

Religion in the Health of Migrant Communities:

Asset or Deficit?

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Where migration patterns stretch the capacities of health care systems of African countries, religious beliefs, rituals and practices represent vital cultural capital. Religiously motivated or based healing and health-related activities, often with strong local impact, generate “religious health assets” that need much more analysis and understanding—for policy reasons and for development theory and practice. The essay explores some of the conceptual and theoretical frameworks necessary for carrying out a deeper analysis, using a local South African context—the historically black settlement of Imizama Yethu, Hout Bay—as an empirical example of how the key dynamics and processes associated with problems in health care promotion and delivery might impact on the role of religious health assets. This is based on a detailed study of local governance in health care in the area by a Norwegian political scientist, who concludes that the key ingredient, mostly missing, is “trust.” The essay defends a religious approach to the issue and outlines the principles of a major project that seeks to explore them in the wider Sub-Saharan African context.

Introduction

Even among relatively homogenous local populations, it is difficult to provide for health when resources are severely limited, infrastructures overloaded or negligible, and the conditions that promote ill-health widespread or out of control. If the local population is heterogeneous, fragmented, fractured and otherwise stressed (e.g., by high unemployment levels), the difficulties increase. Especially then, health, greater than its biomedical dimensions, requires personal, familial and other support structures to strengthen people's capacity to be or to stay healthy.

Personal, familial or local support structures are themselves at risk if not damaged or absent in marginal or overburdened communities, where they are needed most. Further, when local populations are impacted by multiple forms of migration that introduce diversity, competition for resources, and conflict over them, the stress factors enlarge and health is again negatively impacted. For example, intrapersonal and interpersonal stresses associated with migration under conditions of hardship, such as those produced by the loss of a stable context of “belonging,” affect people's capacity to cope, and reduce their confidence in their problem-

solving capabilities.¹ Reduced problem-solving capability impacts negatively on democratic empowerment and economic development.

This suggests that relational and mental health, linked to environmental conditions and personal capabilities,² are as crucial as biomedical issues in considering how one might deal with health crises in any local context.

Religious Health Assets

Here I assume that the capacity of people to be or to stay healthy is linked to the resources or “assets” they might leverage, to their own capabilities and interrelationships. This is particularly important where there are severe environmental deficits and a limited supply of public resources (such as state finances and agencies). “Religious health assets,” sometimes acknowledged, often not, are my particular concern.

Human capabilities and relationships—affecting capacities for survival in the first instance and of enhancement in the second—are often strongly related to forms of religious experience, commitment and engagement that have local impact. Embodied in action to heal people and restore balance to their environment, this frequently leads to structured practices, associations and organizations that deal with health in personal, familial, communal and wider public arenas, including hospitals, clinics, care groups, targeted programmes, and NGO-styled bodies. They may also include events and campaigns, healing movements, and practices of traditional healers. These “religious health assets” (RHAs) constitute a type of endogenous resource that may be leveraged for dealing with health crises as part of public health policy and practice.

RHAs are widely spread across many communities and societies in Africa, often with strong local resonance. Not infrequently, they provide the only significant organizational infrastructure for local health care and promotion, especially where national or public infrastructures are overstrained or dysfunctional. Yet they are often inadequately articulated with public health policies and structures, or not at all. They might even be invisible to policy makers and to social scientists advising policy makers (in the latter case, through the effects of a long-standing methodological prejudice against religion).

What I propose is a new approach to understanding the nature and place of religious health assets in Africa. This leads to a description of a major project I and a number of colleagues are currently developing.

Migration: An Angle of View

The overall theme of migration and health offers a useful focus for exploring the potential importance of RHAs in understanding and responding to local contexts of health and health provision. I will briefly describe one local context, that of Hout Bay in South Africa, on the Cape Peninsula, to point to some of the complexities of migration that affect our cities and the impact this has on an already complex context of health care policy and provision. I will highlight issues that have to do with compromised personal, familial and communal environments, and weak support structures. I assume a link between justice, equity and health, following the WHO's

¹ See on this, P. Paul Heppner and others, "Examining the Generalizability of Problem-Solving Appraisal in Black South Africans," *Journal of Counseling Psychology* 49, no. 4 (2002).

² “Capabilities” reflects the meaning found in Amartya Sen's and Martha Nussbaum's anthropological arguments about economic life—going beyond those theories of utility and of atomistic, freely choosing individuals that underlie the dominant paradigm of liberal and neo-liberal economics.

Alma Ata Declaration (1978),³ and its development for health promotion in Ottawa (1986) and Jakarta (1997). On this basis I will attempt to identify the potential significance of religious health assets.

Hout Bay: A History of Migration and a Growing Health Problem

We begin by probing one local context—the historically black settlement of Imizamo Yethu, Hout Bay, Cape Town, popularly known as “Mandela Park.” What follows depends heavily on as yet unpublished research by Jan Froestad,⁴ a Norwegian political scientist concerned with patterns of local governance, and on the participant observation of my wife, Renate Cochrane, closely linked with the Hout Bay Community Health Forum in her capacity as a Moravian pastor. We also live in the valley.

Decline in Health Standards

Hout Bay has seen a general decline in health standards over the last years, in part because of the effects of largely uncontrolled migration of work-seekers or economic refugees from within and without South Africa into poor living conditions. Cases of STIs, HIV/AIDS, TB, hepatitis A and B, alcoholism, meningitis, gastroenteritis ;have increased, and there is an alarming rise in mental illnesses.

The decline, as one might expect, is most marked in the hillside shack settlement of Imizamo Yethu, where most disadvantaged new migrants are perforce obliged to stay, many of them without legal standing. But the problems are also more widespread.

“Privileged migrants”—the significant number of people from other parts of South Africa and the world who have the wealth or resources to invest in the valley—are the other half of the story. Increasingly, as greater Cape Town grows in international stature as a cosmopolitan “world city,” many of these wealthier residents come from developed countries such as Germany, France, the UK, and the USA, purchasing homes in Hout Bay for occasional use, retirement, or because of value and life-style advantages. Some buy businesses. Many of them supply opportunities for work in the valley. They do not suffer direct deprivation in their health care, as significant private facilities are available to them. Nevertheless, the environmental impact of migration and uncontrolled or unsupported settlement in the valley impacts on the health everyone who lives or visits there, as best intimated in the highest oceanic E-coli counts in South Africa as a result of run-off sewerage down the Disa River into the bay, across its popular beach.

