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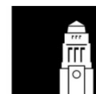

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Health, Faith and Therapeutic Landscapes: Places of worship as Black, Asian and Minority Ethnic (BAME) public health settings in the United Kingdom

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Health, Faith and Therapeutic Landscapes: Places of worship as Black, Asian and Minority Ethnic (BAME) public health settings in the United Kingdom

Abstract

Within the United Kingdom, there is evidence that faith-based affiliations, ideas, actors and organisations play a role in public health (PH) that has been neither properly recognised nor integrated into mainstream health systems (November 2014). Discourses on faith and improving health outcomes have been particularly focused on 'seldom heard' groups, including 'Black, Asian and Minority Ethnic' (BAME) communities (November 2014; Jain 2014; Burton et al. 2017; Muhammad 2018). In this paper we first present findings from a qualitative scoping study carried out in Leeds and Bradford, cities in the UK, between 2014 and 2015, which examined Places of Worship (PWs) as BAME PH settings. We carried out nineteen semi-structured interviews with purposively selected respondents, and three focus groups. Second, we develop a theory that originates from one in the sub-discipline of 'health geography' concerned with 'therapeutic landscapes', applying it to our research findings on PWs as BAME PH settings. The paper argues for the recentring of religion and faith settings back into the therapeutic landscapes literature, reflecting evidence that faith-based affiliations, ideas, actors and organisations are relevant to the pursuit of health and wellbeing. We also contend that a therapeutic landscapes framework provides a way of making the health relevance of PWs visible to both health practitioners and to members of PWs. We argue that PWs act as therapeutic places (i.e. specific transformative sacred sites) as well as therapeutic spaces (i.e. settings that provide adjuncts to formal PH promotion services), and are often part of therapeutic networks included in 'kinship

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groups and networks of care provided by family, friends, therapists and other agents of support' (Smyth 2005: 490). This approach allows us to see how influences on health behaviour are not just confined to bio-medical settings, but that the 'healing process works itself out in places (or situations, locales, settings and milieus)' (Gesler 1992: 743).

Key Words

Place of worship; religion; faith; public health; healthy settings; therapeutic landscapes; BAME

Introduction

Within the United Kingdom, the role that faith-based affiliations, ideas, actors and organisations play with respect to the health of the public is beginning to be acknowledged. However, its role has not been sufficiently recognised nor integrated into mainstream health systems (November 2014). While religious faith has complex and variable implications for health, its relationship to public health (PH) is particularly important at present as statutory PH actors are increasingly seeking engagement with faith actors to achieve their goals. This 'turn to faith' is evidenced in a recent report from Public Health England, which has the remit to 'protect and improve the nation's health and wellbeing and reduce health inequalities' (Public Health England no date). It states that,

> Public Health England understands the importance of faith in shaping the health and care decisions of many people, and recognises that providing appropriate community care is likely to require collaboration with faith leaders

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and Places of Worship (Public Health England 2016).

Such a focus on faith and health is increasingly found within studies about improving health outcomes amongst ‘seldom heard’ groups and individuals from ‘Black, Asian and Minority Ethnic’ (BAME) communities (November 2014; Jain 2014; Burton et al. 2017; Muhammad 2018). There is a substantial body of literature on the links between faith and wellbeing (Koenig 2012; Koenig et al. 2012; Park et al. 2012) and there is evidence that faith traditions shape how some members of BAME communities view their health, and can play a role in activities to improve wellbeing (Morgan 2017). There is also a perception from some PH actors that faith settings provide a good location for accessing members of BAME groups, and that messages communicated within such settings have the potential to change the behaviour of some of their members (November 2014: 22-23; Campbell et al. 2007). While we can access data about self-reported religious affiliation from the National Census (ONS no date), there is no data for attendance at PWs according to religious group affiliation, and it should not be assumed that those who profess to belong to a faith attend PWs (November 2015: 22-23). There are also likely to be gender differences in PW attendance (Author et al. 2015; Authors 2016). Nonetheless, it seems likely, given the overall high levels of self-reported religious identification within BAME communities, that PWs could play an important role in aspects of health education and the delivery of services.

Internationally, much of the literature on this topic comes from the USA, and concerns interventions in Black American churches (Dehaven et al. 2004; Thompson et al. 2009; Newlin et al. 2012). Many fewer studies have been conducted in the UK, and they tend to focus on South Asians – the UK’s largest minority group (November 2014: 38; Bush et al. 2003; Ainsworth et al. 2013; NHS

2004; Department of Health 2008; Rao et al. 2012). We argue that, in the light of the 'turn to faith' by the state – which is increasingly engaging with religious leaders (RLs) and PWs on a range of social welfare issues, from foodbanks (Lambie 2011; Williams et al. 2016) and homelessness (Johnsen 2014), to anti-human trafficking support (Davies 2009) and addiction services (Williams 2016) – a focus on places of worship as public health settings is overdue. In the literature on faith and health, there has been relatively little attention paid to the role that places of worship such as churches, mosques and temples can play as locations where immigrants and minority communities are able to 'maintain and reinforce their religious practice', and the implications of this for health (Agyekum and Newbold 2017: 675).

