Religious Health Assets: What Religion Brings to Health of the Public

An integrative paradigm for religion in the health of the public begins in our thinking with the idea of religious health assets (RHAs). This gives the name to the work over the last several years of the international collaborative we helped found, the African Religious Health Assets Programme (ARHAP). Wherever we encountered others, the first puzzle, quite understandably, was what we meant by “RHAs” and why we were using this term. Explaining this, and laying the foundation for the interconnected ideas that follow, is our task here.

Shacks and Shackles: Health in the Ecology of Place

Near the foot of Africa lies the peninsula known as the “Cape of Storms,” a fifty-kilometer-long chain of mountains poking into the cold Atlantic Benguela current. Driving from the wealthy Atlantic coastal suburbs of Camps Bay and Llandudno into the beautiful Hout Bay valley, a stunning view of the bay unfolds, two peaks standing guard over the ends of a shimmering white beach. Looking left, the valley curls up toward the back of Table Mountain over which lies downtown Cape Town. Following the valley contour, a contradictory scene confronts one, a sprawling, tightly congested, and incongruous settlement of tin shacks and low cost houses spreading up to the last habitable space below the mountain crags. An occasional blackened area reminds one of huts destroyed by fires from a tipped paraffin stove or a fallen candle. The scene mars the panoramic beauty of the valley; it is aesthetically and ethically ugly. This is Imizamo Yethu, known as “IY” or “Mandela Park,” home of the bulk of Hout Bay’s black population, well over fifteen thousand people (no one knows for sure).

Most are there because work is nearby, or resources accessible that are scarce or missing in the distant rural areas from which the majority come. Some are refugees from Namibia, Nigeria, Malawi, and elsewhere in Africa. Very few trace their presence beyond a generation. Under Apartheid, Hout Bay was a
largely white residential valley. Racialized social engineering moved black and “colored” populations from desirable parts of the valley into meager, cramped council housing on the slopes behind the fishing harbor or into shacks on sand dunes. The separation largely remains, along with the associated differences in wealth, privilege, and power. Recently, numbers of other, affluent, immigrants have arrived from Europe and elsewhere, people able to buy a second house in South Africa or acquire a property unaffordable in their native land. Hout Bay, containing a fractured population, is a global microcosm.

Mandela Park can be frightening; one sees open sewerage, scattered feces of animals, trash filling small gullies where children might play, and drug dens and drinking places whose customers are often unemployed young men with insufficient schooling, stilling their despair or simply living in anomic. Cases of sexually transmitted infections (STIs), HIV and AIDS, TB, hepatitis A and B, alcoholism, meningitis, and gastroenteritis have increased, and there is an alarming rise in mental illnesses. The place is a major health hazard. When winter rains come, sullied water cascades down the slopes into the stream that bisects the valley and ends at the beach, producing levels of pollution that far exceed even lenient public health standards and making swimming a hazardous affair. IY is the result of racialized social engineering and, affecting the ecology of the entire valley and all who live in it, it is a symptom, an indicator, of the unhealthiness of the society within which it is located—a prime example of the link between individual health, and the social and environmental determinants of health.

Still, IY has a first rate health clinic served by dedicated professionals and supported by volunteers in an active Community Health Forum. The valley also has an excellent private medical center whose doctors often offer their services pro bono to individuals from Mandela Park, perhaps through an employer. Emergency services are readily accessible and highly efficient, referrals to public hospitals on the other side of the mountain relatively easily handled, and treatments generally free for low- or no-income patients. Altruistic professionals of all kinds offer assistance, while religious groups also do their bit. IY should be a success story, but it is not.

There are many ways to analyze this puzzle, and here too IY is not shortchanged. It is a favorite location for university researchers and graduate students, NGOs and government departments, to the point where locals are sick of being the subjects of investigations that, in their daily experience, change little. Why do local governance and service delivery continue to fail over years? Think of all the contradictions.

First, IY signifies deep inequalities, a toxic social illness. A settlement it may be, but a settled community it is not. Besides the sea of affluence around it, within IY people compete intensely for jobs and services, factional interests abound, divisions between landlords and tenants are common, the presence of syndicated gangs is rife, street children prey on others, and an active, often abusive sex industry thrives. Not surprisingly, issues of security and aspiration, of identity and diversity, and of agency and access tax everyone. To seek health here faces one with a profound conundrum: the conditions that require intervention to achieve healthy outcomes are precisely those that thwart such interventions.