

# Working with faith groups to promote health and wellbeing



# Foreword

At this time of severely constrained finance for local government and the NHS it is essential that we do all we can to harness the skills and assets in our local communities to improve health and wellbeing. Faith groups make an important contribution to this work through their commitment to service, both with their own members and with wider communities. In particular, faith groups are often able to utilise the enthusiasm of their members as volunteers. Also, some faith groups have members who face health inequalities through a higher risk of some diseases or through difficulties in accessing healthcare. These groups are, therefore, well placed to have an active role in tackling health problems in the communities they serve.

I am very pleased to see the excellent work showcased in the case studies in this report which demonstrate how local authorities and faith groups can work together to improve health outcomes. Some of these are using the national Faith Covenant as a framework for establishing closer partnership arrangements and to address the barriers that can exist between public services and faith groups.

The examples that are included are only a few of the positive projects and programmes that are taking place, often unrecognised, in local authorities and the NHS across the country. This is an important area for the development of productive partnerships which is yet to be fully realised. I hope that this document will encourage local authorities and their faith-based partners to come together in a mutual vision for better health and wellbeing in their communities.



**Councillor Izzie Seccombe**  
Chair, Community Wellbeing Board

# Introduction

'Through sharing physical resources, the richness of their connections and networks, their involvement in governance and their collaborative work with others, faith groups contribute substantial and distinctive social capital.'

**FaithAction 2014**

There is a growing body of research which shows how faith groups can have a positive impact on both the health of their members and wider communities. In a few areas, councils are starting to develop a comprehensive approach to working with faith groups to tackle local health problems, and thereby making the best use of joint resources. In many others, councils and health partners have developed specific projects and services with faith-based organisations. However, across the board, there is much more that public health can do to tap into, and support, the assets that faith groups provide.

Working with faith groups is part of asset-based strategic planning which councils and health and other partners are pursuing in health and wellbeing boards (HWBs) through Joint Strategic Needs Assessments (JSNA) and Joint Health and Wellbeing Strategies (JHWS). Strategic engagement with faith groups means public health can involve parts of the community that may be considered 'hard to reach'. Through this, their work can be shaped to fit the needs of diverse communities who may face health inequalities, thus contributing to the Public Health Outcomes Framework.

Faith groups can generally be considered as part of the voluntary and community sector (VCS) of any area. In fact they make up a sizeable subgroup within that sector. National charity and think tank NPC estimates that, overall, more than a quarter of charities in the UK have an association with faith (Wharton and de Las Casas, 2016). Faith groups also have a distinctive approach through their spiritual values. For many, the actions they are taking to help others is based in love and service to a higher source, whatever form that may take. This means that many will undertake their work with great dedication and long-term commitment.

There are advantages for faith groups in closer relationships with local authorities, the NHS and the wider VCS sector. Many tend to operate in isolation, so partnerships can improve their offer to their communities through opportunities to access training for staff and volunteers, and support with policies and procedures such as health and safety. They will also achieve a better understanding of the wider health, care and wellbeing needs of the local area, and will have an opportunity to contribute their views to strategic and local planning. Should they wish to apply for any funding opportunities, they will have the information and contacts to do so.

The national organisation, FaithAction, advises that the relationship between faith groups and councils should be based on mutual respect and a two-way process of information and support (2014). It notes a distinction that has been made between 'faith-based' action which springs from faith groups

recognising and addressing the needs in their communities – such as setting up a lunch club for homeless people – and ‘faith-placed’ action in which external organisations carry out interventions – such as running smoking cessation sessions for faith group members.

Ideally both types of action will be brought together through collaborative working. The purpose of this report is to suggest how this can be achieved. In particular, it will cover:

- the ways in which faith groups can improve health outcomes and tackle health inequalities
- how councils, their health partners and faith groups can all benefit from joint working
- barriers to collaboration and how they can be tackled
- suggestions for how effective partnerships and activity can be established, including through adopting the national Faith Covenant.

The report draws on research and studies about the role of faith groups in contributing to health and wellbeing and wider social action. It also highlights examples of good practice from across the country, and from different faiths, to demonstrate the wide range of activity taking place. It includes messages from discussions with many public health professionals involved in working with faith groups, and from representatives of these groups.

Based on a broad vision of good practice, the report includes questions for councils and faith groups to assess whether there is more that can be done to work well together. It also signposts to useful resources for further learning and action.



## The potential of faith groups to improve health and wellbeing

Some of the main ways in which faith groups can have a positive impact on health and wellbeing include:

- support for ethnic groups who face health inequalities or are at greater risk of developing specific health problems
- social action to improve the lives of people who face problems such as poverty or homelessness
- articulating the health needs of their communities.

In addition, regular involvement in faith activity is linked with greater health and wellbeing for faith members.

### **Ethnic groups at higher risk of health problems or health inequalities**

Some ethnic groups are at greater risk of developing certain health problems than the general population, and many of these conditions can be improved through healthy lifestyle changes (list in appendix 1). For example, South Asians are at increased risk of

cardiovascular disease and TYPE 2 diabetes. Also, some individuals may be less likely to access mainstream health advice or treatment in a timely fashion because of language or other barriers. Many of these may attend faith organisations, which provide a unique opportunity for public health to offer targeted health and wellbeing information and support.

There is a growing amount of research indicating that health interventions in faith settings are effective. The majority of this has come from studies in black American church groups, which suggest that it is possible to support changes in a wide range of areas including weight loss, increased physical activity, improved diet and smoking cessation, with improved outcomes in general health maintenance, Type 2 diabetes, cardiovascular disease, mental health and cancer awareness (FaithAction 2014).