The 'turn to faith' is a response to the needs of increasingly pluralistic societies, where diversity has led to calls for a 'new wave of development in public health and health promotion' (Hanlon et al. 2012: 235), and in which 'the future practitioner will need to understand how different worldviews are profoundly influential in shaping the ways in which all of us understand and act in the world' (2012: 236). It also reflects a move away from purely biomedical models of health care to social models where 'a perspective of health is realized that embraces all aspects of human experience and places health fully in the dynamic interplay of social structures and human agency' (Yuill et al. 2010: 11; Marmot 2005). This 'turn to faith' inside the public sector began in the 1980s, with an increased focus on religious dynamics within UK public policy. This reflected 'the growing public significance of "religion" and "faith" in terms of local and national debates about the politics of multiculturalism' (McLoughlin and Zavos 2014: 165) and the self-representation of many BAME groups in terms of a faith-based identity rather than one rooted in race or ethnicity (Author and Colleague 2016). The recognition of

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religion in the British public sphere was promoted by a communitarian 'New Labour' following their election in 1997, which saw the emergence of a 'faith relations industry' (McLoughlin and Zavos 2014; Beckford 2012) that emphasised the 'bridging' and 'linking' capital of faith groups (Putnam 2000). A growing narrative about the role of faith in 'social cohesion' can also be seen in the shift in language from 'religion' to 'faith', where, as Beckford explains, the introduction of a 'discourse of "faith", "faith traditions", "faith communities" and "faith-based" activities…shifted the focus of public attention away from the differences between religions and, instead, emphasised their common properties as faiths' (2012: 126). Finally, the role played by the neo-liberal welfare reforms since the 1980s and by the austerity agenda pursued by the UK Government since the 2008 global economic recession in this 'turn to faith' also need to be considered (Kus 2006; Farnsworth and Irving 2018). The role played by political reforms with respect to how faith is engaged with in the public sector reached a pinnacle in 2010 in the 'Big Society' initiative, a key policy in the 2010 Conservative Party general election manifesto, which aimed to 'reform public services' through 'redistributing power from the state to society; from the centre to local communities' via engagement with the voluntary sector (2010: 37). As Williams et al. (2014: 2798) note, although 'plans for a "Big Society" have all but disappeared from the political lexicon, the implicit ideals of philanthropy, self-help, and volunteerism through the devolution of power from the state to local communities continue to be rolled out.'

This paper makes two original contributions. First, we present and discuss findings from a qualitative study carried out in Leeds and Bradford – two neighbouring large cities in West Yorkshire – which examined PWs as BAME PH settings (Author et al. 2015; Authors 2016). Both cities are ethnically and religiously

diverse regions, and are becoming more so (Leeds City Council no date, 2014; City of Bradford MDC 2012, 2017). Immigration to the UK increased in the post WWII period, when the government began to encourage people from South Asia and the Caribbean to emigrate to Britain to fill a labour shortage (Panayi 1999, 2014; Brah 1996; Brown 2006; Ballard 1994; Winder 2004; Phillips and Phillips 1998). A second wave of migration took place from the late 1960s, following independence in East African countries such as Kenya, Tanzania and Uganda, which spurred a process of 'Africanisation' that culminated in the forced migration of South Asians (Patel 1972; Twaddle 1975; Ballard 1994). Other immigrants and refugees have since come to Britain, including Sri Lankan Tamil refugees, and more recently people from Somalia, Iraq and Syria. As these communities settled, they established places of worship, first hiring rooms or using members' houses, then purchasing properties to renovate and extend, and eventually building new properties from scratch (Ballard 1994; Burghart 1987). These buildings are important for people to practise their religion, and also for providing meeting places and tangible resources for bringing communities together. This research was significant in that it enabled a better understanding of the role of PWs for people's health, both in terms of intangible dimensions (e.g. prayer, meditation, singing, healing rituals etc..) and tangible ones (e.g. sermons with health messages, the running of services such as blood pressure and diabetes testing etc…). However, given the particular circumstances of this 'turn to faith' by the state, and concerns that faith actors are being co-opted as neo-liberalism's 'little platoons' (Cloke et al. 2017: 12), this research set out to explore what scope there is for PWs to become 'health promoting' and/or 'healthy settings' in a way that is meaningful for those who use them, as well as to ascertain the driving force behind health initiatives in places

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of worship: were they self-initiated or were PWs already engaging with PH actors, and what were the dynamics of this engagement?

