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Developing Community Health and Cohesion Through Diversity: An Evidence Synthesis for Faith-Based Agencies

Geoffrey Meads and Amanda Lees

Additional information is available at the end of the chapter

<http://dx.doi.org/10.5772/intechopen.77974>

Abstract

Aim: This chapter examines the relationship of increasing sociodemographic and organisational diversity to community health development. The particular focus is the contribution of faith-oriented agencies to the processes of community cohesion required to underpin public health improvements.

Context: The background is of rapid growth in the number of economic migrants and political refugees, their mobility and the impact on formal healthcare services seeking to constrain demand. Globally, a need to extend informal and non-statutory interventions, which promote public health, has been recognised.

Methodology: A narrative evidence synthesis was undertaken drawing on research literature and policy documents. Themes emerging were then applied as criteria to elicit key messages from a series of local case studies and service evaluations. The synthesis was undertaken in response to the following two research questions: ‘(How) can spiritual actors and agencies promote relational integration in both new communities and those with rapidly increasing cultural and demographic diversity?’; ‘Which models of well-being practice are most appropriate for faith-based contributions to community health development in settings with such (increasing cultural and demographic) diversity?’.

Findings: The evidence synthesis confirms the potential benefits of and for spiritual agencies especially, in respect of creating communities with identities built on more open communication systems and socially interactive networks.

Conclusion: The topic summary is used to scope a future research agenda in which the profiling of different relationship networks and their development processes is indicated as a priority.

Keywords: diversity, community health, cohesion, faith, social enterprise, Winchester

1. Introduction

In this chapter, we will explore some of the issues for public health that arise as a result of the rapid expansion in frontline well-being practices. This recent growth is a modern global phenomenon, associated with the common requirements of formal healthcare institutions for alternative sources of demand management and the equally urgent need to accommodate new migrants effectively into domestic economies. For public health the Marmot Reviews, and their endorsement by the World Health Organization in 2008 [1, 2], effectively legitimised the modern shift towards more pluralistic approaches. The independent sector, in a myriad of different formats, is recognised as an essential participant. Globally, it has now become a key partner for statutory public authorities through its contributions to health improvement and reductions in health inequalities. While recognising this international context, not least for the purposes of comparative evaluation and transferable learning, the following pages will, however, largely rely on research undertaken specifically for local agencies within the UK.

Of these local agencies, faith-based organisational initiatives have been most significant. These have been especially apparent in the county of Hampshire and the Winchester Diocese of the Church of England, where our Health and Wellbeing Research Group is located. The growth in the range and scale of wellbeing practices is inextricably linked to a policy of the Anglican Communion which seeks to take advantage of novel organisational options for 'missional social action'. At the heart of such 'action' is the expression of Christian values to promote community wellbeing in locations where social need is seen as most acute. In line with this policy, every one of the 127 parishes in the diocese, since 2014, has been required to identify a shortfall in community health and to bring forwards a social enterprise development in response. The result has been an unprecedented growth in voluntary services dedicated to community wellbeing [3].

While 100 plus Good Neighbour befriending schemes and up to 40 food banks are the most obvious examples in the diocese of the new faith-based social enterprises, the latter have also been characterised by a new diversity, including such as a young persons' beach night club and a rural property mediation service. This creative organisational diversity has developed in parallel with the increased sociodemographic diversity of the local communities themselves. This diversity, derived principally from the growth in economic migrants, has itself produced new wellbeing practices, with the expansion in modes of pilates, personal training and massage services the most obvious illustrations of this trend. The overall effect is captured in the changing profile of the High Street, where the concept of wellbeing now rivals that of hospitality in its practical expressions. Together, it is not uncommon for them to provide well over half of the service outlets and shops, with international exemplars in cities such as Melbourne pointing to the future scope for further growth through psychologically oriented interventions that include slumber, stress relief and a variety of counselling clinics and remedial muscular support services, such as myotherapy and naturopathy [4].