So far, information from project evaluations, studies or academic research in the UK is limited, although a small number of studies have taken place or are underway. For example, a study by the British Heart Foundation (BHF) in a Hindu mandir and Sikh gurdwara in London and Wolverhampton resulted in a 50 per cent reduction in saturated fat in community meals, with messages about fat reduction retained over two years (BHF 2014). Establishing screening programmes in faith settings is another area that is proving useful.

Most studies from the US and the UK provide qualitative information on what they have learned about the best ways to undertake interventions in faith settings. Taking enough time to establish relationships and thorough preparation are seen as central to success.

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### Engaging the Salford Orthodox Jewish community in the NHS Health check programme

The Orthodox Jewish community in Salford is part of the second largest orthodox community in the UK and has grown by

48 per cent since 2001. Health needs assessments carried out by public health with the community found that some cultural and religious beliefs, such as not smoking, were protective of health, but there were also low levels of exercise and high rates of obesity. Insight data highlighted community demand for initiatives on topics including cardiovascular health and weight management.

In order to address these needs, and with a view to increasing social capital within seldom heard groups, Salford City Council commissioned Unique Improvements social enterprise to develop Salford Healthy Communities Collaborative (SHCC). The collaborative worked with the community using the Breakthrough Methodology developed by the US Institute of Healthcare Improvement.

This involved an orientation event to identify stakeholders, build awareness and ownership, define the size of the problem and recruit to a local action team. Fourteen community members signed up to be part of a Jewish Healthy Communities Collaborative (JHCC) and took part in a series of learning events with other stakeholders including GPs and public health. Following this, the JHCC was supported to take a structured approach of planned small scale changes to trial in their communities over a 12 month period.

The model of involving volunteers from the community resulted in an effective 'passport' into their networks, and a wide range of awareness raising took place, including women-only events, use of the Jewish media, and discussions about healthier food at local Jewish delicatessens. After the first 13 months of activity, results include 1,440 brief interventions, 410 lifestyle risk assessments on people aged 40 to 74, and 102 signposts to primary care services.

A range of learning has emerged from the project which could be transferable to other projects, including 'testing interventions in small, manageable ways', 'moving from expert

to facilitator’, and ‘demonstrate impact – people engage with what works’.

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Full case study is available on the NHS Health Check website  
[www.healthcheck.nhs.uk/commissioners\\_and\\_providers/evidence/case\\_studies/](http://www.healthcheck.nhs.uk/commissioners_and_providers/evidence/case_studies/)

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## **Elim Connect Church – helping vulnerable people in Mendip**

The leaders and community of Elim Connect Church in Wells agreed that they should put their faith into practice and undertake social action. Basing their work on the gospels, they wanted to help the most disadvantaged and vulnerable in society. After extensive discussions with statutory and voluntary organisations and local people, they decided to work with people who were in danger of slipping through the net – those with multiple complex needs, who were isolated, perhaps homeless or sleeping rough, and who found it difficult to engage with mainstream services.

The church started by delivering a free weekly lunch, and over time created a hub where people felt safe and could connect with each other. From this beginning, Elim’s work started to expand, first through outreach work with rough sleepers, then youth work, a parent and toddler group and a counselling service.

Elim Connect has a good relationship with Somerset County Council and Mendip District Council. It was offered a venue by the county council on the basis that it would be providing a service to the community for many years to come. Latterly, with Mendip District Council, it co-designed a bespoke service for rural rough sleepers who are unwilling to move to urban hostels. Mendip funded the service,

and Elim Connect Direct Access Community now provides six beds in a rural community where entrenched rough sleepers are supported to tackle any physical and mental health problems, find sustainable housing and develop life skills. Outcomes from the service are very good.

The ethos of the church is, “we all have something we can give and we all have something we need,” and this is applied through all their projects. In their work with rough sleepers they are “in it for the long haul” and prepared to help people as long as they want and need it. Elim Connect equally welcomes people of any faith and none.

As well as the faith dimension, Elim Connect has a focus on ensuring high standards of professional service delivery and has comprehensive supervision, training, safeguarding and quality structures in place to enable staff and volunteers to manage the risks of working with rough sleepers.

Another asset is the large number of committed volunteers that support its projects. As its work grew, there were insufficient people from Elim church to volunteer, so other local churches were asked if they could provide volunteers. There were still not enough, so Elim Connect sought volunteers from the non-faith volunteering sector. Its volunteer pool has extended from 20 to around 120 people who either volunteer regularly or can be called upon to help. This mixed group has formed its own community, with a social element and mutual support.

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## National work on work on faith and HIV – Hertfordshire

Hertfordshire Public Health is supporting Catholics for AIDS Prevention and Support (CAPS) to develop a faith approach to HIV. CAPS has recently been awarded funding from PHE's prevention and innovation fund – one of 13 successful projects from 102 applications. The project will update a previous film project 'Love tenderly, act justly' which deals with HIV testing and living with HIV from a Christian perspective. The new resource will provide advice and pastoral advice for churches to raise awareness with their communities. Hertfordshire Public Health is supporting the resource, with local charity Herts Aid. The resource will be launched in 2017

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# Engaging with communities

Local authorities vary considerably in the emphasis they place in engaging with faith groups so they can influence strategic planning and delivery. While all will have points of contact with at least some faith organisations, others have established and provided support or funding for faith networks as formal consultation mechanisms. In some areas, faith groups themselves meet as to consider multi-faith dialogue and action, and some of these are also actively engaged in looking at the health and wellbeing needs of their mutual communities. Even in areas with the most advanced engagement mechanisms, ongoing work is needed to make sure that the widest range of groups are involved, as well as those that are regular contributors

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## Birmingham Council of Faiths – promoting health and wellbeing

Birmingham Council of Faiths is an inclusive body which aims to promote and maintain harmonious relations between people of different faiths in the city. Faiths involved include Baha'i, Buddhism, Christianity, Hindu, Islam, Jain, Jewish, Sikh, and Zoroastrian.

