

Concepts of health and therapeutic options among Congolese refugees in London: implications for education

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ABSTRACT

This thesis is about the perception and experience of health, illness and health care among Congolese refugees. It discusses the role of education, with a particular emphasis on schools, in promoting health in the Congolese refugee community, alongside the role of the Home Office, the health care sector and the Congolese refugee community itself. The thesis identifies three therapeutic systems used by Congolese refugees. These are the Congolese traditional therapeutic systems, the Christo-spiritual therapeutic systems and biomedicine. Analyses of the data demonstrate that in the quest for health, Congolese refugees develop six approaches or options. This is due to their perceptions of illness/disease or predicament, their experiences in the British health care sector as well as their concepts of risk. Moreover, analyses of the fieldwork data establish a correspondence between the conditions in exile and the Congolese refugees' health. Thus, to promote Congolese refugees' health in London, the thesis argues that their culture, their socio-economic and political conditions as well as their experiences in British health care sector must be considered. This, however, cannot be the concern of a single group. It requires the intervention of schools, the Home Office, the health care sector, and the Congolese refugees themselves.

The thesis ends by evaluating its main arguments in the light of Congolese refugees' therapeutic options as well as its methodological stances.

PROLEGOMENON

There is no misfortune, but to act nobly is good fortune.

(Marcus Aurelius, quoted by Kunitz, S.J (1994: V)

To try to understand the experience of another it is necessary to dismantle the world as seen from one's own place within it, and to reassemble it as seen from his. (Berger, Rack, 1991:V)

The biological and the social are neither separable, nor antithetical, nor alternatives, but complementary. All causes of the behavior of organisms, in the temporal sense to which we should restrict the term cause, are simultaneously both social and biological, as they are all available to analyses at any levels. All human phenomena are simultaneously social and biological, just as they are simultaneously chemical and physical (Lewontin, R.C. Rose, S.& Kamin. L. J, in Kleinman, 1988: VII)

In the month of Kislev in the twentieth year, while I was in the citadel of Susa, Hanani, one of my brothers, came from Judah with some other men, and I questioned them about the Jewish remnant that survived the exile and also about Jerusalem. They said to me, "those who survived the exile and are back in the province are in great trouble and disgrace. The wall of Jerusalem is broken down, and its gates have been burned with fire". When I heard these things, I sat down and wept. For some days I mourned and fasted and prayed before the God of heaven (Nehemiah 1: 1-4).

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ABBREVIATIONS

A A= Asylum Aid.

ABAKO= Association of Bakongo.

AFDL=Alliance des forces Democratiques pour la liberation du Congo.

A I= Amnesty International.

BSE= Bovine Spongiform Encephalopathy.

CE= Citizenship Education.

CIA= Central Intelligence Agency.

CJ D= Creutzfeld–Jacob Disease.

CR= Congolese Refugee.

CRA= Congo Reform Association.

CRC= Convention of the Rights of the Child.

DfEE= Department for Education and Employment.

DHSS= Department of Health and Social Security.

DipHE= Diploma of High Education.

Eng= English.

Eph= Ephesians.

ESF= European Social fund.

Ex: Exodus.

FGM= Female Genital Mutilation.

Fr= French.

Gen= Genesis.

GPs= General Practitioners.

Gk= Greek.

HND= High National diploma.

HO= Home Office.

HRF= Harrow Refugee Forum.

HRW= Human Rights Watch.

IDRC= International Development Research Centre.

Jn=John.

Kik= Kikongo.

Lat= Latin.

Ling= Lingala.

LCHR= Lawyers Committee for Human Rights.

LEA= Local Education Authority.

Lk= Luke.

MF= Medical Fondation.

Mt= Matthew.

NHS= National Health Service.

PSHE= Personal Social and Health Education.

RC= Refugee Council.

RETAS= Refugee Education and Training Advisory.

Rev= Revelation.

SRE= Service des Renseingments d'Etat.

SIE= Service Information d'Etat.

UNHCR= United Nations High Commission of Refugees.

USCR= United States Committee of Refugees.

WF= World Factbook.

WHO= World Health Organisation.

WUS= World University Service.

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Chapter I. The historical background and the structures of the thesis

1.1 Introduction

This thesis explores health concepts and perceived therapeutic options among refugees from the Democratic Republic of Congo in London. It relates these to the role of education, with a particular emphasis on schools, in promoting health in the Congolese refugee community, alongside the role of the Home Office, the health care sector, and the Congolese refugee community itself. This chapter outlines the historical context, the aims, the research questions, the rationale and the structure of the thesis.

1.2 The historical context of the research

The idea of this research became possible through my pastoral work among Congolese refugees in London between 1992 and 1995. This constitutes the research's historical context. This notion would corroborate Foucault's concept of 'the conditions of possibility' (Foucault, 1966: 89) which stresses the 'socio-historical origins' as well as the 'epistemological contexts' (Mudimbe, 1988:IX) of discourses.

The view that the centre of Christianity has shifted from the West to the developing countries is beyond any doubt (Bediako, 1995: 128; Mbiti, 1986: 2). To explain African spirituality, Mbiti notes that 'wherever the African is found there is found his/her religion' (Mbiti, 1969:2). These views apply to the emergence of Congolese refugees' Christian churches in London. However, the specific reason for their birth is the quest for cultural solidarity which has to be seized in its multi-dimensional context. For, this quest of cultural solidarity is not only a response to individuals' cultural or linguistic isolation. It is also an answer to the consequences of immigration policies. Thus, while some analogies can be established with factors that resulted in the genesis of West Indies Churches in Britain (Toulis 1997; Calley, 1965:1), immigration policies make the history of Congolese refugees' churches unique.

The prevalence of Congolese refugees' churches corresponds to the pre-eminence of charismatic movements in the Congo (Devisch, 1996c). The latter are viewed in the Congo as a place of true fraternity (Devisch, 1996c: 574). Thus, Congolese refugees gathering in London desired to give to their nascent groups a similar Christian identity to that of charismatic movements in the Congo. From the early nineties, Congolese refugees' churches have grown in number and structures that some are affiliated with British Christian communities. They have provided the social, psychological and moral support needed within the community in issues such as bereavement, marriage, sickness, deportation, and interpretation. It is in this context that I came to be involved in what I would call an incidental benevolent pastoral practice.

La Alpha and *la Beta* Churches, which serve as the paramount scope of this research, came into existence in 1992. Though affiliated to two different British Christian associations, they are charismatic. Some of their striking characteristics are their mobility and the variability of membership. Their mobility is related to economic factors. These are also some aspects that would distinguish them from some West-Indies churches in Britain (Toulis, 1997: 49). None of the Congolese refugees' churches possesses its own premises. Thus, the constant threat, realized in many cases, of being evicted for reasons either related to rent failures or to the owners' need to use the premises.

Four factors justify the particular focus on *la Alpha* and *la Beta* Churches. Firstly, the difficulty in carrying out a study of a widely dispersed community which numbers 14,266 (R.C, 1997:94). Secondly, through these churches most Congolese refugees can be found and reached. Thirdly, my involvement in the existence of *la Alpha* Church. The fourth factor is that these two churches have had joint projects to promote Congolese refugees' health and social conditions.

During the pastoral practice within *la Alpha* Church most issues discussed within the counselling context were health related. The pastoral counselling session became an opportunity to discuss depressions, anxieties and insomnia caused by conditions in exile. Discussions about their experiences within the British biomedical milieu, witchcraft and bad dreams (Bockie, 1993: 91) were also frequent. Likewise, six approaches have been noted in their use of Congolese traditional therapeutic systems, biomedicine and the Christo-spiritual systems. Moreover, the remarkable fact was observed that despite their limited income, as well as being entitled to British health care resources, Congolese refugees in many cases preferred to buy their own medicines rather than getting them free via their GPs.

Though these paramedical issues were at the core of pastoral concern, there was no possibility while being at the centre of pastoral activities to study them in depth. The only recourse was to withdraw from pastoral responsibilities, as I did with their consent to undertake this research.

1.3 The aims of the research

The aims of this research are twofold. This is to say that the thesis is informative and re-interpretative. Informative in that the thesis provides knowledge regarding Congolese refugees' experiences of health and the reasons for their therapeutic options: their decisions for a particular therapeutic approach. The re-interpreting dimension of this thesis is to challenge views about the theses of affordability, acceptability, availability, accessibility, and effectiveness which have been advanced to explain the massive use of African traditional therapeutic systems by Africans (Sindinga et al., 1995:4-5).

1.4 Research questions

The development of research questions requires the interpretation of Congolese therapeutic options in terms of social actions whose meanings have to be investigated. This notion coincides with Ricoeur's (1976; Hekman, 1983: 94) and Douglas' (1996a: 40-43) thoughts on the relationship between social actions and meanings. I elaborate two exploratory research questions. The first is concerned with the fact that traditional views of Congolese refugees in London prevail in their quest for health, despite the availability of biomedicine, health education and health promotion strategies, as well as the physical distance from their homeland. The second is why in different contexts Congolese refugees develop sometimes a one, two or three-dimensional approach to therapy.

1.5 The rationale for the research: the pastoral and academic imperatives

The rationale for undertaking this research is both pastoral and academic. It should, however, be noted that these two aspects are interrelated and encompass political and policy dimensions. Pastoral activity is not without theology and vice versa (Ela, 1995: XIV). Furthermore, theology as an academic practice, and pastoral activity cannot be fully achieved without dialogue with other disciplines of the social sciences.

While I recognize the dynamics of the interrelatedness of these disciplines, two aspects should be clearly pointed out. First, the particularity of pastoring in the context of a community in exile. Secondly, the nature of discourses on health issues deriving from social scientists belonging to ethnic minorities in Britain.

Theological and pastoral discourses are not decontextualised or concerned with abstract ideas. Theological reflections and pastoral activities are about human experiences. Working among the peasants of North Cameroon, the Cameroonian theologian and sociologist, Ela, notes that pastoral work among

Africans must transcend the traditional emphasis on baptism and other rituals.

As he puts it:

“The perspective of our mission is no longer to baptize as many people as possible, to count the number of Easter communions, to settle marriage problems, or to play, as priest, the role of a big shot in the village. I care little for the tangible results or the statistics of my work. It is not so much a matter of completing a list of tasks, as it is of being and living with people, of finding them where they are. In every pastoral program I undertake, I ask myself: Does a community exist here? What must be done to help it come into being? Am I able to draw the people together by the way I’ m living my faith? What are the essential concerns in the life of this village that can bring people together and help the gospel take root?” (Ela, 1995: 6-7).

Ela adds:

“A theologian must stay within earshot of what is happening within the community so that community life can become the subject of meditation and prayer. In the end, a theologian is perhaps simply a witness and a travelling companion, alert for signs of God and willing to get dirty in the precarious conditions of village life. Reflection crystallizes only if it is confined to specific questions” (Ela, 1995: 11).

This way of thinking is at the core of theologies such as the liberation theology from Latin-America, Minjung theology from Korea, and black theology which emerges from both Africa and America (Taylor, 1990: 21). For in these theologies as stated by Cone:

“To preach the gospel without asking about its precise meaning for our time and situation is to distort the gospel. Good intentions are not enough. Being sincere is not enough. Praying daily for divine guidance is not enough.

A religion of liberation demands more than preaching, praying, and singing about the coming eschatological Kingdom of God. It demands a critical theology based on the Bible and using the tools of social sciences so that we can participate more effectively in establishing the kingdom in this world that we believe will be fully consummated in the next. As Gustavo Gutierrez has put it: ‘Poverty of the poor is not a call to generous relief action, but a demand that we go and build a different social order’ (Cone, 1984: 120).

Theological voices from Asia have expressed the theological concern with human realities in the following terms:

“The totality of life is the raw material of theology. Theology deals with concrete issues that affect life in its totality and not just with abstract concepts that engage theological brains. No human problem is too humble or too insignificant for theology. Theology has to wrestle with the earth, not with heaven” (Song, 1984: 6).

The particular conditions and context of Congolese refugees, their concept of pastor and the pastoral responsibilities, can only be grasped and expressed through the academic linguistic of theological trends discussed in this section. For with these theological trends, not only is the pastor the ‘minister of God and a minister of the people’ (Cabestrero: 1984), but the one who sides with the oppressed and who acts with them for their common liberation from dehumanizing conditions. Tutu explains this in the following way:

“The credibility of the gospel is at stake. We, the Church of God, can redeem ourselves if we are determined to work together... to witness together against injustice and oppression and exploitation, to stand together with the poor and the oppressed throughout the world, and here in South Africa with the victims of one of the most ruthless systems in the world. The credibility of the gospel may be restored if we become the voice of the voiceless” (Tutu, 1986:104).

Tutu’s words encapsulate what being a pastor in the context of suffering means. For suffering in the Congolese refugee community is not only related to their experiences in the Congo but also to what I will describe in subsequent chapters as ‘their triple conditions of being non English speaking, Black, and refugees/asylum seekers (derogatorily known as bogus economic migrants). Consequently, a Congolese pastor in the Congolese refugee community is expected by the flock to understand and to deal with all of their social, psychological, legal or judicial, medical, economic and political conditions. Thus, the pastor is approached to deal with any problem that is faced by any member of the community. The pastor is the voice or the advocate of the community, the first person to be turned to for any problem.

The other academic rationale for this study is the appeal from ethnic minority social scientists for the need for studies by ethnic minorities on health issues in their particular communities (Bhopal & White, 1993). These studies are advocated for dealing with issues of equity in the health care sector as well as health issues and the cultural perceptions of disease (Bhopal and White, 1993) as experienced within particular ethnic minorities groups in Britain.

Like Ela (1995) in the context of peasants in North Cameroon, my pastoral practice in the context of exile has not led to a mere *prise de conscience* but to reflections and actions for the welfare of the flocks. Thus, to achieve this research, I construct at the base of the research questions, discussed in section 1.4 (p.22), some hypotheses that should be assessed with the support of fieldwork and readings. The hypotheses are as follows:

- a) Congolese traditional concepts of health are culturally endemic in that they transcend time and space. Analyses on how and why they survive will depend on our understanding of theories on sociology of health and illness as well as on the results of the fieldwork.
- b) The persistence of traditional concepts of health promotes psychological balance. While exile causes multiple losses, traditional practices in the quest for health recapture that which is not totally lost. How this is achieved depends also on the analyses of the data to be collected in the fieldwork.
- c) The Congolese refugees' therapeutic options do not only depend on their concepts of health but also on their unfortunate experiences in the biomedical milieu and their concepts of risk. Fieldwork provides the evidence.

