ON FAITH, PLACE AND HEALTH:

HARNESSING THE POWER OF FAITH GROUPS TO TACKLE LONDON'S HEALTH INEQUALITIES

CONTENTS

Acknowledgements 4

Foreword 5

Key Points 6

Introduction 7

Consultation Design and Method 10

Key Questions and Statements 12

Town Hall 1 12

Town Hall 2 12

Themes and Insights 13

Frontline Response 14

1.1 The COVID-19 Pandemic - Self-efficacy and Faith Groups' Response to Bereavement 14

Protection and Procedure 16

1.2 The COVID-19 Pandemic - Self-efficacy and Faith Groups' Response to Vaccination Rollout 16

Influence 17

2.1 Influence and Social Capital of Faith Leaders 18

2.2 Spiritual Bypassing and Misinformation 18

2.3 Education 18

Partnership 19

3.1 Mutual Trust, Value and Dignity 19

3.2 Data 19

3.3 Funding 21

3.4 Faith Groups as Healthcare Service Providers or Advocates 22

3.5 Faith Groups as Social Prescribers to Widen Access 23

4.1 Discrimination, Knowledge, Care and Cultural Sensitivity 23

A Call for Systems Change 24

5.1 Interconnectedness and a Greater Focus on Social Determinants of Health 24

Faith-Health Interventions as Part of a Whole-Systems Approach 26

Headline Recommendations 27

Government 27

Local Authority and Health Systems 27

Faith Leaders and Peers 28

Additional Recommendations 29

References 30

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About the Group

The Health Inequalities Action Group was founded with the belief that the value of faith groups as community assets was not yet understood. From this, an agreement between some of London's faith leaders was made - that collective action is needed to fully realise the potential of faith communities in improving health outcomes in the Capital.

The Group came together to explore and develop discourse on the relevance of faith groups to local communities and public health solutions.

The Group's distinguishing feature is its effort to take both bottom-up and top-down approaches seriously. The role people, and communities of faith can take in responding locally to health inequalities can shape national policy responses.

The Group and research personnel are grateful for all the support and contributions provided throughout this process. They would like to thank faith leaders, parliamentarians, health specialists and practitioners, civil society leaders and those with lived experiences of health inequalities for their time, insight and experience.

In memory of the late Leonie Lewis MBE, the Health Inequalities Action Group would also like to recognise her as the stalwart community champion she was. The research personnel are especially grateful for her wisdom and teachings on the practicalities and diplomacy involved in interfaith engagements. Her commitment to her Jewish faith, interfaith partnership and community flourishing meant she was incredibly invested in this work and seeing this report come to life.

FOREWORD

I have spent my adult life serving in two of Britain's most prominent institutions; the National Health Service and the Church of England. Experience has led me to believe that co-operation between faith communities and public health institutions can be transformational. This is particularly true regarding better access and outcomes for those who currently struggle to engage with all that our National Health Service offers.

The reality of health inequalities across our nation is undisputed. In recognition of this inequality, the Johnson Government announced its intention to release a White Paper investigating such inequalities. I certainly hope this vital work will be continued, as in this post-COVID world, where the systemic existence of health inequalities was deeply revealed by the pandemic, I believe that this is a moment in time to harness the potential of faith-health partnerships. This is why I convened, the Health Inequalities Action Group to explore what might be offered from the perspective of faith actors in our communities.

As human beings we do not live our lives in silos. We are shaped by many influences and experiences which include our mental, physical and spiritual wellbeing. These are interdependent and both the world of faith and the world of medicine have increasingly recognised that fact. Our health is shaped by many things, including our education, housing, access to physical activities and our ability to practice our faith if we have one.

Faith communities are present in every locality. Those who belong to such communities, and those who connect with them through the many social projects which they sustain, bring with them the whole of their lives, including their questions and concerns about their own health and the wellbeing of those they love. Arguably, therefore, faith communities are uniquely situated as contexts, gateways and signposts to advice and provision.

The report which follows is the output of the Health Inequalities Action Group and is shaped by research, combined expertise and two town hall events held earlier this year. It is offered as a resource and call to action on the part of policymakers, health practitioners, local authorities, faith leaders and their peers.

I am profoundly grateful to those who have worked with me on this initiative to date and thank all the delegates came out to our consultations this year.

I look forward to the next stage as we engage with those who can take this essential work forward. I for one will be championing this report in the House of Lords in my position as a Lords Spiritual, and hope that you as readers of this report can join me in whatever way you can.

+ Sarah Londin

The Lord Bishop of London
The Rt Revd and Rt Hon Dame Sarah Mullally DBE

KEY POINTS

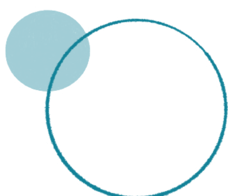
- **Faith institutions, in some ways, can be regarded as civic institutions which represent and reach diverse groups of people and backgrounds.**

- **Faith groups and faith-based organisations should be legitimised as valid community assets to continue their good works.**

- **There should be public value placed on the relational and social capital faith groups have and can leverage to restore trust in contemporary society, by including them in place-based public health and policy planning.**

“There is a goodwill tax on people of faith. Faith organisations are uniquely placed to address health inequalities in their local communities... Going forward, faith communities will need to be equipped with the fundamentals of public health and health promotion to effect change”

Professor Calvin Moorley



INTRODUCTION

London, COVID-19 Pandemic and Faith Groups

In the Summer of 2021, the Bishop of London gathered faith leaders, health specialists, and civil society leaders together to discuss health inequalities in London and identify actions in a pilot response. They became the Health Inequalities Action Group (HIAG) for London. The COVID-19 pandemic had made health inequalities more visible and emphasised the importance of local, yet holistic, approaches. It also highlighted the importance of faith institutions as sources of practical and spiritual support for communities under stress. During the vaccination rollout, faith institutions quickly became mediating institutions between national and local authorities and people of faith.

The Group decided to identify the various activities operating at the intersection of faith and health. We aimed to, first, listen to the relevant stakeholders and, second, draw up their findings for national policymakers; healthcare practitioners and local authorities; and faith leaders and peers to tackle health inequalities.

Who are People of Faith?

British society is made up of people from a range of faiths. More than 60% of people in England and Wales (71% in London) identify as religious– most are Christian, Muslim, Hindu, Sikh, Jewish or Buddhist.[1] These groups encompass a genuine cross section of society: younger, older, economically well off or worse off, LGBTQ+, and those who have historic roots in specific geographies such as Jewish communities in Stamford Hill or Bangladeshi communities in Brick Lane. Faith can almost be seen as a proxy measurement for other social group identifiers.

Why Do Faith Populations Matter in a Conversation About Health?

Faith groups were already active in supporting people who were experiencing some of the poorest health and social outcomes before the pandemic. Yet, public awareness of how much faith groups had contributed before and during the pandemic was limited. Through consultations, interviews and this report, we aim to capture the work and stories of faith communities and health inequalities in London over the last two years (2020-2022).

Churches are delivering care to those in need worth twice as much as the total spend on adult social care by local authorities. The yearly social value of churches in the UK and the activities undertaken therein is around £55 billion*

1 Population estimates by ethnic group and religion, England and Wales: 2019

* Source: https://www.kingsfund.org.uk/audio-video/key-facts-figures-adult-social-care; GADS1597 – NCT House of Good 2021 V7 SINGLE-PAGES.pdf (nationalchurchestrust.org) - p. 5.

Shalom as a Public Health & Policy Framework

The theological rationale for this piece of work was 'shalom' - a Judeo-Christian biblical concept which can be translated as completeness or wholeness or wellbeing. Shalom is given by God and is something greater than humans can conceive; it weaves a community together and is discovered through relationships and practical action. To experience Shalom is to flourish physically, psychologically, socially and spiritually.

The COVID-19 pandemic showed us how critical it is that we leverage a 'whole-systems approach', without siloes, to achieve what seemed impossible. The pandemic highlighted the power of faith institutions to act as mediating institutions between people and the government. Faith groups provided a channel for people to help other people and thereby enhance their own wellbeing at a time of stress, by experiencing agency and a power to be useful to others. This Shalom, or connectedness across sector and society was the premise of founding this group.

Defining Health

The World Health Organisation defines health as "a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity".[2] This is not too different from the framework of Shalom.