My focus here, however, is on the “other” migrants, those who come to find work, who are refugees, or who arrive on the doorstep of a family member who is already in the valley, possibly employed. Almost exclusively, these migrants bring little, if anything, in the way of financial assets; and almost without exception they are black, among those who were not beneficiaries of the long decades of segregation and apartheid. For the wealthier residents of Hout Bay, even if they have only recently arrived in Africa, such migrants are truly “other,” often undesired and seen as alien, generally regarded as having less right to be in the valley. Complicating the situation is that some migration is oscillating. Fisherman from Angola, for example, spend a season or two in the area, and then return home to be replaced by another

³ See www.who.int/hpr/archive/docs/almaata.html.

⁴ Jan Froestad, "Health, Democracy and Governance in South Africa: Two Case Studies," (2002). The material I use is drawn mainly from the chapter entitled "Health, Community and Governance: Why Environmental Health Problems in "Imizamo Yethu" Informal Settlement in Hout Bay are Not Solved."

family member or associate. Many members of extended families of local inhabitants move back and forth from the Eastern Cape and other parts of South Africa, for varying reasons. Control of disease is made that much more difficult, on both ends of the migration route.

A Long History of Differing Patterns of Migration

This contemporary picture rest upon a much longer history of migration. Any early indigenous population there might have been in the area was supplanted by Dutch entrepreneurs after 1652, including loggers who removed large tracts of the milkwood forests, silver miners, and small scale farmers and fishers who settled in the valley.

It remained a small village, cut off from Cape Town by the surrounding mountains, for a long time, its population rising to just over a thousand by 1944, of whom a little more than a quarter were whites.⁵ At that time, not much more than a hundred blacks of Xhosa origin provided labour in the main for dairy farmers, and the rest were “coloured” folk, many involved in subsistence fishing, some owning small boats, others working in the growing fishing industry.

The earliest fish export market was established in 1867 as snoek were traded with British Mauritius, booming in the 1880s, and collapsing not long after. Subsequently, a Frenchman established the rock lobster or crayfish market in 1903 for the Parisian bourgeoisie. It expanded into a lucrative American trade after 1936. This rising fishing industry saw Hout Bay become South Africa's largest small harbour by 1952, in part as a consequence of state investment in fishing and canning factories (South African Sea Products) and in new harbour construction.

Hout Bay was thus incorporated at an early stage into the global economy launched by the colonizing enterprises of European nations. The lure of work and money, recently expanded by foreign investments in luxury housing, has been a pull factor in the character and scale of migrations into the valley for over a hundred years. Settlement patterns have almost always, however, been asymmetric, privileging white or foreign settlers and increasingly disadvantaging blacks, especially in the latter half of the twentieth century. For example, with the Second World War came a new flow of work-seekers from rural areas, African and coloured, provoking concern on the part of local government, run by whites, though laissez-faire segregation remained the norm until Apartheid became established policy. By then, the existing class divisions and racial patterns had set the ground for subsequent formal “racial” division of those who lived in the valley. These patterns persist, despite the larger changes in South Africa.

The Effects of Segregation and Apartheid

Apartheid finally undid whatever relatively harmonious relationships existed then between “races.” In 1950 Hout Bay had been declared a white residential area under the Group Areas Act, forcing Coloured people to give up their homes or land as they were moved into the hill area above the Harbour, then proclaimed a Coloured township. Froestad notes that no provision was made for a specific African group area, though single-sex compounds were set up for African male contract workers close to the harbour. The Prevention of Illegal Squatting Act in 1951 introduced policies to number existing shacks and freeze any new such constructions; the Western Cape was declared a ‘Coloured Labour Preference Area’, setting the stage for ethnic and cultural divisions that still deeply affect Hout Bay; and the 1952 ‘Native Urban Areas Act’ restricted or reduced African migration into the area.⁶

⁵ Ibid., 84.

⁶ C. Greene, “The Origins and Development of Informal Settlements in the Hout Bay Area 1940-1986” (Honours, University of Cape Town, 1991). Cited by Froestad, 2002.

As elsewhere in South Africa, influx controls were often difficult to enforce and only partially effective, so that the growth in population in Hout Bay continued steadily, holding more or less the same balance between “races.” Push factors operating in rural areas and pull factors in the cities continued to operate much in the same way they have elsewhere, though influx control in South Africa lessened the speed at which such internal migration took place until the mid-eighties at least. But it also added that destructive dimension peculiar to Apartheid—the enforced, legalized separation of families, with women and children largely being confined to rural areas after 1950.

This would have had long term impacts upon health—because of the emotional and psychological stresses induced, because of the breakdown of relationships and support structures that often resulted, because it often made it easy for government bureaucracies to shift responsibility for health services elsewhere, and because the forced patterns of oscillating migratory labour made for much easier spread of diseases, particularly STI's. This pattern, of course, is not peculiar to Hout Bay, but characteristic of the whole of southern Africa as the South African economy, particularly the mining industry, drove the economies and migratory labour patterns of neighbouring states.

Hout Bay in the latter half of the twentieth century, with urbanization and the arrival of wealthier home-owners to a desired Atlantic seaboard area, saw demand for labour in construction, domestic work and service industries grow, a demand filled largely by African labour. African work-seekers and their families (after influx control ended) had little option but to commute long distances or seek shelter in the valley. Shack settlements sprang up in several places, unsanctioned. White home-owners and rate-payers tried to put pressure on the state to remove these “squatters,” and when this failed, they sought their relocation onto a piece of state land on the eastern side of the valley. This was to become Imizamo Yethu or “Mandela Park.”

Post-1994 Developments

Changes heralded by the end of Apartheid and the elections of 1994 did little to alter the demographic patterns of Hout Bay, except that the influx of new residents into Imizamo Yethu increased dramatically towards the end of the decade. This was less driven by job opportunities—in many respects shrinking rather than expanding—than by the push factor of extended family members of local inhabitants leaving increasingly desperate rural environments, and the pull factor of resources that marked Hout Bay as a particularly useful place to be, even if temporarily.

Among these resources is a good, expertly staffed clinic on the edge of Imizamo Yethu. Supporting this facility is one of the few well functioning Community Health Forum structures in the region, a result of Reconstruction and Development policies put in place after 1994 by the new government. Also adjacent to or in Imizamo Yethu are: James House for abused and neglected children, run by evangelical churches in the valley; Iziko Lobomi, a multi-purpose community centre, constructed from used shipping containers, used for meetings and skills training and run by the Hout Bay Christian Community Association; and the Moravian Oranjekloof School with strong Moravian presence on its Board.