1.6 The structure of the thesis

The thesis comprises nine chapters. The motives of this first chapter, which concern the historical background and the structures of the research, have

been identified in section 1.1 (p.19). The second chapter deals with the techniques and approaches used to undertake this research. The discussion is carried out in relation to the present debate over the relationship between quantitative and qualitative research in social sciences. The chapter stresses also the issue of my quadruple status and its place in this research. The third chapter deals with the historical background and current conditions of Congolese refugees in London. Analyses of this chapter entailed a social and political historical synopsis of the Congo. Chapter four discusses present theories on health issues. The chapter provides the hermeneutic keys through which Congolese refugees' concepts of health, therapeutic options, as well as their treatment in the biomedical milieu will be discussed. The fifth chapter provides the background to Congolese refugees' concepts of health. It therefore investigates health issues in the Congo. The sixth chapter discusses Congolese refugees' concepts of health and the impact of Home Office policies on their health. Theories discussed in chapters four and five relate to the terms and the language through which their views on health are expressed and to the question of continuity or discontinuity between the Congolese Londoners' views on health and those held in the Congo. The chapter studies also in detail the extent to which the Home Office policies of immigration have an impact on their health. Chapter seven discusses health issues and experiences among Congolese refugees. The chapter studies the history of the three therapeutic systems that are used in the Congolese refugee community. It also investigates the reasons for Congolese refugees therapeutic options. Chapter eight discusses the extent to which schools have a significant contribution to make in promoting health in the Congolese refugee community. Chapter nine concludes the thesis by stressing the role of the schools, the Home Office, the health care sector and the Congolese community in promoting the health of Congolese refugees. Grounded in the fieldwork findings and the scholarly literature used, the chapter offers some suggestions to improve health promotion in the Congolese refugee community. The conclusion points out that the required strategies emphasised to promote health in the Congolese refugee community

falls into the category of what is known as social model. However, to sustain views advocated in this thesis, the chapter starts with some evaluating notes on the main research thesis and the methodology applied.

1.7 Bibliography and appendices

To achieve this research, an eclectic bibliography was necessary. As will be seen in the subsequent chapters and the bibliographical section, I used books from the educational, sociological, anthropological, theological and political literatures.

The thesis has five appendices. The first appendix contains the classificatory tables of the main informants (case studies) on the basis of gender, age and marital status. These tables relate to chapters three, six, seven and eight. The second contains questionnaire I (QI) which is on the concepts of health and the use of the three therapeutic systems identified among Congolese refugees. The third contains questionnaire II (QII) on risks and lifestyles among Congolese refugees. The fourth contains some questions used in the post-fieldwork encounters. The fifth contains some collected newspapers with information on the experiences of Congolese refugees in Britain.

Chapter II Methodological approach to the research

2.1 Introduction

This chapter is about methods used in the collection and analysis of my data. It sets the history of the collection of the data and discusses the ethical issues of the research as well as the validity or reliability of my data and analyses. I argue that my work is a 'bricolage' in the Levi-Straussian sense of the term (Levi-Strauss, 1962: 27; Douglas, 1987:66-7). As a social scientist 'bricoleur', I use approaches and techniques of different paradigms that I find relevant to dealing with particular aspects of this research. However, since the work focuses on concepts of health and the therapeutic options taken by a particular community, that is the Congolese refugees in London, research strategies include ethnography, case studies and ethnomethodology.

2.2 Methodological issues in social sciences

2.2.1 Discourses on quantitative and qualitative methods

Traditional views on social science methodology divide research into two categories, namely qualitative and quantitative approaches (Brannen, 1992:3), with the claim that each approach derives from different and opposed epistemological perspectives.

Quantitative research is primarily associated with research in natural sciences. Its paramount feature is the quantification of data to develop theories that would confirm hypotheses and theses. Quantification provides possibilities of comparing and analysing variables collected either in the field of observation or that of surveys. A type of arithmetic logic prevails in quantitative approach. Sayer (1984) stresses this reasoning in the following manner:

“Advocates of quantitative methods usually appeal to the qualities of mathematics as a precise, unambiguous language which can extend our powers of deductive reasoning far beyond that of purely verbal methods, and, as with logic, the validity of mathematical reasoning is a 'black-and-white' affair, being subject to internal rather than empirical check” (Sayer; 1984:158).

Speculation and theories that cannot be rationally proved are avoided. Bullock *et al* (1992) affirm that when a social science research adopts a quantitative approach, a massive geographical area is required (Brannen, 1992: 85). This permits the researcher to establish correspondences between data, hypotheses and theory. Variables, be they groups, sex, age, concepts, are analytically compared (Schwartz & Jacobs, 1978:4). Bryman advocates the thought that quantitative research deals with the causal rapport between concepts (Bryman, 1988:30). This particular characteristic of a quantitative research compels the social scientist to convert opinions and attitudes into numbers (Tesch, 1990:1). Hence the use of such expressions as: how many, how much, how often and any other expression of the idea of quantity. This stands for natural sciences, mathematics, biology, physics, where the logic of the four arithmetical operations is cardinal. In these disciplines, a theory stands or falls on the basis of mathematical precision.

Concepts such as 'hypothetico-deductive' (Hammersley, 1992b: 48) and 'enumerative induction' (Brannen, 1992: 7) have been used to speak of the analytical approach of a quantitative research. They denote and stress the construction of theories and conclusions from comparative analytical approach of variables.

The quantitative researcher is a detached observer whose observational procedure differs from the qualitative researcher's. His/her relation to the data and studied group is guided by his/her pre-conceived methodological framework through which correspondence between theories, hypotheses and data is made (Bryman, 1988: 96). S/he does not necessarily integrate with, or become immersed in the studied group. Things are seen and interpreted as they appear. The relation between the researcher and the group studied is bipolar and inextricably distant. There is no mutual challenge. The rationale as assumed by Benson and Hughes is to generate knowledge that is 'precise,

objective, predictive and ultimately, formulable as causal laws' (Benson & Hughes, 1983: 39).

Qualitative research by contrast is characterised by an emic perspective, a holistic perspective, and an interactive process of inquiry (Engelard, 1992:1). The emic perspective indicates that research is conducted from the participant's point of view. This expresses the Weberian logic of '*Verstehen*' according to which social action is grasped and interpreted through the 'actor's eyes' (Parkin, 1982: 19). The researcher enters the studied group in order to grasp the issues from the group's perspective. In the holistic perspective, the subject to be researched is presented in its global or multi-fold context. Different structures and values of the group to which the subject is connected are closely scrutinised. They shed insight on the main subject. Lastly, the interactive process of inquiry is the idea that the researcher's interpretation of the data must not be disrupted from the insight gained while immersing within the group. The researcher not only interprets, but also contributes to the production of the data. Kvale has aptly argued that in interviews the data are not collected but co-authored (Kvale, 1996: 183). There is a type of constant dialogue.

The qualitative researcher translates the participants' meanings and interpretations (Schwartz & Jacobs, 1978:7). This is not a mere descriptive exercise. It is an analytical induction. Contrary to the logic of quantitative method that focuses on frequency or quantity, the cardinal focus of qualitative method is reflection on the significance or the meaning of the phenomenon to the group. Philosophical questioning, whereby the meanings of the issues or the phenomenon are apprehended, enriches the qualitative approach.

The debate is whether in their intrinsic characteristics quantitative and qualitative methodological approaches are fundamentally opposed or complementary. Brannen notes that historically 'a gulf' (Brannen, 1992:3) is thought to exist between the two. Quantitative researchers describe qualitative

methodology as 'a second rate activity' (Bryman, 1988:94) that is soft and unrigorous. Its importance is limited to throwing up ideas and hypotheses in the embryonic phase of research. They vindicate quantitative methodology as the analytical approach *par excellence*. In contrast, qualitative researchers argue that a qualitative approach stands by its own right as a rigorous methodological approach in social sciences. Its ability to translate the participants' views is unique and second to none (Bryman, 1988: 95).

These views, however, have been challenged with the argument that the features of both quantitative and qualitative approaches are intrinsically valuable in the social sciences. As Brannen says:

"Indeed, it seems to me that all research involves both deduction and induction in the broad sense of those terms, in all research we move from ideas to data as well as from data to ideas. What is true is that one can distinguish between studies that are primarily exploratory, being concerned with generating theoretical ideas, and those, which are more concerned with testing hypotheses. But these types of research are not alternative; we need both" (Brannen, 1992: 48).

The traditional methodological divide between quantitative and qualitative research is also being bridged by current definition of qualitative research as multidimensional by nature. This definition is nurtured by the fact that qualitative research 'crosscuts disciplines, fields, and subject matter' (Denzin & Lincoln, 1998:2). Denzin and Lincoln's definition is widely shared among scholars. For Nelson et al.:

"Qualitative research is an interdisciplinary, transdisciplinary, and sometimes counterdisciplinary field. It crosscuts the social and the physical science. Qualitative research is many things at the same time. It is multiparadigmatic in focus. Its practitioners are sensitive to the value of the multimethod approach. They are committed to the naturalistic perspective, and to the interpretive understanding of human experience. At the same time, the field is inherently political and shaped by multiple ethical and political positions.

Qualitative research embraces two tensions at the same time. On the one hand, it is drawn to a broad, interpretative, postmodern, feminist, and critical sensibility. On the other hand, it is drawn to

more narrowly defined positivist, postpositivist, humanistic, and naturalistic conceptions of human experience and its analysis” (Nelson et al, quoted in Denzin & Lincoln, 1998:6).

Such a definition of a qualitative research views the qualitative researcher as a *‘bricoleur’* and his/her undertaking as a *‘bricolage’*. The rationale being that the qualitative researcher uses paradigms and research techniques that are available and relevant in the collection and the analysis of the data of the phenomenon under scrutiny. This is what Coffey and Atkinson express:

“The multiple methodologies of qualitative research may be viewed as *‘bricolage and the researcher as bricoleur’*. The bricoleur as someone who is skilled at using and adapting diverse materials and tools: it is a handy metaphor for the qualitative researcher” (Coffey & Atkinson, 1996:24).

2.2.2 Paradigms, research strategies and research techniques

Paradigms, research strategies and research techniques are that by which a social science’s research is characterised. A paradigm is a set of beliefs about reality. Paradigms represent a worldview (Guba & Lincoln, 1998:200). They are human constructions. Three elements comprise each paradigm. Ontology, the nature of reality to be known. Epistemology implies knowledge about what is to be known. It, thus, constitutes knowledge (Goldman, 1986:14). Methodology, expressing the way that knowledge about reality is acquired. These three elements are interrelated. Paradigms, being socially constructed, are subjects of inconsistencies. However, their persuasiveness and utility justify their *raison d’être* (Guba & Lincoln, 1998:202). The four major paradigms to be distinguished below include positivism, postpositivism, critical theory *et al.*, and constructivism (Guba & Lincoln, 1998:203).

Positivism seeks to apply objective scrutiny to reality by the researcher. It does not allow for mutual influences. Hypotheses and theories about reality are subjected to empirical or mathematical verification. Postpositivism advocates the idea of imperfect or probabilities about representation of reality. Reality is not always what or how it is described to be. Critical theory *et al* paradigms

(feminism, Marxism, postmodernism, cultural studies) are a critical trend according to which reality is contextually constituted. It is shaped by social, economic, political and gender factors. The epistemology of critical theory and related ideological positions is subjectivist and transactional (Guba & Lincoln, 1998:206). These trends are committed to social transformation. They are pragmatic, yet, dialectic and dialogue dominate their methodological inquiries. There are analogies between the critical et al paradigm and constructivism in terms of epistemology and methodology. However, constructivism is mainly characterised by the idea of relativism. Reality being viewed as socially constructed is by the very fact subject to various different interpretations.

Research strategy is that by which a particular social sciences research is categorised. There are many research strategies. Yin classifies five research strategies in social sciences, including experiments, surveys, archival analysis, histories and case studies (Yin, 1994:4). Denzin and Lincoln have an exhaustive list, which includes ethnography (Denzin & Lincoln, 1998:25). Research strategies determine the techniques or approaches to be used in the collection and analysis of the data. They 'put paradigms of interpretations into motion' (Denzin & Lincoln, 1998: 29). Yin assumes that the use of a particular strategy is determined by the nature of research questions. Exploratory questions such as *what* can suggest the use of any strategy. Questions such as *how* and *why*, tend to be associated with case, experimental and historical studies (Yin, 1994:7).

Research techniques are methods used in the collection and analysis of the data. They range from observation, participation, interviews, documents, artifacts, personal experience, textual analysis, etc (Yin 1994: 8; Denzin & Lincoln 1998: 25). Though the use of research techniques overlaps between research paradigms and strategies, they, nevertheless, are used according to the research goals (Goetz & Lecompte, 1984:3). In other words, each technique

is used according to the possibility it offers to obtain the relevant data for the relevant issue.

With regard to data analysis, Yin argues that there is no fixed dogma. A view asserted also by Henderson (1995: 467). The analysis of the data is intrinsically related to the researcher's triple objectives, that is rigorous thinking, the reliability of the data and the consideration of alternative interpretations (Yin, 1994: 105-106). Data analysis is therefore, 'an art rather than a science' (Goetz & Lecompte, 1984:166). It implies intuition and creativity. As a theorising art, its hallmarks are 'perceiving, comparing, contrasting, aggregating and ordering; establishing linkages and relationships; and speculating' (Goetz & Lecompte, 1984:167).

Kvale provides five approaches or techniques to the analysis of the data. However, like Yin, he argues that analyzing data purely depends on the researcher ability (Kvale, 1996: 187). The five techniques for analyzing the data he suggests include categorization, condensation, narrative structuring, deeper interpretations, and ad hoc tactics for generation of meaning (Kvale, 1996: 181).