The Department of Health's definition of wellbeing is "a positive state of mind and body, feeling safe and able to cope, with a sense of connection with people, communities and the wider environment". These are the working definitions of health and wellbeing used in this document.[3]

Defining Health Inequalities

Health inequalities can ultimately be **defined as differences in people's health status** that are systematic, unfair and avoidable. One's health status can be shaped by:

1. **the care that people receive** and
2. **the opportunities that they have to lead healthy lives**

Health inequalities can therefore involve differences in:

- **health status, for example, life expectancy**
- **access to care, for example availability of given services**
- **quality and experience of care, for example, levels of patient satisfaction**
- **behavioural risks to health, for example, smoking rates**
- **wider determinants of health, for example, quality of housing.**

England, health inequalities are often analysed and addressed by policy across four types of factors:

- **socio-economic factors, for example, income**
- **geography, for example, region or whether urban or rural**
- **specific characteristics including those protected in law, such as sex, ethnicity or disability**
- **socially excluded groups, for example, people experiencing homelessness.**

2 World Health Organisation; Joint Strategic Needs Assessment Tower Hamlets_Summary.pdf (towerhamlets.gov.uk)

3 Department of Health. No health without mental health. (2011); Joint strategic needs assessment tower Hamlets_summary.pdf (towerhamlets.gov.uk)

Everyone experiences some degree of health inequality except the richest 10% in our society.*

Some of London's most pressing health inequalities are air pollution, smoking, alcohol and substance misuse; mental health in children and young people and poorer maternal healthcare outcomes for Black women.

What do Health Inequalities look like in England?

People living in deprived areas live shorter lives, spend more of their lives in ill health and have poorer access to health care than people in more affluent areas.[4] The average healthy life expectancy estimate in the UK for men is (62.9 years) and for women (63.3 years). The HLE for a man living in the North West of England, specifically Blackpool is 53.7 years, whereas a man living in the East of England in Rutland is estimated to live up to 71.5 years. The HLE for a woman living in the North West of England, specifically Blackpool is 55.3 years, whereas a woman living in the South East of England in Wokingham is estimated to live in to 71.1 years of good health.

What do Health Inequalities look like in London?

London currently has the biggest gap in life expectancy between local authorities of any region in England [5]. We know that the rate of early deaths from preventable causes is twice as high in Tower Hamlets as it is in the nearby City of London. But inequalities do not simply lead to people dying prematurely. They also unnecessarily undermine people's quality of life.

People from some of London's deprived neighbourhoods are unnecessarily living with ill-health for years, or even decades [6].

For example, women in Tower Hamlets can expect to spend 37 per cent of their lives in poor health – that's equivalent to 30 years. Many of their health problems could be prevented.

Black women in the UK are four times more likely to die in pregnancy or childbirth, the healthy life expectancy gap between the most and least deprived communities is 19.6 years and people with learning disability have a life expectancy gap of 15 years compared to the average population [7].

* What are health inequalities? | The King's Fund (kingsfund.org.uk); Tackling-health-inequalities-in-london-final-version.pdf (raceequalityfoundation.org.uk)

4 The Marmot Review 10 Years On

5 The London Health Inequalities Strategy

6 London's health inequalities strategy - Healthy London Partnership Partnership

7 NHS England » Tackling health inequalities in the NHS

BAME communities are at high risk of mental ill health. Depression is 60 per cent higher in BAME communities than white communities, but it is less likely that these communities access services through primary care. Once in contact with mental health services, rates of access to hospital care and longer term detention is much higher for the black ethnic group than for the White British group[8].

The NHS Long Term plan sets out a vision for the NHS not just to treat illness but also to support people to live healthily, and to help people with long-term conditions to self-manage and prevent emerging issues from worsening[9].

The CORE20PLUS5 is the targeted clinical approach to reduce health inequalities in a systematic and most urgent manner[10].

The HIAG recognised the role of faith groups in relation to health outcomes during the pandemic and gathered to ask how future public health planning might take seriously the role of faith communities in helping to alleviate pressure on the NHS and leverage the relational capital they have in their communities for greater health outcomes.

Consultation Design and Method

For the community consultations, we sought to hear from diverse stakeholders working in and/or influencing the faith and health ecosystem. Facilitated by secretariat guidance, we recruited cross-sector leaders from faith groups across London, to health practitioners, researchers and people with lived experiences of health inequalities to come together and explore the role of faith groups in community health. We hosted some community consultations using town hall-style events and focus group interviews with individuals and organisations that contribute to the intersection between faith groups and health inequalities.

Each group was led by 7-8 faith leaders from across London to understand how inequalities impact the health of Londoners in their community and the role of faith groups to promote community health. The faith traditions we worked with for this pilot were:

- Anglican
- Black Majority Church
- Muslim
- Hindu
- Sikh
- Jewish

London is the most religious English city, with over 71% of Londoner's identifying with a faith or belief[11]. We used the ONS National Population Survey and the 2001 census to identify the largest religious groupings in the UK/London in addition to reported statistics on ethnic, socioeconomic and geographic health inequalities to consult the aforementioned faith traditions. The town hall meetings attracted a small number of Hindu, Catholic, Buddhist and Atheist representation.

8 Health and Social Care Information Centre, 2014
9 Mental Health and Wellbeing Joint Strategic Needs Assessment Westminster, Kensington and Chelsea Summary Report.pdf
10 NHS England » Core20PLUS5 – An approach to reducing health inequalities
11 ONS National Population Survey 2018

The consultation was guided by the following objectives:

1. To identify the priority areas for improving the health of people in local communities
2. To understand how faith organisations can help meet the health needs of their local communities
3. To explore how faith organisations and communities are working/can work together to improve people's health outcomes
4. To introduce participants to faith-health models to get them thinking about how, where, and with whom and what they can engage to action the models

There were two town halls held: one in Hackney on February 21st 2022 at an Anglican church and the second on March 28th 2022 at a Mosque in Tower Hamlets. At the town hall, two type of focus group interviews were held.

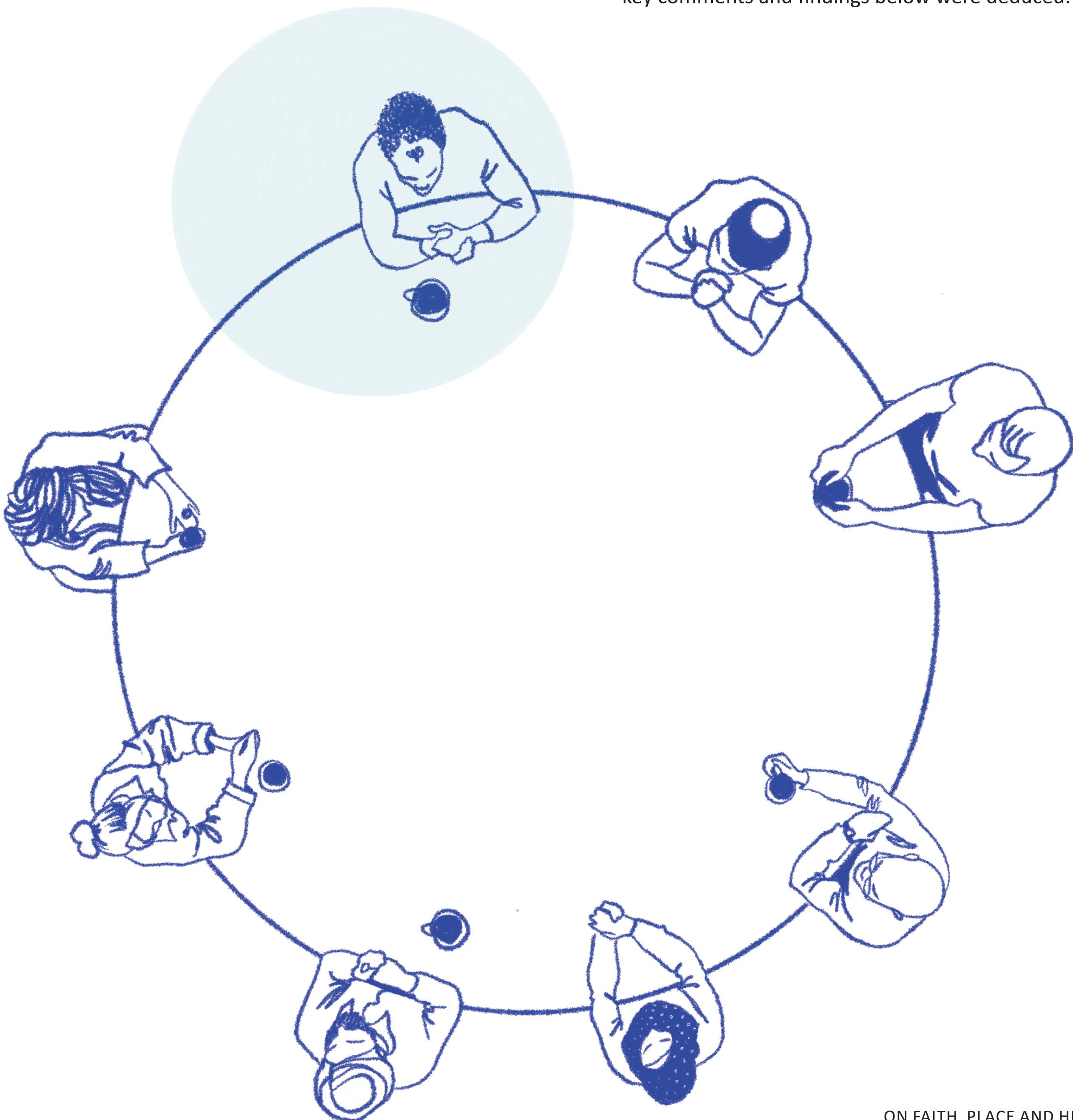
Town hall focus group 1: Intra-faith

This focus group interview was led by faith leaders for intra-faith discussions.