These two formative structural influences of both increased social enterprise and social mobility have helped to shape our research agenda over the past 3 years. A series of local

evaluations and evidence syntheses have been undertaken, particularly for Christian charities and senior clergy. This chapter itself follows on from a request from two diocesan leaders in the Winchester area for guidance in relation to the research evidence and its possible applications in two types of locality where new diversities are apparent: major new housing settlements and neighbourhoods with long established cultures confined to those with white middle-class backgrounds. Both the two research commissioners are keen to discover 'new opportunities for community cohesion from diversity' and thence for enhanced public health.

This interest in new topics from those looking to augment divine revelation with empirical research findings is matched by our own professional researchers' interest in identifying new ways of data capture and analysis that will support the increasingly pluralistic approaches to public health practice. How, for example, can research help identify which profiles of wellbeing practices effectively enhance community cohesion and public health in different types of suburb? Do more diverse neighbourhoods develop distinctive and different relational networks and informal resources to support wellbeing?

Given our personal study interests, this last question is of particular significance to us as a subject in respect of those in the first and last years of life: those 'growing up' and those 'growing down'. As health science students, we have been very aware that, even in public health research programmes, it is trial-based methodologies that still hold sway, notwithstanding the shift to cluster and cohort studies and natural experiments. Such methodologies do seem to struggle with issues of context and communication. Trials do not identify the emergent and sometimes implicit values of newly diverse localities. Their fixed intervals for data collection are not well suited to an informed understanding over time of the very old and very young, who often simply cannot comply with standard written or oral scientific research requirements. Yet, it is such groupings as these which constitute the litmus test for verifiable developments of community cohesion through diversity.

This leads us to the purpose of this chapter. In the UK we hear quite a lot of talk to the effect that the changes in the health system amount to 'a return to the Victorian days' of the nineteenth century, in effect a 're-emerging' public health issue. The implied negative message is one of the clocks being turned back to times when state welfare policy was not universal and churches were the last resort safety nets for the poor and disadvantaged. This perspective points now to a new paternalism, ultimately designed to sustain established elites. But this is not where we are coming from. Our aim here is firmly within the policy framework espoused by the British NHS, which invariably emphasises 'equality and diversity', as demonstrated in the policy document extracts and references provided later in this chapter. These two principles are presented not just as inseparable but interdependent. Accordingly, our aim here is to present research findings which offer the potential to promote public health in communities characterised by diversity. Behind this aim is the aspiration that equivalent positive co-contributions in these communities from their different and distinct members become seen as standard habitual behaviour and normative as a result. For institutions such as the Church of England with its deeply embedded hierarchies, this can be especially challenging. This can be true for those in leadership positions within the Winchester Diocese,

particularly given its strong pastoral care traditions across Hampshire. And, this can be true for their counterparts elsewhere.

2. Methodology

Through the detailed discussions with the diocesan leaders referred to above, the following research question was defined for the initial literature review:

‘(How) can spiritual actors and agencies promote relational integration in both new communities and those with rapidly increasing cultural and demographic diversity?’

The discussions revealed an awareness that there could be risks as well as benefits in such a promotional role. Christian leadership and community health were certainly not taken to be synonymous. Notwithstanding this understanding, the assumption that the review would produce some positive findings led to a second supplementary research question. This is as follows:

‘Which models of wellbeing practice are most appropriate for faith-based contributions to community health development in settings with such (increasing cultural and demographic) diversity?’

The findings in this chapter are from two sources. First, we detail those from a structured background literature review undertaken as a response to the enquiries from the diocesan leaders described above. To reflect our own personal subject interests and to provide a defined starting point, this begun by concentrating on the needs of those ‘growing up and down’ at the early and later stages of life in the context of increasing and increasingly diverse communities and then moved on to a synthesis of recent relevant policy documents. This shift of focus was a response to the relative paucity of research data available because of the novelty of public health-oriented social enterprises and the richness of the recent policy developments.

As our second source, we then summarise the applied learning now available in the various projects undertaken by members of the University of Winchester’s Health and Wellbeing Research Group, with both local NHS and faith-oriented partners, in relation to community health and wellbeing. Mostly local case studies and service evaluations these often augment and illustrate in practice the policy developments referred to in the previous paragraph. The chapter concludes with a short topic summary and the scoping of a future research agenda. The review process is set out in **Figure 1**.