Categorization implies the conversion and reduction of data into codes and statistics that can be represented into tables. Condensation is the paraphrasing in shorter terms of the essential element of the data. Narrative structuring stresses the spatio-temporal context of the data. Here, the different features characterizing an interview can be converted into meaningful accounts. Meaning interpretation seeks to go into the depth of the data for the possibility of other meanings. The *ad hoc* meaning generation is that in which any of the described techniques of analysis can be used for a relevant analysis. Here, there is 'a free interplay of techniques during the analysis' (Kvale, 1996: 203).

As a conclusion to this section, I will state, on the basis of my understanding of the debate evoked in section 2.2.1 (p.31-32) as well as my experience in the fieldwork, that values of quantitative and qualitative methods would pertain any social science study. Thus, I agree with the argument of Coffey and Atkinson (1996), discussed in section 2.2.1 (p. 32), about qualitative method as 'bricolage'. For not only 'bricolage' implies the use of any relevant technique through which data can be collected but, it also justifies the experiences of the fieldwork in which the researcher is not only to be rigorous but also, inventive or creative. This resulted in my case to appreciate the combination of such research strategies as ethnography, case study and ethnomethodology as I will explain it in section 2.3.1 (p.40).

2.2.3 The question of subjectivity, objectivity and ethics in social sciences

Subjectivity and objectivity are among the most used concepts in social sciences (Bourdieu 1997). They are thought to represent two fundamentally opposed analytical ways. The need to discuss these concepts arises from views that 'to be objective or to do an objective study is to be or to do something that is not primarily about ourselves, but about the world itself' (Eisner, 1993: 49). Thus, studies of a social phenomenon by a member of that social group or even by 'lay persons' are often suspected as biased. They fail to 'provide more accurate information' (Schwartz, 1978:5). Scholars note that the bias discourse is more prevalent in 'social and psychological sciences' (Hammersley & Gomm, 2000: 151). I have noted such reasoning with Bourdieu. For scrutinizing the analytical approach of a social actor he states the following:

"An agent who possesses a practical mastery, an art, whatever it may be, is capable of applying in his action the disposition which appears to him only in action, in the relationship with a situation (he can repeat the feint which strikes him as the only thing to do, as often the situation requires). But he is no better placed to perceive what really governs his practice and to bring it to the order of discourse, than the observer who has the advantage over him of being able to see the action from outside, as an object, and especially of being able to totalise the successive realisations of the habitus (without necessarily having the practical mastery that

underlies these realisation or the adequate theory of this mastery)" (Bourdieu, 1990:90-1).

There are reactions against discourses implying that a study carried out in a familiar environment is likely to be biased. The fact is that a scholar in this context, described as 'at home', is specially in need of rigorous tools of investigation. For as argued by Faizang, when:

"The anthropologist is dealing with subjects with which he is in fact familiar, he must always treat them as if they were 'foreign' to him.

This is the rule which the investigator working at home, in Western societies, must observe. The fact that he is dealing with matters which may appear to him self-evident makes it even more important to stick to the rule. We too easily treat phenomena belonging to our own culture as 'natural' when in fact they are not the product of 'nature' at all but simply of society and culture" (Fainzang, 2000: IX).

Views on subjective bias as related to one's position to the issue of research would support the anthropological colonial gaze. Participant observation as the technique for the anthropologists to acquire knowledge about the 'primitive people' doubted the native's capacity for a detached self-discourse. By its nature, colonial anthropology viewed natives as objects and not subjects of self-detached discourses (Mudimbe, 1988:138). Thus, the practice of anthropology was mostly the domain of the expatriates.

Views on subjective bias can be relevant when the researcher or the member possessing the practical mastery or an art is not trained in rigorous scientific discourse. This is what Bourdieu, in my view, fails to indicate in the quotation above. For as it will be said further, Bourdieu's concept of 'habitus', challenges the subjective and objective divide. Nevertheless, within the framework of anthropological practice, and that of the interpretation of social realities, views on subjective bias or inaccurate information, due to one's position, can be suspected as nurtured by a form of hegemonic attitude that would deny social actors the ability of a detached discourse about their own experiences as a people, a group or a race. This, in fact, would conflict with the practice of social

sciences as currently witnessed in existing scholarships. The fact is that social scientists are students of their own cultures and respective political histories. To illustrate, Bourdieu, is no longer a chronicler and an analyst of Algerian Kabyles. He is a student and an ethnologist of his own culture and world. He engages in the diagnosis of the social space, including that to which he belongs, of contemporary France. His theories on the capitals are an epitome of my reasoning.

In addition, the question of subjective bias in social sciences can be regarded as obsolete.¹ A glance at works in social sciences proves there can be 'no view from nowhere' (Nagel, 1986). Yet, in one way or another, the researcher is part of the reality that s/he investigates. The works of Foucault (1973), Bourdieu (1979, 1993), Morin (1991), Giddens (1998), Douglas (1996a), Mudimbe (1988), would support my view. Either they give accounts of historical phenomenon whose impact upon the present is felt, or they speak of contemporary social realities with their effects. Moreover, as far as researches in social sciences are concerned, subjectivity and objectivity are inextricably linked. Views or interpretations are derived from particular standing points. What is subjective is not deprived of rationality or validity. For, rationality and validity in social sciences are also related to cultural relativism and subjective understanding. The fact remains that we only perceive, interpret and analyse from specific standpoints. To stress the importance of subjectivity and how it prevails in most of works in the social sciences, I bring into the discussion ideas of some scholars.

Sen argues that views have a history. They have a starting point that can be either that of 'positional objectivity' or that of 'trans-positional objectivity' (Sen, 1994: 118). Positional objectivity is the recognition of the factors and the context from which views are expressed and sustained. Views that seem to be non-positional are in final analysis transpositional (Sen, 1994: 118). They are produced in juxtaposing different possibilities of interpretations. They are

omnipositional (Sen, 1994: 119). Positional objectivity and transpositional objectivity as defined by Sen bear witness to the place of subjectivity in interpretative and analytic processes. Particular positions from which one can interpret a reality depend on subjective factors such as class, profession, sex and age. Thus, positional objectivities are a construct of various subjectivities. This applies as well for transpositional objectivity that is the juxtaposition of positional objectivities.

Kleinmann (1994) sustains the theory that subjectivity is intrinsically related to any rigorous academic exercise. He draws from his experiences of being an anthropologist and a psychiatrist. He argues that interpretations within social and medical sciences are guided by certain conceptual categories. He illustrates this in the following statement:

“Observation presupposes concepts of what is being observed. The act of measuring ischemic heart disease begins with a concept of what constitutes the condition. This concept is institutionalised as clinical criteria, chest pain, narrow coronary arteries, stress-induced or other causes of insufficient oxygenation of heart muscles. The concept-be it a professional or a lay category-precedes and guides the observation” (Kleinmann, 1994:130).

Kleinmann also assumes that subjectivity is not only inherent to detached discourses (Kleinmann, 1994: 133). It is of prime importance in the assessment of health outcomes. He affirms, on the basis of existent scholarly works, that in some circumstances, subjective or self-assessment of health can be more accurate than clinical objectivity or radiology tests.²

Nagel (1986) approaches the question of subjectivity and objectivity in distinctive terms. He recognises the value of objectivity that he views as incomplete. Reality, in his thought, is never an objective reality. Objectivity of any form is not the ultimate test of reality (Nagel, 1986:26). It is merely a way of looking at a given reality. As such it cannot give an authentic account of a

reality or an experience. Intrinsic qualities of an experience can only be apprehended from subjective positions. As he puts it:

“We will not know exactly how scrambled eggs taste to a cockroach even if we develop a detailed objective phenomenology of the cockroach sense of taste. When it comes to values, goals, and forms of life, the gulf may be even more profound” (Nagel, 1986:25).

Discussing the relevance of subjectivity he also states that:

“Sometimes, in the philosophy of mind but also elsewhere, the truth is not to be found by travelling as far away from one’s personal perspective as possible” (Nagel, 1986:27).

In the articulation of scientific discourses, Bourdieu has described the subjectivity and objectivity divide as ‘ruinous’ (1997: 25). He moves beyond it by asserting that discourses, thoughts, perceptions and expressions are produced by ‘*habitus*’ (Bourdieu, 1980: 92), which is a product of capitals. He explicitly associates a scrutiny of a social phenomenon with one’s subjectivity. The idea of *habitus* implies subjectivity. Therefore, Bourdieu makes of any social sciences’ hermeneutic a positioned form of knowledge.

As a conclusion to this discussion on objectivity and subjectivity, I argue that the researcher however his/her scholarship is always part of his/her analyses and perceptions. For various variables such as academic background, culture, gender, profession, are always part of a researcher’s perceptions and analyses. The truth of this fact about the place of the researcher in his/her research is verified in my quadruple status, above all with my belonging to the community being studied and my pastoral practice. For not only do I scrutinise their experiences, but I also find myself in much of what they narrate. However, my *habitus* is not to be restricted to my belonging and work in this community. For in order to constitute the text of this research, as will be discussed in section 2.4.2 (p.50-51), its process entailed an analytical scrutiny of the data whose main themes have been interpreted on the basis of theories that will be discussed in chapter four. This is what constitutes briefly the research’s

process. It implies a critical gaze on the materials under analysis as required in any rigorous praxis of social sciences (Bourdieu, 1993).

2.3 The process of data collection

This section discusses the process through which the data used in this thesis have been collected. It, thus, discusses the dynamics through which Congolese and other informants have been approached, the nature of feedback as well as of the data.

2.3.1 Applying ethnography, case studies and ethnomethodology

Ethnography is characterized by its focus on grasping the meaning of the phenomenon studied through the social actors or the people's eyes (Schwartz & Jacobs, 1978:7). Hence the importance of 'participant observation' and interviews as techniques of acquiring the information. (Calley, 1965:146; Faizang, 2000:18). Since ethnography refers to the idea of grasping the data through the social actors' eyes, such a research technique proved necessary in grasping reasons for Congolese refugees' therapeutic options. Although, ethnography deals with cases, it, nevertheless, does not focus on quantified data (Donovan, 1986a:85). In ethnography:

"The focus is usually a small number of cases, perhaps a simple setting or group of people, of relatively small scale. Indeed, in life history research the focus may even be a single individual" (Hammersley, 1998:2).

By contrast, case studies, as a research strategy, focuses on the quantification of the data (Donovan, 1986a:86). The relevance to use case studies in this study is explained by the fact that case studies provides a wider and clear view of Congolese experiences in order to substantiate evidence about my analyses or claims (Nisbet & Watt, 1978: 5).

Ethnomethodology is referred to, not only for its ability to render people's daily activities 'visibly-rational-and-reportable-for-all-practical purposes' (Garfinkel,

1967: VII) but also, because of its focus on 'the language used by people in everyday lives' (Donovan, 1986a: 80). This research deals with daily experiences in the Congolese community and the way they are spoken and interpreted by the concerned people. Hence the importance of decoding the linguistics through which Congolese refugees recount their daily experiences. For, as chapter three, six, seven and eight will show, there is a coded and invented language through which Congolese refugees narrate their experiences in London. To illustrate, some expressions that Congolese refugees import into Lingala to speak about their experiences of being in exile are invented, coded or transposed with a new meaning. Terms such as '*Ngunda* used to refer to refugee, *Lubuaku* to prison, *Mbila* to police, *piano* to fingerprints, and *Ngomba* to Home Office, are their own invented terms or coded language to express their situation. For, in their proper linguistic context, the term *Ngunda*, which they use to refer to a refugee, means in Kikongo 'a trial' (Laman, 1936: 695); the term '*lubuaku*' is a deformation of the verb '*Ko bwaka*' which means to throw (Turnbull & Pashi, 1994: 30); *Mbila* is a Lingala word meaning cola nuts; piano is the French and English for piano. Congolese refugees compare the act of fingerprints to that of playing the piano. *Ngomba*, a term they use to speak of Home Office, means mountain (Turnbull & Pashi, 1994: 189) in Lingala. The Lunar House where they go for 'piano' and from where decisions are made about their cases is remote from most of them. Thus, the term indicates the physical distance and geographical location of Home Office. Getting there is like climbing a mountain.

The act of decoding this language justifies the reference to ethnomethodology in this study (Hammersley, 1998: 12). Such an approach which consists of decoding the common and coded language of Congolese refugees implies that this research falls into the category of what Donovan calls a research based on 'the individual level and within the family' (Donovan, 1986a: 88). Here knowledge is constructed through tales or field narratives and not from inherited or preconceived structured and hegemonic discourses (Lyotard, 1974).

Moreover, an ethnomethodological approach is relevant in my work for by its nature, ethnomethodology considers different sources of information on the phenomena or subject under scrutiny (Donovan, 1986a: 82). In researching Congolese refugees' health issues, I go beyond the Congolese refugees' frontier, to listen to what is said about them by others, and what other African refugee communities experience.

2.3.2 The types of data

Although most of my data derive from the context of my fieldwork as a social scientist researcher, there are three cases mentioned in chapter four and six that derive directly from my pastoral experiences from 1992-1995. The first, in section 3.4.3.2 (p.78), is about pastoral concerns in 1993 regarding the impact of Mobutu's regime on the health of some members of *la Alpha* Church. The second, in section 6.3 (p.184-185; Table 6.3; 6.4) and the third, in section 7.2 (p.189-190; Table 7.1), derive from the joint efforts by *la Alpha* and *la Beta* Churches in 1993. These activities were necessary to address the social and health conditions of members of the Congolese refugee community.

The second category of the data is related to my status as a social scientist research student. This data collection took place between 1997 and 1999. It is this type of data, which prevails in this research. These data have three main sources that are interviews, observations and questionnaires as conducted either through participant observation or surveys. They are distributed and analysed in chapters three, five, six, seven and eight.

2.3.3 The practice of fieldwork

2.3.3.1 Participant observation

The two main characteristics of participation observation are covert and overt. The term covert applies when the researcher in the field hides his/her role of researcher by 'pretending to play some other role' (Bulmer, 1982:4). The term overt however, is applied when the researcher in a given context is identified, known and accepted as carrying out a study (Homan & Bulmer, 1982: 120).