Town hall focus group 2: Inter-faith

This focus group interview was led by faith leaders for inter-faith discussions for knowledge sharing.

The data from the town halls was coded and the key comments and findings below were deduced.



Key Questions and Statements

Some key statements and comments that emerged from our town halls and interviews were:

Town Hall 1

Faith Leaders

- How can faith leaders help their congregations put wisdom and faith together and not spiritually bypass health realities?
- How can faith leaders help the congregation and help healthcare practitioners to understand the role of faith in a person of faith's value system?
- Faith leaders and faith groups are uniquely positioned to help alleviate health inequalities but what role do they want to play? And how does it vary in different localities?

- Where can people access trusted information? Who and what is a trusted source?
- Faith groups desire more examples of how people can take action to alleviate health inequalities and engage with varying levels of input.

Health Sector

- How can the perception of those in healthcare be developed to prevent them from dismissing someone based on their religious-based care needs?
- How can healthcare practitioners learn about the role of faith in a person of faith's value system? In what ways can they implement this knowledge in their practice and engagement with patients of faith who wish to have their beliefs influence their course of treatment or engagement?

Faith, Health and Policy Sector

- Faith, health and policy stakeholders operating in the faith and health interface are at different stages in their journeys when it comes to tackling health inequities.
- Faith, health and policy stakeholders have different strengths that, if brought together in a forum such as the town halls, could be the catalyst for developing solutions to tackle health inequalities.

Town Hall 2

Health Sector

- What would it look like to make the health sector's understanding of cultural competence more robust? Is equipping staff in health and care organisations with the knowledge and skills to serve a multi-cultural Britain a path to this?

Health and Policy Sector

- Services provided by faith organisations (like the Maryam Centre) are an extension of health and care services. How will the relevant commissioning bodies make long-term funding more accessible?

- How can we make faith-based healthcare partnerships more dignifying and sustainable?

The Maryam Centre is home to the prayer facilities for women. Based out of East London Mosque, they offer a professional and confidential counselling service for women of all backgrounds, provided by female therapists.

Faith, Health and Policy Sector

- What makes a (faith) leader? Who has the power to influence faith communities?

- Who is recognised and looked to as a leader?

Engagement with these statements and questions will occur throughout the report but it is worth stating that this is the beginning of a larger piece of work, of which this pilot has scratched the surface.

Themes and Insights

This section will highlight the themes and insights that emerged from our consultations and interviews.

1.1 The COVID-19 Pandemic - Self-efficacy and Faith Groups' Response to Bereavement
1.2 The COVID-19 Pandemic - Self-efficacy and Faith Groups' Response to Vaccination Rollout

2.1 Influence and Social Capital of Faith Leaders
2.2 Spiritual Bypassing and Misinformation
2.3 Education

3.1 Mutual Trust, Value and Dignity
3.2 Data
3.3 Funding
3.4 Faith groups as Healthcare Service Providers or Advocates
3.5 Faith Groups as Social Prescribers to Widen Access

4.1 Discrimination, Knowledge, Care and Cultural Sensitivity

5.1 Interconnectedness and a Greater Focus on Social Determinants of Health

Frontline Reponse

1.1 The COVID-19 Pandemic - Self-efficacy and Faith Groups' Response to Bereavement

The Anglican Christian participants spoke on the resourcefulness and organisation of their churches: from community-wide calling services to tackle social isolation, to specialist services for people who die homeless and vaccination delivery out of church gardens. One Anglican chaplain from a hospital in London reported how most of the COVID-19 chaplains they worked with were Anglican. All the chaplains who attended the consultation spoke of their sustained but tired effort to support the mass number of bereavements they witnessed day after day on the wards. One participant said:

> "We had a lot of COVID funerals. We had 20 in one day where nobody was able to turn up but me. There were babies who were buried alone and funerals happening in the community that I also had to be present for. [On the wards] I must have given out 50 or 60 memorial books... maybe more like 100 memorial books... and last year 16 [members of] staff died."

The chaplains' reflection demonstrates the critical role they had to support others during the pandemic. It simultaneously shows us the skeletal staff team supporting those who died and the great loss experienced by the families associated with each memorial book distributed. It is unknown if the chaplains themselves received any psychological or spiritual support to recover since the height of the pandemic. Their discussions simply implied a return to business as usual.

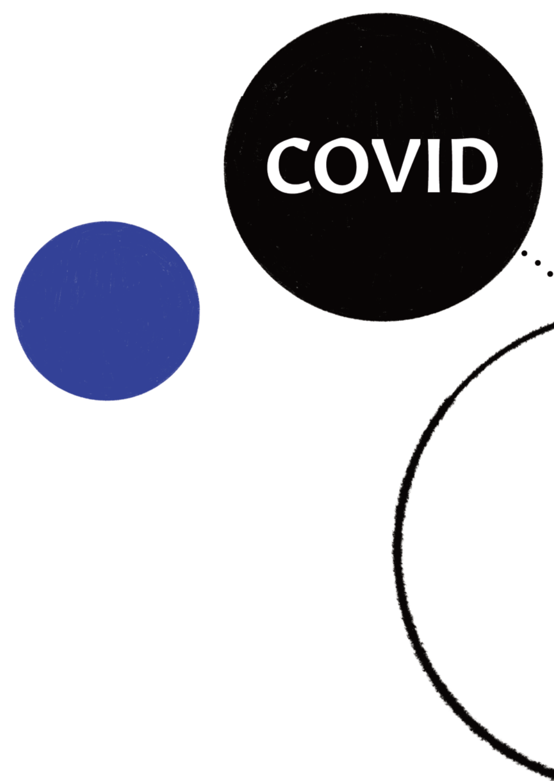
The Black Majority Church representatives shared how they fundraised to meet internal needs of people in the church. One Kings Chapel representative said:

> "we opened a funding pot because immediate financial support was needed and it was anonymous. People could simply say 'I need money for X', and people could donate."

Another representative from a different church said that they too tried to maintain the anonymity when providing financial assistance. They said:

> "we really tried to keep morale and mental health up. So we offered 'Helping Hand' donations which were anonymous, and discreet. There was just so much strain on everyone so we wanted to make it as easy as possible."

NHS Clinical Leader and Chair of Five2Medics[12] shared the disproportionate impact of COVID-19 on those from Black, Asian and minority ethnic communities. She spoke about how Five2Medics mobilised 22 key professionals from Black, Asian and minority ethnic backgrounds to tackle this disparity. They launched



