Perspectives on healthcare services and psychosocial well-being: Congolese migrants in the Netherlands

Amsterdam Master's in Medical Anthropology (AMMA)

Gemma Keyzer
Amsterdam, August 2008

Supervisor: Huub Befiers
Co-reader: Ria Reis

Faculty of Social and Behavioural Sciences
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Le bâton a beau rester dans l'eau 30 ans,
jamais il ne se fera crocodile.

The stick may well remain in the water for 30 years,
ever will it turn into a crocodile
Table of Contents

Acknowledgements...........................................................................................................5
Abstract..............................................................................................................................7
1 Introduction.....................................................................................................................8
2 Research question..........................................................................................................9
3 Research context............................................................................................................10
   3.1 Asylum seekers and health care in the Netherlands.............................................11
   3.2 Mental health culture..............................................................................................14
   3.3 Background information on Congolese communities...........................................16
4 Research methodology and methods............................................................................21
   4.1 Research methodology............................................................................................21
   4.2 Constructing the field..............................................................................................21
   4.3 Research population...............................................................................................23
   4.4 Data collection........................................................................................................24
5 Culture, health and well-being.....................................................................................27
   5.1 Experiences with health care( providers)..............................................................27
   5.2 Mental health care...................................................................................................33
   5.3 Discussion – 1........................................................................................................35
   5.4 Social network........................................................................................................36
6 Nani ndoki? Qui est le sorcier qui nous mange?............................................................39
   6.1 Vignette – enfants sorciers.....................................................................................39
   6.2 Sorcery – Dutch context..........................................................................................40
   6.3 Discussion – 2........................................................................................................42
   6.4 Sorcery – Congolese context..................................................................................43
   6.5 The role of the churches.........................................................................................45
7 Religious beliefs and practices......................................................................................46
   7.1 Origins of Christianity in the Democratic Republic of Congo.............................46
   7.2 Congolese churches in the Netherlands...................................................................48
   7.3 Discussion – 3........................................................................................................52
8 Summary of main findings and conclusions ............................................. 54
References ........................................................................................ ..57
Appendix A - Questionnaire ............................................................... 63
Appendix B - EJCSK - L'Eglise de Jesus Christ sur la terre par son Envoyé Special
Simon Kimbangu ................................................................................. 65
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Abstract

This thesis presents the results of an exploratory study among Congolese migrants in the Netherlands on the question of healthcare and psychosocial well-being. Over the last two decades Congolese migration to the Netherlands has taken place in context of worsening conditions and civil war at home and refugee experiences in Europe. The impact of social marginalisation and acculturation may have for migrants and refugees in terms of physical and mental health, and the socio-economic conditions they are faced with is discussed.

Perceptions and experiences expressed by Congolese migrants interviewed for this study frequently referred to general narrative of inadequate healthcare due to the low status and discrimination of asylum seekers.

Spiritual health and healing and protection against sorcery are found through religious practice in Congolese churches. They offer a safe haven in a familiar African context and an opportunity to actively develop a social role under otherwise unfavourable conditions in the host country.
1 Introduction

Since 1994 I have worked as a community interpreter Dutch-French for Francophone Sub-Saharan African clients in legal assistance and medical and psychosocial care. I have always wanted to ask them what they thought and how they felt about the treatment dispensed to them. Professional ethics do not allow for formal or informal discussion of information gathered while assisting as an interpreter during consultation or other forms of contact. This does not only apply to discussion with third parties; it also stops interpreters from engaging in conversations, questions, feedback with the professionals and/or clients involved, other than strictly necessary for optimising mutual understanding while on the job.

The majority of the Africans I met during work came to the Netherlands as refugees and asylum seekers. They come from many different (francophone) countries, from different socio-economic and political backgrounds and from different religions. From the start the Congolese always seemed very prominent to me. Their history, their country, their struggle against dictatorship somehow struck a chord in me. Thus I specialised in Congolese geography and history for my interpreter certification in the Dutch legal and health system in 2000.

The Dutch culture with its direct ways of speaking, its apparent equality and its insistence on individual conscience and responsibility may be difficult to fathom for outsiders and may easily increase feelings of grief and stress. All the more so when a minority group is small in numbers, as are the Congolese, since they will have less opportunity to create their own migrant culture and specific presence. [Rohloff, 2003] Researching health threats and coping strategies among the small Congolese refugee community in the Netherlands in particular, I hope the resulting data will also yield some information that may be extrapolated to the diversity of other francophone Sub-Saharan communities in the Netherlands.
2 Research question

In this research I will discuss information gathered on the following questions:

a) How do Congolese migrants experience and perceive Dutch health care in general?

b) Which resources, burdens and practices do Congolese migrants in the Netherlands identify with regards to psychosocial problems?

c) Which cultural elements (if any) enhance or hamper their capacity to deal with burdens through problem solving and coping with stress?
3 Research context

This chapter gives a brief outline of the social and health care settings, the basic assumptions migrants and refugees may have had to face, and which will most likely have had an impact on the general narrative referred to in the section on experiences with health care providers (chapter 5). It is also of course a reflection of my personal experience and perceptions as a psychosocial and medical interpreter. Background information on the Democratic Republic of Congo (DRC) is added assuming that these home country experiences will have an influence on the way they make their lives here.

In a research document on migrant inclusion and exclusion in general Gowricharn [2001] sketches the ambivalence of Dutch society where authority shows a friendly face and amiable manners while simultaneously issuing implacable decisions. Strict regulations alternates with freely wielded discretionary powers exercised by civil servants as they see fit. [id: 44] Institutional accessibility to migrants may seem rather labyrinthine. Dutch politicians and policy makers assume blithely that 'participation' and 'integration' will solve everything.

The Dutch culture with its direct ways of speaking, its apparent equality and its insistence on individual conscience and responsibility may be difficult to fathom for outsiders and may easily increase feelings of grief and stress. All the more so when a minority group is rather small in numbers as they will have less opportunity to create their own migrant culture and specific presence. [Rohlof, 2003].

The same dynamics of inclusion and exclusion inevitably play a role in the medical and health care settings. Primary care plays a central role in the medical system. Nearly all residents are linked to a specific family physician and practice. Family physicians act as gatekeepers to the system and must give their approval before patients can access hospital and specialist care. Other primary cares services are delivered by dentists, midwives, physiotherapists and pharmacists. Primary care service in centres for asylum seekers (AZC) differs from the regular service to the extent that nurses are the first point of contact, performing triage and giving advice. It is only after triage that family physicians provide consultation.
Mental health problems may be treated by a general practitioner or assessed and referred to an outpatient centre for mental healthcare (a Riagg) or a psychiatric ward or hospital. Over the last two decades specific mental health clinics for the treatment of traumatized refugees have developed.

Clinical reality is perceived through the prism of a cultural construction: that is to say through diagnostic activities and labelling, health care providers negotiate with patients medical ‘realities’ that will become the object of medical attention and therapeutics. [Kleinman, 1988] In the Dutch consulting room (mental) healthcare such negotiations tend to take place in what practitioners are wont to label as addressing the patient/client on equal terms, tackling problems and private matters directly, in a free easy-mannered way, unintentionally hindering rather than favouring understanding. At the same time the institutional culture, being predominantly universalistic, that is to say rules and values are given priority over personal relationships and urgencies [Van Hutten, 2000], is often at variance with the professed equality. Clients may often find themselves confronted with discouraging changes in practitioner or therapist, compartmentalization and impersonal treatment.

3.1 Asylum seekers and health care in the Netherlands

Migrants’ health and care

Migration whether forced or not, means a loss of social system and familiar activities which will often influence migrants perceptions of health and well-being. Research indicates under use of health services by migrants as compared to native Dutch. [Van Dongen, 2000] In general migrants present a tendency towards over-consumption of somatic health care and under-consumption of mental health care. This so-called somatization is related to the often less favourable social position of migrants. Migrants tend to see their problems as caused by increased burden of work, discrimination, and general climate. Their experience of health, behaviour related to

1 A banal example from my practice is the Dutch standard form of address ‘jij’, in French ‘tu’, which is fairly impolite in a francophone setting.
illness and help-seeking patterns may differ from that which is expected by health professionals and these differences tend to hamper the provision of care. Koos Bartels, a GP in Almere presenting her results on health disadvantages of refugees with a residence permit [Huybregts, 2003] ascertains on the other hand a relative under consumption among this group in view of their many chronic and mental health complaints. Compared to the extensive health and health care research available on asylum seekers and illegal immigrants relatively little research has focused on the well-being of refugees after they have obtained permission have a few years of resettlement in their host country.

Refugee health care

For refugees problems social marginalisation and acculturation can be seriously aggravated by a loss of integrity of the body and personality, the loss of homeland, of relatives, of social networks and family structure, and of social status and possessions, meaning a disappearance of the familiar and dependable environment. They lead to an intrusion on identity and self-esteem, and the loss of cultural continuity [Van Dijk, 2001: 26]. The confrontation with organized violence, in combination with uprooting and social marginalisation can be described ‘as the refugee experience’. The traumas of refugees are generally linked to past violence, having been exposed to war violence, torture, prison, suffering from the disappearance of friends and relatives, the witnessing of violence and the loss of one’s home. These experiences entail a host of problems on a political moral and health perception level. When subsequently in a medical context these problems are narrowed down to a diagnosis of post-traumatic stress disorder (PTSD) refugees are primarily seen as victims, their stories decontextualized, translated into manageable concepts, seen as globally applicable. Changes in autonomic reactivity, sleep disturbances and traumatic nightmares are defined as important symptoms of PTSD.

Researchers and practitioners insist more and more on a culturally sensitive approach. The meaning attributed to a traumatic event may indeed vary across cultures,

1 See DSM IV, American Psychiatric Association
symptoms and behaviour may provoke varied reactions, be expressed in cultural
difference

Refugees themselves rather explain their problems in terms of their social
situation, for which they will seek help within their own circle. Poor social support
indeed appears to be a much stronger predictor of depression in the long term than
severity of trauma [Van Dijk, 2001: 25] and it is the participation in the social process
that breaks down. Traumatic experiences disrupt the structuring of both the social and
mental world. Having lived in a society determined by violence, uncertainty and
mistrust, refugees live in a world without continuity. Familiarity, trust and predictability
have disappeared, communication is problematic; disorientation and isolation dominate.

Sequential traumatization

Several authors [Bartels, 2003; Rohlof, 2003] mention that mental health
problems of refugees tend to increase after the initial period of their stay in the host
country. Acquiring new language skills is more problematic for a person struggling with
health problems. The language barrier blocks participation in schooling or job training,
thus leading to a low socio-economic position in Dutch society, a factor commonly
associated with low health. This vicious circle is difficult to break

Somehow it is assumed that once residence is secured, health problems of
refugees will subside. Bartels research shows this to be unfounded. Though their health
complaints do not significantly differ from the average patient in Almere, refugees do
feel less healthy. They present four times as many chronic complaints and twice as
many mental health complaints. Sixty to seventy percent of the informants are negative
about GP health care. They feel there is little interest or knowledge about their specific
backgrounds.

"Refugees are often forced to cope with multiple stressors and sequential
traumatization." [Bala et al. 1996] For many refugees obtaining residency has been a
long and often traumatic struggle. After applying for asylum they were sent to live in
asylum centres, so-called AZCs. Housing conditions in these centres are poor; often 4
people have to share a room. It is noisy, unclean. The harassment of lengthy asylum
procedures with their unpredictable outcomes and the poor housing conditions in most
asylum centres inevitably entail further loss of privacy and increasing feelings of exclusion and marginalisation, that are shown to undermine health and well-being of those seeking refugee status in the Netherlands [Geuijen, 2003:35]

Refugees and asylum-seekers in the Netherlands often feel misunderstood, mistreated and discriminated against; Congolese migrants form no exception. They struggle with health complaints associated with former life events, often aggravated by their present situation, expecting 'proper' i.e. somatic care and medication. Then they may or may not get a referral to social work or outpatient mental health care (Riagg's) 'to talk about it'. This compartmentalization of somatic, psychosomatic or psychiatric care can be off-putting; for many refugees contact with professional care may stop after one or two visits to a social or health worker [Kleinlugtenbelt 2000, Van Dijk et al. 2001, Van Dongen 2000].