A systematic literature review/meta-analysis was not viable given the lack of empirical papers. An inclusive approach to judging the quality of papers was employed, whereby the two criteria for inclusion were subject relevance and potential for local application rather than the rating of research quality. The literature review employed a cascade approach structured by combinations of overarching terms as keywords: diversity, community health, cohesion, faith, spiritual, social enterprise and network. The Marmot Reviews referenced in this article, and the London government’s explicit watershed acknowledgement that ‘faith-based organisations in multi-ethnic communities are key factors ‘in developing confident, active communities

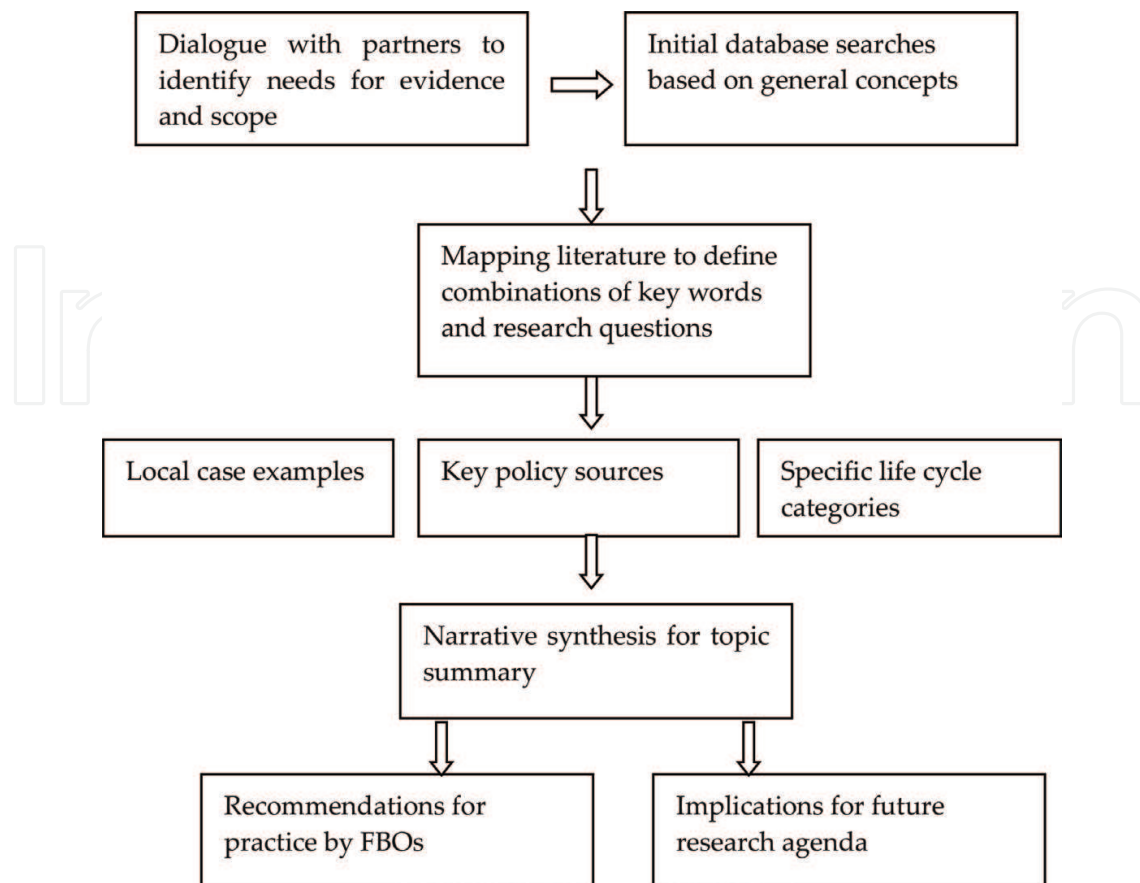


Figure 1. Scoping review process.

and social cohesion’, were identified as the benchmark policy statements for this review [5, 6]. Accordingly, a post-2001 time frame was used for the UK literature search, with some tolerance in respect of international sources to reflect the impetus given to relevant research by the World Health Organization’s Jakarta Declaration of the next century’s public health needs in 1997 [7].