The second original contribution of this paper is to develop the theory of 'therapeutic landscapes' (TL) that emerged from health geography. This is significant as it offers a new conceptual language for articulating the health significance of places of worship, where the healing process is not just confined to bio-medical settings, but also 'works itself out in places (or situations, locales, settings and milieus)' (Gesler, 1992: 743). The growth of health geography since the 1980s signifies an 'increased interest in wellbeing and broader social models of health and health care', and these 'new geographies of health have been cast as emphasizing the centrality of place in the study of health' (Kearns and Collins 2010: 16). The concept of TL represents an important attempt to bring a focus on place together with one on health and wellbeing (Gesler 1996; 2003; Williams 2010; Bell et al. 2017). The notion of landscape goes beyond 'physical and manmade environments' to one with social and symbolic dimensions as well, where

> Concepts such as sense of place, landscape as text, symbolic landscapes, negotiated reality, hegemony and resistance, territoriality, and legitimization and marginalization have been employed…in efforts to interpret human landscapes. All of these concepts can be applied to the explication of therapeutic processes in various settings (Gesler 1992: 735).

PWs can, of course, be non-therapeutic, since health is not their core business, but also because what counts as and is experienced as therapeutic is subjective, may be fragile or temporary, and the activities undertaken in and worldviews promoted by PWs are not always conducive to health and wellbeing. However, the

TL framework is an heuristic device that makes the health relevance of PWs (both positive and negative) visible to PH practitioners – both statutory and third sector – as well as to members of PWs. We argue that PWs act as therapeutic places (i.e. specific transformative sacred sites) and therapeutic spaces (i.e. settings that provide adjuncts to formal PH promotion services), and that they are part of therapeutic networks, which include ‘kinship groups and networks of care provided by family, friends, therapists and other agents of support’ (Smyth 2005: 490).

The theory of TL also has the benefit of being able to ground a more realistic understanding of the role of faith and faith spaces in the lives of immigrant and minority communities as being embodied and relational, rather than captured by the particular kind of individualism on which much thinking about behaviour in the west is premised. Such groups and individuals often strongly engage with faith traditions that enable transnational and historical links to be maintained as they settle in new locations (Vasquez and Knott 2014). Religious faith can facilitate the building of a home-from-home, with places of worship playing both material and symbolic roles in this (Author and Colleague 2016; Colleague and Author 2017). Rather than relying on the reductionist conceptualisations of religion that are dominant within secular western settings, in which religion is viewed as a private rather than a public matter, and faith spaces are viewed as spatially discrete as well as functionally separate from other social settings and spheres (i.e. a place where only religious activities occur), the TL approach views faith settings as relevant to domains other than the ‘religious’, where the impact they have upon an individual extends beyond the actual faith space itself (Knott 2005).

Faith and therapeutic landscapes

The links between faith settings and healing was a focus in Gesler's seminal 1992 article on therapeutic landscapes, as well as in his later work on Lourdes and the Asclepian sanctuary at Epidauros, Greece (1992, 1993). Subsequently, a few more scholars took up this theme and have used the TL framework to interpret the therapeutic significance of specific sacred sites, including holy wells, places of pilgrimage and retreat sites (Foley 2011; 2013; Perriam 2015; Williams 2010, 2013; Maddrell 2011, 2013; Maddrell et al. 2015; Maddrell and della Dora 2013; Conradson 2007). Our paper makes a number of important contributions to this field. First, while many of these authors focus on religious 'places celebrated for their reputed healing qualities' (Williams 2007: 2) our research is interested in the more 'everyday' and 'ordinary' places of worship. These play a role as 'incidental' therapeutic landscapes in that they typically do not have health *per se* as their primary focus. However, they are often 'intentionally' therapeutic, with many engaging in specific activities to promote PH and wellbeing outside of what are often perceived to be their traditional concerns with ritual and worship. Second, while the existing literature has focused on the majority 'white' Christian ethnic group, our study includes Sikh, Hindu, Buddhist and Muslim places of worship in addition to Christian churches. In order to understand the transnational dimensions of immigrant religiosity and the role that this can play for health, we employ the concept of 'therapeutic landscapes of the mind' (Gastaldo et al. 2004), where

> landscapes are also discursive…relational images that we experience alone or share with others to situate us in terms of a complex array of categories present in our histories and cultures. These landscapes may represent our places of origin, or what is healthy and what generates a sense of well-being

for ourselves or others (2004: 160).

For many members of immigrant or diasporic communities – even second and third generation – there is a separation in time and space from one's 'original' home, and a place of worship can play a role as a 'therapeutic coping mechanism for 'missing' the places of home' (2004: 160). This is achieved via collective memories invested in the material location of a PW, living cultural practices (including languages, dress, food, music etc…) and ritual performances rooted in sacred texts and traditions.

Third, a recent paper by Agyekum and Newbold (2016: 675) agrees with us that, 'while the concept of therapeutic landscape has been applied in many areas and scales in recent years little attention has been focused on the role of places of worship', and they explore 'whether immigrant religious places of worship (churches and mosques) are therapeutic places.' Their focus is on Ghanaian and Somali immigrants living in Hamilton, Ontario, and 'the importance of religious places as therapeutic landscapes in shaping health' (2016: 680). We take this further by not only employing the concept of TL to interpret the health significance of PWs to the people who use them, but also arguing that it is relevant for understanding and realising the emerging 'rapprochement' (Cloke and Beaumont 2013) between health and faith actors.