In their confrontation with the Immigration Service (IND) the refugee narratives about experienced violence are pared down, decontextualized. This interpretation can help asylum seekers to get refugee status but at a certain cost to their earlier perception of themselves, their capacity to feel whole and effective. The pressure of these bureaucratic procedures and the interminable waiting is extreme; conflicts among occupants break out regularly. As Kool & Kaasenbrood [2002:28-29] indicate asylum seekers are continuously on the alert. There are many new arrivals, people disappear, police officers come to take people away, and rumours are rife. For asylum seekers there is little safety in group identity.

### 3.2 Mental health culture

Dutch medical culture in general is characterized by reliance on the self-healing capacity of the body, prevention of somatic fixation by minimizing referral to specialists and by minimal prescription of medication. [Van Dijk, 2001] This last feature may no longer be true with regard to antidepressants. The number of prescriptions for antidepressants seems to have risen considerably. A question that would need further research is how pharmaceutical solutions work in different cultural context on illness and cure according to Falicov [2003].

Within mental health care as in general health care therapy needs to be evidence-based, efficient and rational. Mental health therapy often centres on the individual who
is told to verbalise, health problems are approached psychologically, and explicitly formulated patient-therapist agreement are aimed for. [Thung, 2000] This insistence on equality in therapeutic relationships tends to mask power hierarchies and may hamper mutual understanding. According to Al-Krenawi [1999] patients from non-western cultures expect the therapist to adopt a more active and directive manner (as traditional healers tend to be). Otherwise therapy is expected to be short-term highly structured and focused on the problem at hand. Al-Krenawi proposes the use of ritual tools to reduce the novelty of western therapy by connecting to the patient's values and beliefs. In biomedical practice evidence-based usually means evidence based on the dominant culture. It means 'facing the problem' is not so much the migrants' choice as well as the current therapy practice on offer. Transcultural mental health care implies on the part of both therapist and patient a willingness to examine culture-bound values and criteria. Kortmann [2003: 12] affirms that Dutch health care for migrants is focused too much on consequences ( = deprivation) where it should do better to focus on process ( = discrimination)

Thus refugees struggle with health complaints associated with their former life, often aggravated by their present situation. They expect 'proper' i.e. somatic care and medication. Instead they are diagnosed with psychic or psychosomatic problems due to traumas and depressive disorders. A referral outpatient mental health care (Riagg's) 'to talk about it' may have an adverse effect. Having to "talk" about traumatic experiences constitutes a barrier for refugees to continue contact with mental health care professionals. In their country of origin this may be perceived as being labelled a "mad" and will constitute a strong deterrent to any mental health therapy. For many migrants and refugees contact with professional care will either stop at this point or after one or two visits to a social or health care worker. [Kleinlugtenbelt 2000, Van Dijk et al 2001, Van Dongen 2000]

On the other hand mental health care professionals find themselves "challenged in their individual and their professional identity" [Borra et al, 2002:239]. Their professional paradigms are disturbed and feelings of confusion and impotence ensue. Chanet [2003] in his research on mental health indication for asylum seekers in a Maastricht "Riagg" signals an ongoing debate on whether it is a matter of socio-political problems and thus not a mental health concern or on the contrary a matter of a
vulnerable group suffering severe mental health problems demanding mental health care. His results show a considerable variation among mental health professionals in dealing with asylum seekers/refugees as potential clients.

3.3 Background information on Congolese communities

The Congolese (DRC) community in the Netherlands

The Congolese presence here is relatively low in number, in Dutch research the Congolese tend to disappear into a large group loosely termed 'other Africans' or Sub-Saharan Africans. In the latest national statistics published by the Dutch CBS in 2005 [Heelsum, 2006] officially registered population figures immigrants from DRC/Zaire were 8,337, of which more than 25% are under 10 years old. Almost 90% of these children under 10 years old are second generation. As Van Dongen [2000] has pointed out small groups tend be understudied. Especially as the French language barrier adds to their low visibility; Dutch research on "new" migrants from Sub-Saharan Africa focuses on Anglophone rather than francophone communities.

Most Congolese migrants to Europe have preferred to settle in francophone countries such as Belgium (former colonizer), France and Switzerland. A study done in the Netherlands shows that the first Congolese refugees started to arrive in the late 80s in small groups, fleeing the Mobutu dictatorship [Mohogu, 2000]. The early 90s saw larger numbers of refugees coming in from what was still called Zaire, after president Mobutu clamped down on all democratisation efforts. After the overthrow of Mobutu in 1997, they were joined by Mobutu partisans.

The Congolese refugees ending up in the Netherlands were mainly young, single, Bakongo men from the Kinshasa region (Bas-Congo), with little education. Though contacts with compatriots in the Netherlands as well in other European countries are extensive and community spirit is high, simultaneously community networks are rather loose and shifting. Fear of obligations, gossip and envy as well as conflicting political

1 True, moroccan immigrants have been studied extensively. But then only a few, mostly elderly Moroccans speak French. Also they form a long established and economically important immigrant group.
affiliations play an important role and make Congolese migrants in general keep their distance from one another. [Id.]

With the rise to power of Laurent Kabila there was an increase of Congolese couples entering the Netherlands, bringing their children with them, or seeking to get them admitted afterwards. Women also came on their own, expecting to locate their husbands somewhere in Western Europe. With the on-going war in Eastern-Congo more and more Banyamulenge (descendants from earlier Rwandan immigrants), from the east as well as from Kinshasa flee to Europe and the Netherlands. They are associated with the Rwandan invaders of Congo and treated as collaborators and traitors. They may come to feel the Dutch Congolese community treats them much the same here.

Many of the Congolese migrants here have suffered through the harsh living conditions, conflicts and violence in their home country, which are still ongoing. Their experiences no doubt influence the perceptions, expectations and actions on health matters in the Netherlands.

Country information: The Democratic Republic of Congo (DRC)

The country is ripped apart by civil war and foreign invasion since 1997. The two Kabila regimes (Laurent- father and Joseph- son) "seem more concerned about gaining control over the economic networks (...) than about establishing authority and administration over the entire country" [Trefon, Van Hoyweghen, Smis, 2002: 391]

Most of the nine neighbouring countries have at one time or another been engaged in armed combat as 'invited' allies or as uninvited 'aggressors/rebels', looting and pillaging to their hearts content, in what is described rather ambiguously as the DRC's 'war economy'. Diamonds, gold, tropical hardwoods, coltan and cobalt transit via neighbouring countries into the global economy.

State collapse was a reality since 2001 since the war that began in 1998 led to the break-up of the Congo into three (or more) microstates... In 2003 a transitional government with four main rebel leaders as vice-presidents is named. The Kinshasa government directed by Joseph Kabila controls a portion of the territory only. It has

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1 personal observation, work-related
2 countryname since the overthrow of president Mobutu in 1997; earlier names are Zaïre (from 1973-1997), Congo-Kinshasa (1960-1973) and before independence, the Belgian Congo.
nothing to say over the eastern provinces, North and South Kivu. Fighting in the Eastern provinces continues and several coup attempts take place in Kinshasa. By the presidential and parliamentary elections of mid-2006, the first free elections in four decades, substantial areas of the east remain out of government control. Election results are disputed. There is still a situation of ‘no war, no peace’ in East-Congo.

During the 32 years preceding Laurent Kabila’s ascension to the presidency Marshal Mobutu Sese Seko incarnated the predatory state to perfection. His personal symbol was the leopard\(^1\). Political career - or any other type of career for that matter - was factually limited to presidential patron-client networks, which could lead into fast climbs to riches and to equally fast declines into poverty. When Mobutu was finally forced to flee the country his "self-destructive system (had) consumed itself leaving only remnants of a state" [Trefon et al., 2002: 383]

Bearing in mind that many Congolese came to Europe to study and/or to seek political asylum it is important to be aware of the historical and economic relations between Congo-Zaire and the Belgian kingdom and state, and the way this may influence politics and public feelings nowadays in the two countries and among the Congolese diasporas elsewhere. From 1884 to 1906 Leopold II of Belgium exercised a reign of terror, monopolising the Congo as his private estate. This gave rise to abuses and atrocities under the name of ‘red rubber\(^2\) meaning bloodshed, brutality and humiliation. [Kabamba Nkamany a Baleme, 1999: 14]. In 1908 the Belgian state takes over until 1960, and a period of colonial administration, exploitation, introduction of Christianity and biomedical health care follows. After independence (30 June 1960) follow 5 years of riots and disorder until Colonel Mobutu’s (second) coup with the United States at the height of the Cold War in 1965, and the start of the II Republic. Through the years the "treaty of friendship" between Congo-Zaire and Belgium, concluded at Independence, has seen rather troubled times, what with nationalisation, zairisation, inviting back Belgian and French support [Berwouts, 2001]. Through the 1980’s internal Belgian disagreement embittered relations further as the Flemish

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\(^1\) For a tale of Mobutu’s tricks see *Le dinosaure. Le Zaire de Mobutu* by Colette Braeckman

\(^2\) see also Adam Hochschild *King Leopold’s Ghost. A story of Greed, Terror and Heroism in Colonial Africa*
socialist party tended to support Mobutu opponents united in the Union for democracy and Social Progress (UDPS) against the latter's money-grabbing and dictatorial regime, while the Belgian government and industry insisted on saving privileged Belgian-Congolese relations and on showing face-saving respect to the Mobutu-government. In 1989 with the fall of the Berlin Wall support for Mobutu ceases abruptly, cooperation and development aid are interrupted.

President Mobutu is forced to accept some form of democratisation but Zaire continues to be "a classic example of a country in which clandestine networks for the private and illicit control of informal markets have sustained a repressive regime". [MacGaffey, 2000:30] The corrupt Mobutu regime publicly blamed the colonial exploitation and staggering debt payments for the country's poverty, in stark contrast with its riches in mineral resources. Meanwhile the majority of the Congolese population is struggling to survive in a climate of violence and disorder, turning to subsistence agriculture and numerous informal crafts and trades. The question MacGaffey [2000:28] raises on the impact of such violence, disorganization and disruption of social life and morality on the individual, families and communities when the state effectively ceases to exist may well be extended to what happens when subsequently Congolese refugees are confronted with more exclusion and marginalisation after their arrival in the Netherlands.

It is only with the rise to presidential power of young Joseph Kabila that Belgium and Congo take up where they left off before. These last few years public opinion in the media in Belgium and Europe have shown a revival of interest in Congolese affairs. In June 2004 questions were asked in Belgian parliament on debt cancellation and plundering of mineral resources. According to Vanhee & Castryck [2002:320] "the representations of Africa in general and of the African past in particular remain largely polarised along ancient divides in the public debate on historical Belgian-Congolese relations. Representations of the essence of colonialism and its impact on African society are dominated either by the 'politically correct' insistence on the atrocities committed under Leopold II and whether Belgium bears co-responsibility for the murder of Patrice Lumumba, first prime minister under independence; or, on the other

1 in Mobutu's case diamonds
hand, the defence of the great works accomplished in the Congo during the colonial era, mostly expressed by former colonialists. Both the positive and the negative judgments, apparently incompatible, go back to the same ethnocentric preconceptions on African societies, according to the authors [id: 307-309]

*Health and health care situation in the DRC.*

Due to the economic and social degradation and the influx of millions of people displaced by war and/or poverty, health conditions in Kinshasa are going from deplorable to worse. Diseases once eradicated, like sleeping sickness, typhoid fever and tuberculosis have resurfaced in the city, aggravated by diarrhoea, acute respiratory problems, malaria, measles and aids. [OCHA, 2001]

DRC national health budgets, having reached an all time low - no more than 1% of the national budget - have little or no impact on national health care. Health units not supported by external agencies are in a dilapidated state and often lack minimum supplies and equipment. The health sector in Kinshasa has become a flourishing market where regulations are a matter of minor concern. The creation of health units is neither directed, nor demographically oriented. Many of these units are created and managed by a sole promoter, often a male nurse. The treatment dispensed consists of consultation, some basic laboratory tests and heavy prescriptions [id].