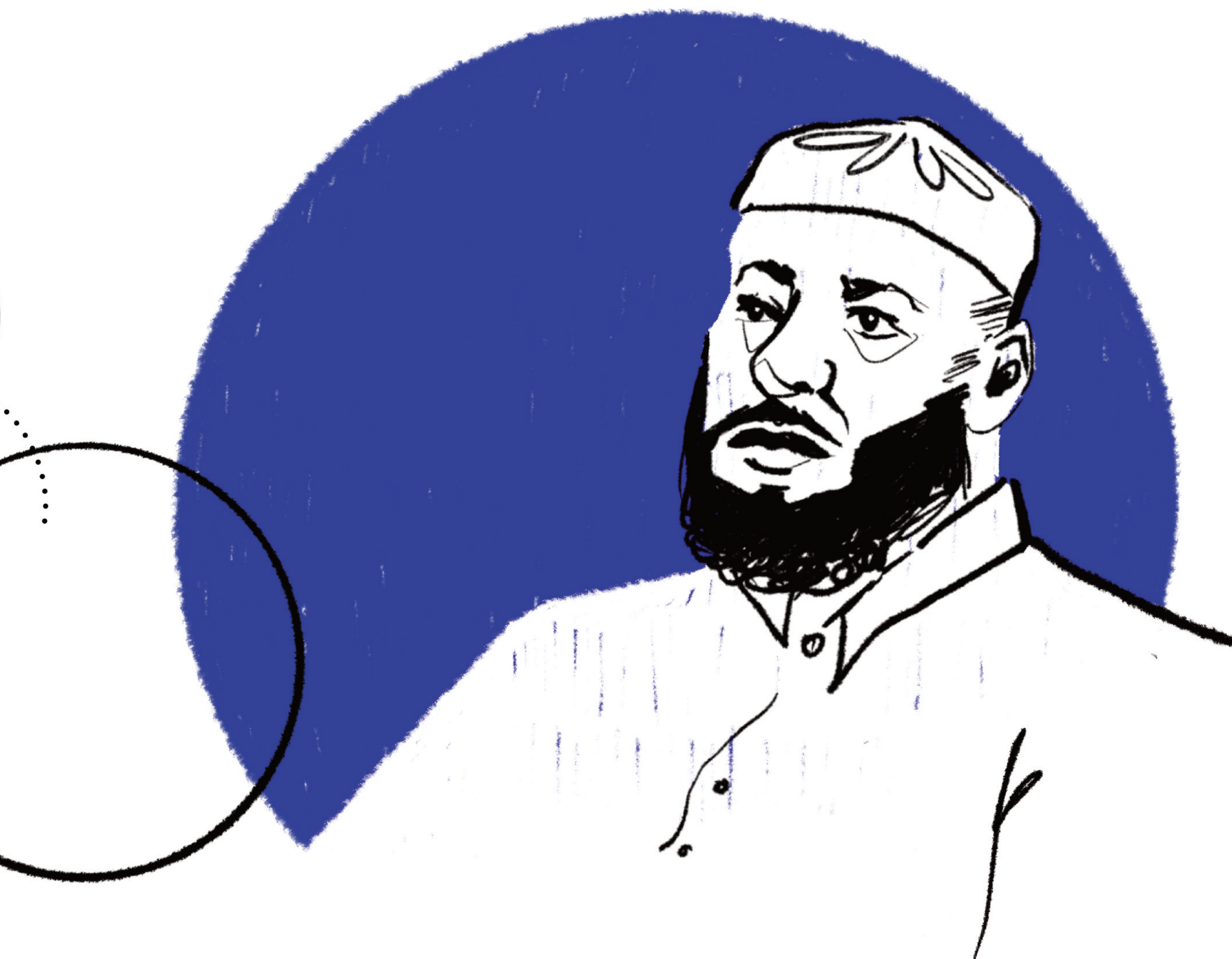
12 Five2Medics is a synergy of health initiatives and partners under the umbrella of Ascension Trust whose main objective is to dismantle health inequalities and racial disparities in health.

a PPE appeal (COVID-19 Standing Together Community appeal) to buy PPE equipment for frontline and key workers. They also worked at speed to provide free counselling sessions and culturally appropriate video consultations with medical partners from Medics2You.

On another table, a senior nurse spoke about Hindu patients he treated in East London intensive care units:

> "We have a big South Asian community in my area. I had to tell lots of people that family were going to die but with help with tech from the younger generation in their families we developed a three way, multi-media, multi-language (oftentimes English, Gujrati and Hindi/Punjabi) communication channel with ICU and family members."

There were lockdown instances where people were dying alone in hospital wards when family members lived right around the corner. This meant that religious leaders faced a real challenge. Across the pond in the United States of America, Rabbis were adapting their mourning ritual – *shiva*, which begins right after the burial and continues for seven days. The process "relies on immediacy and human interaction, two things coronavirus has crippled, even as the virus has hit Jewish seniors hard". David-Seth Kirshner of Temple in New Jersey created a format for a funeral in the time of COVID. They are graveside and they are small. A smart phone is placed upon a tripod and most mourners attend via Zoom or drive by the site to pay their respects.



Protection and Procedure

1.2 The COVID-19 Pandemic - Self-efficacy and Faith Groups' Response to Vaccination Rollout

A senior leader from the Jewish community in North London explained how they designed a tailor-made vaccination service by hosting separate sessions for men and women with the Jewish Hatzola ambulance service. They explained how their strategy included:

> "All the adverts done through newspaper or leaflets, and in Yiddish, because people forget English is not often our first language… we also ensured rabbis there were getting vaccinated because our communities give great weight to the voice of our leaders."

The Jewish Hatzola ambulance service is a non-profit, volunteer organisation established in 1979 to provide pre-hospital emergency medical response and transportation at no cost, to the North London community.

The Muslim representatives focused on the vaccine and expressed how "people did not want it." There was an air of mistrust and hesitancy that stemmed from wider experiences of not feeling considered or thought of in any other instances by the government unless they were acting in their own interests rather than that of the communities.

To encourage vaccine take-up, representatives from the East London Mosque "hosted the vaccine centre – right here [in the mosque] and invited imams – learned scholars – to talk to the community and give them accurate information about the vaccine." They also modelled an Imam getting vaccinated. The representatives spoke on how they had set up a temporary mortuary because Islamic law states one must be buried as soon as possible.

> "The community raised money to set a temporary mortuary up. The mortuary included washing facilities too [to carry out *ghusl* – ceremonial washing of the body with carefully measured cleaning solution]. We listened to the need of our community during the pandemic. People were dying in great numbers but we send off our beloved in a special way. There was a lack of cultural knowledge about how a burial for the Muslim community happens so we did it ourselves. We raised money so people could die with dignity."

The Sikh community leveraged pre-existing weekly practices such as *langar* – the free food kitchen they offer to anyone who would like a meal. A Sikh leader from an East London Gurdwara shared his strategy for vaccination awareness:

> "I was taking information about social distancing and everything from the guidelines and passing it onto the temple. We gave them mats to sit on them – socially distanced – we have lots of hand sanitiser, and we stopped at the free kitchen to do this again. Langar attracts many people in need as well as the Sikh community so it was a strategic opportunity to share accurate information."

The parameters of our consultation meant that we captured a fraction of the activity that went on during the pandemic. However, what we gleaned is that active faith groups were effectively partnering with the NHS and reducing the burden on them whilst serving their own communities.

Influence

2.1 Influence and Social Capital of Faith Leaders

The town halls demonstrated how much credence believers give to their faith leaders. Many spoke of the role model effect - viewing their Imam or pastors as not only moral influences but a first port of call to screen their illnesses. A Muslim representative said, “if I can, I will see the imam instead of a doctor because they’re more likely to get it”. In that statement, ‘it’ refers to said faith leader’s viewing them and their illness holistically. What this participant is communicating is their preference for a holistic perspective of their condition - one that is physically, emotionally, spiritually, psychologically and culturally mindful of them.

In the case of faith and health, the measurement of any kind of leadership is one’s ability to influence another’s behaviour, belief or attitude towards health matters.

The international development sector has long recognised the esteem people of faith place on their faith leaders and has partnered with them to leverage this influence to deliver public health programming.[13] It has been said that faith-based organisations already provide approximately “20-70% of health services in many low- and middle-income countries”. [14]

Whilst the expression of faith-health interventions may look different in Britain, we have seen faith-society interventions here before. These interventions yield society-wide benefits for those of all faith and none. For example, in the UK education sector Christian schools provide public education to all. As we continue to witness the shape of 21st-century globalisation, the UK will have to increasingly consider cross-sector partnership to manage population health.

There was discussion about who are the key figures in the community and who has the power to encourage health-seeking behaviour. Amongst the Jewish participants, one woman stressed that all the official and recognised religious leadership are male. However, Jewish communities generally have large families in which the

13 Building from common foundations : the World Health Organization and faith-based organizations in primary healthcare.

14 Is faith-based health care a stopgap, or a long-term partnership? | Devex

mother mainly influences. She stated that partnership with Jewish community, especially orthodox and ultra-orthodox, must consider both official and unofficial leaders in the community. This participant went on to discuss education as a productive site for influence – for example, women-only seminaries and when mothers are picking up children from school.

Upon hearing discussion from other delegates in the room, the question of *who is a faith leader* arose. In the case of faith and health, the measurement of any kind of leadership is one's ability to influence another's behaviour, belief or attitude towards health matters. This power to influence can be relational in that it is usually developed by regular and proximate engagement to the group or people in question. The power to influence another can also be a positional type of power that stems from hierarchy that is reinforced by tradition, history, cultural customs and social norms. It also matters that the person or group being influenced validate this 'leader' relationship with them and esteem them as such.