Finally, in terms of search criteria, selection was also framed by our particular focus on the early and later years of life. Initial searches on Embase, Medline, PubMed and the NIHR found very few research publications from recent medical research. Through expert advice from the university librarian, ESBO and SCOPUS were then employed as integrated databases which combine health and social care research and practice sources. At this stage it became apparent that the most prominent feature of recent publications was not a particular research project but the detailed policy documentation in respect of diversity and community health. This documentation has an international profile and includes both policy formulation and implementation papers. As a body of work, it was also largely unknown to those, such as our diocesan leaders, who are engaged in addressing the issues of a new diversity in housing settlements.

Accordingly, adopting a pragmatic approach to the review, the effect of our early findings at this stage was to redirect our focus to the material that could be of most utility: the wider policy sources and our own local evaluations of wellbeing sites. Our aim became a narrative

synthesis of these informed by the initial literature review, with the topic summary set out at the conclusion of this chapter as the end product.

3. Findings

Our findings fall into three categories. First, the structured literature review pointed to significant changes in the life cycles of modern community development. In particular, it highlighted the importance and growth of informal relational networks and their alternative emphases on different modes of wellbeing. Secondly, the formative influence of detailed and often quite prescriptive policy documents has been confirmed as drivers of collaborative change for increasingly diverse communities through the creation of increasingly diverse agencies. And, finally, as our third finding, a miscellany of local lessons for operational practice have been identified in respect of critical cross generational roles in community cohesion and the specific role of those on the early and later years of life to these. The evidence suggests that, for all the three findings, those coming from faith backgrounds can make positive and distinctive contributions.

3.1. Life cycle

Communities like individuals have their own life cycles. Historically, the concept of 'life cycle' has been central to an understanding of what constitutes wellbeing. Accordingly, influential writers in the last century still identified the family and the neighbourhood (or local 'clan') as the basic building blocks for both individuals [8, 9]. This applied to what was largely understood as physical and psychological wellbeing in respect of both individuals' recovery from periods of illness and communities in their successive stages of ongoing and largely architectural regeneration. The research literature in this period on wellbeing interventions is characterised by studies of both relational networks and clinical conditions that possess well-defined boundaries, with the health status of (usually lonely) older people especially linked to relationships of geographic proximity [10, 11].

Our review of the research literature indicated, above all else, how increased diversity has helped to change the previously conventional understanding of both wellbeing and then its supportive relational networks. Crucially, as a result the life cycle for both forming and reforming communities is changing, and essentially this fundamental change is characterised by shifts from often quite closed to much more open patterns of communication and by less structural and more socially interactive modes of identity development. For each of these shifts, the contribution of those at the initial 'growing up' and final 'growing down' stages of the individual life cycle appears to be crucial, through, for instance, hosting early years' parental clubs and classes and recruiting to seniors' befriending schemes.

Moreover, equally crucially, it is often the spiritually oriented organisations which are the key agencies in enabling these contributions to be effective in terms of the more recent holistic definitions of wellbeing. As multidimensional post-Millennium 'dynamic equilibrium' theories of wellbeing have gained traction [12, 13] so has the notion that relational networks must expand, in order that individual persons and the public at large can effectively meet accelerating

challenges to physical, mental and social health. Through its case studies, the UK's Community Development Foundation identifies the celebration across newly diverse communities by faith agencies of religious occasions and festivals as a 'baseline' for empowerment and participation [14]. American counterpart bodies to the Foundation similarly record such religious approaches rooted in 'respect, empathy and active listening' as critical to the sense of 'mastery' and 'social connectedness' required for flourishing community health developments [15, 16].

Because of their values, faith-based agencies can be particularly adept at helping to redefine and extend the meaning of 'kinship' in diverse communities to a range of newcomers [17]. The older demographic profile of many church memberships can also be a 'community asset' as a means of face-to-face relationship building for informal networks, simply because older people are more likely to be experienced and comfortable in direct personal contact rather than digital communications [18]. They are also incentivised in emerging communities by the basic need for such contact to combat the risks of social isolation and loneliness [19].