The Council of Faiths works closely with the city council and has a particular interest in helping its members understand the latest developments in health, care and wellbeing. It runs twice-yearly seminars which are attended by faith organisations, health and care staff, academics, voluntary and community organisations, and patients. A recent seminar coincided with Self-Care Week and was on the topic of home healthcare. Other previous topics include young people's mental health, dementia and end of life care –

all important issues facing faith groups. The Council of Faiths also works in partnership with other organisations, including the Scout and Guide Associations to promote interfaith activities for young people including the annual Faiths for Fun event.

Engaging with voluntary and community sector is another important area. In Birmingham, faith groups are the largest subsector of the third sector, and it is important that faith voices are heard, and that faith groups are well linked in to developments such as funding opportunities and consultations. The Council of Faiths has third sector liaison officers providing representation on Birmingham Voluntary Services Council, third sector assemblies and other network events.

All people supporting the work of the Council of Faiths are volunteers, so there is a challenge of finding sufficient capacity to promote new developments. The Council of Faiths feels it is making good progress with promoting issues of health and wellbeing, but it is aware that much more remains to be done – for instance helping to tackle the stigma of mental health, supporting small faith organisations to be more involved, and helping to ensure that the Birmingham Faith Map is comprehensive and current.

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## Belonging to a faith group

A large number of studies have shown that regular participation in group spiritual activity is often associated with various aspects of wellbeing such as feeling positive, happy, satisfied and useful (Spencer et al 2016). It can also be linked to a lower tendency for depression and, possibly, suicide, while church attendance for older people has been shown to be beneficial for maintaining cognitive functioning. Studies also point to a link between spiritual activity and physical health, including reduced mortality. Research suggests that the strongest contributing factors for these benefits lie in the aspects of religion associated with social capital – social networks, social support, involvement in healthy behaviours and a sense of meaning. In the UK the majority of people who volunteer belong to a religious organisation, and volunteering has also been found to have a positive impact on health and wellbeing (FaithAction 2014).

However, the impact of faith groups is not universally positive, and there is also a chance that some can have a negative effect on health and wellbeing of their members. This may be in relation to proselytism, exclusivity, fundamentalism, or cultural views at odds with evidence about health.

## Barriers to collaboration

### Local authority barriers

With the potential for direct health benefits, the alignment with policy requirements, and at a time of scarce resources, why is collaboration between councils and faith groups so uneven? This question has been considered by, among others, the All Party Parliamentary Group (APPG) on Faith and Society, and the LGA in its examination of the faith collaboration with local government (2014). A number of possible barriers have been identified, and more than one of these may be at work in any local authority. Often these issues become more acute when funding is involved.

There may be an unarticulated ethos in the council or NHS partners that secularism

is the most appropriate basis for service delivery, which can result in reluctance to engage with religious organisations. Also, there may be a lack of understanding of faith groups' contribution to health and wellbeing, and concern that there may be intractable religious and cultural barriers to improving health.

Local authorities may be reluctant to provide funding for faith-based organisations (FBOs) that offer a service solely to their own members, or one which is unlikely to be used by a wider community, because this could be seen as unfair to organisations that provide a service to the general population. Indeed, other voluntary and community sector (VCS) organisations may raise such a point, and may express concern about whether faith groups are being treated more favourably.

Where FBOs provide a service to the general population, there may be concern that they could exert pressure on people to share their beliefs or practices; a simple example of this would be prayers before meals. This concern will be most acute where vulnerable groups, particularly children, are involved in receiving a service.

FaithAction describes the challenge for statutory agencies as recognising the potential contribution of faith groups, and developing greater understanding of how they operate (2014).

### Faith group barriers

In its investigations, the APPG heard consistent themes in the testimony of faith groups. Overall, there was a perception that local authorities were secular organisations which would not be interested in their work and would not understand how to relate to them.

Some faith groups were interested in being part of the wide health and wellbeing community, but faced difficulties in how to make contact with the statutory agencies. When contact was made and when applying for funding, some felt that local authorities would not be sympathetic to their faith-ethos. Some felt they have to play the faith aspect of their work down in applications, but were

concerned that ‘taking the faith’ out of faith based work would result in a lack of integrity. A few believed that they had lost out on commissions because of prejudice about faith (APPG 2012 and 13).

Perhaps because they see local authorities as very separate from their work, some FBOs are not interested in making links and operate in a self-sufficient way, running services that may not be well connected with what else is on offer in the area. A danger of operating too much in isolation is that they may not be best placed to advise their members on the full range of support available, and they may also not keep up to date with quality standards and regulation.

Another common reason for faith groups, particularly small organisations, not engaging with local authorities is that they are just too busy doing direct work to get involved in partnerships. A recurring theme in speaking with faith organisations is that links with statutory and voluntary/community partners generally take place when there is someone in the organisation with the understanding, interest and capacity to get involved.

FaithAction describes the challenge for FBOs as taking up a more asset-based approach to their work, developing organisational capacity, and engaging with wider community activity (2014).

“As a faith group providing a public service it is important to take time to understand what the council, the NHS and the third sector do, and learn how we can work together. Building trust does not happen easily, particularly with organisations not used to working with faith groups, and to do this it is vital that we establish positive relationships and deliver what we say we are going to do.”

**Reverend Stephen Fowler, CEO,  
Elim Connect**

## Planning for effective collaboration

The second part of this report considers what

public health can do to develop partnerships with faith groups to promote health and wellbeing, using the following stages:

- understanding local faith groups and their potential contribution to health
- identifying the reasons for engaging with local faith groups
- establishing relationships
- deepening relationships: tackling barriers and supporting faith groups that wish to become more active
- undertaking public health interventions in faith settings.