2.2 Spiritual Bypassing and Misinformation

One Black Majority Church representative spoke of people in their congregation who said "God will heal me", "God will fight for me" and how she witnessed the unfortunate passing of a woman in her congregation. The woman died from a severe illness whose medical diagnosis she ignored. This was because she googled her prescription and found the medication was typically used to treat AIDS. Upon learning this, she went to church to give a testimony about how "God saved her from the doctor's agenda". This example picks up on the air of mistrust shared earlier in the report and demonstrates how this can snowball into an avoidable outcome – even if complex. Researcher Janeé Avent Harris reports how people of faith can spiritually bypass their realities – i.e., make statements like "God will heal me", [15a] "God will fight for me". This happens when they are so disillusioned by absence of positive power in their reality that they skip it altogether and rely on a higher power to get through moments of tension and challenge. In these situations, there is a need for faith leaders to hold informed and confident stances on how wisdom and faith work together when counselling their members. There is also a need for health practitioners to disclose the other uses prescriptions may be used for so as to keep the patient informed on their journey of care.

2.3 Education

In the town halls, the sub-theme of education was discussed. There was a desire to empower people with how to prepare for an appointment and how to communicate symptoms using National Institute for Health and Care Excellence (NICE) guidance. In an interview, a senior leader of a local authority shared how a family member was experiencing a persistent health condition but was continuously dismissed by their doctor. This leader advised their relative to communicate their symptoms using the NICE guidance (a technical language and logical step-by-step process the doctors are familiar with but which is also designed for the public to use). For example, this visual summary[15b] on deciding appropriate care options for an adult with depression list that:

Choice of treatment is based on:

- the severity of the problem
- past experiences of treatment
- the person's preferences

A pre-prepared appointment detailing needs using this framework is likely to help the patient communicate clearly and increase productivity of the appointment. This is not the kind of information one would expect a faith leader to have but it is the kind of information that can be shared in partnership with the relevant bodies that know this information. As a result, co-developing life-course health programmes, which are interventions to ensure prevention at every key stage of life, between healthcare professionals and faith leaders would be a worthwhile project to pursue. Please see 'Faith Leaders and Peers' for more recommendations.

15a Avent Harris, Janeé R. (2021). The Black Superwoman in spiritual bypass: Black women's use of religious coping and implications for mental health professionals.

15b Depression in adults: matched care model (nice.org.uk)

Partnership

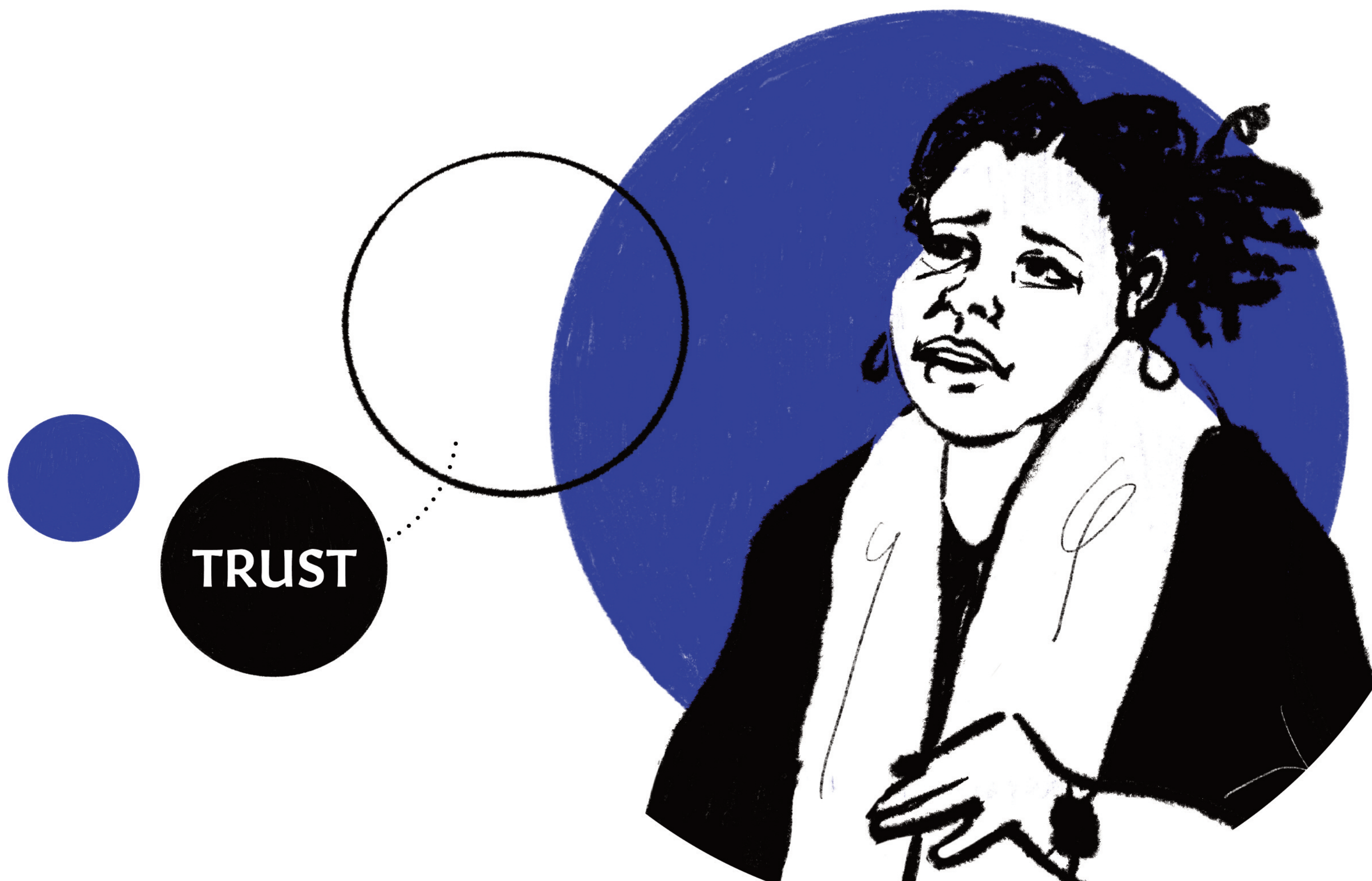
3.1 Mutual Trust, Value and Dignity

Across the faith groups, participants emphasised having to process or engage feelings of mistrust and being undervalued as a community. It became apparent that all faith groups had one thing in common: a non-visible ethic that esteems honour, hospitality, faithfulness – i.e., to be reliable, steadfast and consistent in all conduct. They especially desire to see these things modelled in partnerships. After the pandemic, participants expressed they felt there was a "goodwill tax on people of faith" – that their tiredness and deflation stemmed from their feeling "like they have been working for the NHS over the past two years, except with no recognition". They expressed their knowledge that "what gets measured gets valued" but felt their efforts in addition to the scale of the death of their loved ones had not been noted well.

3.2 Data

In an interview with a senior representative from the Sikh Federation UK, we came to know that death certificates do not document a person's ethnicity or religious belief. This made it challenging to record the kinds of people that were dying from COVID-19 and potentially track trends as to why. This senior representative also highlighted the importance of recording this data for the Sikh community themselves because their faith plays a big part in their life and it should be noted on one's final documentation.

In a letter to then Health Secretary Sajid Javid, the Sikh Federation UK and Sikh Network raised the importance of quality data collection that includes ethno-religious data as a protected characteristic. The coalition raised the importance of gathering this data for all employees and health and care bodies to highlight any inequalities and to assist in decision and policy making compliant with the

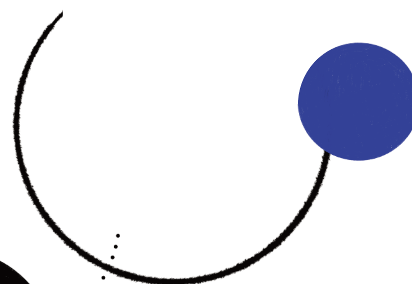


Equality Act 2010. The case for ethno-religious data collection may also improve our national understanding of other groups such as the Jewish and Muslim communities. In many faith communities, one's current life has bearing in their afterlife. This was pertinent in East London where South Asian residents hosted Ghusl workshops (how to ceremonially clean the body of a deceased Muslim person) with young people.[16] It was important to them that they marked the full life of the deceased because it was not happening elsewhere. Recognising one's ethno-religious identity is as much a moral issue as it is a practical one for managing population health and inequality. Scotland has already enabled one's next of kin to submit information about one's ethnicity on the deceased's death certificate. This is something England and Wales could also consider learning from.

Another faith representative shared the following statement:

> "All around me I see homelessness and I live in a densely Asian community. But I also know that young Black people are struggling with severe mental health issues and I don't know where to start. I don't even know where to find this data, so getting moving is challenging."