Background to the project

Religious actors have been involved in the provision of health services in numerous settings worldwide and, in such contexts, faith-based facilities continue to constitute a dominant proportion of national health systems (Gunderson and Cochrane 2012; Holman 2014). A study funded by the World Health Organisation,

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focussing on Lesotho and Zambia, found that Christian hospitals and health centres were providing around 40% of HIV care and treatment services in Lesotho, and almost a third of these services in Zambia (Olivier et al. 2006).

The intersection of 'religious' and 'cultural' worldviews in many parts of the world generates concepts of health and wellbeing that can differ considerably from the biomedical model, which is itself informed by the duality of 'body' and 'soul', each of which requires a different type of treatment (Gunderson and Cochrane 2012). Whilst the biomedical model perceives 'health' in terms of curing diseases that affect the physical body, many communities attach a religious meaning to illness, in terms of an emic understanding of its causes, and hence the appropriate cures needed to treat it (e.g. a punishment from God that requires prayers; or a curse that requires ritual intervention) (Holman 2014). Further, approaches to healing within religious settings may be more focused on the 'whole person' (in which the body and soul are recognised as responsive to each other) rather than on the elimination of a set of physical symptoms (Koenig 2012) . As with the biomedical model, there are both strengths and weaknesses to faith-inspired ways of thinking about health. For instance, some are critical of explanations for illness that may discourage the faithful from seeking medical help, including the Pentecostal preacher 'curing' people of HIV and AIDS (Roura et al 2010; Wanyama et al 2007; Nozaki et al 2013).

A growing body of scholarship recognises the strengths of a faith-inspired approach, where the support provided in faith-based settings and the trust that people place in religious leaders, as well as the tangible resources that religious settings have, can be a great asset in the pursuit of better global health outcomes (Olivier 2015). While faith actors have become more widely recognised in formal

healthcare programmes in the developing world and the USA (Gunderson and Cochrane 2012), this has happened to a much smaller degree in the UK.

Methods

This paper draws on data from an on-going mixed methods research project involving public health actors, religious leaders (RLs), community based organisations and academics in Leeds and Bradford. The research project was initiated by a colleague working in a department of Public Health who was seeking to understand how the contributions of places of worship to the wellbeing of BAME community members might be better understood, mapped and utilised. Having invited us to a number of meetings with other public health colleagues and local religious leaders, we were tasked with designing a research process to meet the aims set by our public health partners. After a number of informal conversations with a range of stakeholders, we conducted nineteen qualitative semi-structured interviews in Leeds and Bradford, with purposively selected respondents, and three focus groups (between early 2014 and late 2015). The research has been published in two working papers which more fully explore the themes that emerged across our data (Author et al. 2016; Authors 2017). Ten interviews were undertaken at PWs with religious leaders (RLs), selected on the basis that we included at least one representative from each main BAME faith tradition in the cities. Our sample of RLs comprised five Christian ministers (three Anglican, one Methodist and one Pentecostal), an imam (the leader of worship in a mosque), two Sikh members of Gurdwara committees, a Hindu temple chairman and the founder of a Buddhist centre. The type of religious leaders we interviewed thus varied. A situation where the religious specialist (e.g. priest or imam) is in charge of running the PW is more likely to be found within a Christian setting. While imams also tend to have a more

public facing role, Hindu and Sikh priests focus on religious/ritual roles and, in these settings, we interviewed members of the temple boards– a secular and, generally, an elected role. We also carried out four interviews with third-sector organisations working on wellbeing (this included two Muslim women's organisations, an organisation working with asylum seekers, and an organisation focusing on mental health and Islam); and five interviews with local authority PH professionals (including a health improvement manager, a commissioner of mental health services, a nutritionist, a children's services member of staff, and a Leeds Health Authority ex-employee).

Prior to undertaking the interviews and focus groups, we had been engaged in a number of conversations with local religious leaders and public health specialists about the health needs of local populations and the intersections between their religious and health related behavior. Certain faith leaders and community gatekeepers became regular interlocuters as we sought to develop our methodology and reflect on what we were hearing in our interviews. Our focus group and interview questions were heavily informed by the informal conversations we had with religious leaders and gatekeepers prior to and throughout the formal research process. Our three focus groups were organized by community gatekeepers, all of whom had been individually interviewed by us before committing to opening up research participation to the congregants or community groups that they work with. In each case, the gatekeeper considered our research and request for a focus group to their congregations/community members to discuss whether they felt it valuable or not to contribute to the research. Our Methodist focus group was organized by the Methodist minister and held in the Methodist church hall. Our Anglican focus group was organized by the head of the Pastoral Support Team who invited us to come along to a regular monthly meeting of pastoral support

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workers at her home. The Muslim women's focus group was organized by a local interfaith community worker whose work with the local Muslim community involved a women's radio broadcasting group. We ran the focus group at the radio studio before the weekly scheduled broadcast and spoke about some of the issues raised in the radio programme which was recorded immediately afterwards. The focus group facilitator was interviewed for the radio programme and was asked to talk in more detail about the research project and findings so far. Whilst each focus group was organized slightly differently in response to the nature of the group and where they might feel it most convenient and comfortable to meet, the same set of cues were used across all three groups.