The report is intended both for local authorities and public health teams where little has been done to engage with faith groups, and for those that have established some relationships, but on an ad hoc basis. The elements described below suggests taking a strategic approach that can develop over the longer-term. As in all similar types of work, areas which have senior leadership – at councillor or chief officer level – to drive progress are likely to establish the most comprehensive approaches.

## Building on the Faith Covenant in Leeds – Faith and Public Health Network

### Council-wide implementation

Leeds City Council decided to adopt the Faith Covenant in March 2015, having recognised that there was a lack of awareness in both the council and in faith organisations about each other’s roles in providing services and supporting communities. The initial purpose was to provide clarity about expectations, and to tackle some of the cultural barriers to working together.

The next stage was to put the covenant into practice. This work is led by the council’s equality team, overseen by a steering group made up of representatives from the council,

faith groups and universities. Some of the aims are to:

- raise the profile of the covenant across the council, its partners and faith groups, and to encourage more faith groups to get involved – a target of 100 has been set
- build capacity in the faith sector in relation to training, skills and understanding of funding opportunities
- establish better links between the faith sector and the wider voluntary and community sectors.

Practical work that has taken place includes the council providing training for faith groups on how to engage with its services and consultations, and a programme to help faith based organisations become centres for reporting hate crimes.

Future engagement between the council and faith groups is also being developed. To reflect the importance of this issue, a high-level group has been formed, involving the council leader and chief executive, and other senior councilors and officers, with representatives of the main faiths from Leeds Faiths Forum. This group will be responsible for agreeing a city-wide strategic approach. It will be supported by a wider group with representation from faith leaders, both those with religious and those with organisational roles, and from the 12 key council services including public health.

### **Public health partnerships**

The council's public health department was involved in the covenant from an early stage, building on and extending work that took place in the PCT to engage with faith groups. As part of the council, public health has better access to a wider range of communities and organisations through working with other council functions.

In order to build understanding of the potential of faith organisations for promoting health and wellbeing, public health, with the support of Leeds Faiths Forum, commissioned Leeds University's Centre for Religion and Public Life to undertake a study. 'Places of worship as minority ethnic public health settings' examines a number of important areas which

will form the basis for an informed approach to future partnerships. As well as quantitative information about religion, ethnicity and health in Leeds, based on census data and national general practice profiles, the study considers qualitative information from a variety of sources including interviews with representatives of places of worship from the main faiths. Topics considered include:

- the characteristics of the place of worship, how is it organised, who makes the decisions and the role of the religious or organisational leaders in promoting health
- health issues facing those who use the place of worship
- activities to promote health and wellbeing tactics that are already being carried out
- religious teachings and practices that shape the faith group's understanding of health and how these relate to behaviour change
- attitudes of public health staff with regard to public health practice in places of worship
- the extent to which places of worship are interested in a local network and further guidance.

One of the recommendations of the study was to establish the Faith and Public Health Network that now meets regularly. A key priority area for the network, out of hospital care, was recently addressed at round table discussion set up as an opportunity for faith groups and local commissioners to begin a dialogue. The event was attended by representatives from council and clinical commissioning group, Voluntary Action Leeds, the University of Leeds and FaithAction. Actions stemming from this are now being considered.

The collaboration and engagement with relevant partners has been crucial and the network will be supporting a series of presentations on faith and public health delivered by the Centre for Religion and Public Life at the University of Leeds.

Overall, the view of people involved in the covenant is that it has brought a much wider group of people together and increased mutual understanding and enthusiasm for

joint work. However the experience is that establishing relationships and building momentum does not happen quickly, and that embedding the covenant will be a long-term initiative.

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## Understanding local faith groups and their potential for health

If areas do not already understand the number and nature of faith groups in their areas, establishing an initial understanding is a good starting point. This can be done by using existing data, including census information, and getting in touch with any local bodies such as interfaith networks or forums. It is also worth asking all existing contacts which groups they are aware of, even if they do not work with them directly. A geographical map of faith groups across the authority, overlaid with information about ethnicity, deprivation, health inequalities and the like can be helpful, provided it is recognised that it will require updating.

### **Deciding the rationale for engaging with local faith groups**

Using the above information, areas can

determine the amount of time and other resources to put into developing faith group relationships, and what direction to take. All public health teams will want to ensure that they have good mechanisms for engagement with faith groups as representatives of local communities. Those operating locality asset based approaches will also wish to support the contribution of faith groups in neighbourhoods. However, areas will need to decide whether specific interventions in faith settings are the best use of public health resources. It can be helpful write up the rationale as a basis for engagement with faith groups.

### **Establishing relationships**

There are a variety of ways to make contact with faith groups. The initial approach would use any existing relationships with public health. Also, if the local authority has extensive connections with faith communities, such as a covenant agreement, public health can build on these. In the case studies that signed up to the covenant – Leeds and Birmingham – public health used this as a spring-board to focus on health and wellbeing.

Where relationships are more spasmodic, public health can have an important role in instigating and supporting a comprehensive approach. Most local authorities and their partners have existing points of contact with faith communities, such as emergency planning and community resilience, fire and rescue, equality work, adult social care and preventing terrorism. These contacts can be used as an inroad into communities, and will benefit from being linked, wherever possible.

Another point of entry are any existing single or multiple faith forums that may be operating without support from the local authority. These will often have an interest in health and wellbeing and are likely to be open to discussions with public health.

When building a network of contacts, it is important to reach out to as wide a range of groups as possible, including being aware of the denominations or sub-groups within a religion. This may involve finding out who to

approach in each organisation – there may be one or several good points of contact including both people in a religious or community leadership role. The use of brokers – perhaps local authority staff or councillors who have connections with faith organisations – can be helpful. While some groups may take the lead because they are more geared up to working with the statutory sector, all should be given the opportunity to participate equally.