In informal network developments which promote open communication such contacts are a source of identity for new communities and those facing cultural challenges. Shared stories and their associated experiences are vital, so that studies consistently point to the need for modern internally diverse communities to develop socially through 'events' rather than structurally through 'monuments' [20]. At Winchester our recent evidence synthesis for the local diocese found much to support the view that faith-based agencies and individuals are particularly well placed to supply the required 'creational narratives'. Their doctrines, backed by conviction, are full of appropriate language and imagery [21].

A note of caution, however, is required. We have noticed that while in practice we know of many examples of faith-based organisations (FBOs) hosting such as toddler groups, 'messy church', seniors' befriending schemes and the like, the academic literature focuses predominantly on developments in the formal as opposed to the informal wellbeing system. For example, this is particularly evident in state-sponsored early years' provision. Over recent years in the UK, a series of policy and practice reforms have aimed to improve outcomes and healthcare services for children and young people. There has been a joint focus on safeguarding children and reducing health inequalities via initiatives such as Sure Start, Children's Trusts, Childcare Partnerships and pre-school education [22]. This bias towards expressed policy as opposed to policy espoused by behaviour points to a future research need.

3.2. Policy sources

Within recent years, two main drivers have emerged for increased engagement with communities as a vehicle to improving health and wellbeing. These are overdemand and systemic strain on traditional NHS-based health services and a growing recognition of the importance of the social determinants of health, which cannot be addressed within the confines of a hospital or GP surgery [1]. These drivers for engagement with communities and citizens are laid out in the NHS 'Five Year Forward View' [23], Public Health England's (PHE) strategy and 'From Evidence into Action' [24]. To promote healthy lifestyles and positive health behaviours, the latter calls for 'place-based approaches and community development, harnessing the collective assets and resources available locally to address local needs'. Similarly, the Marmot Strategic

Review of Health Inequalities in England [25] called for the creation and development of healthy and sustainable places and communities. Like several of its international counterparts, the NHS Five Year Forward View recognises the unique contribution of charities and voluntary organisations with their opportunity to reach underserved groups and respond to local need.

As the responsible national agency, Public Health England [26] has identified a set of local health assets that support the positive health and wellbeing of the community. Shown below, these emphasise the importance of informal networks for social (and intergenerational) interaction, such as babysitting circles, alongside formal provision by the public, private or third sectors:

- The skills, knowledge, social competence and commitment of individual community members.
- Friendships, intergenerational solidarity, community and neighbourliness within a community.
- Local groups and community and voluntary associations, ranging from formal organisations to informal, mutual aid networks such as babysitting circles.
- Physical, environmental and economic resources within a community.
- Assets brought by external agencies—public, private and third sector.

Community-centred approaches to health and wellbeing recognise and seek to mobilise assets that already exist within communities.

Explicating this, South [27] identified a ‘family of community-centred approaches for health and wellbeing’, which are listed below. While the PHE report does not specifically mention FBOs, the FaithAction charity (a national network supporting faith- and community-based organisations involved in social action) highlights the ‘very strong resonance’ between the approaches recommended by a range of policy documents in respect of enhancing health and wellbeing through better engagement with communities and ‘the activities of faith groups’ [28].

Family of community-centred approaches:

1. Strengthening communities—this includes a range of approaches such as creating networks to enhance the wellbeing of those involved. An example given is the Men’s Shed network, which is aimed at reducing the social isolation of men. These approaches work by building social cohesion, awareness and collective action.
2. Volunteer and peer roles—these approaches train individuals to provide information, support and advice and organise activities related to health and wellbeing within their (or other) communities. These can include volunteer health roles and health trainers/health champions.
3. Collaborations and partnerships refer to approaches in which partnerships are built with communities to improve planning and decision-making. These may involve participatory research, co-production projects and community engagement in planning.
4. Access to community resources—this involves the connection of people to resources in their communities such as information, advice, help and group activities. Such approaches may include social prescribing or community hubs.