Imizamo Yethu, originally designed in 1991 to take 417 households on a site-and-service scheme on 18 acres of land,⁷ now unofficially houses up to 12 000 people, most of them there without local residential rights and many seeking work as illegal migrant workers from other African countries. Unofficial estimates suggest that the mix of linguistic or ethnic groups is now

⁷ Froestad, 97.

something like fifty percent Xhosa, mostly from the Eastern Cape, with the rest made up of a large contingent of Angolans from Ovamboland, some Namibian Ovambos, some Zulu and Sotho speakers, and most recently, Zimbabweans.

A large number of these people may be seen as economic refugees, some as political refugees. Employers in the area, including other suburbs on the Atlantic coastline, draw many foreign work-seekers, who are employed at low rates and often under poor conditions without labour legislation to protect them. South Africans also seeking this work, not surprisingly, are increasingly angered by such developments. The mix of peoples in Imizamo Yethu, therefore, is potentially explosive in a number of ways, and some limited violence has already been present as a result of this competition for resources and jobs. Gangs are well able to exploit these conditions for their own purposes, and should be understood as illegal entrepreneurial enterprises in this context though they also function as places of belonging, identity or status. Their "earnings" are visible in clothes, accoutrements or the vehicles they possess.

Outside of Imizamo Yethu, Hout Bay consists of a previously "coloured" area above the fishing harbour, some lower middle class (largely white) housing, and increasingly as former small-holdings and farms are sold off to developers, a large and wealthy elite body of residents, many of them foreign investors.

This constitutes a situation of deep inequality overall. Here, Imizamo Yethu represents a history of economic exploitation and racist social engineering, of dislocated and fragmented families, of massive overcrowding in flimsy tin and wood or plastic dwellings, with all the health hazards associated with such conditions. It is marked by violence-laden competition for jobs and services, ethnic tensions fueled by this competition, fractions caused by divisions between those who do and do not have residential rights according to the original settlement agreements, divisions between landlords and their clients, high levels of alcohol and drug consumption, a growing presence of syndicated gangs, residual alcoholism and children of alcoholic or desperate parents on the streets, as well as an active and often abusive sex industry. Issues of security and aspiration, identity and diversity, tax everyone. Many migrants face a long-term loss of culture and community with a double effect: on the one hand, 'freedom' from social rules that constrain high risk behaviour; on the other, alienating distance from the cultural and religious structures of their home-place that might otherwise offer support.

All of this contributes to a climate of ill-health and disease that Froestad, with considered pessimism, thinks cannot be undone in present circumstances. Re-reading Froestad's analysis, I suggest that any adequate solution will draw in, as fully as possible, the resources of religious health assets, in a manner that overcomes the inherent exclusivities of various faith communities, or at least sublimates them.

Five Factors Contributing to a Negative Prognosis

Without going into the detail of his arguments, available in his extensive research, we may summarize the grounds for Froestad's pessimism the position as follows.

1. The *environment is unfavourable*. The municipal Environmental Health Department estimates that at least 51% of Imizamo Yethu is in the high-risk category, indicating a potential for diseases to spread through the area in an uncontrollable manner. The township generates about 8 617 tons of human waste a week, of which only a fraction is cleared by the municipality. Toilet facilities range from limited shared water borne stations to buckets which are inadequate and often overflow, producing grey water pollution, dirty drains and blocked or leaking sewage. Serious health risks are created by irregular garbage collecting, the absence of a proper sewage

system and insufficient supply of fresh water. Garbage piles up regularly. Public services to address these problems are seriously limited, in part because people do not pay for them. On the other hand residents see little reason to pay, and they lack the means to fix these problems themselves. Many of the ongoing quarrels in the township are thus about human waste and related issues.

2. In Froestad's view, the politics of environmental health cannot be dealt with by *seeking local solutions to problems that are national in scale*, especially in contexts such as Imizamo Yethu. Because of the systemic nature of the problems, the local Cape Town municipal Housing Department, failing to meet the needs in the face of deteriorating resources and budget-cuts, shifted in Imizamo Yethu towards a policy of 'containment'. Attempting to limit its responsibilities towards the inhabitants of the township, it then simply tried to prevent new people from moving in and settling, a policy that has also failed. As Froestad notes,⁸ from the point of view of governance the problem with service to informal or illegal settlements is this: "If you provide services, this is easily taken as a token of acknowledgement, of the legitimacy of the settlement, [and] if you do not provide services, you may be accused of not meeting the liabilities of Government as stipulated by the Constitution, and you get ill health and high risk of epidemics that easily spread to the wider community." Services, especially in a country where they are in short supply elsewhere, are a draw, ensuring that "social processes related to land, housing and services are as supply driven as driven by demand." Thus housing crises in the face of the push/pull factors that put such pressure on housing in the cities cannot be solved locally.

3. A *high level of administrative and professional fragmentation and duplication* in the health sector, observes Froestad, further inhibits a successful resolution of the problems of Imizamo Yethu. Though all public documents since 1994, including the 1997 Government White Paper on Health, have emphasized inter-sectoral collaboration around environmental health problems, the legacy of Apartheid seems to have entrenched a tradition of "working in isolation and organizing hierarchies of authority and discipline delimited to the spheres of particular agencies or occupations."⁹ The public agencies relating to Imizamo Yethu are no exception, with considerable disarticulation between, for example, the Community Development and Environmental Health divisions of the municipality. These kinds of fragmentation also make it very difficult for organizations such as the Hout Bay Community Health Forum to operate efficiently and purposefully.

4. *Conflict over local power structures, petty corruption and nepotism* complicate matters too. Imizamo Yethu is not a "power-empty space" (Froestad). Between a local affiliate of the South African National Civics Organization (SANCO), eight street committees, two ANC structures (women and youth), an Inkatha presence, and members of the United Democratic Movement, considerable jostling for power goes on, and beyond their reach are groups that foreign migrants set up to protect themselves. Economics inevitably play a great part in the struggles to gain, maintain or extend power, and the impact of liquor, drug and criminal gangs and syndicates generally adds to the negative side of the picture. But the major problem that Froestad isolates is the unreliability of local interventions in dealing with the area's problems, whether initiated by external NGOs or internal parties, because of the intrinsic competition for influence over resources that surfaces regularly, and the tendency to seek whatever resources one

⁸ Ibid., 107.

⁹ Jan Froestad, "Interest, Knowledge and Identity: The Potential for Building Administrative Systems Based on Trust in the Health Sector, Some Lessons from the Western Cape Province, South Africa," (University of Bergen, School of Government; University of the Western Cape, 2001).

can command for one's own interests and supporters. While public agencies seem well aware of the petty corruption and nepotism, they are largely dependent on the people who control existing power structures of the township, whom Government appears reluctant to antagonize.