Mobutu's simple order to the nation of 'debrouillez-vous'\(^1\) clearly applies to the health sector as well, leading to corruption, questionable care and arbitrary treatment in the quest for health, leaving few other options to a large majority than self-care and or traditional medicine.

\(^1\) Translates as 'Be resourceful, be smart'. (Harraps E-F dictionary 1981) In the Zairean context understood as 'manage on your own by whatever means you can' and has since become associated with all illegal activities.
4 Research methodology and methods

4.1 Research methodology

"... men and women (seeking) to make their worlds manageable and meaningful - giving vent in the process to their imaginings of the past, present and future." [Comaroff & Comaroff, 1993]. This phrase is one of many used by the authors to circumscribe the rather, in their words, dubious concept of modernity. I present it here as a vignette to illustrate the emphasis on contextualization in my research plans.

Many texts have been written on migrants or refugees and mental health concerns. On the subject of refugees staying in the Netherlands most studies have focused on asylum centres. Much less is known about the health and health problems of so-called 'status holders'.

As an interpreter I mainly get to understand the settings, point of view and the subjects that concern the healthcare workers. In my research I will focus on emic views of Congolese informants on health & healthcare, on their inclusion or exclusion in Dutch society, their connections to the home country and their place in the Congolese or African diaspora elsewhere.

4.2 Constructing the field

Doing research in a migrant, diasporic world the site of one's fieldwork location is less evident and will mostly lead to multi-sited ethnographic work, "an exercise in mapping terrain" [Marcus, 1995: 99] within a fragmentary and dissolute world. "..(it) examines the circulation of cultural meanings, objects and identities in diffuse time-space" [id: 96]. This may be especially necessary in the case of the Congolese in the Netherlands, who form a rather dispersed and small group, with a much larger presence of compatriots in Brussels and Paris. The Congolese in the Netherlands are relatively small in number and as such will experience more difficulties in creating their own migrant subculture [Rohlof, 2003]

Of the estimated 7,000 Congolese in the Netherlands, approximately 2,000 came as refugees. [Kennisnet, 2004] Both general migrants and refugees are included as
informants. Many West and Central Africans coming to Europe express strong feelings of forced migration, of having to live in exile because of economic and political exclusion in their home countries, or because whole networks depend on the money they manage to send home\(^1\).

Recent research [Van Heelsum & Hessels, 2006] on six African migrant groups in the Netherlands identified a number of small Congolese migrant groups that remain relatively isolated. There are a few local cultural initiatives and/or initiatives to support education and development projects in the home country. At the moment there are no coordinating Congolese structures. Jean Biampata of Msada/CNS, one of the key-informants in this study explained that in the 90s there was an active Zairian solidarity association with an permanent office in Amsterdam offering advice and support to refugees and illegal migrants alike, representing their interests in consultative structures and public bodies on a local and national level. This office has disappeared due to lack of funds, as government subsidies have been discontinued. Biampata continues his counselling activities on an individual basis.

Literature on the Congolese diaspora in Europe [MacGaffey & Bazenguissa, 2000] indicates that important venues and social events where Congolese migrants meet and exchange news and/or goods are African shops and markets, street trade, nganda\(^2\), concerts with Congolese musicians and charismatic religious gatherings. During my work as an interpreter in health-related settings the Christian faith is often mentioned as an important support. Christianity did seem to offer one of the most visible and structured aspects of Congolese community life in the Netherlands and Congolese churches a good starting point to recruit informants. In this respect Julie Ndaya Tshiteku's doctoral thesis on the Congolese Combat Spirituel in the Netherlands has been a valuable source of information.

The church as an alternative to unreliable and possible threatening government services played a role in particular in a recent and ongoing case, involving health care, spiritual care and child protection services, where I was present, in my function as interpreter, at some of the lengthy and laborious discussions between parents,

\(^1\) lecture and discussion, Filip de Boeck, Charles Piot Exploring the wealth of the African neighbourhood: The sustainability and creativity of urban life African Study Centre, Leiden 16 September 2004
\(^2\) informal bars where Congolese food and drinks are served and Congolese music played.
professionals and priests over a considerable period time. It has made me look more at
the influence of the Congolese churches than initially planned for this research as it
seemed to assemble and concentrate many essential aspects playing a role in
psychosocial health care in a transcultural setting. An outline of the main elements is
presented in chapter 6. However, professional ethics did not permit in-depth interviews
and extensive analysis of this case.

4.3 Research population

The informants participating in this research were contacted with the help of the
managing director/consultant of an Amsterdam-based Congolese community radio, a
documentation centre for Congolese asylum seekers, a Congolese radio
reporter/consultant and several Congolese churches.

Like the migrant organizations the Congolese congregations are small and
scattered around. They are not always easy to locate, notwithstanding the impressive
directory of Congolese churches in the Netherlands listed on the Africa Server internet
website. Migrant churches, like their members often lead a precarious life. Funds are
low, chapels mostly improvised, and the faithful likely to be on the move or returned to
the home country. This particular list had been compiled in 2003 and proved largely out
of date. Of the five Congolese churches mentioned for Amsterdam, none could be
contacted by the phone numbers (landline or mobile) listed for their ministers. One
chapel no longer functioned, as its ministers had relocated to Belgium; one had
temporarily moved to another location due to construction work at their customary
place of worship; at another one, when I showed up hoping to establish contact this
way, there was no one around half an hour after the scheduled starting time, and no
indication that this was or ever had been their place of gathering.\(^1\)

The directory has probably not been compiled to serve as an (inter)congregational
means of contact, members will no doubt keep each other informed. Keeping the site up
to date to inform external contact seems to be less of a priority. Amsterdam is not an
exception, later I had the same problem in Utrecht and The Hague. Contact was

\(^1\) It was the right place, as I found out later; one of the informants in this research is an assistant minister
of this church. Thursdays service may start much later, because people come after work. Anyway, since
they rent the hall from an anglophone church they often have to wait for first group to finish.
established with the help of Kerkoord Zuidoost (Amsterdam) and SKIN (Utrecht). In this way I have been able to contact and interview a number of ministers (pasteurs) with a view to contacting further research informants (snowballing). I first met pastor Emmanuel Nbanza, the charismatic leader of the Ebenezer Ministries in Amsterdam. Though I participated in several Sunday services and a church outing, this did not lead to further interviews as agreed due to an unfortunate incident involving an overlap with a contact from my interpreting practice. One of the members of the congregation expressed doubts about my presence. Having met me in my capacity as interpreter on numerous occasions, she felt my presence at the church service could only mean I was a spy from the Immigration service (IND). Although later I was able to reassure her on this point the harm was done. Pasteur Nbanza let me know that several people felt I could not be trusted and preferred not to talk to me. Also his fellow minister of the Congolese church in The Hague had no wish to participate, in fact had decided not to do any interviews any longer as it created too much unrest within his congregation.

Thus I decided to go further afield, contacting Congolese churches in Utrecht and Amersfoort. As time was limited I was able to go to Sunday service only once at each church where I met several ministers who agreed to participate in interview at a point later in time.

4.4 Data collection

This study qualifies as an explanatory and descriptive study. The research methods used are in-depth interviews, observation and participation. Interviews were held with 11 (13) respondents and took place in June-July and October-November 2007. Respondents' characteristics:

- age: 30-60 years
- male/female
- national background: Democratic Republic of Congo (Zaire)
- education in home country: secondary school – university
- religion: Christian
- residence in the Netherlands/Europe: on average 10 years (residence permit)
- reason for migration: asylum/study

With a few exceptions, French, the national language used in the Congolese education system, was the preferred language for the interviews. Lingala, one of the languages all the respondents have in common, was not an option as I have barely got beyond the ‘how are you, nice to meet you’ stage in this language and no interpreter was available. Most respondents expressed their pleasure in being able to discuss their views on their experiences in the Netherlands with a Dutch interlocutor in a language in which they feel more at home. They themselves qualified their ability to speak Dutch as below standard. "ik spreek slecht Nederlands"). Three interviews were held in Dutch. Two men, who had both come to the Netherlands to study at university, enjoyed being able to do the interview in Dutch. One woman, besides being adamant about the importance of using the language of the host country, apparently had little French. Though she spoke Dutch with a heavy accent and a grammar that could be a little confusing at times, she made herself clearly and very graphically understood.

Using the snowball sampling technique to select respondents there is always a risk of the final sample showing limited variation. To mitigate this effect in some ways, I have chosen different entrance points into the community under study. Van Heelsum & Hessels [2006] note that roughly speaking half of the adult Congolese population in the Netherlands is married or living with a partner. When looking at the labour market more than half of the Congolese here are unemployed; those that have found employment tend to be overqualified for the job. In this respect it can be said that the sample of respondents shows a slightly more positive image. Eight of the eleven respondents have a job, ten of them are married or living with a partner. They tend to be fairly to highly educated, little inclined to talk about the sector they work in, implying more or less that the work is a downshift compared to what they were used to or aspired after.

Other sources The endless stories of past and present suffering and struggling told by numerous African migrants seeking refuge in Europe, that I listened to and translated during the last thirteen years as interpreter, have undoubtedly oriented my studies and also influenced this research in many ways. Hearing the sound of their voices,
'unknowingly' observing the interaction, the supportive contacts as well as the stumbling misunderstandings between practitioner and client, whilst searching to give proper expression to their emotions and feelings has nourished me and will have 'coloured' my vision, my readings and to a certain extent my findings. The clients came from all over Francophone Sub-Sahara, but over the last few years more frequently assignments seem to involve Congolese clients. Partly this seems to confirm, as mentioned by other researchers, that the Dutch language is an important barrier to their insertion in society, more so than for other African francophone groups. Partly it may be due to the relatively high proportion of young families among the Congolese as compared to other groups. As mentioned before 28% of the Congolese in the Netherlands are under 10 years old, 90% of these children were born in the Netherlands [id, 2006]. Problems with parenting and school education bring them in contact with youth care and child protection services.
5 Culture, health and well-being.

The concept of psychosocial well-being sees individuals as part of bigger social units such as families, households and communities. Three key issues, human capacity, social ecology and culture & values affect psychosocial well-being of individuals. Human capacity includes the physical and mental health, as well as his or her knowledge and skills. Social ecology refers to the social connections and support that people share and that form an important part of psychosocial well-being. The third issue, culture and values points to the specific context and culture that influence how people experience, understand and respond to events [Psychosocial Working Group].

The key challenges of post-migratory experiences of resettlement and adaptation are dealing with the loss of social and occupational roles, handling the difficulties of operating in an alien culture, and adjusting to the loss of material and financial resources. Difficulties with immigration or other officials, separation from family and experiences of racism or the potential of such experiences can have particular influence on health outcomes for individuals with prior traumatic experiences in their country of origin. [Ager, 2001]. Social linkage, defined by Ager as co-ethnic support and intact marriage serves to enhance a sense of identity and belongingness, protecting against the socio-cultural stresses, though less so against the effects of prior trauma and deprivation [id.].

5.1 Experiences with health care( providers)

General narrative In general respondents expressed a low opinion of the Dutch healthcare system, highlighting a major lack of confidence within the Congolese community, feeling they are not being taken seriously, their health concerns easily dismissed. Paracetamol seems to be the overall cure, whatever your symptoms may be. Prescriptions for “proper” medication are few and far between, a referral for specialist examination hard to obtain. Examples of insufficient medical care or malpractice given often refer to cases of asylum seekers. Stories were repeatedly told, of people dying through misdiagnosis and negligence, or being saved in the nick of time because they went to see doctors recommended by a fellow-asylum seeker, doctors, if not practicing in Belgium or France, then residing in Limburg or near the German border. In this
research I did not study these stories in more detail but rather see their circulation as part of a general narrative, illustrative of the atmosphere of continued mistrust of the Dutch medical setting.

**Competence to access Dutch health care system**

All informants agree that the Dutch language barrier is an inhibitive factor and often prevents them from achieving a satisfactory consultation with health care professionals or with Dutch institutions in general. There is an awareness that Congolese people have particular trouble in mastering the Dutch language, more so then other African minority groups [see also Heelsum 2006, Kitenge 2002]. As one of the informants, disabled as a consequence of torture in his home country who failed to get a referral to a specialist, expressed it:

*Ah. je parle hollandais, mais c’est un hollandais AZC donc* (Oh I speak Dutch but is AZC’ Dutch)

This lack of language skills tends to elicit a rather negative response from professionals as well as from Dutch society in general, especially where people are concerned who have been living in the Netherlands for more than 5 to 10 years. Partly this failure to reach a sufficient level of Dutch may be explained by the forced idleness and exclusion of lengthy asylum procedures.