If there is sufficient interest, the next stage is often to set up a meeting for a group discussion. Where there are existing relationships and enthusiasm, a conference or event may be the way forward to build confidence and plan further action. In the case study areas, a conference or workshop was often the jumping off point for faith groups that want to become more involved in health and wellbeing.

Public health workers supporting this activity do not need to have a faith, or be an expert in different types of faith. However, they need to be open and interested in discussion. It can also be helpful to research some basic background information on the faith groups that are likely to attend any event, to improve understanding and avoid problems with things like timing of meetings and acceptable food.

Advice from case study areas and others that have been involved in faith group dialogue is that this must be a two-way process. Faith groups will want to understand what public health is seeking and what it has to offer, and similarly public health should be open to the perspectives of faith groups. It is also important that faith should be part of the agenda – there should be opportunities to discuss the relationship between religions and health and wellbeing.

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## Building on faith social action in Hertfordshire

In Hertfordshire, the Director of Public Health is the council's Faith Champion which ensures that working with faith groups is considered at chief officer level. Developing partnerships with faith groups is promoted through the

council's diversity board, which works closely with Hertfordshire's independent Interfaith Forum.

The council and the Interfaith Forum, working with FaithAction, have recently delivered an interfaith event with the aim of celebrating the contribution of faith groups to public services so far, and to explore ways in which the council and faith groups can work together more closely in future. The event considered a number of case studies of local faith activity:

- **Testing Faith** is a partnership to provide support to those affected by HIV and encourage HIV testing in general. The black African community are a high risk group in Hertfordshire, making up 47 percent of those diagnosed. During national testing week a testing and awareness-raising event was held at the Open Heaven Church, with 41 people tested, of whom 28 had never been tested before.
- **JAMI**, the mental health service for the Jewish community, has launched the Head Room information and awareness-raising service which provides an eight-week mental wellbeing course, mental health first aid, and seminars on various mental health topics including family resilience.
- **The Harpenden Hopper** is a volunteer-based community bus service providing access to local services in an area with limited bus coverage. A group from local evangelical Christian churches were involved in establishing a community interest company – Harpenden Community Connect to set up the service.
- Religion can influence social attitudes towards tobacco use, for example chewing tobacco in many South Asian cultures also has symbolic implications at ceremonies. Tobacco Control Hertfordshire enlisted the help of faith leaders from Newham in awareness raising in local faith settings.
- Faith advocates for fire safety: community advocates from a wide range of faith groups support the fire and rescue service to carry out their role effectively in communities. For example the Sikh Activity

Programme supports communities where there are language barriers and Side by Side promotes community safety and cohesion in districts with 25 per cent from black and minority ethnic backgrounds.

The event was attended by 40 people and feedback showed that it was very successful. It became clear that faith communities and county council departments want to work with one another and there were a number of areas of synergy. Issues raised included more awareness raising for councils and the NHS, interfaith leads to ask each district and borough to be invited to Local Strategic Plan meetings and building confidence in faith communities to work with the public sector.

Both sides felt that the compact used with the voluntary and community sectors did not fully cover the specific issues around working with faith communities – for instance the limits of where faith specific activity and wide community activity interact. The group agreed to develop some draft principles and a policy statement, building on work in the Faith Covenant, as a basis for future joint work.

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“It is important that people of faith work beyond their own religious silos, and together promote peace and tolerance. Faith organisations also need to look beyond their own networks, and engage with civil society where the values they promote can contribute to a better life for the communities they serve.”

**Dr Peter and Jean Rookes, Joint Secretary, Birmingham Council of Faiths**

## Deepening relationships: supporting faith groups that want to become more active

### The Faith Covenant

The Faith Covenant is an excellent option for areas that want to take a comprehensive approach to engaging with the faith sector. The covenant is a one-page document which includes general principles and commitments for local authorities and faith groups (appendix 2). Principles include respect, no discrimination, listening, and being stronger together. Commitments for local authorities include establishing trust, encouraging involvement, clear guidelines on funding, and sharing opportunities for training and learning. Commitments for faith-based organisations include serving all local residents equally, not proselytising, using funding for a service wholly for that purpose, and good standards in areas such as child protection and health and safety.

The covenant can be used as a framework for local discussions about working together and addressing barriers. It can help organisations to better understand what they can offer and what they can expect from each other. Open discussions about the nature of faiths, and any concerns about their role in largely secular public services, can take place within an established framework for engagement, backed up by case studies, and good practice, and with some developmental support from the FaithAction team. It can be used as a development tool even if there is no formal adoption at the end, although signing the covenant does signal joint commitment.

While using the covenant tools is extremely useful, public health and faith groups may want to consider developing their own principles for working together, or an equality and diversity statement that organisations

can discuss and sign up to. For example, it is very important to be clear with faith groups that funding can only be allocated

for agreed service outcomes, not for religious activity. Christian think-tank Theos has produced a guide for faith-based organisations on how to integrate faith into their charitable initiatives (2016).

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## Building on the Faith Covenant in Birmingham – health promotion in faith settings

In Birmingham, signing the Faith Covenant encouraged the city council to engage with a wider network of faith organisations. A faith network was set up as a key consultation mechanism, and membership has risen from around 15 to 67. The council has also created the Birmingham Faith Map which details the activities run by faith communities and currently has more than 650 entries.

As part of work to implement the covenant, keeping children safe was identified as a priority for both the council and faith leaders, and a programme of events has been planned, including specialist support, training in online procedures and multi-agency training.

The council's public health department was involved in the covenant, and improving health and wellbeing was another priority. A collaboration is now taking place between the council's public health department, Public Health England West Midlands and faith groups.