5. The final weakness Froestad identifies lies in the *nature of community involvement in health issues*. This has to do with the ideology that accompanied the change in government in South Africa after Apartheid, in particular the Reconstruction and Development Programme that guided the first years of transition, and more narrowly, the principles of primary health care that promoted a strong commitment to broad-based community involvement in public policy making. This early commitment has not been embodied in more recent policy.¹⁰ In short, Froestad describes three main sets of problems:

- i) a dwindling level of political commitment towards the whole idea of community involvement,
- ii) unproductive politicisation of the new institutions and the utilization of them as means to personal ambitions and careers, and
- iii) local rationalization of the structure of civic representation potentially reducing the initial plurality of the system.

From "Empowerment" to "Users"

By the end of the decade, the Health Department had shifted away from its emphasis on community participation, mobilization and involvement in health and, as part of a ten-point plan of health interventions, had reduced it to the single issue of improving the quality of care. With this came a linguistic turn as well: Instead of "empowerment" and "participation," health was now defined in terms of supply-side agencies and their "users," a form of client-centred thinking that is far more entrepreneurial, top-down, and market related. This no doubt represented reshaped policy priorities in the face of substantial resource deficits, financial strictures and multiple simultaneous pressures on government budgets and bureaucracies, including problems of implementation and delivery. Still, it reflects a substantially different agenda, one more aligned with neo-liberal economic assumptions about development than anything else.

In those South Peninsula Municipal structures responsible for Imizamo Yethu, where an attempt *was* made to formalize interaction with community representatives in health policy decision-making, the budgeting pressures and ideological shift nevertheless made their mark. As a result, two institutions initially set up specifically to link with community representatives—the 'Integrated Working Group' (IWG) and the South Peninsula District Health Forum—subsequently shifted to a view that the relationship between local government and community was one of municipal authority and responsibility, with community participation limited to that of an advisory role.

The Hout Bay Community Health Forum, whose work has been recognized as among the best of its kind, found itself largely disempowered in the process, even if it had strengthened its political role over time. It increasingly struggled to get local authorities to act quickly and efficiently or at all, its place in the overall structure of health care having been downgraded. Some related loss of credibility and support on the ground followed. Made up of local representatives working with people from wider public and private institutions in the valley such as the Lions Club, religious communities or specialized NGOs, the Forum has ended up being largely an activist organization, even though its original purpose in government policy was

¹⁰ See, for example, *Restructuring the National Health System for Universal Primary Health Care* (Department of Health, 1996, 12) which states that "...it will be vital to build in a meaningful 'bottom up' component, with the active participation of users, communities, NGOs and community based organizations...."; note that roles and powers of such bodies were not specified.

community empowerment at the grassroots level to enable people in local contexts to develop their own strategies and grow their own assets in dealing with the problems they face.

That government agencies are trying to reshape their ethos to one of efficiency and simplicity in dealing with external bodies like the Forum has its own logic; but it does not promote consensual politics. It is a move toward what Jürgen Habermas calls technical or instrumental rationality, easily mathematized and thus characteristic of state bureaucracies. It tends to undermine the communicative rationality that lies behind discursive strategies for resolving social problems and establishing consensus. In short, it appears to act against local representation and democratic participation or empowerment, favouring instead those who already wield power and influence, including knowledge, understood as expertise held by elites. Policies then, notes Froestad, shift in “response to problems of Government, and less as a requirement of the needs of civil society.”

The Developmental Significance of Trust

Froestad's five points of analysis suggest that the chances of dealing adequately, let alone well, with the health problems of Imizamo Yethu, or of Hout Bay more widely, are slim under present conditions. The major message arising from the analysis is that environmental health problems in informal settlements like Imizamo Yethu are not primarily technical issues, but problems fundamentally tied up with various social and political conditions. They will not be solved by throwing more money, more technical expertise, or more bureaucracy at them, though contributions of that kind remain important. They will only be solved discursively, that is, by dealing with the significant inhibiting dimensions of human, relational interaction that prevent financial, technical, or service delivery from functioning adequately, or even at all.

Froestad's analysis, as a political scientist whose field is public administration, derives directly from his interest in understanding what would make for better service delivery. I read his conclusions as directing us not to questions of instrumental rationality, the stuff of public policy science since the 1950s, but to questions of culture, of lifeworld.

This may be an institutional culture. Thus the various public agencies that deal with health, shaped by a legacy of mistrust under Apartheid, “have a tradition for working in isolation, organizing hierarchies of authority and discipline delimited to the spheres of particular agencies or occupations. Units stick to their own definitions of problems and solutions, suspect the interpretations and practices of others and hide or hesitate to share information.” As Froestad puts it, “Suspecting others, assuming that you can only trust your closest friends or relatives, keeping your guard up all the time, not telling others more than what they as a minimum need to know, seem to be attitudes and behaviours nurtured by such regimes.” Hidden agendas abound, and coded, indirect discourse instead of open encounter is often the order of the day, perhaps as a defense mechanism against perceived threats to one's position, capabilities or responsibilities, as a way of coping with or managing potentially hostile and risky environments.

There is only one antidote to this kind of culture, and that is the rebuilding of trust, an inherently complex and profoundly challenging task. This is not a task that can be carried out simply through instrumental or technical rationalities and interventions.

Such rationalities and interventions, moreover, in another twist to the story, work against what is needed to build a discursive context for resolving problems and regulating common life. Put another way, the early concern of the RDP to mobilize and empower people goes contrary to bureaucratic rationality. Empowerment is messy, inefficient and inclined to escape control and rational management from the point of view of bureaucracy; administrative efficiency and

externally planned intervention tends to disempower, to alienate one from the point of view of people on the ground. Two kinds of knowledge are in fact working against each other, the one formal, expert driven and usually external to the local context, the other local, informal and experience driven. Froestad calls this the contradiction between predictability, reliability and confidence on the one hand, and decentralization and participation on the other. But it is the latter that will more likely generate trust. In what many regard, for obvious reasons, as a “low-trust” society, the issue could not be more important.

Thus Froestad's judgement, after some eighty pages of written analysis, is deceptively simple but profoundly interesting: “... trust may be a crucial resource in the attempt to build a national health system that fulfils the expectations of equity, accessibility and quality.” Trust, in fact, is crucial to any capacity to “liberate and mobilize human agency, to release creative, uninhibited, innovative, entrepreneurial activism towards other people. ... [to free people] from anxiety, suspicion and watchfulness, ... [and increase] chances of cooperation.”

These judgements, in my view, point directly to the potential of religious health assets.

Religious Health Assets: Why Religion?