*Avec ceux qui parlaient un peu le français il y avait une petite compréhension, mais avec ceux qui parlaient le néerlandais, ils appelaient un interprète, souvent par téléphone, bon si deux personnes ne se comprennent pas, alors une troisième personne. mais bon...* (With those - health care professionals - who had a little French there was some measure of understanding, but those who only spoke Dutch called in an interpreter, often by phone, so when two people do not understand each other, then a third person... but well)

This Kimbanguist pastor, who came to the Netherlands as a refugee in the early nineties, was forced to live a bachelor’s life in an asylum seekers centre over a long period of time, his wife and children were able to join him only after he obtained official refugee status. He still feels his Dutch is inadequate, and as many of his compatriots, he relies on church members who have a better command of the Dutch

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1 AZC = Asielzoekerscentrum, relief centre for asylum seekers
language, or Dutch friends of church members whenever a situation arises where his needs and demands are likely to be misunderstood.¹

*Adequacy of treatment*

An elderly man speaking of his experience during his years in an asylum seekers centre in Eindhoven

*Puis pour les soins, par exemple quand on était très grippé, pour les médicaments il fallait attendre longtemps, on vous donnait le paracetamol. Quand on fait maintenant une forte fièvre, on dit il faut boire de l’eau, ça me faisait de la peine. Alors après trois jours finalement on commençait le traitement. Alors on se posait la question, mais comment ça est-ce que je m’exprime très mal ? Je suis fièvre quand même, j’ai de la fièvre...* (And for treatment, for instance when you had a bad case of flu, you had to wait a long time to get some medicine, they gave you paracetamol. When you have a bad fever they tell you to drink water. That really distressed me. It was only after three days that they finally started treatment. I am feverish for goodness sake, I have a fever.

In a tropical context with its many fatal diseases fever denotes a more urgent danger signal. The ‘let’s-wait-and-see-whether-it-will sort-itself-out’ approach is understood as a lack of interest and professional expertise on the doctor’s side, if not as a sign of disrespect and discrimination. It may easily lead to discouragement and appointments not kept on the side of the patient. It contrasts sharply with treatment dispensed in the home country as described by one of the informants, a woman recently divorced, who for years suffered from severe headaches and unexplained abdominal pains.

*Maar in mijn land als je hoofdpijn hebt, prik, buikpijn, prik en dan genees je snel en hier... met een prik genees je echt heel snel. Je gaat naar een polikliniek, een dispensaire, die zijn overal. (But in my country if you have a headache, a shot, a bellyache, a shot and you get better fast and here.....with a shot you get better really fast. You go to a polyclinic, a dispensaire, they are everywhere)*

¹ Though feelings of language inadeqacy are widely shared he was the only informant who alluded to professional language assistance. I refrained from mentioning the subject myself, feeling this would distract from the main subject. Interestingly, during the same period I had a discussion with a young Congolese mother, while waiting for our courtcase to be called , where she explained that the calling in of a professional interpreter to her felt like a sign of disinterest, signalling that her efforts to speak Dutch were not worth the trouble, and robbed her of an occasion to practice her language skills.
She added that of course those who did not have the means to pay need not even bother to show up at the dispensaire.

**Confidence**

This perceived disinclination to prescribe medication might lead to a certain mistrust of health care professionals, raise doubts about the ability to identify the need for quick intervention. From the informant who worried about his fever

*Ce que j’ai constaté, c’est qu’il y a une différence entre les Belges et ce qu’on fait ici en Hollande. Est-ce qu’on connaît ici la médecine tropicale ? Parce que les Belges ont été très longtemps en Afrique, au Zaïre. Ils comprennent mieux ou c’est que la langue me fait défaut ? (I noticed a difference between the Belgians and what they do here in the Netherlands. Do they have tropical medicine here? Because the Belgians have been in Africa, in Zaire for a very long time. They have a better understanding or is it the language that fails me?)*

Another elderly informant, currently on sick leave after a long period of various ailments complained that you don’t get proper care in the Netherlands, doctors neglect you, urine and blood test results are never given. Information not given, information not received was a recurring theme in the conversations. The woman with abdominal trouble mentioned before, was well satisfied with her doctor, underwent all kinds of tests, she was hospitalised twice with extreme pains. The tests all came back negative, but however much the doctor insisted, she still could not bring herself to speak directly about her marital problems, her husband’s aggressiveness. Africans do not speak openly about such things she said. The marriage had been arranged by the family and had never been very good. But in Congo she had had her own business whereas here they were constantly thrown together.

One of the Congolese counsellor respondents argues that misunderstanding and mistrust of Congolese patients can be reduced by a better explanation of the methods of medical practice here. He spends a lot of his time explaining how body tissues and organisms need to adapt to a different climate and changing circumstances; why it is necessary to let time do its work, discussing also possible psychosomatic issues. At the same time health care providers should be more aware of the need of and/or make more of an effort to build a relationship based on mutual trust. This might entail discussing...
family matters, illness, and genetics in a more circumspect way. Abrupt questioning, addressing traumatic asylum issues directly is felt to be offensive and makes people shy away.

**Consulting health care professionals in other European countries**

All informants could mention one or more examples of compatriots who had travelled to Belgium or France, or settled there permanently to get better medical treatment. The reason given for seeking treatment in either varied: medical practice is more advanced in Belgium, dissatisfaction with diagnostics in the Netherlands, medication more readily available in Belgium or France, availability of medicine that was thought to be unknown in the Netherlands, better standards and facilities of medical examination in Belgium and France, the opportunity to consult Congolese medical doctors.

The informant currently on sick leave explained how a few years ago when he was diagnosed with a herniated disc, he got nothing but painkillers. Fortunately he went to Brussels, where a Congolese doctor working with a Belgian specialist, cured the pain with three monthly injections. He also prescribed effective medicine to relief his swollen legs, something he had been unsuccessfully looking for in the Netherlands for years. Continuing treatment in Belgium is a heavy financial burden, as it is not covered by Dutch insurance. So he struggles on in the Netherlands, but has clearly lost faith. His doctor doesn’t know the Belgian medication and he is not happy with the replacement drugs prescribed to him. He does not understand why his doctor refuses to recommend him for operation on his enlarged prostate.

The Lisanga counsellor regrets this tendency among his compatriots. They are easily discouraged after the first attempt, lose faith and try their luck in France or Belgium. He explains that a certain lack of assertiveness also stems from the fact back home in Congo they have not had much occasion to become familiar with democratic ways and means. They are not used to continue within the system until their needs are recognised.
Preconceived ideas and discrimination

"La mauvaise volonté. Celui dont qui est médecin. Ils ont fait des études de médecine. Ils savent ce qui se passe dans ce corps humain. Alors pourquoi me mentir? On ne nous aide pas les réfugiés qui viennent. Si j'étais surinamien-noir ils allaient me traiter, mais tandis que je viens de là... Souvent les enfants du pays nous appellent les envahisseurs. » (Bad faith...these doctors... They have studied medicine. They know what is going on in the human body. Why then do they lie to me? They don't help us refugees who come here. If I was a Surinam-black they would treat me but since I am from over there... The natives, they call us invaders...)

A victim of torture, as mentioned above, suffering severe pains in knees and hips he speaks with bitterness about the eight long years he went from doctor to X-ray department to physiotherapist and back again, getting painkillers and exercise and the reassurance that everything was all right. It was only when a Dutch friend accompanied him to his family physician and she insisted on a referral once again for further examination that he was sent to hospital where X-rays showed that his knees and hips were foutus (ruined), a case of slight bone fissures, surgical intervention was not deemed possible. It was the association Lisanga writing a formal letter to demand a second opinion that led to the various replacement operations. As is clear from his reactions above he felt that treatment was withheld all those years because he is African black.

Several respondents informants expressed similar feelings relating how they themselves or others have managed after many failed attempts to finally get the right diagnosis and adequate treatment only through the advocacy of Dutch relatives or friends.

As one of the ministers said:

*Mais il y a beaucoup de cas aussi, quand tu appelles ici, tu ne parviens pas à faire venir le médecin ou qu'on te fasse ce que tu veux. Alors on faisait souvent appel à des amis néerlandais et quand eux ils appellent là-bas, puis on a la réponse directement. Alors je ne sais pas, est-ce que c'est la langue... parce qu'ils parlent aussi très bien le néerlandais. (But there are many cases, when you call you do not get the doctor to come and visit or that they do for you what you want. Then one often called in Dutch friends and when they call there, you get a reaction straightaway. So, I don't know, is it the language... because they also speak Dutch very well)*
His intonation and subtext clearly implied a disregard for Africans was involved here.

To be labelled African prohibits free access to healthcare, affirms another minister.

“They feel superior to Africans, believe us to be inferior and thus we have to wait until it is really serious before we get any care”

*Traditional medicine as frame of reference*

During the interviews or informal contacts little reference was made to traditional medicine, neither as a first course of action or after a failed attempt to get satisfaction from the Dutch medical profession. An alternative course would still entail consulting other biomedical professionals either in the Netherlands or abroad. When specifically asked the examples given mostly referred to herbal medicine, plants for minor ailments which can surely be got hold off in Brussels, but not here in the Netherlands according to informants.

5.2 Mental health care

Informants did not mention mental health care concerns as a category. In locating potential informants I have not targeted mental health problems in particular, but I looked, at first, rather broadly for people willing to discuss their experiences with Dutch health care. Then I focused more specifically on religious groups where mental health will involve also a spiritual element. Where the topic did come up opinions were reserved or negative. One informant talking about his three-year treatment with De Vonk, a (poly)clinic for traumatised refugees, explaining the cure proposed to him:

*Oui, le Prozac et parler, parler... je ne crois pas... j'ai parlé de tout, mais je ne crois pas que ça me soulage. Quand je parle cela m'apparaît encore.* (Yes, Prozac and talking, talking... I don't think... I talked about it all, but I don't think it helped. When I talk, it all comes up again.)

One of the counsellors on anti-depressants:

*Ja, dan denken mensen meteen, maar ik ben toch niet gek. Ze zullen eerder met familie praten of iemand van de kerk. Veel mensen die die middelen gebruiken, zijn begonnen toen ze in de procedure zaten, omdat ze daar niemand hadden., geen*
steun van andere Kongoiseen (Ah but people will think, I'm not crazy, am I. They will prefer to speak to some family member or someone from the church. Many of those who are on pills, started taking them during (asylum) procedure, because they had nobody else, no support from other Congolese)

That this role of family and friends can here be taken over by professionals remains an unfamiliar concept for many of his clients.

The pastor of the Ebenezer ministries has the impression that doctors focus too readily on the stereotype of the African asylum seeker, sleepless nights, psychological troubles, uncertainty about residence permit, okay, tranquillizers, it must be due the war and flight experiences. They know nothing about the origin and the background of the individual, their life in the Congo, superstitions that play a role in certain disorders, according to him. It is well known that certain troubles have a spiritual origin

**Spiritual health and healing**

The pastors I had contact with in this study, distinguish between physical, mental and spiritual health and acknowledge biomedical health care as a primary necessity. There is no objection to traditional herbal medicine, but these are difficult to get hold of in the Netherlands. The use of fetiches or an appeal to a feticheur are strongly condemned. They believe in the healing power of prayer. It is God who enables biomedical progress. As one of the travelling pastors sums it up: “you can take medicine, but it is God who cures.” They all give examples of people who have been cured miraculously. Thus through illness and healing God’s glory may manifest itself.

On the other hand certain illnesses, actions, behaviour or madness may be the work of demons that can only be exorcised through prayers, by leading the person in question unto the Lord Jesus Christ. There may be a question of demonic influence or spirit relations in cases of for example drugs or alcohol addictions, psychotic afflictions, shoplifting or possibly, as one of the travelling pastors mentioned, a case of cancer where antibodies are rendered ineffective when up against cancerous tissue infected by the devil.