This representative's remarks echo the freedom of information request made to the ONS asking for cancer deaths by age, sex and ethnicity amongst other things[17]. They were met with the answer that they do not systematically track this data nor can they create a dataset to answer the request[18]. The ONS also said that it is complex to do this because the (deceased) individual themselves must consent to give this information, and so they triangulate (COVID) deaths by ethnicity using census data.[19] This seems like an unnecessarily lengthy process to be able to track who has died and effectively prevent more of these deaths, especially upon clinical and journalistic reports that the rate of death is uniquely high amongst these social groups. As the representative alluded, a lack of this information disempowers actors to target these inequalities in systematic ways. Faith groups and relevant stakeholders alike could be empowered to tackle health inequalities if they could receive an accurate picture of what they look like in their localities. [20]



16 Ghusl Mayyit: Why young Muslims are learning the funeral tradition - BBC News

17 Deaths by selected causes broken down by age, sex and ethnicity - Office for National Statistics (ons.gov.uk)

18 Scotland introduces record of ethnicity on death certificates | The BMJ | Written questions and answers - Written questions, answers and statements - UK Parliament

19 Coronavirus (COVID-19) related deaths by ethnic group, England and Wales - Office for National Statistics (ons.gov.uk)

20 Place-based approaches for reducing health inequalities: main report - GOV.UK (www.gov.uk)

3.3 Funding

In line with the theme of value and funding, remuneration for service delivery came to the table. Participants felt they could be better supported during the pandemic. A Muslim participant noted:

> "our services were going to close because there was no funding – Islamic relief funded us for 1 year to keep it going but it wasn't enough. Why isn't there funding from the health services because this is health based work – they say you're doing it well but do not support us to keep it going."

Prior to, during and after the pandemic, available funding for projects at the intersection of faith and health tend to be:

> "these smaller funds [that] are always overstretched; so we often exceed our targets. Due to word of mouth, more people come looking for support, and we are a victim of our own success. More people do come forward that need support but we end up falling short of resources to meet their need."

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.*

This statement supports the Health Foundation's finding that the government will need to consider interventions to health that are long-term and this applies to the funding of the services needed to deliver health interventions.

A Black Majority Church representative also highlights the challenges associated with bidding for funding:

> "the problem with those [funds] is the reporting and criteria might not align with our beliefs and this can be a barrier… they tend to have strict metrics, and so it's based on what they need and not what we need."

This speaks to criteria of funds for public programming being co-designed to meet the mutual need of the community applying and the service distributing the funding.

In addition to this, there is a need for remunerated advisory seats for religious leaders[21] on the relevant commissioner and decision-making bodies – e.g., ICBs, Trusts, PCNs and Councils. Funding distributors should consider widening access to VCSE criteria to recognise faith groups as legitimate members of civil society.

* The Faith Covenant - APPG on Faith and Society

21 The Group's definition of leadership can be referenced on p.17-18 - who is a faith leader.

3.4 Faith groups as Healthcare Service Providers or Advocates

Another sub-theme was faith groups and their leaders considered being healthcare service providers or advocates and partners. On the whole there was a mixed preference for both, with one participant saying,

> "we've got to inform the policy made for our people. We've got to be advocating on behalf of the people who come to our churches. They come with their whole life circumstances, and we have to look at them as a whole [person]."

Another said,

> "We can't do everything, but we can be advocates to sign post and make sure people are going to the right places for help. Facilitate rather than providing it. Give people the space and safe environment to have those conversations… Realistically we don't have the capacity. We can advocate though."

Another participant raised how "being a provider will help people who trust the church more than a health service. If the church can get funding to provide that service, then people might access that service more in their congregation." This does reinforce the success rate the Jewish and Muslim representatives claim they had on increasing vaccine uptake. Ultimately, a decision like this will depend on the needs and capabilities of the faith and health authorities in a certain area.

THE HISTORICAL CASE FOR INCLUDING FAITH GROUPS IN INTEGRATED CARE SYSTEMS AND SOCIAL PRESCRIBERS

There are numerous historical examples of people of faith in London, particularly Christians, being involved in the provision of healthcare. They have typically brought values of justice, inclusivity, creativity and compassion to such work, resulting in services which bring new solutions to longstanding population health problems, particularly amongst those forgotten by society. Local health service development in interwar Bermondsey is one example from modern history of these values in action and provides a compelling argument for allowing faith groups to be involved in integrated care systems today.

In the years between the First and Second World Wars there was great local freedom and flexibility in the design and provision of healthcare services. Local governments had powers to establish and run services across three broad categories: environmental health, personal healthcare and health education. As a result, there was significant variation in the quality and composition of services between boroughs. Services were ultimately shaped by the concerns and beliefs of the local political and medical leaders that governed them. In Bermondsey, many of these leaders were Christian Socialists. From 1922 onwards, the borough was run by the Labour Party, which was led locally by Ada Salter, a Methodist social worker and mayor of Bermondsey, and her husband Dr Alfred Salter MP, a Quaker. Both had been motivated to move into the heart of one of London's most destitute boroughs and to later represent the borough politically, after encountering Bermondsey's immense poverty through their professional work.

Under their leadership, the borough's services took a keen interest in what we today would call the social determinants of health. One key priority was increasing stable employment and pay in an area in which work was incredibly precarious and hard to come by. Low pay was recognised to result in poor nutrition and, ultimately, increased mortality amongst infants. Desperation to find and keep work would often push men of working age to attempt to ignore serious illness, work through their sickness and end up in even worse health as a result. The council took a borough-wide approach to this public health issue, for instance by implementing a policy to only hire local unemployed workers on council projects, giving preference to those unemployed the longest.

Contributed by Dr Christopher Mitchell

3.5 Faith Groups as Social Prescribers to Widen Access

What is promising is the Bromley-by-Bow case that facilitates social prescribers through a church's premises. One local GP even acclaimed it "as the golden standard for social prescribing" and how its model could work well in other localities. Many faith groups welcomed this and we recommend local authorities explore this with places of worship across the country.

We know from discussion on access and digital inclusion of the COVID-19 messaging that, for the elderly, be they White British or Gujrati-speaking, a degree of translation needed to occur. Many town hall delegates shared how they developed translation services of vaccination messaging through their places of worhip. Solutions will never be binary in that they are either wholly universal or solely customised, but policy makers and local authorities should prepare to make adaptations and implement a multi-pronged approach to diverse communities as is demonstrated in the international development sector.

4.1 Discrimination, Knowledge, Care and Cultural Sensitivity

Many participants felt some level of misunderstanding and discrimination for their faith, ethnicity and/or ethno-religious identity. Jewish and Muslim women brought up the importance of female doctors and recommended monthly women-led clinics in densely ethno-religious populated areas.

A woman from the Black Majority Church shared how her late husband was misdiagnosed with athlete's foot when he had diabetes. His situation led to critical surgery, amputation and complications from which he died. The Sikh Federation UK also reported an incident in Southall where a 71-year-old Sikh who had a stroke and was unable to speak had his moustache and beard cut without obtaining his permission or seeking the consent of his family. Upon further investigation, it was also found this was done without any clinical reasoning. In Sikhism, hair is a foundation of Sikh *Rehat* (rules for conducting Sikhism), so to have it cut without consent was deeply offensive.

In most cases, misdiagnosis and failure to seek consent can be avoided. A senior nurse working in another London hospital recommends how situations like this can be avoided.

- First, ask more questions about their systemic symptoms and family history.
- Carry out some tests, checking every possible scenario.
- Collect data about religion upon hospital admission along with screening questions such as: Do you smoke? Who is your next of kin? Do you have a faith? How prominent is faith and spirituality within your value system? Is there a chance we might need to accommodate your spiritual needs during this hospital visit? Can we contact your next of kin for further information on this?

When reflecting upon the incident with the elderly Sikh man, the senior nurse mentioned how, "for better or worse, I personally would not have known that hair is a sacred aspect of the man's identity." He later reflected and said "but this might be due to my White British upbringing where we don't discuss sensitive topics like this but we need to make it routine early on in order to fulfil our duty of care". In less critical situations where misdiagnosis or failure to seek consent has not yet happened, two things are clear:

1. practitioners need to be more careful in their assessments and,
2. patients need to vocalise the extent of their conditions and needs.

The precursor to achieving the aforementioned outcomes requires a degree of awareness, if not training, on both the practitioner and patient sides.[22]

22 The Sikh Federation is in the process of designing a Code of Practice for healthcare professionals to help with respect to the Sikh Faith.