This study is overt in relation to the collection of data among Congolese refugees. This is due to their consent. There is only one case study in which, I adopted a (semi-) covert position. This is the case study 7.3, 'a post-natal clinic conflict' in chapter seven (p.200), in which case I served as an interpreter. Only, Mafuta, the patient's mother, was aware of my other role of a researcher. Reasons for this will be discussed in relation to ethical issues in section 2.4.4.2 (p.53-54).

To collect my data, I frequently visited people either at hospitals or at home. There were times, like in many cases in chapter seven, ie. the Nsenga's family (case study 7.7; p.207) and 'a palaver at the Salomon's (case study 7.9; p.210), that pastors and church leaders invited me to attend some of their sessions of social conflict resolution, healing crusades, and counselling sessions. I have also been given opportunities to discuss health education issues such as sex education (Case study 8.4; p.239) in one of the churches. Some other families aware of my research willingly invited me to participate in private sessions where they dealt with specific issues including social conflicts, exorcism, long illness, bereavement, and conflict with medical diagnosis (Case study 7.3; p.200). In some of these sessions, I was not only an observer but an active participant.

Five times I was asked by some families to accompany them to doctor surgeries either to interpret or to clear up a misunderstanding. As on other occasions already mentioned, we agreed about the extent to which I would use these experiences in my research.

A great deal of information has been collected while visiting the bereaved. Families and friends of the deceased often provided information and interpretations of causes (Ma Mpolo, 1976; Janzen, 1978) that led to the death of a loved one. The tears and exclamations from the bereaved Congolese are mostly accompanied by a mass of aetiological and nosological information that

the researcher is able to scrutinise.³ I also had the opportunity to speak with parents on the role of schools in promoting health in the Congolese community.

2.3.3.2 Survey: the questionnaires

I have used two questionnaires in the collection of my data. I constructed these questionnaires (Appendices II and III; p.279-281) in such a way that they encompassed the types of issues dealt with in this research. This is to say that these two questionnaires considered the two research questions mentioned in section 1.4 (p.22). Questionnaire I dealt with such issues as concepts of health and reasons for therapeutic options. The questionnaire also provided the information needed to understand their views of the British health care sector. Questionnaire II has revealed much about Congolese refugees' health promotion self-discipline, knowledge and attitudes to present discourses on various risks.

Ninety samples of questionnaire I were distributed between November-December 1997, May-June 1998, and December 1998. They were distributed to 53 men and 37 women. In May 1999, one hundred and twenty copies of questionnaire II were distributed to 67 men and 53 women. These questionnaires were distributed to people of various social, religious and ethnic backgrounds. The age of those who responded to my two questionnaires range from 22 to 45.

2.3.3.3 Interviews

57 interviews among Congolese have been reported in this thesis. While most of them have been reported integrally, some of them, like case studies, 7.3 (p.200); 7.8 (p.208); 7.10 (p.210), appear in forms of summary. My interviews covered issues such as health status self-evaluation, reasons for exile, socio-economic and political conditions and concepts of health and therapeutic options. The ages of my Congolese interviewees range from 7 to 49. These interviews were structured and unstructured (Schwartz & Jacobs, 1978:40).

Structured interviews are those in which I used the questions of my designed questionnaires I and II. Unstructured interviews have mainly been used in observations in the context of therapeutic quests (Case studies 6.1(p.169); 6.2(p.170) & 6.3 (p.171)) although, I also referred from time to time to some of my structured questions. Unstructured interviews have also been used to get information related to experiences or conditions in exile (Case studies 3.1 (p.76); 3.6 (p.95); 3.7 (p.96) & 3.8(p.97)). It should also be noted that some unstructured interviews were collective in which I acted either as the principal and the unique interviewer (Case studies 6.1(p.169); 6.2 (p.170)& 8.4(p.239))or the principal observer (Case studies 6.3 (p.171) & 6.4 (p.172)). In unstructured interviews concerning the conditions of exile, I was the only interviewer (Case studies 3.1 (p.76) & 3.2 (p.77)).

The reason why interviews were unstructured, in these contexts of therapeutic quests and that of dialogue about the Congolese refugee conditions of exile, is the fact that questions to be asked depended on the nature of the informants' discourse or conditions. Hence the relevance of the statement that:

“The success of this undertaking is ultimately contingent upon the skill and sensitivity of the interviewer, who must ask the right questions at the right time, refrain from questioning at the right time, and generally be a nonthreatening, understanding, and empathetic listener” (Schwartz & Jacobs, 1978: 40).

As for the distribution of my questionnaires, I interviewed people from different social and ethnic backgrounds. Students and couples have been the most available. Most of my interviews were conducted in churches and homes. While interviewees who do not attend *la Alpha* and *la Beta* churches were often interviewed on Saturdays' evenings, sessions with Church leaders and their members occurred either Saturdays or Sundays. Thus, as previously mentioned, the ability to question, to listen, to adapt and being flexible proved necessary during these interviews (Kvale, 1996).

I had some 'key informant interviews' with anthropologists like Rene Devisch (University of Leuven), Pierre-Joseph Laurent (University of Louvain), and regular dialogues with Professor Mary Douglas (London). These interviews were related to methodological questions as well as their understanding of Congolese therapeutic options. In the last stage of this research, I had the privilege to correspond with Professor Janzen whose writings on the Kongo therapeutic systems have been useful. I also had interviews with some officers of the Medical Foundation (London) and Amnesty International on different aspects of questions treated and raised by this thesis. Congolese pastors and their Church leaders were my key informants on different issues regarding Congolese refugees in London. My interviews with non-Congolese key informants were also unstructured. However, their difference lies in their constant reference to academic texts and to analytical questioning.

2.3.3.4 Documents

I had access to several documents regarding Congolese refugees' histories, experiences and conditions in Britain. Sources of these documents include the British Refugee Council, the Medical Foundation, Asylum Aid and other Non-Governmental Organisations. I corresponded with officers of Asylum Aid who twice sent me useful materials. Some newspaper articles have also been read. The White Fathers library of the University of Leuven, Belgium, has provided me with some documents.

2.3.3.5 The response rate

The response rate to the ninety samples of questionnaire I distributed was 80% (72 responses). This included 40 men (55.6%) and 32 women (44.4%). 20 % (18) have not responded. They include 5 women and thirteen men. Among those who have not responded to my questionnaire I, in December 1997, two cases have been recorded as being deported and one moved to another country after being refused asylum. The response rate to the one hundred and twenty samples of questionnaire II was 70% (84 responses). This means that

30% (36) have not responded. They include 21 men and 15 women. The division in terms of gender of these respondents includes 46 men (54.8%) and 38 women (45.2%). The results of questionnaire I and questionnaire II can be represented in tables as follows:

Table 2.1 distribution and response rate of each questionnaire by gender

	<i>Questionnaire I N=90</i>				<i>Questionnaire II N=120</i>			
	<i>Women</i>		<i>Men</i>		<i>Women</i>		<i>Men</i>	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
<i>Copies distributed</i>	37	41	53	59	53	44	67	56
<i>Returned</i>	32	86.5	40	75.5	38	71.7	46	68.7
<i>Non-returned Copies</i>	5	13.5	13	24.5	15	28.3	21	31.3

Table 2.2 Total distribution and return of each questionnaire

	<i>Total of QI Women + Men</i>		<i>Total of QII Women + Men</i>	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
<i>Total of copies distributed</i>	53+37= 90	100	67+ 53 = 120	100
<i>Total returned</i>	40+32= 72	80	46+ 38 = 84	70
<i>Total of non returned copies</i>	13+5= 18	20	21+15= 36	30

Table 2.3 Total distribution and return of QI and QII by gender

	<i>Questionnaire I + Questionnaire II (90+120)</i>			
	<i>N=210</i>			
	<i>Women QI+QII</i>		<i>Men QI+QII</i>	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
Total copies distributed	37+53= 90	42.9	53+67= 120	57.1
Total returned	32+38= 70	77.8	40+46= 86	71.7
Total of non returned copies	5+15= 20	22.2	13+21=34	28.3

Table2.4 Total distribution and return of QI and QI

<i>Questionnaire I + Questionnaire II</i>		
	<i>N</i>	<i>%</i>
Total of copies distributed	120+90= 210	100
Total returned	86+70= 156	74.3
Total of Non returned copies	34+20= 54	25.7

Table 2.4 indicates that two hundred and ten samples of questionnaire I and II have been distributed. The total feedback is 74.3% (156). 25.7% (54) have not responded. Reasons for this include as previously evoked deportation and lack of time due to their daily lives imperatives.

2.4The management of the data

By the management of the data I mean the way the data were collected, transcribed, analysed and presented. These issues entail the consideration of the reliability of data as well as the question of research ethics.

2.4.1 Collecting, recording and transcribing the data

I have collected my data using Lingala, Kikongo, French and English. My questionnaires have been written in French and in Lingala. Most of my interviews with Congolese have been carried out in Lingala. This is the lingua franca mostly used by Congolese in London. Kikongo and French were used among them when necessary. I used English, French and Kikongo in my dialogue with Professor Devisch. English and Kikongo were used in my correspondence with Professor Janzen. French only was used in my dialogue with Professor Laurent. French and English were simultaneously used in most of interviews or dialogues with Professor Douglas.

Among Congolese refugees, recording a counseling session can be intrusive and would jeopardize one's work. Thus in many cases, it has not been possible to record their voices. Although this is not always the case, I would, therefore, differ from anthropologists and social scientists working in an esoteric culture and carrying with them, tape recorders and camera. I used tape recording in some few cases, such as case study 8.4 (p.239), when it has been allowed. However, my dialogues with Professor Devisch and Laurent as well as some of my dialogues with Professor Douglas were recorded.

I took notes of most sessions (interviews, dialogues, and observations) in accordance with research practice. At times, as in the case of dialogue with members of *la Alpha* Church about sex education in chapter seven, the church secretary took also notes, which were given to me. Where notes were not used the power of memorising had to be exercised. This occurred in some informal sessions and visits to bereaved people. Any observation I made or any information I collected in this context was translated into notes as soon as I got home.



My knowledge of Kikongo, Lingala and French contributed in the translation into English of metaphors and dictums used by Congolese to narrate their stories and particular views. The use of metaphors, parables and proverbs has been common in Congolese accounts of their concepts of health and their conditions as refugees.

2.4.2 The process of analysing the data

I analysed my data in line with views asserted in section 2.2.2 (p.34) that the interpretation of the data in social sciences is first and foremost related to the researcher rigorous mind to engage with the data (Yin, 1994; Henderson, 1995). I, nevertheless, established three exegetical levels that guided my analytical process. First, I triangulated the data and their sources. I focused on similarities and differences of views about themes that are discussed in this research. (ie. Concepts of health, conditions of refugees in UK, reasons of exile, etc) The second level is the rephrasing of differences and similarities about themes and issues discussed. The third level consisted in questioning these similarities and differences. At this level, my analytical process implied the decoding and the organization of informants' accounts (Henderson, 1995: 469) and their contexts. Thus, the relevance of immersing within the Congolese ethno-poetic universe as well as the oral performance and body language that characterised the narrative studied. For tones and gestures carry meanings (Hammersley, 1998:XI). The uncovering of reasons for a coded language referred to in section 2.3.1 (p.41) is symptomatic of their enigmatic identity. Since being a refugee is a demeaning reality, they find it necessary to invent a language, only understood by them. It is through this coded language that they discuss their conditions and experiences of being refugees (*ngunda*). The same applies for bodily symbolic rituals used by Nzumba in case study 6.5 (p.172-173). The act of spitting on the 'husband', beating the earth and turning her back on her husband suggests her victory over the evil action coming from her husband's side. Because of the fact that coded language and body language are vehicle of a truth or message, exegetical questions that guided my analyses

included: what does the statement mean? Why do they use such expressions in their statement? What does the family or the person really mean? On the basis of my fieldwork I concur with Coffey and Atkinson who observe that:

“Metaphorical statements have a number of features that deserve analytical attention. They can reveal shared understanding and situated realities of the social actor or social group. What terms are used in a metaphorical statement and what characteristics are implied can reveal common knowledge and what is taken for granted as shared understanding” (Coffey & Atkinson, 1996:83).

2.4.3 The reliability of the data and analysis

I questioned the reliability of my analysis and data by a constant triangulation of data and their sources (Blaxter, Hughes & Tight, 1996: 200). In this context it should be added that besides many works that I have used, studies by Harper-Bulman (1997) and Tubb (1996) on the experiences of African women, as well as that of Torkington (1991) on the experiences of Blacks, in the British biomedical milieu have been useful to assess my interpretations and understanding of Congolese refugees experiences in the British health sector. Moreover, to assess my position as a social scientist researcher, I regularly broke contacts with my informants, and occasionally distanced myself from my own milieu. In such a way, I was able to see my research from ‘a perspective of an outsider’ (Blaxter, Hughes & Tight, 1996:198). For I share the truth asserted by Faizang when she remarks that:

“Medical anthropology then conducted ‘at home’ brings its own special difficulties, due in part to the lack of distance between the observer and his subjects. This distance must however be constructed if the analysis is to be effectively carried out. It is possible, as it is also essential to look at the familiar with the eye of the outsider. By rendering the familiar foreign, and looking at French society with the same astonishment with which the European usually looks at an African society...” (Fainzang, 2000: X-XI).

My reference to non-African scholars, as will be demonstrated in subsequent chapters, as well as my dialogues with anthropologists on Africa bears witness to my stereoscopic social vision. I, thus, would state that my critical approach in

the collection and the analysis of my data would concur with Hammersley's concept of 'methodological purism' (Hammersley, 2000: 124). As he defines it:

"Methodological purism might be interpreted as an emphasis on the need to meet high methodological standards, and a resistance to deviation from those standards for reasons of personal preference, expediency, social pressure, etc" (Hammersley, 2000: 125).