All the religious informants agree that illness does not come from God, but may well be caused by demons as mentioned in the bible, demons that will appear in a different guise according to local custom. In Africa, in Congo demonic influence
manifest itself through *kindoki* (sorcery). The concept of *kindoki* will be further discussed under chapter 6.

5.3 Discussion

Most informants express a feeling of dissatisfaction with the available health care services in the Netherlands, either out of personal experience or with reference to a more general negative narrative. Health complaints do not get enough attention, examinations and tests are hard to obtain or test results and diagnosis insufficiently explained. Treatment and medication are carelessly withheld in cases that would claim immediate attention and appropriate medication in the home country or in neighbouring countries in Europe such as Belgium or France. Negative personal experiences and general narrative are likely to lead to a lack of confidence in and feelings of mistrust towards health care professionals. All informants agree that they or their compatriots in general have problems to express themselves clearly in Dutch and that this may partly explain why misunderstandings and dissatisfaction arise.

All informants report discrimination and preconceived notions with regards to their black African origin of health care professionals as a root cause of inadequate or unsatisfactory healthcare outcomes, either from personal experience or as part of the general narrative.

Informants who were forced to spent long periods in asylum centres and had less Dutch language skills reported more personal experience of discrimination. Other informants, who where housed on an individual basis, outside asylum centres, were more confident and tended to report discrimination more as a part of the general narrative. Although the study sample is far too limited and unrepresentative to allow definite conclusions, this tendency seems to correlate with findings in other studies that the long-term policy aimed at the social exclusion of asylum seekers has had a negative impact on their capacities to engage satisfactorily with health care and other professionals in the host country.

To remedy situations with a negative health outcome informants may resort to personal advocacy of compatriots with better qualifications in the Dutch language or

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1 No language course, no work, very little interaction with Dutch society apart from professionals
other Dutch contacts to obtain better satisfaction from health professionals. Several informants prefer to consult a doctor in Brussels or Paris via co-ethnic contacts.

5.4 Social network

The study group lives rather dispersed, which perhaps can be seen as emblematic of the situation of Congolese community in the Netherlands. Due to the limited time frame of the fieldwork, six weeks and the unfortunate circumstances mentioned before, being unable to continue with the church group I started out with, I opted for visits to different churches. Thus there was little occasion to participate in spontaneous and informal meetings with informants or follow a group of people over a longer period of time.

In the interviews social connections and support mentioned centred around family and church. Sunday church service can be quite lengthy and would give rise to participation in supplementary prayer group meetings during the week. It is also the place where information is exchanged and trips are organised to collectively attend weddings and go to pay one's respect to the bereaved (matanga).

Most informants were somewhat reluctant or simply not interested to discuss their job or their contacts in the work environment. This may partly be due to the fact that most them have had to accept downward mobility and are employed in for instance production work, cleaning or in the case of two women with a university degree in French literature, care for the elderly. Only one informant mentioned having found suitable employment. He had come to the Netherlands to study and after he obtained his degree in technical studies a power company recruited him.

Contact with relatives in Congo and Europe are frequent. For shopping, medication concerts, theatre, keeping up with what is happening, Brussels and in particular the Matonge neighbourhood is the centre of attraction. The minute I got off the train at Brussels North Station last year, indeed Lingala was the first language I heard

Congolese migrants are mobile and travel easily for various motives and varying lengths of time. Seen from the DRC the important thing is getting to Mpoto, to Europe, the promised land. [Ndaya, 2008:39] Belgium and the Netherlands seem practically one

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1 to get a vivid impression of Matonge see the film Juju Factory, 2007 by Balufu Bakupa-Kanyinda,
country. Drawbacks are realised later. Over the years, the Congolese people have dropped the expressions of Miguel or Mpoto in favour of Mikili (worlds), thus referring to all European countries with Congolese communities. Brussels has become Mpotoville, or the capital of Mikili.

Intact marriage is found to be a protective influence in psychosocial well-being [see studies cited in Ager, 2001]. Exact data on marital status for Congolese migrants are not easy to find and such figures on marital status would probably not be representative of the actual matrimonial situation. Under customary law a Congolese couple is considered to be married when the groom’s family transfers the agreed dowry to the bride’s family. Such a marriage cannot be registered according to Dutch law. Women who live in a polygamous matrimony might not freely speak about their circumstances for fear of official repercussions. All in all, Ndaya affirms that an important number of Congolese women migrants are single, a situation they experience as social failure. They have difficulty finding a partner among their compatriots in Europe, especially when they have arrived here alone, not under the authority of a husband. They are considered too emancipated, too westernised.

Pastors and counsellors agreed that they see many compatriots with marital problems and divorce rates in the Congolese community are high. Where the pastors would point to a penchant for a showy and luxurious lifestyle, both counsellors I spoke to expressed their doubts about excessive religious fervour that splits up families. Other reasons mentioned for the high divorce/separation rates are the long periods of separation and duress during flight and asylum procedures, difficulties to resettle and adjust to new circumstances in the Netherlands, financial difficulties. Where a wife is economically active and a husband is not it becomes difficult for him to trust that she will continue to defer to him as is his social due.

In this respect the selection of participants in this research presents a bias, as ten out twelve informants live in matrimony or a similar partnership. The single women I contacted did not find the timeframe convenient, were unwilling to participate or did not respond.

The subject of kindoki did not come up spontaneously in any of the interviews or informal contacts with informants. When I brought it up, usually towards the end of a
conversation, the general reaction was that, "yes it is an African reality, we know that you Europeans, you whites, you don’t believe in it", followed by some examples from personal experience or hearsay. In her doctoral thesis Ndaya [2008] gives several examples where a single woman, especially when economically successful is suspected of being involved in kindoki. Such accusations of kindoki are not infrequent among Congolese communities where social control is intense. Trust is easily withheld and contacts within the community tend to shift easily
6 Nani ndoki? qui est le sorcier qui nous mange?¹

Kindoki can be roughly defined as a knowledge (ngangu) and a power (lendo) that enable a person who possesses them to “eat” (to do away with or cause the death of) another person [Buakasa, 1973: 29]

The French terms for kindoki (phenomenon) and ndoki (agent) by informants and authors is sorcellerie and sorcier which is why I use the term sorcery and sorcerer in English, leaving aside any distinctions between sorcery and witchcraft as set out in Evans-Pritchard’s classic work on witchcraft among the Azande. Rather than something one does or does not believe in kindoki is a given, a fact of live. It is part of the ideological structure [Buakasa, 1973] and as such a force to be reckoned with.

6.1 Vignette – enfants sorciers.

The outline of this case must be necessarily sketchy since for reasons of confidentiality certain elements cannot be disclosed. Also as interpreter, there was little or no occasion for me to discuss matters with the parties involved, and of course I was not always ‘on the case’. A Congolese family of refugees with four young children felt their eldest son (8) and daughter (6) had been put under a spell by a sorcerer while waiting for a visa to join their father in the Netherlands. It was after the arrival of the children that all sorts of predicaments and misfortunes had befallen the family. According to the parents, the children had confessed that they engaged in all kinds of nightly activities in an invisible world seeking to ‘eat’ their parents. The parents had enlisted the help of several Congolese pastors who confirmed their suspicions and prayed for deliverance. The family was also in contact with two pastors of a local Dutch evangelical church who accepted the parents’ perception of possible demonic influences.

¹ who is the sorcerer eating us?
6.2 Sorcery – Dutch context

Figure 1 institutional involvement in child protection case

The example of “enfants sorciers” as presented in the vignette unfolds in a context of disruption and deprivation, migrant parents and unruly children\(^1\). Since the children’s arrival there is nothing but failure and misfortune. The parents feel the children wilfully “block the way” – kokangisa nzela – to economic success. They detect many signs of ndoki activity, the children must have been contaminated in Africa, having eaten food that was offered to them by a person unknown, or at least not further specified by the parents. They insist they do everything in their power to take good care of their children and try to save them. Although the children have some health

\(^1\) The children’s confession, in its basic elements are quite similar to the eleven portraits of “enfants sorciers” described in Deboeck [2004:148-153]
problems, the general practitioner whom they consult with regularly does not find anything medically wrong with the children and expresses no cause for concern.

The Congolese pastors consulted by the parents confirm the kindoki accusations and some prayer sessions with the family take place at home, some in church. But the churches are too far away for regular visits and do not have the means to support the family on a more permanent basis or offer a refuge to the children as they would in Congo where churches have taken over social assistance from the failing state. In effort to purify the house and diminish the danger the parents have placed loudspeakers in all the rooms and play religious music at low sound level 24 hours a day. They wake up the children at night to make sure they haven’t just left their bodies behind to go on their nightly sprees.

Welfare intervention After schoolteachers expressed their concern over the inappropriate, disruptive behaviour of the children and their possible neglect, a social worker was called in as well as the family’s general practitioner. When matters did not improve the Youth Welfare Service (Bureau Jeugdzorg) was notified, who in turn asked the Child Welfare Council (Raad voor Kinderbescherming) to investigate and advise the Child and Family Court (Kinderrechter) whether to issue child protection orders to ensure the children’s safety. All these organizations paid several home visits to assess the family environment. Parents, authorities and care organizations agreed on the need for help. But when the issue of kindoki came up, this analysis of the problem situation was rejected by the different organizations involved, arguing that the sorcery is a considered non-existent entity in the Netherlands. A separate youth crisis relief team, called in by the Youth Welfare Service started a series of talks with the family to define and implement the necessary interventions for the children’s safety, while liaising with all the individuals and organizations involved. The parents were prepared to accept that the children be placed in protective care of a church facility be it temporarily. They rejected psychiatric help as useless though since it would do nothing to solve the core problem of kindoki, bring no salvation to their children and endanger parents and children only further. This perception by the parents of their children as risk as well as at risk finally led to a police raid in order to place the children in foster care. The official organization for guardianship (Nidos) took over the cooperation of further care monitoring. None of the contacts with the many youth welfare institutions seems to
succeed in establishing some measure of working relationship with the parents. The confusing number of organizations involved and frequent change of persons in charge or colleagues replacing one another are hardly conducive to a measure of trust. After the interventions of police and court the gap of mistrust deepened. The parents turn down the offer of Nidos to bring in a Congolese expert in kindoki affairs. They seem to have more confidence in the local Dutch evangelical church who offers them continuing guidance in dealing with the welfare organizations, in opposing the decisions of the Child and Family Court, and in countering demonic influences by religious means. The parents have severed all contact with professionals. The children continue in foster care.

6.3 Discussion – 2

This child welfare case can be interpreted as a negotiation of social and medical realities between the different parties involved, resulting in court-ordered child protection measures. Within the explanatory model of the parents the safety of their children and themselves could only be ensured by engaging in prayers and religious music, placing the children in the care of the church. Social and healthcare professionals on the other expressed their concerns in terms of possible maltreatment or mental health issues and insisted on the need for psychiatric help. It is important to realise that from the first concerns expressed by the schoolteachers to the police raid nearly six months had passed as far as I know. Before and after the police raid a bewildering number of professionals trudged through the family’s lodging, explaining their objectives, their status, offering assistance, proffering a litany of questions. This made it difficult to create a mutual basis for trust. When the kindoki issue was brought out into the open, the official stand was quite clear: “with all respect, in the Netherlands we do not believe in sorcery”. This was immediately belied by the two Dutch pastors who were present at some of interviews at the parents’ request.

They clearly did believe in demons and were willing to offer the religious means available to deal with this kind of problems. Notwithstanding the antagonistic reactions of some of the professionals present, the pastors ‘translated’ the necessity to accommodate the eldest children elsewhere, temporarily anyway, preaching responsible parenthood in biblical terms. The parents visibly relaxed and reacted favourably to the reframing of an offer of assistance in terms that made sense to them. A tenuous
agreement on how the local Dutch church would play a role in ensuring the children’s safety seemed to have been reached. The next day the police took the children away. Fear of failing to assist a child at risk had been stronger.