In dealing at some length with the example of Imizamo Yethu in the Hout Bay valley, I have not focused specifically on what faith communities or religiously motivated people and groups are doing about health, though many of the institutions and practices that do impact on health there have overt religious motivations. Nor have I focused on how inhabitants of the shack settlement may find resources in some or other religious world-view, though most people hold strong religious convictions of one kind or another. Yet I have from the outset located this essay in relation to the question of religion.

What interests me most here has to do with questions of identity, security, aspiration and hope in a context of plurality, dislocation, marginalization and despair. Such issues are implicit in all the problems that Froestad has isolated, affecting every level of interaction—personal, familial, communal, administrative and public. They also lie at the heart of what we call the religious—that which fuses social practice with the human imaginary, and infuses daily life with questions of meaning, trust, agency and purpose. I will briefly sketch a contemporary analysis of the significance of this link for understanding what is happening to people and institutions in a world defined by mobility and transience rather than stability and tradition, and how we may identify strengths in that context, defined as religious assets, for engendering and maintaining health.

Reassessing the Role of Religion

Migration patterns such as those in Imizamo Yethu stretch the capacities of health care systems by introducing diversities not easily comprehended through single frameworks of reference. It is a single frame of reference that usually defines a public agency because of its bureaucratic location and its intrinsic intention to carry out predefined government policy that in most contexts still bears the marks of a single, instrumental, technical rationality. Other frameworks are necessary as crucial correctives, among them the capacities or assets that already exist within a local community.

One potential endogenous asset to take note of lies in “cultural capital” people bring with them when they migrate. This includes their own strategies for linking to or establishing support structures in new contexts; their search for new ways or “belonging”; their ways of seeing “the other,” of imagining cause and effect, of interpreting what health practitioners do, and of

anticipating positive outcomes. Our knowledge of how to work with such resources or ideas for preventive and curative health is largely still limited, often incoherent, spread across disciplines that seldom “talk” to each other.

HIV/AIDS work offers one example. Trust decreases between local people and “foreign” experts when one party’s world view suggests that illness originates from a failure to meet some communal obligation linked to rituals that venerate ancestors, and the other party argues that the disease has no such link even when they can offer no clear explanation of its original cause. We may treat the former position as unscientific; but it would be better to respond to health promotion and care by adopting mixed systems of knowledge and understanding, as many in the medical profession now acknowledge. As powerful as biomedical models of disease are at some levels, they are limited by their *a priori* methodological dependence on a dualistic, Cartesian, experimental paradigm.

In seeking a more holistic conception of health, religious beliefs, rituals and practices represent vital cultural capital should be taken into account alongside any biomedical strategies. There are a few good reasons to do this. Negatively, health care systems struggle with all kinds of local resistances when cultural factors and resources are ignored. Positively, religiously motivated healing and health-related activities, including those of African traditional religion, have strong local impact, which is important for proactive health promotion activities. In Africa, traditional health practices impact on mental health, especially in its link to wider relationships. They also represent a science of their own in indigenous knowledge systems concerning symptoms, diagnoses and curative medicines or herbs. Finally, religious movements often deliver a variety of benefits in the promotion of health, including direct care, support systems, a concomitant reduction in stress, and even physiological healing through a variety of so-called “alternative” medical practices; and this is so even if one discounts “faith healing.”

Demographic realities alone ought to raise our level of awareness, for example, the impact of Evangelical Christianity in Africa, particularly in its Pentecostal or Charismatic varieties, which are strongly present in Imizamo Yethu. About 72,6 percent of South Africans now claim to be Christian, with the increase among black Africans the most dramatic, rising from 26 percent in 1911 to 76 percent in 1990. Indeed, “Christianity is growing faster in sub-Saharan Africa than anywhere else on earth” it is claimed.¹¹ Most of this growth has been among the Pentecostally oriented African Instituted Churches (AICs),¹² who now constitute the largest sector of Christianity in South Africa.

Anne Bernstein notes that “... this is one of the few areas of South African life in which an effective hybrid between indigenous African culture and Western influences has developed.”¹³ She sees religion as the sleeping giant of South Africa in terms of the impact that this phenomenon could have, favourably citing the work of David Martin who has analyzed religion in relation to cultural transformation through rapid urbanization and dislocation in Latin America. Without being uncritical, Martin points out that¹⁴

¹¹ “Praying for Success,” *Time*, 7 February 2000.

¹² Also widely referred to as African “Indigenous” or “Independent” or “Initiated” churches; in each case the acronym remains AICs.

¹³ Ann Bernstein, “Globalization, Culture, and Development: Can South Africa Be More Than an Offshoot of the West?,” in *Many Globalizations: Cultural Diversity in the Contemporary World*, ed. Peter L. Berger and Samuel P. Huntington (Oxford, UK: Oxford University Press, 2002), 230.

¹⁴ David Martin, *Tongues of Fire: The Explosion of Protestantism in Latin America* (Oxford, UK: Blackwell Publishers, 1990), 284.

Pentecostalism renews the innermost cell of the family and protects the woman from the ravages of male desertion and violence. A new faith is able to implant new discipline, re-order priorities, counter corruption and destructive machismo and reverse the indifferent and injurious hierarchies of the outside world. . . . millions of people are absorbed within a protective social capsule where they acquire new concepts of self and new models of initiative and voluntary organization.

Policy makers have not been blind to this reality. Christians and people of other religions who associated themselves with the anti-Apartheid movement in the past have been astonished, and not a little dismayed and perplexed, at the easy and positive relationship that Nelson Mandela and other members of government have established with representatives of neo-Pentecostal and Charismatic groups post-1994.

This relationship has grown, in my analysis, precisely because officials have recognized potential mobilizing partners to deal with local problems of the kind that Beyer calls "residual."¹⁵ These are problems that the operation of the more powerful globalizing systems (economy, nation-state, legal, scientific-technological, etc.) create but do not solve—including problems linked to the environment, equity, justice, changing or collapsing traditions, values and virtues necessary for social contracts to work, and so on. All are the kinds of problems that have great social impact, and for which, Beyer argues, religion has a particular affinity, even as it is no longer central—hence residual—to the systems that create them. At the same time, religious institutions or movements also have a local capacity often missing from state organizations.

This capacity of a particular kind of religious faith to promote and motivate action on a local level is not peculiar to Charismatic or Evangelical Christianity. It is inherent to most religious sensibilities, a characteristic of the lifeworld shaping power of religion in its capacity to energize persons, binding them into local solidarities, and open up possibilities for transformation that are never merely internal, spiritual, or personal.