In accordance with standard qualitative data gathering protocols, the purposes of the research were introduced at the beginning of the interviews and focus groups and signed consent was required from all who participated. The interview and focus group conversations were recorded and transcribed verbatim and the transcripts combed for emerging themes (coding) by both authors. In addition to the interviews, our data and analysis has been informed by notes taken at relevant meetings about faith and PH, and by the websites of organisations and places of worship. Ethical approval for this research was obtained from the University of Leeds Research Ethics Committee.

Apart from the three focus groups described above, we did not carry out research with members of congregations. This limited the range of perspectives captured, and this is being addressed in current research. However, the aim of this project was to carry out a scoping study, initially commissioned by the Public Health Directorate in Leeds City Council, to build up evidence about the kinds of PH activities already taking place in PWs; to make some recommendations to PH actors and PWs wishing to engage in this area; and to point towards areas for

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future research and collaboration (Author et al. 2016). While our aim was not to compare settings *per se*, we followed this up with a similar project in Bradford, funded by the third-sector organisation FaithAction (Authors 2017).

Methodologically, the fact that this research was initiated by non-academic partners required us to engage with considerations that are absent in typical academic research, but are critical to scholarly debates about the implications of the ‘impact agenda’ in UK academia (Pain et al 2011; Slater 2012; Pain et al 2012). The impact agenda, introduced as a performance measure for academic departments by the Higher Education Funding Council for England (HEFCE), allocates ‘a proportion of the government funding that it distributes for research…on the basis of the “demonstrable benefits [of research] to the wider economy and society”’ (Pain et al 2011: 184). This impetus to show the social and economic impact of academic research has incentivised a range of cross sectoral partnerships in which academics are actively seeking collaborations with public and third sector organisations. The implications of the impact agenda for the work of scholars and external organisations alike are complex, and much discussed across a variety of disciplines (Smith and Stewart 2017; Chubb et al 2017; Ní Mhurchú et al 2017; Gunn and Mintrom 2017). Our own experiences illuminate some of the complexities of cross-sectoral partnership which we were continually negotiating, throughout the life of the collaboration. First, the research aims and objectives were not set by the academic partners, although they did shape them through their existing knowledge. Further, in addition to carrying out the research, the academic role was also to produce something that was useful to the non-academic partners. Second, the collaboration between academics and Public Heath Leeds meant that the research participants viewed the academics either as representatives of PH Leeds or as being able to relay concerns back to the

council – something which may have influenced the responses received in the interviews and focus groups. Finally, the whole process involved and continues to involve high levels of negotiation between different sets of needs and interests: those of the academic social scientists, who wish to capture and interpret complex social dynamics; PH Leeds, which seeks practical solutions to gaps in its knowledge about and capacity to engage with PWs around PH goals; and RLs and members of local communities, who are the research participants, but also individuals with experiences of seeking to secure health and wellbeing in Leeds and Bradford – a domain over which they perceive PH Leeds to have a high degree of control.

Findings

All the RLs interviewed were relatively well informed about the health issues facing their communities, were involved in some kind of health-related work in their PWs, and were generally positive about taking this further, viewing it as a natural extension of their 'religious' activities. According to a Methodist interviewee – 'it's just the other side of what we are about really…It's the practicalities of what we…do (theologically)'.

Health concerns amongst BAME communities in Leeds and Bradford include some that are associated with ethnicity and culture. These include sickle cell anaemia, as well as recessive disorders (especially amongst Pakistani Muslim communities in Bradford) resulting from the practice of marrying blood relatives, typically cousins. Smoking, chewing tobacco and the use of shisha pipes were also highlighted. In the Sikh and Hindu settings, we were told that members of the older

generations are less likely to exercise than members of the younger (and 'better educated') members of the community, and that their South Asian heritage diets mean that they consume high levels of sugar and fat. In Bradford, obesity amongst the Pakistani Muslim community, particularly in children, was highlighted, with links made to social deprivation, the easy availability of cheap fast food and low rates of breast feeding (Authors 2016). Whilst some health conditions, for instance diabetes and sickle cell anaemia (Department of Health 2001), have genetic links, other structural influences also play a role in BAME health inequalities, including poverty, deprivation, racist attitudes, culturally insensitive services that fail to reach the target audiences, and religio-cultural factors.

One of the perceived strengths of PWs is that they draw on volunteer labour, typically offering services for free or cheaply, and that they are embedded within communities, providing a safe and trusted space. A Christian respondent felt that religious leaders have 'a certain amount of weight. And sometimes, people will say to us, "so-and-so needs to see the doctor. Will you have a word?"' There is evidence that PWs offer a way of reaching groups and individuals that may not access conventional health care services by providing a location for PH interventions ('faith-placed'), as well as those generated within the PW as part of their normal activities ('faith-based') (Campbell et al. 2007).