A Call for Systems Change

5.1 Interconnectedness and a Greater Focus on Social Determinants of Health

Participants discussed a litany of issues causing stress and poor health in communities –rental/housing issues; time scarcity and healthy eating; debt; job security; zero-hour contracts; living on a low income but not qualifying for statutory support.

A GP participant shared the systemic nature of health inequality and its effect on her staff:

> "I had a team of 6 that was actually operating as a team of 2 where people kept getting signed off sick... If staff were supported to get their own healthcare needs... I've had to get people signed off against their own will. I've signed people off sick reluctantly, as the department was so short staffed, and then it turned out to be cancer. If people are unwell and need time for their outpatient appointments, they can't do that."

This same GP goes on to describe increasingly common engagement with primary and secondary care units:

> "Staff are stressed or have PTSD meaning they respond to patients with hostility, waiting times are endless, healthcare centres are understaffed and the pay for many isn't worth the stress. I have patients who struggle to tell me their issues and deserve a correct diagnosis all within the 15 minute slot. The NHS is a system with limitations."

These limitations are expressed in both workers' experiences and patient health outcomes.

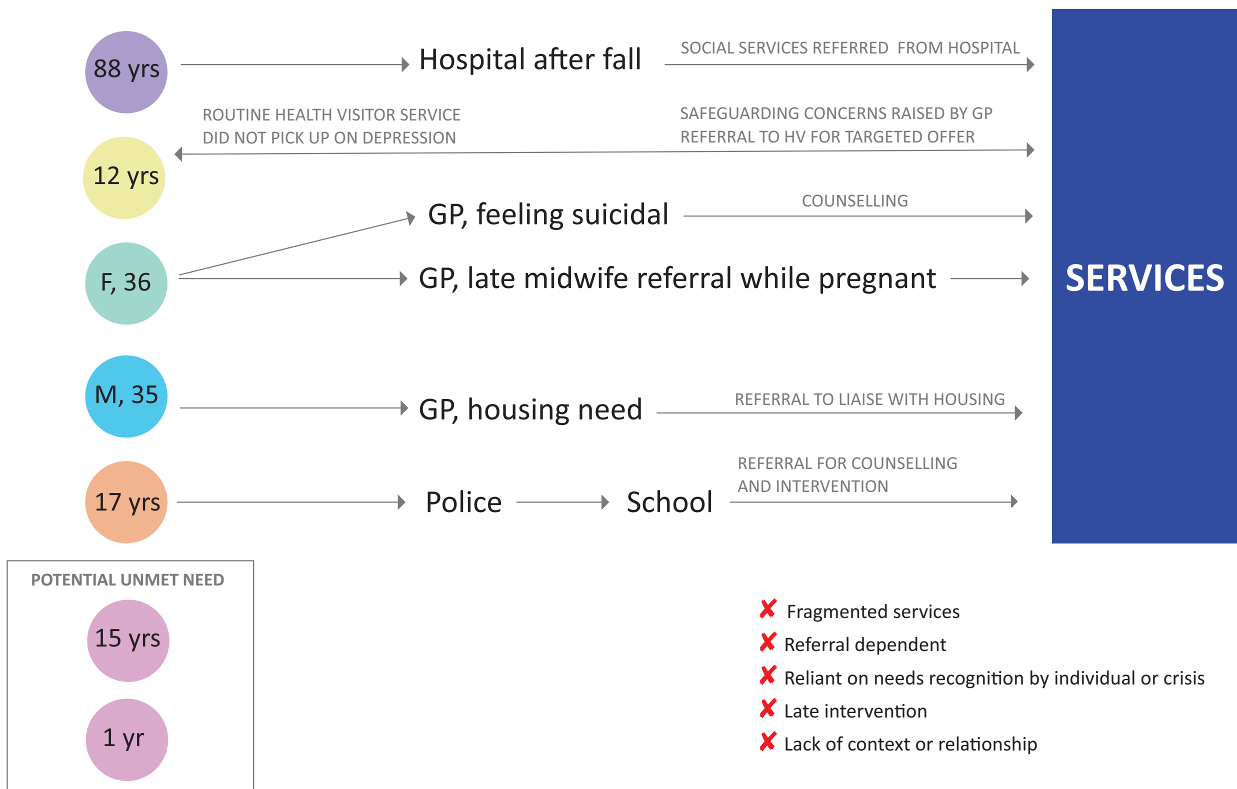
These limitations are further explored in public attitudes and beliefs about the efficacy of our health service. In a Muslim and Hindu group, a consultant physician reflects on end-of-life care, and life expectancy is discussed:

> "I was really concerned as what is actually happening is that older women are dying younger and having about 20 years of morbidity, so they are ill for a much longer time. This means that younger women are looking after the older woman and so this is not just about older women.
>
> My experience is with the health services... people were not scared, they were hesitant that they were not going to get anything out of the health services, because they've consistently not got anything out of them.
>
> This means that older women are really sad and the younger women are busy looking after their mothers and aunts and mothers in law and then they're getting more ill because they're not even going to the doctor themselves. Younger women are then becoming the next generation of women who are going to be ill for a very long time. I think this inequality is linked to end of life care which seems to be a topic that [Muslim] people are afraid to talk about."

This observation was shared in March 2022 and it is supported by the Health Foundation's recently published statistics, which state that "a 76-year-old woman in the wealthiest area ... will spend more than half (43.6 years) of her life in ill health compared with 46% (41 years) for a woman in the wealthiest areas." This example also shows us a pattern of intergenerational dependency and the reproduction of inequality within families that are shaped by real life limitations within the health system. This work is complex, interdisciplinary and whole-life. There is an increasing need to heed recommendation of life-course health programming and interventions which increase the effectiveness of interventions throughout a person's life.[23]

23 Health matters: Prevention - a life course approach - GOV.UK (www.gov.uk)

Family members

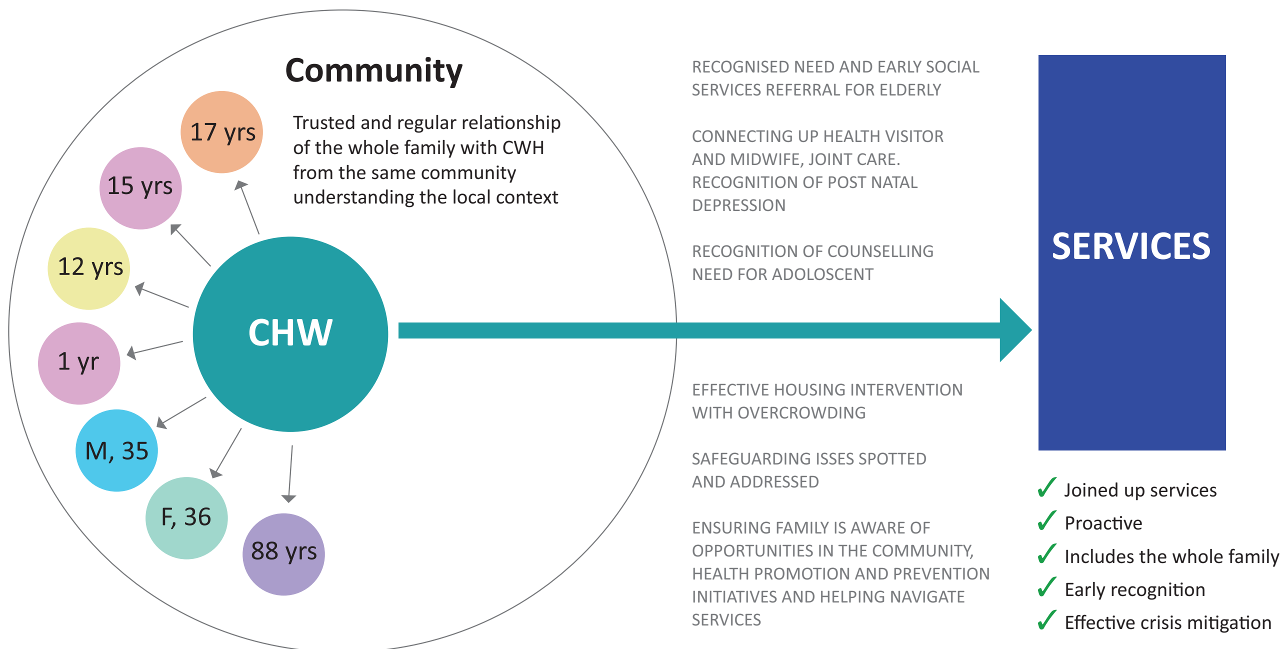


Source: Adapted asset from Westminster City Council, Public Health Department, 2021.
Society without a Community Health Workers Programme.