'Health Promotion in Faith Settings' is a locality-based health promotion project with a focus on ethnicities and inequalities in health. The pilot project will use a Five Ways to Wellbeing Model and will assess the health needs and assets in two Birmingham wards.

Discussions are taking place, initially with leaders in mosques or mosque-allied community centres, to identify the health needs of their communities and what is currently being provided, and to explore whether faith places could play a role in addressing health concerns. Initial feedback is that some mosques are already involved in activities to improve health, such as in-house counselling or a cycling club. The project will

develop a resource based on what has been learned in the pilot areas.

If the pilot proves successful the aim is to roll the approach out to other faith groups, including developing interfaith public health and wellbeing networks to provide further faith community engagement on health promotion.

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## Mapping and directories

Once statutory and faith organisations have decided to work together, they often find that there is a lack of awareness about what services are taking place in faith communities. The next step, as a basis for future joint work, is often to undertake mapping of the faith groups from the point of view of assets, needs and potential for partnerships. This work should be tied in with any service directories for the public.

### Dedicated network

A faith group network which is specifically focused on health and wellbeing, or which considers this as part of wider interest in social action, is a useful basis for developing joint work. For example, Birmingham Council of Faiths considers health, care and wellbeing as part of its agenda, and invites public health and others to support its work at seminars and awareness raising events. In the other case examples, councils have supported faith groups to come together to focus on health and wellbeing. Undertaking joint work and activities that enable partners to get to know and understand one another better is important. For example, each group could deliver a short

presentation on their communities and their role in health and wellbeing, as in Middlesbrough Interfaith Network.

All case studies make the point that once connections are made there is considerable enthusiasm for improving health outcomes, and harnessing this energy with action and some quick wins is important.

### **Key part of the voluntary and community sector**

Establishing good links is important for both faith groups and the VCS. Faith groups are likely to make up a large component of the overall sector – in some areas it may be the biggest sub-group. Being active members of the sector means that faith groups have access to information about funding and training opportunities and are able to network and engage with peer support. Through increasing faith group membership, the VCS widens its range of skills, expertise and perspectives.

However, national charity New Philanthropy Capital (NPC) suggests that the VCS needs to understand faith-based organisations better, and view them as a valuable part of the sector. For instance, the VCS should recognise the size and significance of the sector, do more to tackle concerns, and celebrate the positive aspects of its work (Wharton and de Las Casas 2016).

Across the country, links between the faith and VCS are patchy. In some areas faith groups form an important subsector of the VCS as well as being involved in VCS work as a whole. For example, Locality, the national network of community-led organisations has a section for faith members, and in Sefton, the mission of the VCS is to 'promote and assist voluntary, community and faith (VCF) sector activity. In others, the VCS needs to do more to engage with faith groups; public health can help this process by encouraging connections.

### **Capacity building**

Limited resources and capacity in faith groups is often a significant barrier to faith group involvement. The mapping exercise described above can be used to identify what needs to

be done to build capacity in faith groups that wish to become more involved. A Mission and Contribution Audit workshop model, specifically aimed at helping faith communities understand their needs and strengths, has also been developed (McManus 2016). A model dedicated to faith groups has the advantage of focusing on the faith aspects of their work and how these can contribute to health and wellbeing. In a recent report, Theos argues that faith-based organisations do not need to secularise to provide public services, but should exercise caution and transparency in how they operate (Bickley, 2015).

Local authorities provide a range of capacity-building training and support for faith groups on topics including engagement with the council, policy and quality standards, considering how best to represent their members, and applying for funding. Public health will need to decide on a case by case basis whether it is more appropriate to target capacity-building activity at faith groups, or whether to encourage them to take part in general support offered by the VCS. Targeted work may be useful in the early days to build relationships and mutual support.

FaithAction provides guides for faith groups on topics such as fundraising, networking, and volunteering.

### **Sustaining momentum**

A number of suggestions have been made in case study areas, and others, as to how to maintain momentum, after partnerships are established.

- Clear points of contact – so faith groups know who to approach in the first instance. More than one contact is better to provide continuity when people move on.
- Health and wellbeing champions in faith groups and faith champions in public health – to raise awareness, and maintain enthusiasm.
- A small investment scheme to generate interest, achieve local outcomes, and bring groups together.
- Test health and wellbeing interventions in

faith settings, evaluate what is done and share learning.

- Keep trying to involve faith groups who have not yet become engaged – seeing success may encourage them to join in.
- Consider how faith groups could be involved in a wide range of public health activity such as civil resilience and supporting the bereaved (CLG 2008).

### Local action

Faith groups have an important contribution to make to the neighbourhood, asset-based approaches to health and wellbeing that are being pursued by many local authorities. The measures described in this section to deepen the relationship with faith groups – mapping, networking, part of the VCS and capacity building – will all help ensure that faith groups are prepared to play a full part in this work. For more information see forthcoming LGA publication, ‘Working with the voluntary and community sector to promote health and wellbeing’, due March 2017.

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### Middlesbrough – participatory budgets for faith groups to promote resilience

Middlesbrough Interfaith Network brings representatives from different faith and belief groups together with officers and elected members from Middlesbrough Council. The network has a particular interest in how faith groups can support their members to improve health and wellbeing. In order to consider this in more depth, the network held a number of events, including a workshop on ‘sustaining personal resilience in challenging times’.

The workshop was attended by over 60 members of faith groups, and representatives from the council, the NHS, the voluntary and community sectors and other local agencies. Key speakers included the Director of Public Health and the Bishop of Whitby. One of the conclusions of the workshop was that there should be opportunities for faith groups to develop practical examples of promoting health and wellbeing, and, following further discussion, a participatory budget programme was established.

Faith groups were invited to identify ideas or projects to help build resilient communities and were invited to apply for up to £2,000 to put the ideas into action. A number of the groups who applied for funding had never done so before.