Of course, religion also contains a potential for separation, differentiation, exclusivity, and hostility in relation to the other who does not share one's perspective and faith, and it is this contradiction that has scared off social scientists. As we know, the rise of social science, an expression of the Enlightenment sensibility par excellence, was deeply linked to a rejection of religious authority and superstition, and this dynamic entrenched itself so deeply that one might say that most social sciences depend methodologically on the fundamental first assumption of secularization.

Public Religion: Decline of the Secularization Thesis

This is changing, necessarily. Whether we think of Comte, Marx, Durkheim, Weber or any number of other "fathers" of social science, and whether they viewed this as a positive development or not, a common denominator in their work was the taken-for-granted belief that religion, under conditions of modernity, was bound to decline. At the end of the twentieth century, this assumption had been so contradicted by experience that it has led to a veritable explosion of new literature on the subject, from a range of disciplines, among the most surprising

¹⁵ Peter Beyer, "Religion and the Transition to a 'New World Order'?" Some Preliminary Evidence from Canada," in *Religion and the Transformations of Capitalism: Comparative Approaches*, ed. Richard H. Roberts (London & New York: Routledge, 1995), 122. A lengthier definition of "residual problems" may be found in the earlier work, Peter Beyer, *Religion and Globalization*, ed. Mike Featherstone, Theory, Culture and Society (London: Sage, 1994), 104-107.

contributors to the recent debate being Gianni Vattimo, Jacques Derrida,¹⁶ and Jürgen Habermas.¹⁷

One of the best analyses of this sea-change comes from José Casanova, out of the Princeton-based Institute for Advanced Social Research.¹⁸ Taking an approach that investigates several different societies during the last decade or two, Casanova concludes that the secularization thesis is only valid in one aspect under conditions of modernization, viz., the separation of the state from religious authority in the face of religious pluralism and democratic citizenship. This does not by any means imply the withering away of religion, as is obvious in the USA. On the contrary, with the possible exception of some European nations, religion continues to flourish, entering into public life in innumerable ways that are not necessarily similar to the pattern of the “established” church in Europe, though theocracy as a concept is not dead either (in Iran, for example).

Social science, and policy makers who might utilize its insights or analyses, must perforce once again come to terms with religion as intrinsic rather than as peripheral to the workings of society. This implies a situated, contextual, and conjunctural analysis of the place of religion in any particular society, just as it implies that the core idea of secularization as the disappearance of religion so central to much of the history of social science is no longer sustainable.

The Impact of Globalization

The question of the relation between religion and globalization is relevant to this analysis. The complex link between the local and the global has implications for policy and development practice. An epidemiological perspective on the major health crises would also be impossible if it paid no attention to this link and its complexity. The short history of Imizamo Yethu and Hout Bay above points to this larger dynamic as intrinsic to the current situation in the shack settlement, Hout Bay as we know it being dependent upon economic and political forces of globalization from the outset.

Roland Robertson, a key figure in globalization theory, is useful at this point, partly because he argues persuasively for a view of globalization that takes culture seriously—contra theorists from the right and the left who insist that globalization can only be understood economistically and who, in classic modernist style, would therefore locate culture, hence religion, as epiphenomenal or secondary. We should not be detained here by the tired arguments about whether or not culture is derivative. Enough evidence has been presented in the last decades to demonstrate that it is not, however important economic or material reality may be. The interaction between systemic and lifeworld arenas, to use the language of Habermas, is the more pertinent issue. Indeed, it is precisely that interaction that lies at the heart of everything I am trying to say here.

Robertson argues that the global and the local must be grasped in relation to each other, for which purpose, drawing on the Japanese word *dochakuka*, he has coined the term *glocalization*.¹⁹ This must be understood in relation to two other claims: That the notion of

¹⁶ Jacques Derrida and Gianni Vattimo, *Religion, Cultural Memory in the Present* (Cambridge, UK: Polity Press, 1998).

¹⁷ Jürgen Habermas, *Religion and Rationality: Essays on Reason, God and Modernity* (Cambridge, UK: Polity Press, 2002).

¹⁸ José Casanova, *Public Religions in the Modern World* (Chicago: University of Chicago Press, 1994).

¹⁹ While Robertson has used this term in several writings, I am drawing here specifically on one which treats religion, namely, Roland Robertson, "Globalization and the Future of 'Traditional Religion'," in *God and*

“tradition” is itself modern, a form of “countermodernity that became a feature of modernity,” a defensive response to modernity in fact²⁰; and that the “relativization” of traditions represents a threat to “traditional culture” that may produce the kind of response now commonly, though imprecisely, called fundamentalism. From within this framework, Robertson argues that the local is “manufactured” or “constructed,” in relation to the “extralocal.” Hence, traditions are themselves “reconstructed” or “invented.” Rather than speaking of any particular tradition as if it is a fixed entity readily present to us for observation, like an insect under a microscope, we should speak instead of processes of “traditionalization.”

Extralocal forces traditionalize local contexts in new ways that may not be “really local,” especially under the contemporary market rationality which commodifies everything, including religion, for commercial or other instrumental interests. In any particular context, therefore, such as Imizamo Yethu for instance, exogenous pressures on tradition meet with endogenous transformations of tradition. In contexts where insecurity, instability and diversity are strongly present, such as those most often characterized by migrant populations of one kind or another, these dynamics are likely to be particularly fluid and potentially explosive, leading to a situation where defensiveness rather than openness will tend to shape the conditions of survival and the interests of particular groups. To come back to Froestad’s point about what is needed if the health of the population of Imizamo Yethu is to be secured and maintained, trust is the one commodity that is likely to be most lacking and most needed.

Robertson’s analysis, while neither pessimistic nor optimistic about the interaction between the local and the global, suggests certain entry points for my own concern about how one may work with “religious health assets” to transform local contexts. The fact that the global cannot be understood without the local (and vice-versa, but that is not my focus here), suggests that it is important to pay attention to local traditions, to take them seriously in our analysis and in any policy recommendations that may flow from them.

But what does it mean to take local traditions seriously? If local traditions are less controlling ideas than “phenomenon available for reconstruction—indeed, for invention”, if what we call local traditions are already “traditionalized,” manufactured out of the shifting contexts that determine the local, then two implications follow. First, we cannot understand what is going on at the level of the local without understanding its larger, “extralocal” context. To this I would add the importance of understanding what I call the “translocal,” the ways in which local phenomena are directly, overtly, consciously connected by local people to similar phenomena elsewhere as traditions are reconstructed or invented. Third, the very claim that local traditions are in the process of being manufactured means that they are fluid, changing, and therefore, open to influence. The key issue for local activism—for mobilization, for engagement, for effective interaction with the local—is then clear: How may one encounter and interact with the processes of “traditionalization” in order to open them up to interests and concerns larger than those represented by the group or community involved in reshaping its traditions and related practices?