THE FAMILY HEALTH STRATEGY IN BRAZIL AND COMMUNITY HEALTHCARE WORKERS IN WESTMINSTER

Initially the goal for the Family Health Strategy in Brazil was to improve access to health care for low-income and vulnerable groups. Community healthcare workers (CHW) are assigned 150 households within an area and visit each family at least once per month. Their job is to pick up on potential health issues and navigate members of the community to the appropriate levels of care. CHW serve as a friendly face which family members can regularly check in with, they also organise and deliver group education meetings for individuals with chronic disease. This has improved the uptake in cervical, chlamydia, bowel and breast screening through identification of target groups and signposting. CHWs are facilitating pathways for early detection at various life stife stages.

Furthermore the Family Strategy improved employability and job stability within the community due to these new job roles. This approach is already being piloted in Westminster City Council where they are considering remuneration and paid volunteer models for those leaders within the community who are uniquely positioned to improve this service such as those from faith communities.



Source: Adapted asset from Westminster City Council, Public Health Department, 2021. Society with a Community Health Workers Programme.

Faith-Health Interventions as Part of a Whole-Systems Approach

When referring to the distinct but complementary nature of government objectives and faith-based objectives for health, World Council of Churches' Program Executive for Health and Healing, Mwai Makoka, said, "our mission is the same, but our motivations are different…The government's looking for cost effectiveness of delivering health care. For us, churches may do some things which may not be cost-effective, but they are serving the marginalized." [24] However, as has been said, this whole-system approach will require mutual respect and realistic resource allocation for all partners to deliver and/or enable the shared flourishing we seek.

The role of faith communities in British public life is set to increase as the extent of globalisation realises itself. It is estimated that 2/3 of the world identifies as either Christian or Muslim. [25] This means that public engagement with diverse groups of people and the faith values they hold will make up a large part of public programming and their accompanied budgets. We recommend the relevant sector and stakeholder view the parts for further recommendations on how to take what we have learnt forward for where we are today.

24 Is faith-based health care a stopgap, or a long-term partnership? | Devex
25 Ritchie, Angus. Inclusive populism: Creating citizens in the global age. University of Notre Dame Pess, 2019.

HEADLINE RECOMMENDATIONS

Government

Member of the Health Inequalities Action Group Dr Chi-Chi says there is "huge potential for joined up working, between faith groups … but it's important to state that gap needs resources for plugging. Religious leaders and places of worship are assets – 'trusted voices in trusted places'[26] – councils and the government need to get behind faith groups and efforts need to be sustained."

1. Publish the **Health Disparities White Paper**.

2. Widen access to **VCSE funding pot criteria to recognise faith groups** as legitimate members of the civil society and VCSE groups.

3. Mandate the collection of **ethnicity, ethno-religious and religious data** from people of different ethnicities, faith and ethno-religious backgrounds at strategic points in engagement with the healthcare system and wider society.

4. Create a **data taskforce** leveraging the unique strength of:
    a. health data from NHS Trusts,
    b. population data from the ONS and
    c. local data from councils

    to create an accurate and accessible understanding of local health inequalities. This, in turn, will practically empower stakeholders on all levels working to tackle health inequalities.

5. Nationally **scale up Westminster City Council's, cost-effective Community Health Workers programme** across boroughs to serve as a bridge between the community and primary health care. Leverage remunerated and/or paid volunteering schemes to enable people from the community to work within the community to navigate people to the appropriate area of care.

Local Authority and Health Systems

With a cost of living crisis, overstretched healthcare practitioners and record waiting lists, we have arrived at a point where we must work innovatively to alleviate pressure from the NHS.

1. Develop budget for **remunerated advisory seats for faith leaders on commissioning health boards** – e.g., ICBs, CCGs, etc. Faith leaders should have: 1) desire to share their knowledge and be equally supported with clinical expertise to improve community health and 2) have evidenced influence on the target population whose health outcomes need to be improved.

2. Ensure all councils have **adopted the Faith Covenant code of practice** to partner with faith communities in faith-health interventions – for example, increased number of places of worship as social prescribers and twinning partnerships (see 'Faith Leaders and Peers' section below).

3. Support the **development and integration of an Interfaith Health Council** with national health structures to represent faith communities.

Faith Leaders and Peers

"People of faith come willingly with all of their issues and problems and challenges, the mosque [and places of worship] has become a one stop shop. With the government's role receding, there is a greater onus on places of worship to upskill and influence, and improve our services, our role – whether we wish it or not – will become greater in our communities".

– Sheikh Mohammed

People of faith generally heed the advice of their faith leaders across whole-life issues, from the start of life to its end. The responsibility to grow more informed and develop strategic partnership when at capacity is greatest now more than ever.

Micro

1. Faith leaders should develop further sensitivity to the unique power they have and try to **model health-seeking behaviour** instead of spiritually bypassing real symptoms and illness.

2. **Share positional power with unofficial leaders** by co-developing suitable leadership roles in their community to ensure the community health needs are being met.

Macro

1. Develop **'twinning partnerships' with health statutory bodies** to complement the spiritual and emotional counsel they offer with professional health expertise, in turn delivering a holistic offering to their members. For example, consider developing a **partnership and training action plan** in line with **life-course public health interventions** to ensure prevention at every key stage of life.

2. Co-develop **an Interfaith Health Council** with national health structures to represent faith communities.

Additional Recommendations

Training

1. Develop **funding for state-sponsored Faith and BME therapists' educational training.** Consider creating an education-to-public-health pipeline to work with public health bodies (both clinical and non-clinical, such as faith institutions and schools or youth centres) to reduce overall health inequalities.

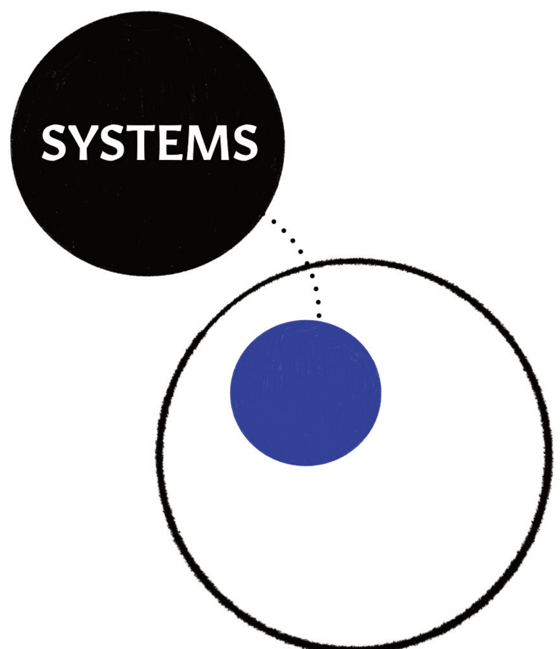
System design

1. Further implement **life-course public health interventions across different sectors** (e.g., HPV vaccination programme in secondary school years) to ensure prevention at every key stage of life. Creatively leverage faith groups' cradle to grave positioning in this endeavour.

Awareness and Education

1. **Leverage existing Faith in Partnership week** and/or create a **National Faith and Health Week** to disseminate culturally sensitive health promotion.

2. Facilitate and support faith community groups through seminars and educational talks to help tackle misinformation on healthcare.



References

1 Population estimates by ethnic group and religion, England and Wales: 2019

2 World Health Organisation; Joint Strategic Needs Assessment Tower Hamlets_Summary.pdf (towerhamlets.gov.uk)

3 Department of Health, No health without mental health. (2011); Joint Strategic Needs Assessment Tower Hamlets_Summary.pdf (towerhamlets.gov.uk)

4 The Marmot Review 10 Years On

5 The London Health Inequalities Strategy p.64

6 London's health inequalities strategy - Healthy London Partnership Partnership

7 NHS England » Tackling health inequalities in the NHS

8 Health and Social Care Information Centre, 2014

9 Mental Health and Wellbeing Joint Strategic Needs Assessment Westminster, Kensington and Chelsea Summary Report.pdf

11 NHS England » Core20PLUS5 – An approach to reducing health inequalities

12 ONS National Population Survey 2018

13 Five2Medics is a synergy of health initiatives and partners under the umbrella of Ascension Trust whose main objective is to dismantle health inequalities and racial disparities in health.

14 Building from common foundations: the World Health Organization and faith-based organizations in primary healthcare.

15a Avent Harris, Janeé R. (2021). The Black Superwoman in spiritual bypass: Black women's use of religious coping and implications for mental health professionals.

15b Depression in adults: matched care model (nice.org.uk)

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25 Ritchie, Angus. Inclusive populism: Creating citizens in the global age.

26 About Five2Medics | Ascension Trust

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