2.4.4 Research ethics

Ethical issues are at the core of social science practices. Social scientists are accountable not only to what they scrutinize but also to individuals whose views, practices and conditions are the object of academic investigation (Bulmer, 1982: 3). Researchers dealing with sensitive matters, in particular, are required to present rigorous ethical reasons. This is what Lee expresses when he writes:

"Those researching sensitive topics may need to be more acutely aware of their ethical responsibilities to research participants than would be the case with the study of a more innocuous topic" (Lee, 1993:2).

Such an awareness of the research ethical dimension would consider, in my view, three different ethical issues that a researcher has to wrestle with. They include the rationale of one's research. This is the prime justification of any research. In other words, what right does the researcher have to approach the subject of his/her inquiry? The second issue is that of the research technique. The researcher has to justify why s/he adopts a particular research technique. The last issue is about the representation of the informants. These questions consist the basis on which I account for the ethical aspects of my research.

2.4.4.1 The rationale of the research as an ethical argument

The academic and pastoral imperatives evoked in chapter one, section 1.5 (p22-25), account for the ethical standing of this research. For to be involved or concerned with realities of Congolese refugees is a fundamental pastoral and academic enterprise that must be supposed to fulfil its responsibilities. This

reasoning which explains my concern with the conditions of Congolese refugees in London concurs with present thought that:

“Researchers cannot simply stand aside and adopt a passive disinterested stance -on the contrary, they have to be very much in, and part of, the world they are researching. Researchers are not scientists working in a laboratory or even scientists in the field seeking to understand social life. Whilst they approach their work with scientific rigour and whilst they seek to understand, they seek also to transform” (Scott & Usher, 1999:33).

Moreover, given the complexities and sensibilities associated with health issues, I assume that such a research requires the abilities and the approach of a qualified social scientist not only with symbolic and cultural capitals (Bourdieu, 1980) but also accepted by the members of the community. For respect for the subjects' dignity is ultimately related to that of researcher. Research on Congolese refugees' health issues, as chapter six will show, is a sensitive issue. Hence the need for the researcher to be not only accepted but also to share much with them. This is what I have been reminded in my dialogue with the Belgian anthropologist, Professor Laurent of the Catholic University of Louvain-La Neuve, in stating that:

“Who can understand and speak better of Congolese refugees in London, if not a refugee Congolese anthropologist pastor working among them, and who tries his/her best to dialogue with theories in social sciences?⁴

(Fr: Qui peut mieux comprendre et dire les realites des refugies Congolais a Londres, sinon un Pasteur-anthropologue refugie et Congolais travaillant parmi eux, et qui constamment cherche a dialoguer avec les sciences sociales?)”

2.4.4.2 Ethics and research techniques

As I have shown in section 2.3.3.1 (p.43-44), I conducted my fieldwork as a overt researcher. For I had the consent of my informants. The reason why I adopted a (semi) covert approach in case study 7.3 (p.200) was to protect the relationships between Mafuta and her GP, and to witness the natural interactions between both of them. A view relevantly expressed by Lee that:

“A primary justification for covert research is that it avoids problems of reactivity. Because they do not know they are being studied, research participants are not threatened by the research and do not change their behaviour even though to outside eyes it might be regarded as deviant” (Lee, 1993: 143).

My position as Mafuta’s compatriot serving as an interpreter did not pose a threat to the doctor. Certain scholars such as Bulmer (Homan & Bulmer, 1982) and Shils (1982: 131) react negatively to the use of a covert approach. Nevertheless, I would maintain that some information about some sensitive issues can only be obtained in this way. The vivid illustration is that of Festinger et al.’ experience in their study of a religious movement that predicted the end of the world. As their account goes:

“Our very first contact with the central figures of the group, their secrecy and general attitude toward non-believers made it clear that a study could not be conducted openly. Our basic problems were then obtaining entrée for a sufficient number of observers to provide the needed coverage of members’ activities, and keeping at an absolute minimum any influence which these observers might have on the beliefs and actions of members of the group. We tried to be nondirective, sympathetic listeners, passive participants who were inquisitive and eager to learn whatever others might want to tell us” (Festinger et al, 1956: 234).

2.4.4.3 Protecting the subjects

Arguments in sections 1.5 (p.22-25) and 2.4.4.1 (p.52-53) indicate that my commitment to this study goes beyond sympathy. Thus, it defies any academic quest of knowledge whose basis is an intellectual voyeurism. Having established a form of consent with Congolese refugees, I opt for ‘a consequentialist model’ (Denzin & Lincoln, 1998: 39), which rests on the ethical principles of mutual trust, collaboration and caring. It is in this context of trust that data are collected, analyzed and exposed to the public.

As part of this approach, the trust and dignity of Congolese refugees are to be protected. Thus, an academic and professional deontology is required. This is the wisdom which is often used in many ethnographic studies. For instance,

Bourdieu (1993) has used and vindicated it. In order not to put at risk the trust from informants, Bourdieu *et al* decide to not unveil explicitly names and places of their informants. I have adopted anonymising in my research.

Moreover, there is also a political reason for using anonymity. Most Congolese refugees in London do not want to be referred to as refugees. This is a result of demeaning experiences within different social arena where they have been recognised and treated as bogus economic migrants. This generates what I will refer to in chapter six as the enigmatic identity of the Congolese refugees. For these reasons I find it necessary to adopt this scholarly deontology. Names of people whose case stories are mentioned in this research have been systematically altered. It is not possible to identify individuals from my research. I also refused to reveal the addresses and names of the churches where much of the data has been collected.

2.5 Doing research among the Congolese: advantages and difficulties

2.5.1 Advantages

Advantages in this research are related to my quadruple status of social scientist research student, pastor, Congolese and refugee. Being one of them, Congolese refugees have accepted my status of social scientist without suspicion (Calley, 1965:146) or conflicts. Moreover, though people accepted my status of a social scientist researcher, this status has not undermined my status as a pastor. Most people encountered in the field often called me by my title or my status 'Pastor'. Hence, *Pasteur oye!* (Pastor you' ve arrived).⁵ My researcher status, as they often claimed, is to support and to enlighten my pastoral vocation. Thus, in spite of power relations between them and me, common 'biographies' (Scott & Usher, 1999: 114) and membership of the same social world sustained harmony. I am still one of them. It would follow that my presence among Congolese refugees has not created suspicious power relation or tensions that might be compared to those of a French white female scholar who in order to collect her data joins the Bisa women in Cameroon to pound

millet (Fainzang, 2000: 19). Consequently, the information that I have gathered on the basis of my quadruple identity of being a social scientist, Congolese, pastor and a refugee encompasses all that would be required for this research. Nevertheless, I have restricted myself to use the data that I have found most relevant (on the basis of quality of time spent with these cases) for the purpose of this research. However, my selection does not underestimate the informative value of case-stories that have been dropped.

The other advantage related to my quadruple status of social scientist research student, pastor, Congolese and refugee is accessibility to meanings. It would, thus, appear that theories about 'cultural relativism and subjective understanding' (Barrett, 1991: 7-8) stressed by anthropologists have another meaning in my context. For as a researcher among my people, I am like an ethnographer, or a 'chronicler of the transactions and reflections' (Atkinson, 1990: 57) of my community. Given my quadruple status, despite my gaze at the data with a foreign and rigorous eye, what I am doing in this research would fall, to some extent, to what Ricoeur calls 'the hermeneutic of praxis' (Ricoeur, 1991: 225) (*L'hermeneutique de la praxis*). This is the logic that transforms and converts our actions into a text that has to be read, deciphered and interpreted.

The last advantage, while conducting my fieldwork, was that of my pastoral skills which enabled me to deal with confidence within the context of unstructured interviews. For in this context as discussed in section 2.3.3.3 (p.45), the researcher has to demonstrate skills of listening and questioning.

2.5.2 Some difficulties in collecting the data

My research is not immune to difficulties. The first difficulty is ethnically related. Despite the acceptability of ethnic differences and mutual respect within the Congolese refugee community, ethnicity has, in some circumstances, significance in the ways information is given or help is sought within the community. Ethnicity therefore can be the basis of preference. To illustrate, the

openness of a Congolese refugee from the Eastern Congo to a Congolese social scientist from the Lower Congo (as I am) may be restricted. Gender was the second disadvantage. Men communicated more easily with me than women. For instance, men spoke more easily about their experiences of exile, detention, and changing of identities than women. The third difficulty was pessimism resulting from the conditions of being a Congolese. Despite their consent about data and their appreciation of such research, some Congolese remained pessimistic about the impact that a study by a fellow Congolese refugee can have to challenge or eradicate the ethos of their treatments in the British biomedical milieu. The fourth difficulty is related to my status as Pastor. Some Congolese would normally use crude or obscene language about their affliction. Such language is avoided when speaking with a pastor. For the pastor in the Congolese refugee community incarnates some power of moral authority. Hence, they had to choose words to use while speaking with the researcher-pastor. The lack of accessibility to such a language can be a barrier to grasping different levels of their critique of British health care sector and the penitentiary sector.

2.6 Conclusion

I would reiterate that my research is both quantitative and qualitative. Thus, it is a bricolage. Moreover, following the ideas of some of the authors discussed in this chapter, my *habitus* enriches my analytic approach. For, I am not only a social science researcher but also a pastor, as well as a member of the group being studied. In addition, despite of some difficulties related to my quadruple status, none of my identity aspects has been a barrier in either the collection or the analysis of my data. As a matter of fact, this quadruple status offered me the privilege, which would be denied to external researchers, to participate in many social conflict resolutions as well as in different processes for the quest of health. This aspect has been grasped by Janzen who in his works on the anthropology of war trauma in the context of the African Great Lakes region states that:

“Anthropologists who are trained to take notes and record narratives may or may not be equipped to catch the emotional subtext of the stories they hear. Yet it is essential to do just that, for the way trauma is inscribed upon the individual, and the way it is dealt with effectively or not, become the starting point for understanding and dealing with it” (Janzen, 1999: 39).

As a matter of fact, the relevance of my identities or status in this research can be grasped in the light of the following analysis:

“Research on refugees differs from studies of other population in another way that relates to the refugee experience. The horrors and losses which refugees have suffered at the hands of the governments and others from whom they have fled may often make them wary of outsiders, including researchers. A further problem in conducting research on refugees is that ethnographers themselves must develop coping mechanisms for dealing with refugees’ pain, with the horrors refugees recount during the course of the research” (Krulfeld, 1994: 147).

The quoted scholars’ reflections in this conclusion prove the methodological and analytical dimensions incarnated in my quadruple status. Approaching a community in exile for scientific purpose requires more than an academic sharpened armour. To do otherwise can only be seen as suspicious and bound to fail. While this applies in any refugee context, this is very significant in the context of Congolese and other third world citizens exiled in Western Europe.

In contrast to experiences of exile in such places as the Great Lake regions and many African countries, as will be discussed in the following chapter, exile in Western Europe is characterised by the constant threat of deportation or of being labeled as a ‘bogus asylum seeker’. Thus, a genuine degree of trust in the researcher is fundamental. Unless the refugee community studied is convinced that the research being conducted is not a threat to their quest for exile, the researcher can be constantly under suspicion and denied the materials required for the research. In fact, rather than being approached, the researcher might be avoided. Yet, even when s/he is approached, narratives

that s/he might be given are constructed in such a way that much of what these refugees are, remains hidden and undiscovered.

2.7 Notes

¹ Mudimbe, for instance, notes in his 'Invention of Africa'(1988:xi) that his acclaimed scholarly work is subjective.

² Kleimann refers to Idler, E et al (1990). Self-evaluated health and mortality among the elderly can be more predictive of mortality than 'objective bio-medical measures', in, American Journal of epidemiology, 131 (1): 91-103, idem p 133.

³ Such expressions are heard: *Lufwa Lua Nzambi* (Kik), *Liwa Ya Nzambe* (Ling) = Death from God; *Lufwa Lua Satana* (Kik), *Liwa Ya Moyini* (Ling)= Death from Satan . *Lufwa Lua Ba ndoki* (Kik), *Liwa Ya Bandoki* (Ling)= Death from Sorcery.

⁴ A dialogue with Professor Laurent Francois, Universite Catholique, Louvain La Neuve, Belgium, March 1999.

⁵ Welcoming expression in the fieldwork.

Chapter III. The historical background and conditions of Congolese refugees in London

3.1 Introduction

This chapter has two main concerns. Firstly, the background and secondly, the current socio-economic and political conditions of Congolese refugees in London. Their background, which includes their country's political history, is an indispensable factor in understanding the reasons for their presence in Britain. Narratives from my own fieldwork, as well as existing literature on refugee issues in Britain constitute the basis for analyses of conditions of Congolese refugees in London. Referring to some fundamental texts on human rights, this chapter criticizes the treatment of Congolese refugees in particular and refugees in Britain in general. To provide a picture of the Congolese social, cultural and ethnic background, I present within this introductory chapter three maps of the Congo (p.62-64).

3.2 A brief geographical, social and political history of the Congo

Situated in the central region of Africa, the Democratic Republic of the Congo (ex Zaire) covers an area of 2,345,000 square kilometers, which makes it the third largest country on the continent. It shares a border with nine countries (map 1, p.62). The length of the borders with eight of these countries are as follows:

“Angola 2,511 km, Burundi 233 km, Central African Republic 1,577 km, Republic of the Congo 2,410 km, Rwanda 217 km, Sudan 628 km, Uganda 765 km, Zambia 1,930 km” (Rosenberg, 1998:1).

Exploratory trips by Stanley and Dr Livingston stressed the uniqueness of the Congo-River (map 2, p.63), the second largest in the world after the Amazon. The Congo's flora, fauna, as well as its natural resources have captured the interests of the developed world. Its geographical position and wealth have determined its strategic geopolitical value (Ntalaja, 1998:16-17). Thus, the enthronement of Mobutu by the West as an officer against the expansion of communism in central Africa is not a fruit of hazard.

Area: 2,345,410 sq. km

Population: 47,440,362 (July 1997 est.)

Age structure: 0–14 years: 48%; 15–64 years: 49%; 65 years and over: 3%

Population growth rate: 2.34% (1997 est.)

Birth rate: 47.66 births/1,000 population (1997 est.)

Death rate: 16.61 deaths/1,000 population (1997 est.)

Infant mortality rate: 105.7 deaths/1,000 live births (1997 est.)