FaithAction [28] has itself produced a report highlighting the particular role that faith-based organisations (FBOs) can play in the promotion of community health and wellbeing. One particular strength of FBOs relates to their access to communities at risk of marginalisation and/or specific disease profiles. In cases where language and other barriers exist amongst particular communities, members often do not engage with primary health services and miss out on preventative services such as health screening or advice. FBOs, through their engagement with these communities have valuable access and understanding of their needs and are valuable partners to health providers in working with these populations. This is of particular use where certain ethnic groups have a higher risk for certain diseases. Most of the evidence in this regard is situated in US-based Black American churches. A well-developed body of research shows the role that churches can play in promoting behaviour change for prevention/management of diabetes and cardiovascular disease, as well as encouraging the uptake of screening programmes. The literature in the UK is mainly situated with the South Asian community for similar reasons but is less developed than the evidence base in the United States. An example of one UK study is the development of an antismoking educational intervention for Bangladeshi and Pakistani communities—developed in conjunction with Muslim faith leaders for delivery in mosques, faith schools, women’s groups and madrassas. The programme aimed to discourage smoking in homes was based on Koranic teaching about not harming oneself and others [29].

There is a further body of research that shows positive benefits to mental health, wellbeing and social capital in being regularly involved in religious activities. These benefits appear to be linked to increased social support and sense of meaning. FBOs also have a number of assets and resources suitable for health promotion, including established presence and networks within communities, buildings and culture of volunteering.

The authors do, however, note that there are examples of some negative FBO contributions relating to fundamentalism and exclusivity. Similar challenges are highlighted in a small-scale study of antipoverty projects in one city in the South of England. This found ‘virtuous yet simultaneously exclusionary cycles’ stemming from social action by faith groups. This related specifically to the preference by Christian organisations (who in this city were the predominant faith group) to partner only with other Christian projects—meaning that minority faith groups were excluded from ecumenical networks for social action. In this study, Hindu and Muslim faith groups struggled to mobilise resources to support local community projects—focusing rather on supporting the wider community of believers overseas in disaster relief efforts [30].

3.3. Local lessons

In this section of the chapter, we simply summarise some of the transferable learning available—but not necessarily published—from eight local research and consultancy projects either initiated or commissioned by local faith-oriented agencies. Three of these concerned services for families with young children, while each of the rest involved leading contributions from seniors either as clients or service providers. All the agency names have been withheld for reasons of confidentiality. The projects have been undertaken by members of the Health and Wellbeing Research Group at the University of Winchester.

Cross generational communications have long been promulgated as a potentially rich but underutilised resource for sapiential learning [31]. The findings in two of our projects supported this view. In the first active and trained older men served (with consent) as befrienders for families at risk of breakdown across a range of new and older housing estates. In these families the father was absent for reasons of custodial incarceration or partner separation. Perhaps, surprisingly, it was the fathers who scored this service the highest in terms of positive satisfaction, with some highlighting the prospective benefits of being able to draw on older mens' experience and contacts for future employment and training opportunities. A second project for families which have suffered parental loss is similarly highlighting the contribution of older persons as both sponsors and carers on a citywide basis.

Two further projects locate older people in pastoral roles. The findings here seem to confirm those of comparable previous past service evaluations and organisational analyses in terms of identifying the peculiar benefits of seniors' 'brief interventions' and 'moderating influences' [32, 33], because such young street partygoers or busy and stressed commuters perceive them as safe, non-threatening sources of wisdom and authoritative guidance. For these older people too, there is the perceived advantage of having spiritual vocation with prayerful peer support. The term 'moderating influences' also applies to our studies of governance in faith-based social enterprises. These specific contributions by 'experienced elders' have been important in the process of evolution through which exclusively faith-based trustees 'bridge' between their missional aims and the needs and demands of the wider community [34].

Our recent work focusing on the evaluation of health literacy resources for parents of children under 5 [35] highlighted the barriers faced by parents (white British and those for whom English is not the first language), with low literacy/health literacy. This represents a paradox that those who are most in need of health literacy resources are least likely to access them [36]. Vulnerable groups have the need of additional support to access, understand and apply resources, but identifying these needs is challenging as these communities are reticent to engage with research [37]. Researchers who are serious about engaging with minority groups will need to address any cultural, language and practical barriers that exist. As outlined above, FBOs and community groups already engaging with these groups are likely to possess useful insights. The current work within our Health and Wellbeing Research Group is focused on identifying how to effectively engage vulnerable parents/children in research, by learning from the existing good practice of community and faith-based organisations already working in these domains.