Could the mediation initiative of the Dutch pastors have worked? Could it have helped to avoid police intervention? It is very difficult to say of course. Actually the Dutch pastors were the only persons who had succeeded in establishing some measure of confidence and trust with the family, given the fact that the care professionals were mostly associated with enforced state interference. Although efforts had been made to enlist co-ethnic help and consultancy, this was likely a question of too little, too late. The unfamiliar territory of sorcery and ethnic background, combined with antagonistic reactions to pastoral guidance hindered any joint action. This lack of knowledge and expertise calls for further research, for a collection of information on cases where mental and spiritual healthcare overlap and support each other, on sorcery cases and the lessons learned there, for more background information on specific religious communities and perhaps most important of all how to make this information available to workers in the field.

6.4 Sorcery - Congolese context

Authors agree [Tonda, 2000; De Boeck, 2004; Geschiere, 2000 etc.] that in the last decades in Congo, as elsewhere in Africa, sorcery tends to invade public space more and more. This is particularly so in the case of “enfants sorciers”, in Kinshasa. Kindoki is a vital concept that may manifest itself in urban as well as rural space, among the elite and the state, as well as in popular culture. Buakasa [1973] emphasizes that in Kongo society social order, success, failure, suffering and death, work and family get their coherence and significance through the global ideological structure of kindoki. Conflicts are perceived as resulting from an invisible world reality whose effects show up in the visible world by material traces, tell-tale signs of occult forces. The balance of power has been disturbed, violation of values held by members of a society may have been committed by the sufferer or by someone close to the person. Order needs to be
restored through action either in the concrete (first world) or in the imaginary (second world) reality.

Where before suspicions of kindoki would mainly concern adults, though the figure of enfant sorcier is not a new phenomenon, in Congo-Kinshasa over the last decade, a steep increase in accusations against children has taken place. Such accusations within one's own family have become a common occurrence that transcends all rank, class and ethnic division [De Boeck 2004: 168] Children, who may be as young as three, four years old are perceived/may admit to transforming into a ndoki after accepting food or a drink from a passer-by. This person then comes to them at night demanding to be fed with human flesh in return, asks them to kill a relative. In the nocturnal, second world the children gather transforming into adults, they kill to share the human flesh, they pilot small objects turned into planes to travel to Europe en US, they throw money around and drive in big cars. The girls, transformed into beautiful women, lure their fathers and uncles into their beds. Each morning they lose their cherished possessions and take on their child selves once again. The essential characteristic of the ndoki is the betrayal of their family for selfish reasons. The expression commonly used, "mangeur d'âme", relates to the absorption of the victims vital energy by the ndoki and signifies to kill, but also, as Tonda [2000: 53] explains, to weaken, to render "dumb" at school, inefficient at work, loathed by superiors, badly thought of in the family etc.

The children are expelled from their families or decide to take themselves unto the streets to join the rising numbers of street children, child witches, child soldiers, who roam the streets at night and sleep during the day. The children accused of being ndoki often find themselves in a vulnerable situation to begin with, being a stepchild, an orphan, a child whose parents have gone abroad. This shifting away from ndoki accusations from elderly males to young children can be related to a generational conflict, to a changing balance of power, a transformation of society in the context of individualisation and globalisation in a rapidly disintegrating, destabilized society, where 70% of the population is under 18.

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1 In a lecture De Balie, Amsterdam (20-01-2008) Deboeck estimated the number of streetchildren in Kinshasa alone at 40,000.
2 see country information appendix
3 lecture Deboeck, see note 1
6.5 The role of the churches

The only road to redemption open to the accused children is through the church. The church offers a place of refuge, removing the children from a family context where they risk physical and psychological violence. During the seclusion the children will be subjected to a period of fasting and ritual purification. Pastors and their assistants help the children to formulate their narrative, to prepare and structure a public confession and name of the ndoki who recruited them, which traditionally presented an opening to solve the crisis. The “deliverance” performance takes place in a prayer group ritual. Reintegration into the family often remains problematic, the rejection becoming final.

Although it cannot be said that the churches actively produce child witchcraft accusations, they rather limit themselves to confirming accusations brought to their attention, the role they play is ambivalent. The belligerent discourse of fundamentalist Christianity against the forces of evil, the ungodly and the demonic, echoes and reinforces the obsessive fears and dynamics of sorcery. The more evil there is to be feared, the greater God’s glory and power will shine. The solution offered is a Christian lifestyle and an individual relationship with God, which will ensure health and good fortune for the faithful. In this respect Tonda [2000: 55] suggests sorcery can be defined as the science of the pre-Christian, pre-capitalistic world, as well as the science of the Christian and capitalist world. Thus one might just as well advance the proposition that the sorcery ideology provides a fertile substratum for the biblical ideology of good and evil.

The Christian minister, the nganga Nzambi seems to have transformed the role and taken over part of the vocabulary of the nganga nkisi, the diviner, concerned with the promotion of good fortune and the counteraction of misfortune [Schoffeleers, 1994: 79-80] The ambivalence of the nganga resides in the suspicion that to uncover and counteract the harmful activities he inevitably needs to have occult forces at his disposal. The nganga Nzambi by focusing on the demonic passages of the Bible may contribute to the production and the omnipresence of the ndoki figure in the social field and thus become part of the problem as well as offering solutions for its consequences.
7 Religious beliefs and practices

Like most other African groups who have settled in Europe over the last few decades, the Congolese came here as adherents of a religion that was originally imported to Africa, in their case Christianity [see Ter Haar, 1998]. The Christian religion is overwhelmingly present in every day life in Congo and Congolese migrants have reimported their Christian beliefs and practices in Europe.

7.1 Origins of Christianity in the Democratic Republic of Congo

As Ter Haar argues, and many authors agree, African societies tend to be more religious than those of modern Europe. African societies can be described as non-secular, as religious in nature, operating within a worldview which distinguishes but does not separate the visible from the invisible, the material from the immaterial. In Congo-Kinshasa religion is predominantly Christian and omnipresent in political, public and private life. In this respect Bazonzi speaks of Kinshasa as a "ville surchristianisée", where the charismatic renewal religious communities ("églises de réveil") based on an evangelical, Pentecostal theology, proliferate.

Historically various missionary attempts can be traced to bring Christianity to Africa and the Congo. Around 1880 an important wave of missionaries, of catholic and protestant denomination settled themselves. Africanised catechisms originated in various African regions soon after. The Kongo prophet and incarnation of the Holy Spirit Simon Kimbangu, a former Baptist, started preaching his beliefs. Considered a subversive element by the colonial authorities he was imprisoned in 1921, his movement banned, to remain there until his death in 1959. After independence the 'Eglise de Jésus-Christ selon son Envoyé Spécial Simon Kimbangu' is officially recognised as a church in its own right next to the catholic and protestant churches.

The catholic missions, closely intertwined with the Colonial State, were run by Belgian missionaries. The protestant missions were mainly of North American, British or Scandinavian origin. After independence in 1960 the protestant missions evolved into a union called the Church of Christ in the Congo. The missions, catholic and protestant, were highly involved in education and health care both before and after independence. The Church of Christ leadership were staunch supporters of the Mobutu regime. The
The Catholic Church was ambivalent, more critical especially in the later stages of the Mobutu regime.

The arrival of American evangelical missionaries in the 1980s gave rise to a wave of independent African charismatic renewal churches, laying strong claim to an African and Christian identity, as opposed to western missionary Christianity. [Hinga, 1994] No longer controlled by the colonial and postcolonial hierarchy of the Catholic and Protestant establishment, prayer groups started up under the guidance of a charismatic pastor, as shepherd directly inspired by God. These shepherds consider a classical theological education of little importance, as they are spiritually gifted to offer guidance to their flocks.

The World Factbook 2007 (US government) states the following data for the different denominations: Roman Catholic - 50%, Protestant - 20%, Kimbanguist - 10%, Muslim - 10%¹, other - 10% (includes syncretic sects and indigenous beliefs)

**Presence in public space** With the democratisation process accelerating in the early 1990s, the intensification of the socio-economic crisis and the fall of the Mobutu regime, public space is more and more taken over by religion and music, in streets, bars and churches alike, with religious lyrics and sermons getting more and more airspace in the media. [De Boeck, 2004:95]. The new religious movements are initiated by relatively young urban middleclass individuals who make use of radio and television broadcasting, audiovisual material, internet and telecommunications. Social mobility, political goals or radical change are to be achieved more and more by associating with Christian moral behaviour and lifestyle. [Marschall-Fratani & Péclard, 2002] Musicians, politicians, religious leaders and individuals alike express their worldview in a shared Christian discourse. One sees former political leaders from the Mobutu era make a bid for popular favour proclaiming to be inspired by God or the Holy Spirit. Thus divine power and political power have become closely interconnected. As Tonda [2000] shows Christian God, miracles, fetishes, sorcery are all modern phenomena, part and parcel of the construction of politics in Africa, be it in pre-colonial, colonial or postcolonial times. Urban public space becomes increasingly haunted by anxiety, by popular obsession with representations of occult spiritual forces

¹ Mainly in the eastern Congo
Religious practice Facing precariousness and adversity in deteriorating settings and failing political structures many people, disappointed with the traditional Christian churches look for radical change and find new hope within charismatic prayer groups and movements of the ‘églises du réveil’, which may vary in size and visibility but share a number of common features and practices. Bible texts are taken literally and constitute the functional and emotional heart of praying, preaching, singing, miraculous healing. The prosperity gospel, the spiritual battle, the practice of deliverance, the techniques of *semence*¹ are recurring themes.

7.2 Congolese churches in the Netherlands

Located for the most part in the four main cities of the Netherlands, Rotterdam, The Hague, Amsterdam and Utrecht the Congolese churches tend to be charismatic, evangelical churches. Independent, erring from location to location, because funds are low, they are not always easy to find for an outsider. My starting point was a list of African churches compiled by a Dutch priest in 2002 that is listed per country on the Africa Server². Typical names are *Eglise de Dieu Vivant, Eglise Évangélique, Armée de la Révélation du Dieu Vivant, Assemblée Évangélique pour Christ*, etc³

For this study I located, with some difficulty, three churches mentioned on the internet list, differing somewhat in origin or organizational approach: the *Ebenezer Ministries* in Amsterdam, the *Eglise Kimbanguiste* in Utrecht and the *Basilea Church* in Amersfoort.

My first contact was with the *Ebenezer Ministries*⁴, when they had just moved into a temporary accommodation, a garage church rented from another African congregation. The Ministries are led by a married couple mr. and mrs. Nbanza. I attended five services during July- August 2007. Attendance was low, due to the recent move, the holiday season and internal problems as mentioned above. The service is in

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¹ literally seed or semen; the faithful are encouraged to ‘sow’, to donate to get into God’s good fortune
³ Church of the Living god, Ecvaigilical Churc, Revelation Army of the Living God, Evangelical Assembly of God, etc.
⁴ The Ministries referred to can be local or international and include missionary and educational activities, women’s groups youth groups etc.
French as the main language, while bible readings and sermons are interpreted consecutively in Lingala, lasting for three hours approximately, though not everyone is necessarily present from the start. The services start with a session of fervent praise of the Lord Almighty in French led by one of the worshippers, supported by musicians and three women singers, the ‘groupe de louange’ (songs mainly in Lingala).

The Bible texts chosen refer to exile, to persecution, to imprisonment, to suffering from hunger and drought followed by visions of miraculous escape, unfailing nourishment and raising of the dead. There is Abraham leaving, his parents, his country to go into exile; Peter rendered invisible to escape his prison cell, Elias and the widow of Septa, her child resuscitated; Abraham again and again ready to sacrifice his child. The faithful are urged to vigilance in their fight against idolatry, to beware of the demons of jealousy, Satan incarnate. They are reminded of the necessity of sacrifice, namely a contribution in cash, to ensure the continued use of a venue for the services and prayer group meetings, and above all God will grant you personal prosperity¹, shower you with material and spiritual welfare. The success of the pastoral couple is set as a shining example and serves as an incentive. Mrs Nbanza was ordained in June 2007, a major event for the community, with visitors from Europe, Asia and Congo. Mr. and Mrs Nbanza, besides French and Lingala, speak Dutch and English very well, are both full-time employed, their ministry is based in Amsterdam but they are often invited to preach in religious gatherings elsewhere.