Religions: Roman Catholic 50%, Protestant 20%, Kimbanguist 10%, Muslim 10%, others and traditional beliefs 10%

Languages: French (official), Lingala, Kingwana (a dialect of Kiswahili), Kikongo, Tshiluba

Literacy: total population: 77.3%

Independence: 30 June 1960 (from Belgium)

Chief of state: Gen. Laurent-Désiré Kabila (since 17 May 1997); the president is both chief of state and head of government

GDP: composition by sector: agriculture: 59% industry: 15% services: 26% (1995 est.)

Labour force: total: 14.51 million (1993 est.)
by occupation : agriculture 65%, industry 16%, services 19% (1991 est.)

Natural resources: cobalt, copper, cadmium, petroleum, industrial and gem diamonds, gold, silver, zinc, manganese, tin, germanium, uranium, radium, bauxite, iron ore, coal, hydropower potential

Industries: mining, mineral processing, consumer products (including textiles, footwear, cigarettes, processed foods and beverages), cement, diamonds

Agriculture products: coffee, sugar, palm oil, rubber, tea, quinine, cassava, palm oil, bananas, root crops, corn, fruits; wood products

Exports: total value : \$1.47 billion (f.o.b., 1995 est.)

commodities: diamonds, copper, coffee, cobalt, crude oil

partners: Belgium, US, France, Germany, Italy, UK, Japan, South Africa

Imports: total value: \$1.25 billion (c.i.f., 1995 est.)

commodities : consumer goods, foodstuffs, mining and other machinery, transport, equipment, fuels

partners: Belgium, South Africa, US, France, Germany, Italy, Japan, UK

Source: *World Factbook 1997*

GÉOGRAPHIE

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Carte 1 — Voies de communications au Congo en 1938
(*Atlas du Congo, De Rouck, 1946*)

THIS IMAGE HAS BEEN REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES



Carte 2 — Principales ethnies du Zaïre
(d'après Van Sina, 1966)

The Congolese population is estimated at about 47,440,362 people (W.F, in, Ntalaja, 1998:4). It is divided into more than two hundred ethnic groups (Kaplan, 1978: 118; map 3, p.64). Predominant groups that include the Kongo, the Luba, the Ngala and the Mongo are described as the Bantu. The Mangbetu-Azande is another family of ethnic groups described as Hamitic. This would imply that the majority of the Congolese are indigenous Black Africans. However, it must be noted that the modern demographic history of the Congo entails its description as a multiracial geographic space. Thus, other Congolese include Portuguese, Belgians, Italians, Greeks, Arabs, Lebanese, Pakistanis and Indians. Their presence in the Congo is related either to economic or political factors.

Prior to the Berlin Conference of 1885, some of the Congolese ethnic groups constituted kingdoms and empires. The Kingdom of Kongo, due to its history, remains one of the most famous. The fame of this Kingdom has also been enhanced by two important facts in twentieth-century political, religious and social history of the Congo. The birth in 1921 of Kimbanguism, one of the largest African independent churches. The second fact is the place of the ABAKO in the struggle against colonialism and the accession to independence. As a direct result of this Kingdom's influence, the country has ever since been named after terms whose origins are Kongo. The term 'Congo' is a French orthography of Kongo. The term 'Zaire' imposed by Mobutu in 1971 derives also from a Kongo word, '*Nzadi*', meaning Great River. Zaire is the mispronunciation, of Nzadi, by the Portuguese explorer Diego Cao in 1482 (Tshibangu, 1976: 27).

Christianity claims the quasi totality of Congolese population. However, Roman-Catholic, Protestant and Kimbanguism are the three main Christian denominations. The numbers of these three Congolese Christian denominations are estimated as follows: 18 million Roman Catholic, 10 or 12 million Protestants and 3 million Kimbanguists (Mbaya, 1992: 7). Though the Roman Catholic presence in the Congo can be dated from the 15th century

(Hastings, 1996: 73), its current existence, as with Protestantism, dates from the 19th century. This is to say that it is related with colonisation. The Kimbanguist, in contrast, resulted from a counter discourse to the colonial ethos. Its founder, Simon Kimbangu, a catechist from the Baptist Missionary Society Church protested against the inhuman Belgian treatment. Stressing human (interracial) fraternity, Kimbangu, and many of his followers, were arrested in 1921, and sent to prison in Katanga where he died in 1951 (Ash, 1983: 24).

It should be mentioned that the Congo is one of the African Sub-Saharan countries where the proliferation of African independent Churches and other Christian communities cannot pass unnoticed (Konde, 1994). These are churches whose liturgies and theologies attract many Congolese (Devisch, 1996c: 553 & 580) longing for healing and spiritual celebration in Congolese styles. Their existence is strongly felt in urban cities. Among them are found churches such as the '*Nzambe Malamu*' (*Ling*) meaning God is good, '*Mpeve-A-Nlongo*' (*Kik*) meaning Holy Spirit and various communities known as '*groupes des prieres*' (*Fr*) to mean prayer groups.

Like Christianity, the modern educational system is a by-product of colonisation and missionary enterprise. Its structures, not its curricula, remain as created by the Belgians. They include six years of primary school, two to six years of secondary education (vocational or training programs) and four or six years of University training (Leslie, 1993: 76). Universities are very recent. The first University, *Universite de Louvanium/Kinshasa*, dates from 1952 (Kanza, 1979).

Despite strict conditions of admission to some leading schools, education was compulsory, viable and available for every citizen till the end of the first republic in 1965. The Congo was regarded as an intellectual centre of French Africa attracting students from beyond the African continent (Devisch, 1996b: 23). The policy of the indigenisation and self-management of public welfare, introduced

by the Zairianisation ideology in 1971, jeopardised the Congolese educational system. The whole history of education in the post-first republic era is disastrous. Poor quality, systematic interruptions, high fees and the proliferation of private educational institutions distinguish it. This was confirmed by Mobutu who described the then Zairian educational system as 'a huge, broken-down machine that no one knows how to repair' (Ato & Lukunga, 1993: 160).

Two periods are crucial to an understanding of the political history of the Congo. These are the colonial and the post-colonial eras. The first has two phases: from 1885 to 1908, during which time the country called the Congo Free State was owned by a single person; the Belgian King Leopold II. The second phase covers the period of 1908 to 1960 during which the administration was transferred to the Belgian government. This transfer was a reaction against the policies of systematic abuse inflicted on the Congolese by those in the service of Leopold II. One account of events subsequent to his recognition as the owner of the land by the Berlin Conference describes how:

"King Leopold's army subjected the Congo to a period of such sustained violence that the Belgian government was compelled to intervene. Leopold imposed draconian and excessive labour taxes on Africans as a pretext for demanding large quotas of wild rubber. Entire villages were destroyed and inhabitants shot indiscriminately by guards brought to enforce the payments of taxes. King Leopold's officers required guards to produce the right hands of the dead as evidence that their instructions had been carried out and their valuable ammunition put to good use" (LCHR, 1990: 13).

Ntalaja has accounted this transfer in the following terms:

"With the celebrities like the African-American leader Brooker T. Washington and the writer Twan leading the American branch of the CRA, the US Government was compelled to join Britain and other major powers in obtaining King Leopold's ousting as Congo's ruler. But the King's transfer of the country to Belgium did not mean the end of suffering for the Congolese people" (Ntalaja, 1999: 6).

There is a trend among some scholars on Africa to relate present Congolese experience to the colonial ethos. They would include Mudimbe (1988,1994),

Buakasa (1996), Kelly (1996), Ntalaja (1999) and contributors to '*Zaire: repression as policy* (1990)'. The latter put it strongly that:

"Zaire's modern history began with the 19th century European expansion into Africa.

It was during this period that many of Zaire's legal, social, economic and political foundations were laid, and pattern established for harsh repressive rule. Since independence in 1960 the country has faced continuous social and institutional crises, coupled with ongoing abuses of human rights" (LCHR, 1990:13).

Mudimbe (1988) has summed up this accusatory attitude in the following words:

"Although in African history the colonial experience represents but a brief moment from the perspective of today, this moment is still charged and controversial, since, to say the least, it signified a new historical form and possibility of radically new types of discourses on African traditions and cultures" (Mudimbe, 1988:1).

It must, nevertheless, be pointed out that the post-*perestroika* era has inaugurated another attitude in the making of African critical political discourses. Scholars such as Mana (1993) and Mugambi (1995) have stressed the postcolonial African contribution to the predicament of the continent. This reasoning, which, particularly, derives from African Protestant theologians sees this self-critical attitude as a prerequisite for the re-construction of Africa. Hence, the birth of the theology of reconstruction. It consists at inviting Africans to repent from their contribution to the predicaments of their continent and, to engage, for a new social order, in concrete humanising actions (Mana, 1993; Mugambi, 1995:15).

The Congolese postcolonial era commenced on June 30th 1960. It can be divided into three periods: the first republic, lasting from 1960 to November 24th 1965; the Mobutu era from 1965 to May 16th 1997; the Kabila era which is the present. The first era was a period of mounting political insecurity, civil wars, and the secession of Katanga. It claimed the lives of many and particularly of two internationally known figures. The assassination, on the order of President Dwight D. Eisenhower, of Patrice Emery Lumumba, a suspected communist

ally. The second is the death in a plane crash, over the Congolese skies, of the UN general secretary Dag Hammarskjöld in a mission to sort out the Katanga secession (Ntalaja, 1999: 6). This period ended with the CIA assisted military coup of November 24th 1965 (Kelly, 1996), which inaugurated the three decades of Mobutu's despotic regime, ending on May 16th 1997 with the rise to power of Laurent Desire Kabila. Thus, began the third period of Congolese neocolonial history whose salient characteristic is the war between Kabila and his former allies.

3.3 Social Stratification in the Congo

Scholars have noted the fact that the issue of class and social stratification in Africa is very complex. According to Biaya and Tshonda, the concept of social classes:

“has always been problematic. Its handling becomes even trickier in a country such as Zaire, which makes nonsense of all established rules and theories. One major problem hampering scholarly work in social classes in general, and studies on class-consciousness in particular, is the lack of a well-defined, hard and fast identification criteria. The lack is most perceptible among orthodox Marxists. In their opinion, there are no social classes in Zaire” (Biaya & Tshonda, 1993:99)

Another major factor explaining the complexity of classes or social stratification in Africa is the cultural, social, economic and political conditions of the continent. As observed in the context of the Congo:

“Zairian society does not present a scenario in which old traditions are faithfully preserved. Neither has there been a thorough-going penetration of capitalist system growing unchallenged on the abandoned ruins of archaic forms of production. The situation is much subtler, with the new and old forms, developing within the same society” (Biaya & Tshonda, 1993:99).

Despite the existence of this complexity of defining the notion of classes or social stratification in the Congo, it is noted that prior to the encounter with Western civilisation, there was a form of social stratification. This social stratification was based on agricultural power (Ntalaja, 1983: 59), knowledge of,

and expertise in, specific activities; as well as on gender distinction and primogeniture factors. The encounter with Western civilisation brought new forms of social stratification (Ntalaja, 1983: 60). The trilogy of race, religion and education, based on the philosophy of imperialism were its intrinsic formative and distinctive elements. Hierarchically constructed, the Belgian colonial social structure was multilayered. Its hegemonic pinnacle, the metropolitan or imperialist bourgeoisie, was above a horde whose lowest level was the lumpenproletariat (Ntalaja, 1983: 60). Second to the metropolitan or imperialist bourgeoisie was the middle bourgeoisie. An exclusively white class of Belgian businessmen and representatives of religious orders. The third class, the petty bourgeoisie, is that which towards the end of the colonial era included among its white members, foreign African employees and businessmen as well as some Congolese civil servants to whom *une carte de merite civile*¹ was given. These Congolese were described as '*les evolues*' (Fr). They have achieved the colonial evolutionary civilising process (Mudimbe, 1988: 52).

Other classes within this colonial social stratification scale included the traditional ruling class, the peasantry, the working class and the lumpenproletariat for whom no ascendant social mobility could ever have been expected (Ntalaja, 1983: 60).

Social stratification, in this colonial Congolese context was of a paramount importance with regard to access to education and health resources. It imposed a formal political dichotomy in terms of educational and health resources. Each class had corresponding schools and health resources.

The postcolonial social stratification is described as the continuation of the colonial paradigm (Kaplan, 1987:172). Regarding social stratification during Mobutu's regime, it is noted that, its main differences to the colonial stratification were that it was 'African, unproductive, and primarily from Equateur'² (Leslie, 1993: 72).

Two main classes have been distinguished within the Congolese postcolonial context. The Congolese bourgeoisie and the lower class (Biaya & Tshonda, 1993:102-106). The Congolese bourgeoisie is made up of the political elite, the trading bourgeoisie and the middle class. Though the latter is considered as part of the Congolese bourgeoisie, its economic power and education influences have little in common either with the political elite or the lower class. The lower class is made up of people of different social categories including 'the proletarian masses, the self-employed workers, temporarily and permanently unemployed, the rural masses and the peasants' (Biaya & Tshonda, 1993: 106). The difficulty of a social stratification or social classes discourse in the Congo has been noted by Kaplan who remarks that every Congolese living in the rural area is described as a peasant (Kaplan, 1987:172).

Nevertheless, it should be stated that the outstanding ethos of postcolonial social stratification is that political office, rather than education, is the means for socio-economic prosperity (Leslie, 1993: 72). Yet, accessibility to national educational and health resources was the privilege of those with economic resources. Thus, to ensure accessibility and affordability to these resources the imperatives of creating social relations are entailed. This is what is summed up in the Congolese familiar jargon, '*ndeko ya....*' (*Ling*). The expression refers to somebody whose relatives or friends have a very important role in the established regime' social stratification to maintain multiple egocentric interests. It is the basis for Kleptocracy. The accumulation of economic capital by a small group and its unequal distribution create the condition whereby rather than an *alma mater*, the country becomes an arena of structured hellish experiences.