An answer to this question must take seriously the worldviews—the habituated assumptions about the world and the personal convictions that arise from particular experiences

Globalization: Theological Ethics and the Spheres of Life, ed. Max Stackhouse and Peter Paris (Harrisburg, PA: Trinity Press International, 2000).

²⁰ Though it has since been given a more confident foundation in the work of Gadamer; see Hans-Georg Gadamer, *Truth and Method*, 2nd revised ed. (New York: Crossroad, 1998). More directly related to the focus of this paper is Hans-Georg Gadamer, *Hermeneutics, Religion and Ethics*, trans. Joel Weinsheimer, Yale Studies in Hermeneutics (New Haven: Yale University Press, 1999).

to support them—that are most fundamental to local people. This does not mean capitulating to any particular worldview or any of its fundamentals, especially where they might function regressively—that is, exclusively, oppressively, or uncritically—, but it does mean understanding it in regard to its importance for the person or people one wishes to approach, sufficiently to be able to gain the trust that is needed to open it up to other possibilities. The implications for development workers are deep,²¹ but equally so are the implications for policy makers and religious leaders, in as much as the relevant worldviews are religiously framed.

This judgement leads me to the final part of this paper, which introduces and outlines a research programme aimed at exploring some of these issues in Sub-Saharan Africa, around those focal points of local activity that deal with health on the basis of a religious commitment and framework—“religious health assets”—with a view to addressing the need for a greater articulation between these assets and public health programmes and policies, in order to respond to the profound health challenges facing Africa.

Religious Health Assets and Public Services: Potential Partners

In his *The Postnational Constellation*,²² Jürgen Habermas argues that the debilitating and destructive aspects of globalization undermine democracy and consensus politics through the instrumental rationality and extraordinary current power of the market. Because of this, we urgently require the active promotion of “a form of self-referential politics” aimed at “strengthening capacities for political action itself and at reigning in an uncontrolled economic dynamic both within and beyond what still counts as the authoritative level of nation-states.”²³

This strongly suggests, in the context of our discussion on Imizamo Yethu, that policy makers in state or governmental bureaucracies they lead, in their concern to represent and meet the interests of the populace they serve (at least ideally) and to counteract the deleterious impact of exogenous forces on society, would be seriously remiss in not paying particular attention to local people’s organizations and the broader social movements that mobilize them or connect them to society at large. By implication, this means confronting the contradiction between instrumental and communicative rationality that Froestad sees as lying at the centre of the respective interests of government departments and community activists. The “self-referential politics” that Habermas points to is not served by the kinds of blockages that Froestad identifies in inhibiting any effective solution to Imizamo Yethu’s health problems. It is also difficult, if not impossible, to embody such a politics in a context ridden with mistrust at all levels, because the discursive will necessary for it is absent.

Again quoting Habermas, and parsing his more general claim as one which has particular significance at the local level too, “Individual cultures can only make a positive contribution to the rise of a world culture if they are respected in their own, stubborn individuality. This tension needs to be *stabilized*, not resolved, if the net of intercultural discourse is not to be torn.”²⁴

My parsing in relation to Imizamo Yethu is that the discursive basis for a self-referential politics capable of strengthening political capabilities must be supported in two directions:

²¹ Among other things, the position taken here would support “fourth generation” development theory, so-called people-centred development, as well as recent work that emphasizes the crucial role of women in development as a result of gendered conceptions of reality that interfere with development hopes (mainly through patriarchal blockages) or enhance them (mainly through women’s greater and wider influence on the well-being and welfare of families and local communities).

²² Jürgen Habermas, *The Postnational Constellation: Political Essays* (Cambridge, UK: Polity Press, 2001).

²³ Habermas, *Religion and Rationality*, 153.

²⁴ *Ibid.*, 155.

Opening up the space between various parties needed for providing for effective health policies and practices so as to enhance their capacities for interaction and action; and, doing so on the basis of respect for the cultural claims and needs of particular parties as a crucial element of building trust and providing for a broader framework of knowledge that will help address constraints on and possibilities for action. The tension Froestad sees between the two kinds of rationality to which we have referred is precisely what needs to be stabilized—not eliminated by a reduction of the one to the other.

This task, in a context in which “a democratically responsible politics” has been “outpaced” by globalized markets (including the tourist and housing investment markets), is not something that can be done through moral theory or philosophical analysis; rather, thinks Habermas, “it demands a great deal of empirical knowledge and institutional imagination. In the final analysis, of course, the best design is of no help unless the political process comes into play.”²⁵ Precisely this interest lies behind the research programme I would now like to describe.

Its institutional focus is what I am calling “religious health assets.” Its goal is to gather the empirical knowledge about these assets that we need to help inform and ground imaginative responses to health crises in Sub-Saharan Africa, recognizing that social justice and equity are deeply implicated in health or its lack. Our intention is therefore transformative, programmatic, pragmatic in Habermas’s language, rather than simply descriptive or theoretical. But because we are dealing with phenomena that are under-researched and often profoundly misunderstood, the descriptive task and the generation of new theory are just as important.

An African Religious Health Assets Research Programme

The African Religious Health Assets Programme (ARHAP) is being set up jointly between colleagues from the Rollins School of Public Health at Emory University and myself at the University of Cape Town, in collaboration with others from Africa and Europe, with links to existing networks of religious health practitioners in Africa, and a planned launch by mid-2003.

ARHAP takes as its guiding principles the following: that we need to shift from crisis intervention to health creation; that a focus on the institutional, structural and cultural assets that are present in Africa is crucial to this shift; that a vital sector of these assets, often available locally where much else has failed or ceased to exist, are religious health assets; that these religious health assets are usually both insufficiently understood (in themselves and by others); and, that they are poorly articulated with public health systems and with one another.

Our overall sense of what is necessary to deal with health in a context of globalization, with all of its regional and local manifestations including unprecedented migratory flows of people, is strongly inspired by the case studies, models and theories underlying the work of the Institute for Health and Social Justice in Cambridge, Massachusetts, as expressed in *Dying for Growth*, the composite inter-disciplinary publication by twenty-seven of its associates.²⁶ In his foreword, Paul Farmer notes that this research was prompted by the question of “how large-scale forces come to have their effects on the bodies of the poor and the marginalized,” while clinical experience suggested that “deserted places” are more important for discerning the impact of economic policies than centres of power and influence. The poor and the marginalized, because of the “thousand secret ties” that irrevocably link them and the wealthy, “remain our mine-canaries,” living in “squatter settlements, refugee camps and slums [that] show to best advantage

²⁵ Ibid., 166.