Some of our interviewees also drew attention to the fact that people's interpretations of health issues are often influenced by their culture and religion, with mainstream health services not taking this into account. A Pentecostal RL told us that,

> Some years ago…one of the church members [was] sectioned under the mental health act, and I went to see them, and…they were classed as

> being delusional because they were 'praying in tongues' as we call it in our sort of churches, which is normal behaviour for us.

Conventional health services may not be suitable in such situations and PWs and RLs can play a role in facilitating culturally adaptive mental health provision. Their potential as translators across worldviews can be leveraged to inform the perspectives of PH agencies. A representative of an organisation called Sharing Voices Bradford (SVB) – originally the UK's only Transcultural Psychiatry Unit – explained that,

> A person might be saying, 'I'm possessed' or 'I'm afflicted by', in people's words, 'black magic'…So that's quite a stark contrast [with] a medical model, so the medical model would define that as problematic, and [reflecting] symptoms of underlying mental health conditions….

Another project working on mental health, called 'New View', was run by Leeds-based organisation 'Touchstone'. This aimed to 'increase the number of people from BAME communities who are able to access appropriate and timely care through their faith', while at the same time working through 'Black Majority Churches and communities to challenge myths and stigma' (Touchstone no date). Touchstone has also undertaken a similar project in mosques to find ways of tackling and destigmatising issues surrounding mental health amongst Muslims.

Regarding the possibility of more coordinated engagement with PH agencies, respondents were mostly interested, but also raised concerns, including that PH actors viewed PWs as a 'resource to be milked' in this era of budget cuts. One Hindu interviewee explained that, since 'most of our donations come to the temple

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for religious purposes', the committee needs convincing to spend the money on other activities. In a Pentecostal setting, there was interest in taking things further, but our interviewee stressed that it would have to be 'at an appropriate level…because my primary role is being a spiritual leader.' RLs are not normally medically trained, nor will they necessarily be 'outward facing' enough to know where to signpost people to. Other limits to the work of PWs in this area included not always having appropriate space or facilities. Also mentioned was the issue of 'timing', and it was suggested that where health-related activities are an 'extra', they should be tagged onto something that people are already attending.

Others stressed that religion can get in the way of good health when people view illness as 'God's will', a punishment as the result of sin or *karma*, or in a way that suggests it is stigmatised. According to one of our Christian respondents,

> The danger is that people can spiritualise it and say, 'well, I don't want to go because I've prayed about it', or 'I've got my minister to pray for it already, and if I go that means I'm demonstrating a lack of faith'…But that's not something that we encourage. We will pray, but we will encourage people to go just to verify that they have been healed.

Another limitation to PWs as PH settings is the impact of moral and social dynamics, which can limit their ability to address issues related to sexual health, women or those who are in LGBTQ+ groups. In our focus group with Muslim women, respondents discussed the fact that women are less likely to attend the mosque than men as they are not obliged to pray there, and often there are no separate facilities for them. While there are different types of mosque – some of which actively encourage women's participation – there was a perception of

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mosques as being relatively unwelcoming, and Muslim women often chose to meet in alternative spaces.

Discussion: Places of Worship as therapeutic landscapes

Smyth (2005) suggests that it is useful to explore therapeutic landscapes in terms of three main themes, and we use her framework for interpreting our findings. First, we look at PWs 'therapeutic places', enabling us to explore 'some of the ways in which specific places developed, and have subsequently sustained, a reputation for healing' (2005: 489). This was the focus of the early literature on TL, in which 'therapeutic places' are seen as specific natural features and indeed special religious sites associated with healing (Gesler 1996; Foley 2011; Perriam 2014; Williams 2010; Dobbs 1997; Conradson 2007; Wilson 2003). Second, Smyth draws attention to more recent studies on what she calls 'therapeutic spaces', which comprise more generalised spaces 'within which health is played out such as the institutions of health care, including hospitals and clinics, and other institutions that provide therapeutic functions' (2005: 489). The former concept thus picks out 'places' that have the inherent ability to provide therapy or healing, whereas the latter picks out 'spaces' where therapeutic or health-related activities may be carried out. Finally, Smyth argues that, in addition to therapeutic places and spaces, we also need to consider the 'therapeutic networks' 'through which people gain support and care, often outside the biomedical tradition' (2005: 489-490). Below, we map our findings onto Smyth's three aspects of therapeutic landscapes – places, spaces and networks (2005).

PWs as therapeutic places

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> A therapeutic landscape arises when physical and built environments, social conditions and human perceptions combine to produce an atmosphere which is conducive to healing. The term healing is used here in a broad manner to include cures in the biomedical sense (physical healing), a sense of psychological well-being (mental healing) and feelings of spiritual renewal (spiritual healing) (Gesler 1996: 96).