3.4 Congolese refugees in London: demography and socio- economic and political conditions

3.4.1 Current issues of refugees in London

Current issues on refugees in Great Britain are characterised by the prevalence of discourses of 'bogus economic migrants' (O'Nions, 1999:1) and conflicts between political parties and non-governmental organisations (Travis, #

January, 2000:1). These perceptions and tensions have generated and reinforced the policies of social and economic marginalisation (Worrell, #6, 2000:1) and deportation (Worrell, #3, 2000:1). While distinguishing a genuine refugee from the 'bogus economic migrant' is the principal concern of immigration officers, asylum seekers attempting to 'challenge over the way they have been treated by the British immigration authorities will be cut off from all state support, including food and lodgings, under new Home Office proposals' (Travis, #February, 1999:1).

Issues prevailing the British current discourses on refugees should be scrutinised in the light of international laws on Human rights. The first article of the Refugee Convention of 1951 is the most referential text about the concept of a refugee. It speaks of a refugee as anyone who for 'well-founded fear of persecution' based either on race, religion, political opinion, social group or nationality leaves his/her country to seek protection in another country' (Weis, 1994: XIV). The fourteenth article of the Universal Declaration of Human rights expresses the same concept of refugee when it reads that 'everyone has the right to seek and to enjoy in other countries from persecution' (Davies, 1988). It should be recognised that this definition of a refugee in terms of 'persecution' is open to complexities (Rosenblatt & Lewis, 1997: 26). For some forms of abuse of human rights are said not to fall within this definition (Ruthstrom-Ruin, 1993: 68). As commented by Ferris:

"This definition excludes those individuals who are displaced by violence or warfare and who have not been singled out for individual persecution. The UNHCR handbook on procedures and criteria for determining refugee status states that 'an applicant must normally show he individually fears persecution'" (Ferris, 1993:12).

The difficulty in defining the term 'refugee' is not to be limited to reasons evoked in the last paragraph. For diplomatic (Sjoberg, 1991: 9), political and economic interests of host countries are also factors on whose grounds a refugee status can be denied to a person or a group. Such people, like Congolese exiling in Britain, are suspected as 'bogus economic migrants'. Thus, a denial of

refugees' status on the basis of the UN 1951 Convention of Refugees (Loesher, 1993:6) can, therefore, be a mere excuse to protect the country's interests.

As a matter of fact, the current magnitude of global migrations, whose reasons are manifold and interrelated, questions the narrowness of this concept of a refugee. This is what can be read into the following statement:

“Because of the close relationship between political conflict and economic and social problems, it is sometimes difficult to distinguish between refugees and migrants” (Loesher, 1993: 6).

The complexity related to the definition of the 1951 UN Convention does not deprive Congolese in London of refugee status. For they have grounds to demonstrate individual persecution. In addition, the fact that political factors have an impact upon individuals' social and economic life cannot be denied (Ferris, 1993:12). The ethos of Mobutu's regime, sustained by its allies (Kelly, 1996), conditioned the social and economic crises whereby individuals were deprived of their fundamental rights (Shatzberg, 1991). Thus, against the bogus economic migrant discourse, it can be argued that poverty is endemic to political factors whereby the interests of a particular group, class or race are sustained. As such, poverty is a political issue. It is a form of oppression and injustice. It is a vicious political tool to oppress those who are not members of the ruling or governing class. This concept of poverty as a man-made reality can be grasped in Rousseau's concept of moral or political inequality. Distinguishing it from natural or physical inequality, Rousseau defines moral or political inequality as that which:

“...depends on a kind of convention, and is established, or at least authorized, by the consent of men. This latter consists of the different privileges which some men enjoy to the prejudice of others; such as that of being more rich, more honoured, more powerful, or even in a position to exact obedience” (Rousseau, 1973: 44)

3.4.2 The phenomenon of exile in the Congolese context

Exile is a recent phenomenon for the Congolese. It dates from the postcolonial era, mainly at the beginning of Mobutu's regime. It rose in importance since the late seventies. From this time the option for exile was no longer the reserved

domain of the Congolese intelligentsia, businessmen and political opponents, but everybody's desire and reality (Tipo-Tipo, 1995:52)

Congolese nationalism and the Congo's physical and social capacity to accept refugees from surrounding African countries have always been advocated as reasons for Congolese not to go into exile. Congolese nationalism, as incarnated through Simon Kimbangu and the Kimbanguists (Simbandumwe, 1992), Kasa-Vubu and the ABAKO (Van Lierde, 1994), Lumumba and the M.N.C, before and five years after the independence, claimed the repossession of the land. The presence within the Congo of multitudes of West African and Angolan refugees sustained the Congolese view of their country as worth recapturing and dying for. The Congolese reminiscent discourse of that era is portrayed through the Congolese oral poetry: '*A l'époque qui avait l'envie d' aller ailleurs sinon, voir Leopoldville et mourir?*'³ (Who in the past dreamt of going outside of Congo while every body dreamt of seeing Leopoldville (Kinshasa) and die).

The above reminiscent discourse sustained Congolese nationalism, according to which it was believed: '*Extra Congo, nulla salus*' (Lat) to mean, outside Congo, there is no salvation.⁴ This colonial nationalist sentiment has given in to the current paradoxical experience. While an important number of Congolese long for exile, their country is still a place of exile. As reported by the U.S Committee for refugees:

"Zaire has hosted about 455,000 refugees at the end of 1996: an estimated 200,000 from Rwanda, some 100,000 from Angola approximately 100,000 from Sudan, about 40,000 from Burundi, and some 15,000 from Uganda" (U.S.C.R, 1997: 1).

However sustainable the Congolese reasons for the non-option of exile before the second republic, there is an argument that travelling to a foreign country was prohibited. Belgian colonial authority suspected that Congolese travelling abroad might learn what could enhance their process of undermining the colonial authority (Kanza, 1972: 39). Nevertheless, whatever factors prevented

Congolese in the colonial era from going into exile, reasons that will be discussed in section 3.4.3.2 (p.78) are the basis of the current phenomenon of exile of Congolese.

3.4.3 Congolese reasons for exile to Britain and the motives for their exile

3.4.3.1 The option for Britain

Britain has become the Congolese country of choice for asylum. This is related to factors of opportunity and safety/security. This is what the following statement confirms:

“Two reasons why more Zaireans have fled to Britain recently are that refugees fleeing from ethnic conflict in Shaba travel via Zambia, and there are more flights to London from Zambia, than there are to Brussels or Paris. It is believed that the SIE operates in France and Belgium, and there are allegations of Zairians being kidnapped from these countries and forcibly returned. Zairians also believe racial harassment is worse in France and Belgium than it is in London” (R.C#11, 1993: 2).

The question of safety or security has been crucial for many Congolese who have been exiled to Britain. The despotic regime of Mobutu represented a threat to Congolese refugees in neighbouring countries, as well as in French speaking European countries. There have been systematic kidnappings of Congolese in those countries. For instance, in order not to jeopardise its economic interests from Mobutu's investments, the Swiss government opted for a massive deportation of Congolese refugees in 1985. The Asylum Aid study on Zairians' experiences in the U.K. reports that the historical ties between France, Belgium and Mobutu had led to the rejection of Zairians claims for exile in those countries (A. A, 1995: 22). Thus, there is a significant rate of those who came to London after being rejected by immigration or refugee services in other European countries. This phenomenon was widespread between 1991 and 1994, a period characterised by increasingly restrictive immigration policies in France, Switzerland and Belgium. This can be substantiated by the following account:

Case study 3.1 The Mpembele' story of exile

A.N.N: Mpembele, can you tell me about your exile experiences.

Mpembele: It is a long story that would take days. It is an experience of sixteen years

A.N.N: What I would like to know is how did you get to Britain from the Congo?

Mpembele: Berthe, my wife, and I got to Brussels in April 1981. We applied for political asylum one week after our arrival.

A.N.N: Why did you not apply at the airport?

Berthe: We had to learn from friends how to apply. (Basengaka yango ngulu ngulu te)⁵

A.N.N: What happened?

Mpembele: Six months after we were told to get out of the country.

A.N.N: You were not deported?

Mpembele: In those days, the Belgians used to tell people in advance that you have to leave the country. For fear of being deported we decided to go to Switzerland.

A.N.N: How did you get there?

Berthe: It was not easy but finally we got there with new names. We applied and lived in Geneva. In 1983 our first child was born. We decided to find a one bedroom flat since we lived in a very small studio. It is while we moved to our new home that the police and the Immigration services got interested in our case.

A.N.N: How?

Mpembele: A quick arrangement was made by the immigration officers to interview us about our case. On May 1984, we received a letter saying that we had to leave Switzerland. There was no time to waste knowing how the Swiss government of those days was dealing with the Congolese. There was no need to appeal. Some of our friends were deported while in their process of appealing.

Berthe: (Quick intervention). In fact, we were wise and predicted the coming massive deportation of the Congolese by the Swiss government.

Mpembele: With our baby, we decided to go out. We entered France, where we spent about ten years. We had two of our children born in France. In July 1985 we were in France. We applied for political asylum in Paris. Our application was rejected and we moved to Strasbourg where it was accepted. For ten years we never had refugee status. The coming to power of 'la droite/Gaullist' brought despair. We knew that it was our end. Our 'demande d'asile' asylum was finally rejected. We decided to move to another country. We originally thought to go to Canada but we ended up in Britain. We have been here since January 1997.

Their history shows the type of exile trajectory that is the experience of many Congolese. Not only that their journey seems to be unfinished but its

imperatives require the changes of identity (names, civil status, date of birth). Where their next direction will be and what their next identity will be is unknown. They still wait to hear from the Home Office.

Concerning the opportunity factor it should be noted that many Congolese in Britain have traveled via African English-speaking countries where Mobutu's influence was thought limited. Nigeria, Kenya, Zambia, Tanzania and South Africa are in this case the most important ones. The U.S Committee for Refugees states that at the end of 1996 there were 40,000 Zairian refugees in Tanzania, about 20,000 in Zambia and several thousand in South Africa (U.S.C.R, 1997: 1). While some have been accepted in these countries as refugees, those for whom the right has been refused had no alternative but to take the first opportunity to escape from Africa. Given the preponderance of British airlines in these countries there is no other choice than that of flying to Britain.

Case study 3.2 Tshimbombo' story of exile

A.N.N: *Tshimbombo how did it happen for you to be exiled to London?*

Tshimbombo: *I have never thought that one day I would be in London. I am from the oriental Kasai region. I was born and grew up in Kinshasa. (He gave me the address). After my secondary school, my parents decided to send me to L'universite Officielle de Lubumbashi. In 1991, we were involved in campaigns against Mobutu's regime within the university. Mobutu's commandos, who had already killed tens of our colleagues invaded the university. Some friends and I managed to escape to Zambia. We got to Lusaka where we stayed for a year and a half. Conditions were harder in Zambia. We managed to have some work. We taught French in order to survive. The presence of Mobutu' system was felt in Zambia. We decided to get out to South Africa. We were informed of the mighty presence of Mobutu' system in South Africa. We therefore decided to exile to Britain. This was the only option...*

The opportunity to travel to Britain for reasons of exile has been higher among Congolese from Eastern and Southern regions. This is due to their proximity to countries such as Uganda, Rwanda, Tanzania and Zambia which they could get to either by car or trains.

3.4.3.2 Congolese reasons for exile

The incessant socio-economic and political instabilities in Zaire/Congo together with the psychological and physical threats are reasons for their exile. There is a higher rate among Congolese refugees of those who have been directly victims of physical abuses by the regime system. Motives for their arrest included mainly opposition to the regime's ideology and ethos. A Medical Foundation study of 92 Congolese asylum seekers indicated that all of them had been subjugated to 'ill-treatment from Zairian security forces, 78% still have scars of tortures, eighty one of them experienced prison while twenty eight of them experienced prison more than once' (M.F, 1995: 3). This can be supported by special pastoral counselling sessions, which took place in 1993 within *la Alpha* Church. These sessions indicated that 54% (63 members of the then 117 members) of *la Alpha* Church's members had been physically abused by representatives of Mobutu's regime. These special counselling sessions were conducted following massive psychological trauma manifested by many of the church members. This pastoral exercise disclosed that sexual and physical abuses under the regime had severe pathological effects of which this 54% of *la Alpha* Church longed to be healed.

What is to be added in relation to physical abuses in the Congo is the fact that these vicious tortures represented means of surveillance/control (Shatzberg, 1991: 31) of the majority of the Zairians by the government. Carried out by specially appointed services, they ensured the survival of a regime based on an emerging kleptocracy. In the case of *la Alpha* Church, only pastoral counselling sessions helped to restore and create a psychosocial balance for those who constantly said that their dignity had been stolen or lost.

Unlike members of the Congolese petty bourgeoisie and political class, the Congolese lower class does not separate political reasons from social and economic. Though many of this lower class have been subjected to systematic physical and psychological abuse (Shatzberg, 1991: 30), they nevertheless give

political meaning to their social and economic experiences. They argue that they are political in that they are the outcome of the ethos and politics of the dictatorial regime. This is what is demonstrated by these collected fieldwork accounts.

Case study 3.3 Kiala' s account of asylum

A.N.N: *Kiala how long have you been here?*

Kiala: *I have been here since 1992.*

A.N.N: *What are the reasons for exile?*

Kiala: *(He laughs) You ask me the reasons of my exile? (The phrase suggested that as a fellow Congolese I should know the reasons of his exile, because he assumes they are common to all of us).*

A.N.N: *Yes.*

Kiala: *Suffering, oppression, hunger, and all those calamities caused by the regime are the grounds for my exile.*

A.N.N: *You have never been personally directly, physically or morally oppressed by those at the service of the regime?*

Kiala: *What are you talking about? Do I need to see a gun pointed at my head to prove that I am persecuted by the regime? Are not the socio-economic deterioration of the country, the psychological pains of not speaking my mind against the regime, the systematic beatings and kidnapping of friends sufficient in order to prove that I deserve to apply for political asylum?*

A.N.N: *What did the Immigration Officer decide in your case?*

Kiala: *All is up to them. Is there something they believe from us? They never believe in our pains. You must have directly worked with Mobutu, like the former Minister Ngunza-Karl-Bond, to be considered as an authentic refugee. My four friends Mbeki, Salomon, Djo-Mali and their sister Nkembo have been arrested by Mobutu militia for having opposed the appropriation of their house by a General from Mobutu's tribe. Their family is still in prison. However, neither them nor I have ever been granted a status. We have been here for five years now.*

A.N.N: *What happens if the Home Office turns you down?*

Kiala: *I will not go back home.*

A.N.N: *What will you do?*

Kiala: *I will appeal*

A.N.N: *If the appeal fails?*

Kiala: *I will still not go home...*

Congolese difficulty in distinguishing political reasons from social and economic ones derives, as will be seen in chapters five and six, from their concept of health. In their minds, the dichotomy of economic, social and political reasons

is purely for an academic (Dorlodot, 1994), administrative or functional purpose. Their grounds for asylum are the threat to their wellbeing.