In an interview Mr. Nbanza stresses the importance of integrated social, mental and spiritual health care within the ministry. In sermons, prayer group meetings and individual consultations, he urges adults and youngsters to acquire language skills, get diplomas, learn a trade, a profession, coming up with suitable bible cases to underline his point. He agrees that the Dutch language is problematic for many Congolese here and forms an obstacle to integration. The language chosen for church service is French so as to attract a wider francophone audience, with a Lingala translation for the benefit of Angolese and Congolese participants with little or no French.

¹ The theology of prosperity [Bégot, n10, 2004] modifies the believer’s relation to God, no longer is God’s grace implored as a reward for leading an ascetic life, it is claimed as due for professions of faith and payment of cash
The Kimbanguist church can be said to be the most Congolese of the three churches presented here and radically African in its prophetism. The founding father is Simon Kimbangu, Prophet and Envoy of Jesus Christ, come to console the black race is venerated as the Holy Spirit. His birthplace Nkamba, has become the New Jerusalem, the three Congos: Congo- Kinshasa, Congo Brazzaville and northern Angola the ancient Kongo Kingdom is its territory of reference. The church’s religious principles are summed up in *kintuadi* - community solidarity and food sharing, and *Bolingo, Mibeko, Misala* - Love, Commandments (Twelve), Good Works. More information on the African roots and theology of this church, which is relatively unknown in Europe, although present in Belgium, France and Great Britain, is added in Appendix B.

In the Netherlands the Kimbanguist as well church has been established in 1995 Utrecht. The language used here is mainly Lingala, though bible readings are in French. The service recently moved from a more central venue to a large gym on the outskirts of Utrecht due to complaints about the noise. The national delegate told me I would have no trouble finding my way from the train station to the church, I could simply follow the people dressed in white and green, the colours of the Kimbanguist church. The dress code is indeed strictly adhered to, with women wearing a headscarf. Where in Congo the service may last from 10:00 to 20:00, here time was limited from 12:30 to 18:00, the hall being needed by other users after that. The service includes singing, music, prayers, bible reading, sermons and socializing. Male, female and youth choirs sit in separate rows, a few brass players and two recorders sit at the back. A group of mainly teenage girls act as *surveillants* (supervisors) dressed uniformly in ankle-length dark green skirts with white blouses and a green beret. The singing is a capella either by one of the choirs or the whole parish, singing psalms or ‘chants *inspirés*’¹. The universal dimension, their world mission is an important pillar of the church, throughout the service the slogan ‘*Espoir du monde Eglise universelle*’ is repeated in unison. That particular Sunday (mid august 2007) prayers were dedicated to the sick and suffering in the world, for people in Peru (earthquake), Afghanistan, Iraq and Lebanon (Israeli attacks).

¹ heavenly songs transmitted through divine inspiration by different intermediaries. These songs speak of Christ’s message, the saving of souls, the glory of the hereafter, prophecies and above all the question of the black race. The words of spiritual leader Papa Diangienda (youngest son of Kimbangu) – 1959–1992, are held sacred and are integrated into the bible interpretation and *chants inspirés*, they have become the words and memory of the kimbanguist community [Gamplot, 2000: 46]
In conversations with the national delegate for the Netherlands (residing in Antwerp) and several pastors the way the religious community is structured was explained further. The concierges contact those who are absent to find out what the problem is, be it medical, social or lack of faith, and support or motivate the absentees. The diacres (deacons) administrate the church funds offered by the faithful to pay for the rent of the meeting-place and the maintenance and embellishment of N’kamba. The catechistes teach the Christian faith according to the Kimbanguist doctrine and several principal pasteurs advise and offer spiritual guidance to their local communities. This is as far as it goes here in the Netherlands but in countries with a larger presence the ecclesiastical hierarchy is comparable to the Catholic structure with the highest spiritual leader and legal representative having its seat in Nkambe New Jerusalem.

In this context the word chrétiens may refer to the Kimbanguist Christians themselves exclusively, and then again they may use it in a general meaning. They consider the catholic and protestant church, like themselves, to be proper churches and regard the other Congolese, charismatic and Pentecostal groups negatively, as sects and sect members not quite up to scratch though relations are on an individual footing are not necessarily strained. Kimbanguists follow strict rules and regulations, they do not eat pork or drink alcohol, dancing is not allowed, they dress conservatively, thus they tend to socialize within their own circle. Mourning and marriage ceremonies are participated in more widely.

Simon Kimbangu banned all use of fetishes and sorcery, all idolatry. This fight is still going strong. One of the pastors regretted the widespread distribution of Jesus portraits in Africa, so many actors with long hair and beards, where God had forbidden portrayal. The walls at his home were covered with large portraits of his religious leaders, descendants of Papa Simon Kimbangu.

As many of their members, fed up with minister Verdonk’s immigration policy, had left for other countries the Basileia Church, still listed as a Congolese church on the internet, has merged two years ago with a pastor and a group of some members of a white Dutch evangelical community. Their services are hosted in the Dutch Reformed Fonteinkerk built in the sixties in Amersfoort, but the Basileia, once again, is looking for a new meeting-place as their contract ends in December 2007. The
resident pastor, Mr. Paku has Baptist origins. He went on to study theology at an American institute in Paris and graduated after 4 years, before he came to the Netherlands. The services are bilingual, in French interpreted into Dutch or Dutch, with a French interpretation. Both pastors have a sufficient command of their second language to communicate directly with individual members.

The service I attended was led by pastor Rommers, the language of communication was Dutch. The black churchgoers sat in front, the white ones at the back. Two guitars and a keyboard played reli-pop music, two women staying in front of the audience with the pastor sang solos while short rather repetitive songs of praise alternatively in French or Dutch were taken up by all the attendants, the texts being clearly written out on slides. The service lasted from 13:00 till 15:00 (September 2007); the first 45 minutes were taken up by music, praise and testimony followed an instructive step-by-step programme, to be continued for the coming five weeks, on how to build/keep a sound Christian marriage relationship with the pastor an his wife (one of the singers) as a model. The testimony, given by one of the young (guest) guitarists spoke of deliverance by the Holy Spirit from drugs and a demonic lifestyle. Pastor Rommers is an enthusiastic, gifted raconteur compared to whom the French interpreter would stumble somewhat. New prayer group meetings are announced where prayers will be said in support of those of the members who troubled.

When asked for his thoughts on how the association between the two group is coming along pastor Paku intimates that, like in any marriage, concessions need to be made, there are advantages and disadvantages.” It is a chance to get to know each other better, an opportunity for mutual support. The Dutch tend to have a more critical, intellectual approach, we Africans value the spiritual, the expression of the love of God in a natural, joyful way. “That is why we remain very attached to our songs, our cultural riches, the language, all that is part of the history of the church. These cultural aspects help to create and sustain a distinctive atmosphere of religious fervour. People get restless when these are absent of our weekly practice for more than a few weeks. ..

“...there is a difference of mentality. Children running around in a place of worship are not tolerated, time schedules are strictly adhered. Having a Dutch secretary handling church administration has proved to be an advantage though.”
7.3 Discussion - 3

Religion in general, and more especially the selected bible readings, clearly provide a shared framework of understanding of oppression and violence, echoing the traumas of forced migration. The practice of ritual, music and language create an atmosphere of conviviality, an ‘ambiance’ offering a sense of belonging, of inclusive identity, of security. [Bégot 2004, Fabian, 1981, MacGaffey, 1994]

Unconditional support is assured though the divine. “Where lawyers can help you no longer, where psychologists do not understand your problems, Jesus, our living God will help you”. This can be helped along by financial offerings, paying one’s debts to God imploring His favours. Social support and mutual aid, recreating the ties of family hood and kinship are important factors. The emphasis on these values and the integrated approach contrast favourably with the bureaucratic and fragmented approach of the Dutch professional care system as discussed in chapter 3.

Due to the obstacles in my fieldwork, notably the limited timeframe of this research and the participant observation with one of church communities cut short, I have not been able to gather more specific local data on this topic. Ndaya [2008] and Nell [2001] offer Congolese examples from the Netherlands and Belgium respectively.

The social and spiritual support and integrative framework offered by the religious groups described in this study clearly constitute a protective influence. It is important to realise that in their fight against superstition, fetishism and sorcery they are not so much contesting the existence of kindoki, but seeking to replace the means of by which the occult forces are conquered. Like all ideologies kindoki is subjected to social manipulation, there is always a risk of domination and exploitation.
Summary of main findings and conclusions

Within a small-scale exploratory study such as this, findings need to be presented with the utmost care and are necessarily of a limited nature. Answers to the research questions must be seen as preliminary, as useful indicators for possible further research.

Experiences and perceptions regarding Dutch health care

Overall the available health care services in the Netherlands as experienced by Congolese participants in this study were perceived as inadequate. Informants expressed feelings of dissatisfaction either from personal experience or with reference to a more general negative narrative. Health complaints do not get enough attention, examinations and tests are hard to obtain or test results and diagnosis insufficiently explained. Negative personal experiences and general narrative are offered as an explanation for the lack of confidence in and feelings of mistrust towards health care professionals.

Insufficient command of the Dutch language is given as an important reason for failures to engage satisfactorily with health care and other professionals in the Netherlands. Informants also report discrimination and preconceived notions of health care professionals with regards to their black African origin as a root cause of inadequate or unsatisfactory health care outcomes, either from personal experience or as part of the general narrative.

To remedy situations with a negative health outcome, informants may resort to personal advocacy of compatriots with better qualifications in the Dutch language or other Dutch contacts to obtain better satisfaction from health professionals. There is a tendency to consult health care professionals in Brussels or Paris via co-ethnic contacts. The Belgian and French health care systems are felt to be more appropriate, more knowledgeable with regards to the need for medication and standard practice of the Congolese.

Psychosocial well-being

For several reasons this study does not include specific data on mental health experiences and perceptions among the Congolese community. Within the limited timeframe available for this study the snowballing technique to select respondents did not permit to identify potential participants dealing with mental health complaints in a
regular mental health care setting. Informants contacted were rather reluctant to refer to persons facing or having faced psychological problems. Some informants maintained that the Congolese were not likely to seek help from these quarters. In Congo people are more likely to look for help within a religious setting. The church has virtually taken over psychosocial assistance and public life, the state having proved itself a hostile and failing entity. Furthermore, one particular case where conflicting issues of health care, spiritual guidance and child protection were at stake, focussed and partly reoriented my research in the religious domain. The initial project for participant observation with a Congolese church was cut short when one of the members of the congregation voiced her suspicions regarding my presence. Having met me in my professional capacity as interpreter in a child welfare case she was convinced I was a government spy. The ensuing atmosphere of discomfort and mistrust resulted in a further research change, I decided to broaden the field by contacting different Congolese congregations and study their specific backgrounds. This is how the Kimbanguist and Basilea churches came to be included.

Within the Netherlands the Congolese compatriots find their main places of gathering in co-ethnic prayer groups and churches. The social and spiritual support and integrative framework offered by the religious groups described in this study clearly constitute a protective influence. The Christian religion, and in this instance the selected bible readings taken quite literally provide a shared framework of understanding of oppression and violence, echoing the traumas of forced migration. The practice of ritual, music and language create an atmosphere of conviviality, offering a sense of belonging, of inclusive identity, of security.

This integrated system of mutual support and psychosocial assistance contrasts favourably with the bureaucratic and fragmented approach of the Dutch professional care system.

Cultural values

Thus within the migrant Congolese communities in the Netherlands cultural continuity passes through the celebration of Christian faith and religious practices so central in modern day Congo in private as well as in public life, in media and music. The Kimbanguist church is historically and ideologically the most Congolese of these communities. It presents a tightly knit network of mutual support and control. Other
churches seem to be based on looser and more shifting grounds. Social and material well-being is closely associated with spiritual welfare, the latter preceding and ensuring the former.

*Kindoki,* sorcery, is a vital concept in Congolese society, a phenomenon that transcends rank, class and ethnic division. This explanation of the reason why misfortune and adversity befall a person also plays a role in the relationships among migrant communities here. The regularly occurring accusations of child sorcery in Congo also resound in Europe. In this respect it is important to realise that the Congolese churches in their fight against superstition, fetishism and sorcery are not so much contesting the existence of *kindoki,* but seeking to replace the means by which the occult forces are conquered.