In order to decide which groups should be successful a voting event was held at the town hall, where each of the twelve shortlisted groups had an information stand and gave a five minute presentation on their project. They then ranked each other’s projects, with the top 10 receiving funding. In the end, the groups agreed to take a 10 per cent cut, and for all the projects to be funded.

Projects include an Islam awareness course, which included participation in a neighbourhood clean-up, singing for people with dementia, health and wellbeing awareness sessions for young Muslim women, support for destitute asylum seekers, Christmas meals for the elderly and homeless, hot food and drinks for the homeless, adult football, conflict resolution sessions, children’s breakfast club, and facilities for a drop-in centre. A video of the projects will be produced shortly.

The process brought groups together and created mutual support and understanding, and implementing practical projects have resulted in more interest in promoting health and wellbeing. The next initiative being considered is mental health first aid training specifically for faith groups. Also being considered is a programme of to identify health champions in faith/belief groups to embed sustainability and the potential to take things forward.

### Contact

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“Help and goodwill can’t be taken for granted and may involve a great deal of effort and relationship building before any actual intervention can take place.”

**British Heart Foundation 2014**

## Health and wellbeing interventions in faith settings

### Establishing relationships and preparation

Information from research, studies and projects all confirms that thorough preparation for health and wellbeing interventions, such as increasing physical activity, in faith settings is fundamental. The engagement and partnership activity described above is an investment in relationships that mean it will be much easier to undertake this work. But where faith groups are not already established within the voluntary and community sectors, have no previous experience of joint work, and where there are language barriers and minority ethnic groups, preparation may need to be extensive.

For example, the British Heart Foundation study that introduced healthy food in places of worship points to the complexities of building a rapport with religious leaders and committees, and emphasises that without this the work would not have been possible (2014). Also, pilot research into reducing second hand smoking in South Asian men in Yorkshire ultimately succeeded in recruiting and retaining people from mosques, but the researchers found that they underestimated the time it would take to get people on board. They identified the need to understand the internal dynamics of the organisation and to navigate complex decision-making structures to build support (Shah et al 2015).

Asset-based community work skills are needed to establish interventions – building on strengths, ideas and contributions of communities, acting as facilitator rather than expert, and engaging not just with leaders but with a range of key individuals in an

organisation to gain the widest possible interest.

Where the faith groups involve people from minority ethnic groups, it can be helpful to use community workers from that group or faith, as in the second hand smoking study, or to support groups of people to come together as an instigating group, as in Salford’s Jewish Healthy Communities Collaborative.

Understanding the religious and cultural beliefs and behaviours that relate to health can be crucial. From a public health perspective some aspects will be helpful – such as the Islamic prohibition of alcohol – and others harmful. Some studies have used helpful characteristics as drivers for change. For example, behaviour change could be built on principles of not harming oneself or others, common to many religions. In studies in black American churches, secular healthy lifestyle programmes were amended to include concepts such as faith and self-control, and were augmented with inspirational stories (FaithAction 2014).

Examples of harmful behaviours include fasting during Ramadam for people with health conditions such as people with Type 2 diabetes, and consanguineous marriage in some Jewish and Muslim communities, which brings increased risk of genetic defects in children. Both these examples are of cultural, rather than religious, behaviours – Islam permits ill people not to fast, and there is no religious requirement to marry close blood relatives in Islam or Judaism (ibid). Public health has a role in working with faith communities to highlight the health risks in cultural behaviours.

### Evaluation and overview

As in many areas of community-focused public health, there is a lack of information at national level about what interventions are most effective, and how best to deliver them. Discussions with local authorities suggest that many excellent programmes have been delivered, but sometimes these are standalone, and when the work is completed or the person driving it moves on the learning

and the relationships are lost. This is a poor use of resources, since it means that any new project needs to start from scratch, and that opportunities to continue to engage with the faith group have been lost. Ideally, every intervention will have an appropriate level of evaluation, and will leave a legacy of what has been achieved. At the very least, areas will benefit from keeping an overview of the projects that have been undertaken to inform future work.

FaithAction also encourages faith-based organisations to evaluate their work, so they are able to demonstrate the impact it has. It provides a range of resources to support faith groups in evaluation, including collecting evidence, measuring and collecting data and sharing the outcomes (2016).

# Questions for public health to consider when working with faith groups

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## Understanding local faith groups and their potential contribution to health

- Do you know the number and extent of faith groups in your area?
- Is there a map of faith groups in neighbourhoods, overlaid with information about ethnicity, deprivation, health inequalities?

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## Identifying the rationale for engaging with local faith groups

- What arrangements are in place for engaging with faith groups in public health and in the council?
- Is there a multi-faith forum?
- Are faith groups an active part of locality approaches to health and wellbeing? Does this include all or most faith groups or just a few?
- Do members of faith groups face health inequalities because of race or deprivation?

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## Establishing relationships

- What contact do you have with faith groups?
- Would faith groups know who to contact in public health?
- What arrangements does the council as a whole have to working with faith groups? eg Faith Covenant, faith forum as consultation mechanism, contacts with individual departments?
- What preparation have you done for working with faith groups? Do you have a basic understanding of key issues?
- Have you considered contacting FaithAction for information?

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## Deepening relationships – tackling barriers and supporting faith groups that want to become more active

- Is there a senior leader in the council and public health interested in championing faith developments?
- Have you considered the advantages of using the Faith Covenant as a model for engagement?
- Is the faith sector an active member of the voluntary and community sector (VCS)? Does this apply to most groups or just a few?
- Is the VCS proactive in engaging with the faith sector?
- Is there a map/directory showing the services faith groups provide?
- Is there a named person in public health for faith groups to contact?
- Is there an ongoing mechanism for engaging with faith groups on public health?