Gesler's focus here is upon 'Lourdes as a unique therapeutic landscape or healing place' (1996: 96). While ordinary PWs are not well known as iconic places of healing in the way that Lourdes in France or the River Ganges in India are, they nonetheless possess therapeutic qualities, as can the people and objects found within them. PWs can be *transformative sacred places* that require modification of behaviour (e.g. removing shoes, deepening one's thought, covering one's head, kneeling or genuflecting) and, in turn, can have a transformative impact on devotees. It is important to think about the role that bodies of both devotees and religious specialists play in such processes of healing. PWs are places of embodied and relational practice, as they bring bodies together to participate in rituals that can have a mutually beneficial impact, as well as bringing bodies into contact with religious specialists considered to have direct healing powers. Sacred objects, such as amulets, which people might acquire in a place of worship or have blessed there, are worn on the body for protection and healing purposes.

Scholars have attributed the transformative quality of sacred places, such as PWs, to their ability to deliver devotees into a liminal state. Building on the work of Van Gennep ([1909] 1960), Turner (1969) argued that 'rites of passage' have three phases: separation, liminality and reassimilation. Applying this to places of

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pilgrimage such as Lourdes, Gesler tells us that pilgrimage is a 'journey from one place to another, from one aspect of one's life to another…many people experience pilgrimage as a transformation. Religious pilgrimage, in particular, can be viewed as a movement from the profane to the sacred' (1996: 96). Within such a liminal or 'threshold' state – brought about by participating in rituals and prayers or even entering a PW – healing can be experienced. This is a view of health/healing that goes beyond the physical and brings about mental and 'spiritual' transformations that can contribute, maybe only temporarily, but often cumulatively, towards a person's overall sense of wellbeing.

PWs can therefore be therapeutic places by virtue of such intangible processes of transformation, and form one aspect of what we are calling the 'business as usual' approach to health and healing. The second aspect involves tangible and everyday religious rituals or practices being given a health-related spin. This might include the integration of health messages into religious festivals and weekly forms of worship; and lay pastoral support teams and chaplains that extend faith-based healing and support into people's homes as well as hospice and hospital settings.

However, the role of PWs as therapeutic places can place them in tension with biomedical approaches. One of our interviewees in an Anglican setting explained that, 'whereas people might talk of illness in relation to other people as a punishment, for themselves, they tend to think of it as a test of faith where part of this response might entail praying in the middle of the night for the relief of pain, rather than taking prescribed pain killers'.

PWs as therapeutic spaces: the 'healthy settings approach'

The second type of engagement between PWs and public health activities involves projects or activities initiated by PWs in their capacity as 'therapeutic spaces'. As Smyth writes,

> recent work examining the relationship between health and place has tended to focus less on specific places and, instead, has paid attention to therapeutic 'spaces'. As such geographers have concentrated attention on the less extraordinary locations of health care including institutional spaces such as the hospital…the birthing room …the family planning clinic…and other sites where health care is not the primary function such as the prison…schools…and the gym (2005: 490).

The focus here is on spaces that are not obviously linked to health, as well as upon how these 'therapeutic spaces' can be designed so as to be as beneficial to health and wellbeing as possible. The WHO 'healthy settings' initiative is an example of this approach, where, according to the 1986 Ottawa Charter for Health Promotion, 'Health is created and lived by people within the settings of their everyday life; where they learn, work, play, and love' (WHO no date). Work on this has been carried out within schools, workplaces, hospitals, prisons and universities (Dooris 2005; 2007), but virtually no attention has been paid to places of worship as 'healthy settings', with the exception of Corcoran et al. (2013). Our research agrees with Corcoran et al.'s assertion that 'religious organisations and faith groups have often been able to engage in important roles in health…and thus have potential as a health promotion setting' (2013: 121), and may 'allow access to some populations that traditional health promotion efforts may not reach, including specific ethnic groups and older people who may be traditionally low users of health care' (2013:

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122). Our research found that both Christian and non-Christian PWs are playing a role as therapeutic spaces, with interviewees in the Buddhist, Sikh and Hindu settings we visited all talking about the involvement of alternative traditional health practitioners in their PWs. In one of the gurdwaras we visited, doctors and dentists from the membership had given health-related talks, and another, the Ramgarhia Gurdwara Bradford, had established itself as a 'dementia friendly gurdwara' – the first in the UK – winning first place in the voluntary sector category of the 2014 Alzheimer Society's Dementia Friendly Awards. Other self-initiated initiatives were wide ranging, including food banks, luncheon clubs, exercise classes, yoga and meditation and cookery lessons (Author et al. 2015; Authors 2016).

PWs as therapeutic networks

The third type of engagement between PWs and PH involved outside agencies, such as Public Health Leeds, utilising PWs to deliver their PH messages and services, where PWs are part of broader 'therapeutic networks'. According to Smyth,

> Unlike notions of therapeutic spaces, therapeutic networks are less formalized arrangements of support and care that often exist outside (or in parallel to) the traditions of biomedicine...[T]he concept of a network may enable geographers to think about the provision of health care in new ways. Health care is increasingly being provided outside the formal setting of the institution and inside more informal settings such as the home, the garden...and the 'community' where multiple sources of support may exist in the form of a therapeutic network (2005: 492-493).