The case of child sorcery discussed in this study, opposing as it did mental and spiritual health care, leaves many questions unanswered. The child protection issue, aggravating the atmosphere of mutual distrust and miscommunication among all parties concerned, did not leave room for further transcultural mediation by ministers of the Dutch or Congolese churches. The question can be put whether the church can be seen as part of the solution or whether it is part of the problem. No doubt there is a need for a better understanding and expertise in matters of religious or supernatural ethnic support and networks and the role they can play in mental health issues. This calls for further research, on cases where mental and spiritual healthcare overlap and support or contradict each other, on sorcery cases and the lessons learned there and how to make this information available to workers in the field.
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Appendix A

Questionnaire

*Medical symptoms*

What is the explanation of your symptoms/illness. How do family and friends explain it?

What do you call your symptoms/illness in your own language?

How would people care for someone suffering like you, how would those around him try to help?

What kind of treatment do you get here? What helped/ Would help you? Where do you get information on how to find help?

If you had emotional difficulties in your own country what did you do? Where did you go?
(if not to family, where could you go?)

Is there anyone in the Netherlands from whom you receive (emotional) support (when you are sad) – member of your family? Talk with others?

*Cultural questions*

Do you have/miss other people having the same cultural background as yourself. Are there aspects that you miss? Why?

What aspects are most important to you (norms & values, feast days, faith)?

Do you bring up your children in the same way as you were brought up?

To what extent is it possible for you to follow your culture’s way of life her in the Netherlands?

Are there any aspects in your culture which bother you or which you find less attractive?

Do you feel involved with the Dutch culture? (social events, following information on how things work in Dutch society) anything you adopt from Dutch culture?
Religion

When do you go to church?

Who do you meet there, who is important for you there?

Do you listen to Christian music/dvds?

How does prayer help you?

What do you pray for?

How have your religious beliefs and practices changed from when you were in your country?

What do you expect from the pastor; how does he help you?

What do you expect from the congregation; how do they help you?
Appendix B

EJCSK - L'Eglise de Jésus Christ sur la terre par son Envoyé Spécial Simon Kimbangu

The prophet
At the time appointed by the Lord "le Blanc deviendra Noir et le Noir deviendra Blanc" (the White man will be Black and the Black man will be White). In 1921 this prophecy earned Simon Kimbangu lifelong imprisonment under Belgian colonial rule. A central figure in the history and the identity of the Kongo nation, Kimbangu, during his travels as an apostolic preacher at first gathered a faithful following after miraculously curing a young woman at death’s door. He not only healed the sick and preached against sorcery but also opposed the colonial order. He used biblical quotes and examples to explain political wrongs, thus setting in motion a spiritual movement against the Belgian, French and Portuguese oppressors. He promised his people peace, prosperity and the power of science to surpass the colonising powers.

Five months after his first miracle he was arrested, tried and condemned to death, a sentence afterwards changed to lifelong imprisonment. In 1951 he left his prison cell to be hospitalised where he passed away shortly after. Prof. Dr. Lembe-Masiala, national delegate of the Kimbanguist church in the Netherlands explained to me how Simon Kimbangu had predicted the exact hour and date of his death. A hospital autopsy, carried out shortly after Kimbangu expired revealed the astonishing fact that his corps proved the lack of vital organs, no heart, liver, lungs, stomach or intestines were found. Soon afterwards physical apparitions of Kimbangu were reported, sometimes in several places at once. Apparitions, miracles and healings are said to continue until present times.

Officially recognised by the Belgian colonial authorities in 1959 and admitted into the Ecumenical Council of Churches, the Church of Jesus Christ on earth by his Special Envoy Simon Kimbangu, in short Kimbanguist churches and congregations are present in francophone and Anglophone Africa and have made headway in the United States, Great Britain, France and Belgium, largely following migration patterns. [Le Kimbanguisme, Garbin n.d.]
As in other groups religious beliefs are found to be an important resource within the Congolese migrant community. Kimbanguism offers a pan-African vision of redemption. Kimbangu is considered the Saviour of the black race, the incarnation of the Holy Spirit. His native village Nkamba in Bas-Congo is identified as the New Jerusalem, where a mausoleum and temple are erected, a sacred city of international status where Kimbanguists from all over the world come to visit the historical and spiritual sites at least once in their life. A strategic black identity is at the heart of the reinterpretation of the biblical message. The scientific notion of Africa as the cradle of humanity is claimed as confirmation of the precedence of black people. Adam and Eve, the mythical ancestors, are perceived as black, sorcery as the original sin, cause of the decline and oppression suffered by the Africans, their exclusion of inventions and discoveries the consequence of divine malediction.

After the death of the prophet is his youngest son Papa Diangenda succeeds him as head of the Kimbanguist Church (1959-1992), coinciding with the rise and triumph of Mobutu. The principal of submission to state authorities, the apolitical support of Mobutu and other postcolonial regimes ensured the continuing expansion of the Kimbanguist Church. The offspring of Simon Kimbangu, known as "la descendance" continue to play a more or less sacred role. Grandson Simon Kiangani, considered to be a reincarnation of Simon Kimbangu, has succeeded his uncle Diakungana (1992-2001), though there are some dissident voices.

The religious sources of Kimbanguism are the Bible, the prophetic messages of Papa Diangienda and the "cantiques inspirés". The Bible has been stripped of its western content and adapted to the black identity of Kimbanguist followers. The Church adheres to the Ten Commandments adding twelve rules which for instance forbid the consumption of pork or monkey, alcohol, tobacco or hemp, the use of charms or magic, dancing etc. The Kimbanguists form a close-knit community, well structured, manifesting themselves by wearing the Kimbanguist colours, white and green, remaining closely attached to the authentic site of Nkamba New Jerusalem, contributing to its expansion of the constructions and their upkeep.

In his article "Kimbanguism & the question of Syncretism in Zaire" MacGaffey places Kimbanguism in its social context of the structural pluralism of a colonial and postcolonial state in which two separate institutional sets are maintained, the
bureaucratic institutional set and the customary set. Between 1908 and 1960 the Bakongo were converted to Christianity and participated in the state, church and industry, but on an entirely different footing from Europeans. In their private lives they remained subject to Kongo institutions, belonging to two different societies where all matters of social purpose, religion, identity and ontology were expressed in two different languages Kikongo and French. MacGaffey represents religion among the Bakongo as two partly overlapping circles B and C: B is bureaucratic and French; C is customary and Kikongo. Within a common area of ambiguity or shared misunderstanding, items of belief and practice are expressed in a special colonial vocabulary assigned alternative meanings by Europeans and Bakongo. Thus a common language developed where interaction and ritual arise from two cultures embedded, 'mediating a non-communication'\(^1\)

In such a pluralistic context Kimbanguism has moved from customary (C) into bureaucratic (B) which is also apparent from the twelve rules the church follows in addition to the Ten Commandments [MacGaffey, 1994: 247-248], for example in rules

1. *Respect the government* and 9. *Pay taxes.* Rule 8. *No use of charms or magic* relates to the European precept of 'no superstition' as well as the Kongo sense of 'no self-seeking tampering with the occult'. Other rules are no alcohol, no drugs, no dancing, no pork. Good moral advice in the rules *love everybody; no quarreling; do not harbour resentment, admit your ill doing before witnesses* can in Kongo perspective be read as prescriptions against witchcraft or attitudes that might give rise to witchcraft.

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\(^1\) Examples cited by MacGaffey 1994:246: *nkongo,* which meant 'holy' to Europeans and something like 'taboo' to Africans; *sumuka* 'to sin' or to 'violate a taboo, to pollute'; *nkadi a mpemba* 'the Devil' or 'a vengeful ghost'
Local Knowledge Seminar

Venue: University of Amsterdam, Bushuis, Kloveniersburgwal 48, VOC-room
Date: Wednesday October 1, 2008, 15.00-17.00
Format: Two presentations of 30 minutes followed by a Q&A-session of 45 minutes

In collaboration with the Amsterdam Masters Medical Anthropology (AMMA), ETCNetherlands/Compas, the branch office Amsterdam of the International Institute of Asian Studies (IIAS), and the Amsterdam School for Social Science (ASSR), a seminar is organised on Local Knowledge Traditions. The seminar aims to inform MA en PhD students of the University of Amsterdam as well as fellows of the IIAS, on the importance of local practices, theories and materials for their current or future research.

Local Knowledge consists of theories, practices and materials, and their linkages. Local Knowledge can be either the primary or secondary focus in social-cultural research. An example of local knowledge as the primary focus is the research on Thai health practices employed in combating HIV and Aids. Local Knowledge can also be included as a secondary focus, for example in research dealing with the way local social-cultural and economic realities transform global ideas and practices.

Local Knowledge and its propagation can be analyzed from various perspectives:
- a cultural system that invests the lives of people with direction and meaning. The study provides insights into the ethos of the people under search.
- a means to empower people in material and immaterial ways.

The seminar wants to address the following questions:
1. What is Local Knowledge (indigenous knowledge) and what is its role in processes of change in fields such as medicine, livelihood, governance, and education? Is Local Knowledge a means to guarantee development from within and make people the agents of their own processes of change?
2. Does Local Knowledge in the form of beliefs, practices and materials contribute to development? Why is Local Knowledge so popular in development circles? Is Local Knowledge at the margins of mainstream development marked by westernization, rationalization, professionalization, standardization, commercialization, and objectification, or does Local Knowledge offer a viable alternative to modernization as westernization and therefore promotes "development from below/within"?
3. What is the link between the reinvention and revitalization of Local Knowledge in certain localities such as India and Africa and the promotion of indigenous trajectories of modernity? Do modern "things" such as agricultural rationalization and biomedical diagnostics rework local practices, materials and notions? Are these subordinated to global science, technology and the market, or does Local Knowledge transform these global forms?
4. What kind of analytical tools in the form of research methodologies and techniques do we have that can guide the documentation, analysis, validation and application of Local Knowledge?
5. Is Local Knowledge also relevant in the North?
Program

15.00 - 15.05 The chair introduces the seminar and both speakers

15.05 - 15.30 Maarten Bode PhD, Medical Anthropology & Sociology Research Unit, Foundation for the Revitalization of Local Health Traditions, briefly introduces the theme of local knowledge and presents the case of marketing Indian medical knowledge (Ayurvedic) products. The marketing discourse on Indian medicine provides a space for discussing the articulation of tradition and modernity in contemporary India. Ayurvedic branded medicines are offered as remedies against the venom of Westernisation such as stress, impotence, environmental pollution, fast food, alcohol consumption and the taking of Western medicines. Ayurvedic manufacturers promise consumers that their medicines make people effectively modern, i.e. make them stronger in a spiritual, mental and somatic way.

15.30 - 16.00 Katrien van ’t Hooft, MSc, ETC Netherlands/Compas programme, discusses the cross-cutting elements of the documentation, evaluation and implementation of Local Knowledge in the South and the North. In what way can they learn from each other in guiding a process of development that implies both local and modern elements? ETC Netherlands is an NGO that works in close collaboration with partners in the South: universities, farmers’ organisations and NGO’s. The Compas programme documents, evaluates and implements local knowledge in fields, especially agriculture, natural resource management, and (animal) health. ETC Netherlands also has a programme in the Netherlands, working towards sustainable systems with Dutch dairy farmers.

16.00 - 16.15 Tea break

16.15 - 17.00 Discussion in which the prepared questions of the participants will be addressed. AMMA and PhD-students are asked to mail two local knowledge related questions to both speakers (m.bode@uva.nl; katrien.hooft@etcnl.nl). Preferably questions and concerns related to previous work experiences and/or current or future research projects. The deadline for mailing the questions is Monday 29 September, 13.00 hrs.

For inspiration and preparation the seminar participants are invited to look at the following websites:

- www.unutki.org (United Nations University Traditional Knowledge Initiative)
- www.who.int (look for ‘traditional medicine’ on this site of the World Health Organization)
- www.giftofhealth.org (look for ‘traditional antimalarial methods’)
- www.compasnet.org (Compas programme)
