Assets

Why 'assets'?

The language of assets is commonly used in community development work to help individuals and communities to think about growth, change and action. It is widely recognised that to focus on what communities have (their assets) rather than what they do not have (their needs and problems) fundamentally alters the way that individuals and communities think about themselves – inspiring them to conceive of themselves as agents who can generate change, rather than victims of the situations they may find themselves in.

What are '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 wellbeing and to help to reduce health inequalities. These assets can operate at the level of the individual, family or community and population as protective and promoting factors to buffer against life's stresses” (Morgan and Ziglio, 2007; p.18).

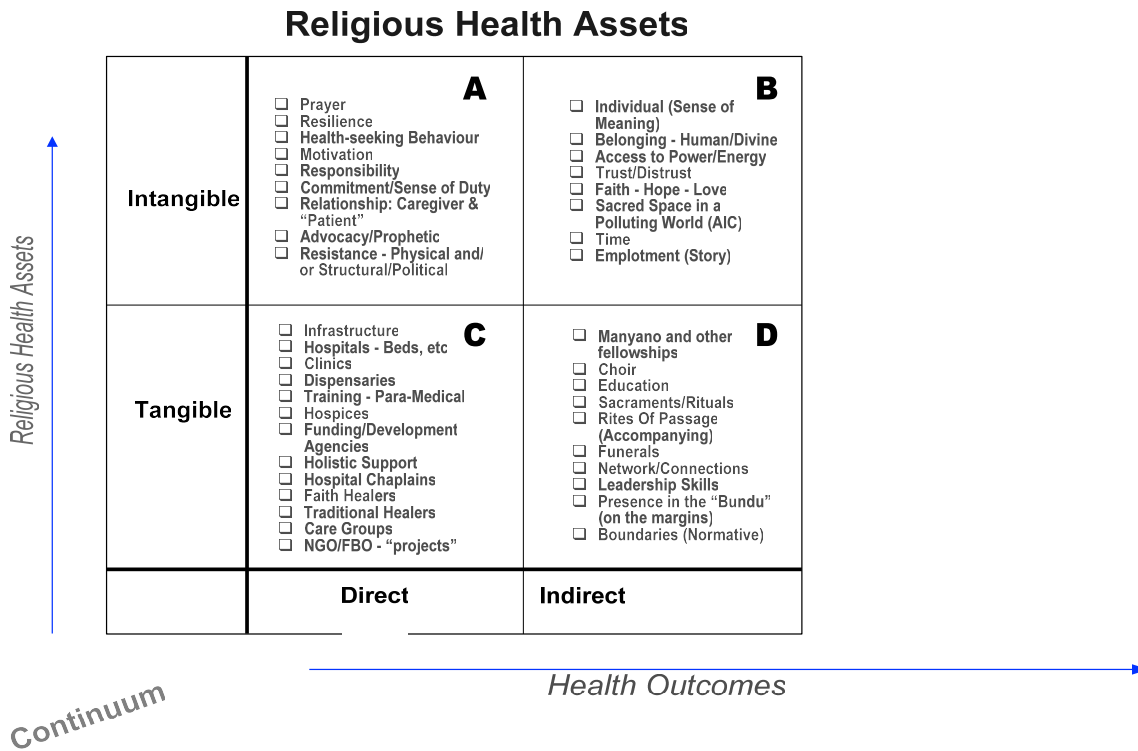
Assets include the following:

- 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).

However, although health assets 'exist' within different settings, they are not necessarily recognised or used 'purposefully or mindfully'. They could also be 'leveraged and utilised' more effectively and consciously. An important first step is to develop a way to identify the 'religious health assets' present within a place of worship. There may be some common types of RHA that exist across religious traditions or within particular traditions, but these may also vary down to the level of individual places of worship.

One approach to identifying RHAs has been developed by the African Religious Health Assets Programme (ARHAP) and is depicted in the following figure:

The “ARHAP Theory Matrix:



A key feature of the work of ARHAP has been to support communities to carry out assessments of their ‘religious health assets’. 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. The matrix is not a scientific tool but can be used as a guide to thinking about and recognising the kinds of assets that may be held by places of worship. The question ‘What kinds of practice contribute to health?’ might be useful in stimulating deeper thinking about the things that a place of worship or faith tradition already has/does that contribute to the wellbeing of congregations. Below we present a blank matrix that can be filled in by members of places of worship.