4. Discussion

4.1. Topic summary

We now need to draw together the learning acquired from our data capture and analysis. This has to begin by acknowledging that policy development has outstripped research when it comes to setting the agenda for communities affected by modern trends in diversity. Empirical studies are in short supply. The pace of change is such that the process of producing

a clear summary that describes well-defined elements of the topic's subject areas, as the starting point for the commissioning of future research, is a difficult challenge.

In responding to this challenge, we return to what became our main aim of identifying the potential for public health of increasingly diverse communities. In pulling together our literature review findings with local practice examples, we are in the position to provide a narrative synthesis of this potential. This now follows.

What we can assert with confidence, in a topic summary, from the evidence so far is that diverse communities can be cohesive and that this cohesion can be a source for health promotion. Two key factors have been identified as positive factors in achieving this cohesion. The first key factor is the development of more open communication systems in and across communities, and the second key factor is the expansion of more socially interactive means of identity development within them. These two determinants possess corresponding factors which have been dominant but are now required to be less influential if diversity and cohesion are to be enhanced: the focus on internal communications and physical structures for community development.

We can also postulate that while many agencies are able to contribute to local health improvements, the two core positive features of diverse but cohesive communities do provide particular opportunities for those with a faith orientation. The research so far supports this assertion, which aligns for example with some recent studies from the United States [38, 39]. Faith-oriented agencies are particularly well placed in terms of values and vocational commitment to facilitate and integrate the growing range of informal networks and wellbeing service outlets which posited the policies that we have noted for place-based public health. Above all their spiritual orientation means that there are no boundaries to the reach of their relationships with people located across all sociodemographic categories, political affiliations and economic classes.

4.2. Implications for research

Geared to alleviating health inequalities, evaluations of the effects of all community-based health and wellbeing interventions must pay particular attention to accessing with sensitivity the views of those most at risk of being disadvantaged. For the significance of spiritual actors and agency researchers must be prepared to learn from faith-based and other organisations already working in these domains. The two-way exchange between faith and empiricism can only help to address inherent and novel cultural, language and practical issues arising in new communities. A number of scholars have begun to address these issues in other areas of research (e.g. [40]). Those seeking to enhance community health and cohesion through new forms of diversity can be encouraged by the findings of past studies while recognising the pressing need now for further supportive research.

While there is a growing body of research in respect of relational network developments which can effectively support older people, there does appear to be a particular gap in terms of early years' studies. Whether more charity or business-oriented, FBOS are clearly now a fact of life and further research is needed across all age ranges, 'growing up' and 'growing down'

are included. There are methodological challenges here for researchers. Traditional 'closed system' experimental approaches will not suit community interventions that take place within the complex systems of social relationships that increasingly characterise more diverse communities. The cohesion of these depends on a better understanding of what they are and how they can grow. The opportunities for ethnographic and realist research approaches [41, 42] are abundant, and it would be the prudent leader of a faith-oriented social enterprise who incorporates action research or participant observation into his or her toolkit.

It is a limitation of this chapter that it has only scratched the surface of such qualitative enquiry methods in its exploration of the new profile of wellbeing interventions. Our research process for this process has been essentially iterative, responding both to the particular agendas of our partners and the sometimes unexpected direction provided by the sources accessed. Local case studies from arbitrarily selected locations can only ever be, at best, indicative and generalisable findings in respect of our two initial questions regarding the contribution of faith-based agencies are still out of reach. But the topic summary above does provide a platform on which more in-depth studies can now be formulated.

5. Conclusion

We have described the unique role that faith-based agencies can play through their existing presence and infrastructure within communities and their associated social (or religious and spiritual) capital. Relevant policy and practice guidance have been identified which iterates a range of models to maximise engagement of existing health services with faith-based and third sector organisations, and evidence for some of these models has been presented. As has been stated earlier, policy has outstripped research in this area, and there is much scope for further research and evaluation in the area of faith-based contributions to health and wellbeing.

Author details

Geoffrey Meads* and Amanda Lees

*Address all correspondence to: geoffrey.meads@winchester.ac.uk

Health and Wellbeing Research Group, University of Winchester, Winchester, UK

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