²⁶ Jim Yong Kim and others, eds., *Dying for Growth: Global Inequality and the Health of the Poor* (Monroe, ME: Common Courage Press, 2000).

the physical vulnerability of the whole species”²⁷ Nothing could be more apposite to the case of Imizamo Yethu in Hout Bay.

We assume the World Health Organization definition of health as ‘a dynamic state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity.’ In this respect most, if not all, religions contain within their most basic claims and statements about reality some kind of discourse that has to do with *comprehensive well-being*,²⁸ with health therefore. This common, experientially shaped, discursive framework opens up the possibility of bridging the divides that otherwise separate religiously motivated groups from each other and from “secular” discourses on health. If this is so, then there are good grounds for policy makers and implementers to pay much greater attention than is generally the case to religious health assets, particularly those that reside in something other than the highly visible, large, centralized hospitals that are more often integrated into national systems.

We use the language of “religious health assets,” for several reasons.

First, it captures the basic idea that assets carry value and may be leveraged to create greater value. *Needs*, by contrast, imply that we are seeking to identify and overcome what is found to be lacking. Another common concept, *resources*, as distinct from assets, is more passive; they are there to be *used* rather than leveraged and grown. Assets suggest a stronger agency in the local context, and prompt us to identify what is already there to work with, rather than beginning with lack or need, concepts that emphasize outside agency, even undermine local agency.²⁹

External resources are obviously important, but policy, usually driven “from above,” and therefore inherently oriented toward prioritizing external resources, might be better served by an approach that mobilizes existing internal *assets, strengths and capabilities*. This is simultaneously to work against ingrained habits of dependency and disabling gift giving or patronage, derived largely from generations of colonialism, that have been hard to break. Constraints must also be taken seriously, but not as determining.³⁰

Regarding local or community assets, we will not avoid the ideological tensions Froestad identifies between local empowerment processes and the bureaucratic imperatives of delivery and service. A policy choice is inevitable, and it will determine the potential for delivery and implementation. The example of Imizamo Yethu is an important signifier in this respect, strengthening the case, in the face of the Froestad’s pessimistic prognosis for health, for policy that pays attention to endogenous assets.

We assume, moreover, that local religious health assets can be supported by intellectual assets present in Africa that we will engage through various partnerships. With them, we aim to generate and disseminate a greater and more fully integrated understanding of the actual and potential role of faith-based assets in transforming Africa’s health situation, health structures and health-related institutions.

²⁷ *Ibid.*, xiii.

²⁸ The phrase “comprehensive well-being” comes from a recent, detailed argument from a Christian theological point of view, drawn specifically in relation to contemporary economic, ecological and scientific theory, by Klaus Nürnberger, *Prosperity, Poverty and Pollution: Managing the Approaching Crisis* (London: Zed Books, 1999).

²⁹ We are in obvious sympathy here with “asset-based community development” theories; cf. the work of Jody Kretzmann and John McKnight and colleagues at the Institute for Policy Research, Northwestern University (<http://www.northwestern.edu/ipr/>).

³⁰ Here we make implicit reference to the idea of “sustainable livelihoods” as complementary to asset-based community development; cf. the work of the International Institute for Sustainable Development (<http://www.iisd.org/>).

This will require conceptual frameworks and analytical tools for studying the interaction of religion and health at the institutional and structural levels, about which remarkably little has been written to date. These frameworks and tools are likely to include notions of “praxis-based researcher/practitioner partnerships,” “intermediary roles,” and “executive seminars” to promote dialogue between key stakeholders in a formal intellectual framework based on “strategic collaboration.”³¹ The objectives are to understand and objectively assess the impact and growth of such assets in fostering health in all of its dimensions as defined by the WHO, to fuel research that will promote a greater and more complete understanding of the role of religion and religious institutions in health promotion, and to provide evidence that can influence health policy and health resource allocation decisions made by governments, religious leadership, inter-governmental agencies and development agencies at all levels.

We have striking evidence of the scale of religious health assets in Africa;³² there is broad consensus among those involved in health promotion activity in Africa that these religious health assets are insufficiently understood or appreciated in public policy-making generally; there are good grounds to believe that harnessing the best that these assets can offer would make a substantial difference to the capacity of all involved to respond to health crises more efficiently and effectively; there are important potential spin-offs in respect of equity and justice by enhancing these assets and their articulation with public health programmes and institutions; and these programmes and institutions themselves are likely to be strengthened in their own goals by virtue of such articulation.

In sum, the story of dysfunctional health services in Hout Bay under conditions where migrants of various kinds live together in poor conditions suggests that trust is the commodity perhaps most lacking in developing the strategies and systems to deal with serious health challenges that are characteristic of many similar situations in South Africa and Africa more widely. It is our hypothesis that a concerted, more solidly researched turn to religious health assets—especially among those who most suffer ill health and a lack of well-being because of their poverty and marginalization from well-resourced centres and functioning public service—is of vital importance to the capacity of African societies to deal with the task of engendering and maintaining health on a large scale.

³¹ These are terms used by colleagues in the NGO Participation Programme, Hauser Center, Kennedy School of Government, Harvard, with whom we anticipate some collaboration in an emerging project on “global religion and equity.”

³² According to a recent, preliminary assessment by Dr Charles Ausherman, *Religious Health Networks Survey Report* (David and Lucille Packard Foundation, 1998), Survey religious health institutions and networks comprise the second largest overall health complex in Sub-Saharan Africa, operating 40% of health resources. In 1999 the Ministry of Health in the Democratic Republic of the Congo formally turned over responsibility for health care in 60 zones (of a total of 306), with a population of 12 million, to a coalition of mostly faith-based nongovernmental health organizations, under a contract administered by the Interchurch Medical Agency in co-operation with the Protestant Church of the Congo (Frank C. Bear, “I.M.A. signs \$25 million contract for SANRU III,” in *Forum*, Christian Connections in International Health, May 2001, www.ccih.org). In Kenya, 34% of hospitals are owned by religious organizations; in Zambia the figure is 53% (Tara S. Hackney, “The Invisible Giant: The Christian Health System” (Masters, Emory University, ?). The Christian Health Association of Nigeria (CHAN) includes more than 300 health institutions and 3,000 outreach facilities, the largest nongovernmental health care provider in Nigeria, serving at least 40% of the country's population—primarily in rural areas or urban slums (Traci L. Baird, “Christian Hospitals in Nigeria Provide Post Abortion Care and STI Management,” in *Forum*, Christian Connections in International Health, March 1999, www.ccih.org).

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