Religious health assets matrix		
Tangible		
Intangible		
	Direct	Indirect

8 Endnotes

¹ <http://www.hematology.org/Patients/Anemia/Sickle-Cell.aspx>

² www.faithandsociety.org/covenant; www.faithaction.net/2015/03/05/leeds-council-signs-covenant-today/

³ '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).

⁴ http://www.fph.org.uk/what_is_public_health

⁵ http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/

⁶ <http://www.who.int/bulletin/volumes/86/10/08-031008/en/>

⁷ Formed in 1997 between the IHP and five US universities (<http://www.cartercenter.org/news/documents/doc782.html>)

⁸ <http://interfaithhealth.emory.edu/about/index.html>

⁹ <http://interfaithhealth.emory.edu/about/History.html>

¹⁰ http://www.irhap.uct.ac.za/about_history.php

¹¹ <http://stakeholderhealth.org/promising-practices-mapping/>

¹² If this matrix were to be used in Leeds, it would need to be adapted in consultation with local faith communities and PH professionals. For instance, some obvious elements may be missing (e.g. pilgrimage) and there may be alternative views about whether particular assets are tangible or intangible.

¹³ <http://www.neweconomics.org/projects/entry/five-ways-to-well-being>

¹⁴ http://b.3cdn.net/nefoundation/8984c5089d5c2285ee_t4m6bhqq5.pdf

¹⁵ <http://www.corab.org.uk/background-information>

¹⁶ <http://dash.sphsu.mrc.ac.uk>

¹⁷ ONS, <https://www.nomisweb.co.uk/census/2011/lc2201ew>

¹⁸ <http://www.leeds.nhs.uk/phardata/atlas/ChooseAnMSOA/atlas.html>

¹⁹ <http://www.leeds.nhs.uk/Mapping/JSNA/Atlases/PDF/Chapeltown.pdf>, p. 5

²⁰ <http://fingertips.phe.org.uk/profile/general-practice>

²¹ <http://systems.hscic.gov.uk/data/miquest>

²² <http://www.leedsfaithsforum.org>

²³ <http://mosques-map.muslimsinbritain.org/maps.php#/mosque/932>

²⁴ Figures derived from Table 2

²⁵ <http://www.jamyangleeds.co.uk>

²⁶ Ratnasambhava Kadampa Buddhist Centre, NKT (<http://meditationinleeds.org>); Jamyang, Tibetan (Geluk, FPMT) (<http://www.jamyangleeds.co.uk>); Leeds Buddhist Centre, Triratna (<http://leedsbuddhistcentre.org>).

²⁷ <http://www.leedsjewishcommunity.com/about.html>

²⁸ <http://www.leedschurches17.org.uk/st-barnabas-3>

²⁹ <http://www.stmartinleeds.org.uk>

³⁰ <http://www.leedsnandemethodist.org.uk/roscoe.php>

³¹ <http://www.jamyangleeds.co.uk>

³² <http://www.leedschurches17.org.uk/outreach-mission-and-care>

³³ <http://www.leedsnandemethodist.org.uk/roscoe.php>

³⁴ <http://www.leedsnorthccg.nhs.uk/your-health/staying-healthy/stopping-smoking/resource-pack-for-muslim-teachers/>;

<http://www.tevv.nhs.uk/Global/Conferences%20and%20workshops/Spirituality/spirituality%202013/wrkshops/Addressing%20depression%20in%20Muslim%20communities.pdf>;

<http://www.tevv.nhs.uk/Global/Conferences%20and%20workshops/Spirituality/spirituality%202013/workshops/Fusion%20therapy.pdf>

³⁵ <http://www.york.ac.uk/healthsciences/research/public-health/projects/mclass/#tab-1>

³⁶

<http://www.leedssouthandeastccg.nhs.uk/Downloads/Your%20health/Smoke%20free%20homes%20i%20mams%20resource%20pack/Smoke%20Free%20Homes%20guide%20for%20Muslim%20religious%20teachers.pdf>

³⁷ <http://www.ljwb.co.uk>

³⁸ <http://www.ljwb.co.uk/home/about-ljwb/mission-statement/>

³⁹ Reproduced from www.touchstonesupport.org.uk/wp.../11/New-View-Project-Outline.pdf; see also <https://newviewproject.wordpress.com/>; see

<https://newviewproject.files.wordpress.com/2014/10/worship-pack-1-new.pdf> for link to the worship pack

⁴⁰ <http://www.fgfleeds.org>

⁴¹ This was the focus of one of the chapters of WHO 1975.