- Do faith groups understand the health needs of their membership and the local community?
- Has there been a capacity audit to identify what support faith groups need to do more?
- What capacity building is on offer? Do faith groups get access to support on matters such as funding opportunities, quality standards, engaging with their members and local communities and health and wellbeing awareness?
- Would the local authority and the VCS benefit from learning more about faiths?
- Are there health and wellbeing champions in faith groups, and faith group mentors in public health?
- Are faith groups active members of local communities, taking part in any local authority-led or commissioned activity? Are increasing numbers of groups becoming involved?
- Have health and wellbeing interventions been tested in faith settings?
- Have you considered signing the Faith Covenant?
- Alternatively, have you developed another way of establishing principles for joint work?

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### **Undertaking public health interventions in faith settings**

- Has the team considered information from national and international research in this area?
- Does the team need additional understanding in the faith/faiths involved?
- Has local work been done to identify the best contacts in the faith setting and who should make contact?
- Is the intervention evidence-based?
- Does it make best use of the positives of the faith setting?
- Is an evaluation and ways of sharing learning built into the model?

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jim.mcmanus@hertfordshire.gov.uk

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## NHS Health Check case examples

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## Helpful organisations

FaithAction – national network supported by the Department for Communities and Local Government, the Department of Health, NHS England and Public Health England. FaithAction funds, trains, advises, campaigns and innovates to support faith-based organisations working in local communities.  
[www.faithaction.net](http://www.faithaction.net)

Catholics in Health and Social Care  
[www.cbcew.org.uk/CBCEW-Home/Subjects/Health-and-Social-Care](http://www.cbcew.org.uk/CBCEW-Home/Subjects/Health-and-Social-Care)

The Cinnamon Network – helps churches to respond to the needs of their community by providing a menu of best-practice projects, advice, funding, support and leadership training. Faith-based, but not faith-biased – serve people of all faiths and none.  
[www.cinnamonnetwork.co.uk](http://www.cinnamonnetwork.co.uk)

Muslim Charities Forum  
[www.muslimcharitiesforum.org.uk](http://www.muslimcharitiesforum.org.uk)

Theos – a Christian think tank which seeks to inform the debate about the place of religion in society.  
[www.theosthinktank.co.uk](http://www.theosthinktank.co.uk)

# Appendix 1

## Main diseases associated with ethnic and faith groups

### South Asians – predominantly Muslim, Hindu and Sikh

- Increased risk of cardiovascular disease (CVD).
- Type 2 diabetes – overall, six times more common for men and women of South Asian descent – Bangladeshi, Pakistani, Indian. The exact level of prevalence varies according to country of origin and sex.
- Smoking – much higher smoking rates in Bangladeshi men, but lower rates in Indian men.
- Hypertension – prevalence in Indian men is comparable with the general population, but lower for other South Asian men and women.

### Some Jewish and Muslim communities

- Consanguinity more than doubles the risk of recessively inherited disorders such as congenital deafness and heart disease. Marrying blood relatives is more common in some Jewish and Muslim communities where it is a social and cultural, rather than religious, behaviour.

### Christians

- White Irish men and women, largely Catholic, are most likely of any ethnic group to exceed alcohol guidelines.
- Obesity is higher in black Africans, especially adolescent girls. A high proportion of black Africans report themselves to be Christian.
- The majority of HIV infections in the UK is in heterosexual black Africans.
- Caribbean-born men are 50 per cent more likely to die of stroke than the general population.
- Greater incidence of schizophrenia is consistently recorded in UK black Caribbeans – although there is a strong body of thought that a contributing factor may relate to prejudice and misunderstanding of cultural behaviour.

Source: FaithAction 2014

# Appendix 2

## The Faith Covenant

The Faith Covenant is a joint commitment between faith communities and local authorities to a set of principles that guide engagement, aiming to remove some of the mistrust that exists and to promote open, practical working on all levels.

Together, local authorities and faith communities should work out a local version of the commitments below, according to the priorities and needs of that locality.

### Principles

- Faith communities are free to practise their beliefs and religious observances without restriction, and to raise their voice in public debate and to be respected, within the framework of UK law.
- Public services and faith-based social action should respect service users from all backgrounds, with no discrimination on the grounds of religion, gender, marital status, race, ethnic origin, age, sexual orientation, mental capability or long term condition.
- The voice, participation and solutions that faith communities bring are important, and consultation should enable them to be brought to bear for the benefit of the wider community.
- Organisations and services are stronger for drawing on diverse sources of funding; monopolies of funding, action and participation are damaging.

### Commitments

Local authorities commit to welcome the involvement of faith groups in the delivery of services and social action on an equal basis with other groups. In addition, they commit to:

- Building relationships and trust with faith groups.

- Adopting strategies for the engagement of faith communities in consultation exercises.
- Encouraging faith groups and their members to be involved in the reshaping and redesign of local services.
- Establishing clear guidelines around funding.
- Sharing training and learning opportunities between faith communities and the local authority.

Faith-based organisations commit to work actively with local authorities in the design and delivery of services to the public. In addition, they commit to:

- Seeking opportunities to bring people together to serve the community, particularly its poorest and most isolated members.
- Serving equally all local residents seeking to access the public services they offer, without proselytising, irrespective of their religion, gender, marital status, race, ethnic origin, age, sexual orientation, mental capability, long term condition or disability.
- Using resources provided for delivering a service wholly for that purpose, and not for any other.
- Ensuring excellence in child protection, health and safety, accountability and transparency.
- Responding to consultations where appropriate.
- Sharing training and learning opportunities between faith communities and the local authority.

Source: APPG on faith and society, 2013, Faith Covenant.  
[www.faithandsociety.org/covenant](http://www.faithandsociety.org/covenant)



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