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Smyth's notion of 'therapeutic network' enables us to see PWs as part of broader 'health systems' that include formal and informal 'health providers'. For faith communities, the idea of a place of worship as part of a therapeutic network extends beyond the local setting, since PWs have transnational links to communities and affiliated institutions overseas, which provide practical support and spiritual guidance, including the movement of religious specialists to work at PWs in the UK. The idea of therapeutic networks resonates with recent writing on 'health systems', which argues that we should view PWs and other faith based organisations as part of broader health systems comprising networks of interlinked service providers, social spaces and public and private institutions (Olivier 2015).

Our research on PWs as part of therapeutic networks is ongoing, and we are currently engaged in a two-stage process of 'neighbourhood mapping' to enable us to see how PWs, third sector organisations and public-sector health actors are connecting around health. As a first step to deepening our understanding of how faith actors intersect with and participate in 'therapeutic networks', we have begun to map PWs in areas in Leeds with high BAME representations. This has allowed us to present information in the form of an online interactive map, which will be useful to public and third sector organisations that have limited knowledge in this area, as it will provide them with the locations of PWs and the externally visible health and wellbeing related activities they engage in, such as fitness and language classes, lunch-clubs and food delivery services. The second stage has involved research in the form of community workshops to identify the subjective experiences of the membership and congregations of PWs in order to ascertain their perceptions of the 'health assets' available in their local communities and how their personal faith and local PWs contribute to them. In contrast to a 'needs-based'

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approach, which focusses on the negatives or what is missing, an 'assets-based' approach looks for things that already exist within a community that are being or could be leveraged by that community to achieve their goals (Foot and Hopkins 2010; Lightfoot et al. 2016).

Conclusion

This paper makes two original contributions. First, we present and discuss findings from research carried out in Leeds and Bradford which examined PWs as BAME PH settings in the light of a 'turn to faith' by PH actors in recent years (Author et al. 2015; Authors 2016). This should also be seen against the backdrop of a shift in PH praxis towards an 'asset-based' approach to health and well-being that can play a role in community building, and 'as a potentially empowering means to address the social determinants of health (Roy 2017: 455). However, both the 'turn to faith' and the assets-based approach have been criticised 'for being a tool of neoliberalism' (Roy 2017: 455) and for functioning as its 'little platoons' (Cloke et al. 2016: 12). While we agree that the impact of neoliberal welfare restructuring does pose a threat to the potential of community-based models to transform people's lives, this critique could become overstated and get in the way of improving the integration of community assets and worldviews into health systems. There are opportunities to be taken up, which, if utilising partnerships, could offer better ways of achieving health and well-being for the most marginalised. Our findings are significant as they suggest that some RLs and community members do consider that their PWs have a relevance for health, and many are keen to explore ways of developing them as 'health promoting' or as 'healthy settings'. Nonetheless, the feedback we received indicated that for this to be meaningful for

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and attractive to those who use PWs, it would require a collaborative approach that included local communities as equal partners rather than substituting service providers for the neoliberal state. We found that although PH actors are becoming more interested in developing PWs as BAME PH settings, that there is already much health-related activity in PWs that could be built upon, both incidental and intangible, and intentional and tangible. Roy argues that ‘the knowledge of “lay” people working outside of formal public health systems [is] crucial to addressing long-standing issues of public health concern’ and ‘the public health impact of the work of community practitioners operating outside of formal health systems requires to be better appreciated and understood’ (2017: 462). Our research demonstrates that there is a specific role here for RLs and PWs in informal health systems that warrants greater attention in academic studies as well as in PH policy and practice.

Our second original contribution was to develop a new framework for thinking about places of worship as therapeutic landscapes. We have argued that this is significant as a therapeutic landscapes framework is a way of making the health relevance of PWs visible to health practitioners – both statutory and third sector – as well as to members of PWs themselves, as sites that are not normally associated with healing in mainstream western approaches to PH. We provided an original analysis in identifying three types of engagement between PWs and PH-relevant activities. The first type we have called ‘business as usual’, where PWs are viewed as sacred and liminal places with the inherent ability to provide healing, or where every day religious practice can be given a health-related spin. The second type of engagement between PWs and PH activities involves health projects/activities initiated by PWs in their capacity as ‘therapeutic spaces’ with the

resources to meet health and wellbeing goals. Finally, the third type of engagement is where outside agencies have utilised PWs to deliver their PH messages and services, in which PWs are part of broader 'therapeutic networks'. We employ the concept of TL as 'an analytic framework, a way of looking at, assessing, those places that existed…where healing was supposed to be taking place' (Gesler 2017: 5). However, we also seek to go beyond this in agreeing with Williams that the concept of therapeutic landscapes provides 'a tool for informing and mobilizing positive change in the world' (Williams 2017: 12) that enables us to 'take up the challenges of being more intentional with respect to the needs of vulnerable Populations' (2017: 13).

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Highlights

- Faith-based actors and organisations play role in BAME public health.
- Examines places of worship as BAME public health settings.
- Recentres religion and faith settings into therapeutic landscapes literature.
- Influences on health behaviour are not just confined to bio-medical settings**.**

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