To summarise arguments about reasons for Congolese exile in London, the following should be stressed: socio-economic and political instability as well as psychological and physical threats are causes driving Congolese into exile. In fact, it is being argued that the post-Mobutu era shows no signs of stability or restoration of people's lost dignity. The violent circumstances which led Congolese into exile during Mobutu's reign still exist. Inhumane treatments of citizens by the new political leaders are reported to be the current Congolese experience (H.R. W, #9, 1997: 16). As Amnesty International have noted:

“Since it came to power in May 1996, the AFDL government has committed numerous human rights abuses against critics of the government and representatives of civil society, including church leaders. Hundreds of people are reported to have been arrested. Dozens of people have disappeared or have been extrajudicially executed” (A.I, #28, 1998: 1).

3.4.4 The demography of Congolese refugees in London

The geographic distribution of Congolese refugees is quite difficult to imagine. Congolese refugees are scattered throughout London. However, based on the geographical distribution of members of both *la Alpha* and *la Beta* Churches, it can be asserted that a vast majority of Congolese come from North & East London. This would concur with Carey-wood et al.'s (1995) observation that 85% of refugees in Britain live in London and that the vast majority (66%) had settled in inner London 'of which the northern sector has the largest concentration (17%)' (Carey-Wood et al., 1995: 103).

The background of Congolese Refugees in London varies on ethnic, social and political affiliations. They represent the mosaic of cultural ethnic diversity among the Congolese whose main important medium of communication remains *Lingala*. This must be stressed given the inconsistency in education (R.C, #11, October 1993:2) and regional distance which make the use of other national

languages, (*French, Kikongo, Tshiluba, Swahili*), difficult for the majority of Congolese. Socially, most of the Congolese refugees would represent the deprived class created by the three decades of Mobutu's regime. Economic factors were thus conditions for knowing these languages.

As I indicated in section 2.3.3.2 (p.44) my surveys indicate that the Congolese refugee community in London consists of a population that is relatively young (Appendix I, p. 274-278). The dominant age group is between twenty and forty years old. Whilst Congolese refugees are predominantly from the Congolese economic and social disadvantaged class, there are among them those with professional and academic qualifications. Their national political affiliation or orientation depends either on their ethnic origins, or on the basis of their personal ideological preference. In this particular context, I would define Congolese refugees' relations as 'associative relationships' (Weber, 1947: 136). Depending on the interests of the group, these relationships might be either closed or open (Weber, 1947: 139). For as said above, some of these groups admit people on the restricted basis of the same ethnicity, political ideology, school and regional background. Such groups would include the Association of Bakongo peoples, Association of Bangala peoples, Association of Peoples from Lemba Zone, the Association of Peoples from Bumbu, etc. It must, however, be mentioned that despite the complexity of relationships that might exist in the Congolese refugee community in London, they are nevertheless united by the fact that they came to Britain to apply for political asylum. This is what some of the case studies to be evoked in this chapter will be stressing.

Based on the revised government statistics of August 1997, the Refugee Council notes that since 1986, 14,266 Congolese have applied for asylum in Britain. This is what is presented by the table below which provides a formal division of this figure by year.

Table 3.1. Numbers of Congolese asylum seekers in UK, 1986-1996

1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	Total
26	53	157	525	2590	7010	880	635	775	935	680	14266

Source: The Refugee Council, (1997, p94)

The table indicates that the first arrivals of Congolese in Britain are dated from the second half of the 1980s. There is a phenomenal increase in number in the first three years of the 1990s. The period from 1993 to 1996 is characterised by a decline. This factor, as it will be said further, is related to the policies of the Conservative government towards Congolese applicants. Surprisingly, on the European scale the United Kingdom is said to have received more Congolese than any other country. This is verified by the UNHCR' s report:

“During 1994, some 9,300 Zairian nationals sought asylum in Europe, some 25 per cent less than the year before. The total of some 74,000 Zairians who applied in Europe between 1990-1994 constitutes almost three percent of all asylum seekers in Europe. Applications were mostly received by the United Kingdom (24%), France (23%), Germany (22%), and Belgium (17%)” (UNHCR, 1995: 5).

The following table shows the Home Office treatment of the Congolese cases during that period.

Table 3.2. Asylum Statistics, Decisions. 1986-1996.

	Total decisions	Granted Refugees Status	ELR	Refused After full consideration	Safe third country refusal	Non compliance refusal	Backlog
1992	4825	10	10	95	70	4645	4320
1993	1715	5	10	195	30	1470	3515
1994	700	10	5	260	40	385	3575
1995	935	15	15	480	60	365	3560
1996	1075	15	35	900	75	50	3150
Total	9250	55	75	1930	275	6915	

Source: The Refugee Council, (1997, p94)

Table 3.2 indicates the three main categories of people generally termed as refugees. These are asylum seekers, holders of Exceptional Leave to Remain and those with refugee status. Asylum seekers are those whose cases have not been decided upon yet. A standard acknowledgement letter is given to them (R.C,#1, 1994:2). Holders of Exceptional Leave to Remain are people whose cases have been rejected. However rather than being deported to their countries, they have been accepted on humanitarian or compassion grounds (R.C,#1, 1994: 5). Those to whom a status has been given are officially described as refugees. They are thought to have met the requirements of the 1951 Convention of Geneva.

In fact, Table 3.2 indicates that at the end of 1996 there were 65% of decisions of the 14266 Congolese asylum seekers in Britain. Of this percentage, 0.6% were granted refugee status, 0.8 % were given Exceptional Leave To Remain, 20.8% were refused after full consideration, 3% were sent back to the safe third country and, 74.8% were refused on the ground of not attending meeting with immigration officers. Applied in the context of the two churches, the following statistics are elaborated. In 1997, for the 140 members of *la Alpha* Church, 94.3% had Temporary Admission (standard acknowledgement letter) and 5.7% cases had been heard and refused the status. The situation in *la Beta* Church was that 88% of its members had Temporary Admission, 3% were given Exceptional Leave to Remain, about 1% with refugee status and 8% cases were refused. Numerically, the situation presented itself as follows.

Table 3.3 Home Office decisions in the context of *la Alpha* and *la Beta* Churches, 1997.

<i>Churches</i>	<i>Number</i>	<i>Temporary Admission</i>	<i>Exceptional Leave to remain</i>	<i>Refugee Status</i>	<i>Refused</i>
<i>Alpha Church</i>	140	132	-	-	8
<i>Beta Church</i>	260	228	7	3	22

It is worth noting that 65% of the members of these churches have been in the UK for more than five years. Nevertheless, the statistics for the distribution of Congolese into different categories have changed considerably since the coming to power of the Labour Government. Labour's Immigration and Asylum White Paper of 1998 proposes to:

"- let over 10,000 asylum seekers who have been waiting for a first decision from the H.O since before 1st July 1993 settle in the UK by giving them Indefinite Leave to Remain (ILR). This excludes any asylum seeker who made a claim between those dates but who has received a first negative decision from the HO.

- give asylum seekers who claimed asylum between 1st July 1993 and December 31st 1995, and who are waiting for a decision from the HO, grant of 'Exceptional Leave to Remain (ELR)', which will be

considered on an individual basis, taking account of the delay, compassionate and other exceptional factors. Perhaps 20,000+ people will fall into this category.” (RC, July 98, Briefing: The Immigration & Asylum White Paper’: p4).

3.4.5 Home Office policies and the Congolese refugees

The Home Office policies towards Congolese have been described as unfair by organisations such as the Medical Foundation (M.F, 1995: 19), Asylum Aid (A.A, 1995) and the Refugee Council (R.C, #11, 1993). The uncompromising statement of the Refugee Council on this is as follows:

“The treatment of Zairians by the Home Office is of great concern to the Refugee Council. Zairians are detained with regularity disproportionate to their numbers. One recently attempted a suicide, while being detained at Canterbury Prison. The Home Office gives no reasons as to why they are more likely to be detained than other nationalities. Prejudice may account, press articles in early 1992, in the run up to the General Election and a Government effort to rush through the first version of the Asylum Act, have not enhanced the reputation of Zairian asylum seekers” (R.C, #11, 1993:2).

Asylum Aid has denounced the Home Office treatment of Zairian refugees in similar terms. This is what is written:

“Zairians have borne the brunt of the Home Office’s negative policies towards asylum-seekers. Hundreds, even thousands, of Zairian refugees living in the UK are being threatened with return, either imminently or eventually...”(A.A, 1995:1).

Backlog, deportations, detention and reporting regularly to the police were common experiences among Congolese in London. While some deportations occurred as soon as an individual entered the country, some occurred from the detention centres, at the police station or from places where an individual lived. The following accounts bear witness to the existence of these three phenomena among Congolese refugees.

Case study 3.4 Zola and Makambu’s detention

Makambu and I are ‘companions de lutte’, struggle companions. We met in Dar-es-Salam where we discovered that we come from the same ethnic background. We told each other stories and found out that his father like my elder brother were among many Congolese kidnapped by Mobutu’ security

officers and of whom no family members have a knowledge of their location. Makambu and I traveled to London by British Airways. As we got at the airport, as advised by friends in Tanzania, we applied for political asylum. That was in June 1993. We were interviewed for about three hours and later put in a room with the hope that we be shown where to live in London. Around 2 p.m four men, two of those who interviewed us, came with four other persons to whom we were yielded. We were under such security and taken to a hidden entrance where we were told to get in a big car. As we got in I realised that this was it. I told Makambu that we had been arrested and I suspected that we were being taken to a detention centre. I asked Makambu if he had noticed that the car we were in resembled the cars we had seen in the movies in which prisoners were carried. In fact, I was right. As we got to our destination, we could hear big gates opening and found ourselves in confinement. We were put in our cell. That was Haslar where we spent nine months. Our release was a miracle since we met fellow Congolese who have been there for one year and saw others being deported to the Congo. For more than six months, we regularly reported to the police. At times, the police used to phone us at the hostel, checking whether we were present.

Still, the treatment of Congolese asylum seekers in detention has been of much concern by humanitarian organisations (R.C, #3, 1995:3). As Zola's account shows, it can be confirmed that many Congolese were put into detention without clear knowledge of their destination. It is not until that they are surrounded by police and put in a 'penitentiary van' that they suspect the beginning of the process of their detention and what is happening. In October 1991, Omasese Lumumba was killed while in detention in Pentoville Prison. This was caused by systematic submission to inhumane methods of control. Omasese Lumumba, according to the British Amnesty International report:

“...sought asylum in England in September 1991 and was detained. From 19 September until his death on 8 October 1991, he was locked in a prison cell for more than 20 hours a day and was in a depressed and anxious state. Omasese Lumumba died during a struggle when prison staff involved attempted to forcibly remove his clothing. According to the prison doctor, the prison staff continued to restrain him after his body had gone limp” (AI, newsletter, 1993: 24:1).

Congolese maltreatment in Britain's detention is not to be restricted to immigration officers. Fellow inmates also subject them to inhumane treatments. This is what is contained by the following account:

“Zaire, March 1994, 5 am. Security forces burst into Kalala’s parents’ house. His ‘crime’? Taking part in an opposition party demonstration the day before...

Kalala is thrown into a cramped prison cell with four other men. Every four hours the cell falls deadly quiet. A rattle of keys. A shaft of light. For a heart-stopping moment each of the five men shake with terror...

Three times a day Kalala is summoned for ‘questioning’. The interrogation is never predictable. One day a beating with a two-foot truncheon. The next Kalala is kicked and punched. On other days electric shocks to his genitals. The pain is terrible. For hours afterwards he has no feeling from the waist down...

Kalala is eventually released. This is his fifth incarceration, so he decides to flee Zaire and arrives in Britain by boat. He can’t prove to the British immigration officer who he is or why he is fleeing Zaire. He barely speaks English at all...

For this, Kalala is imprisoned for six months. He has left a torture chamber for a prison cell in Britain. In neither case has he been tried or convicted of a crime. *Instead of the refuge he sought, he finds himself in a cell with convicted criminals who subject him to insults and racial abuse*” (HRF, July, 1999, Vol, 1, Issue 1).

Depression and disorientation among those who have experienced or are experiencing detention are noticeable. In addition, frequent suicidal tendencies among them have also been symptomatically revelatory of their disoriented existence. The Refugee Council’s reports on an Algerian detainee case supports this reasoning:

“An Algerian asylum seeker, who was detained in Campsfield House, was moved to HMP Wandsworth because Immigration Officials decided he was ‘an exceptional suicide risk’. After 4 months in Wandsworth, he sent a letter to Amnesty International, which stated, ‘Today is my birthday and I’ am in such a hopeless situation that I wish I was never born, and I did nothing to deserve it, I only wanted peace and to be free. This prison, without hope and faith to survive, is hell. Please help me” (R.C #3, Feb, 1995:2).

Congolese former detainees describe detention as a place of total isolation. It is a ‘*Kafela*’. *Kafela*, being an isolated island in the Congolese Equatorial forest where Mobutu used to send most of his opponents. It is a place of uncertainties or many risks. Congolese refugees’ lack of sufficient proficiency in English

makes it so impossible to communicate that nobody knows what is coming next. Also, the lack of a linguistic medium has led to the conditions of not knowing the main reasons for being detained. This corroborates with the fact that detainees are, at times, denied a full explanation for their detention as well as medical assistance (RC#3, 1995:3). In fact it is observed that:

“Detention might also be used as a deliberate deterrent. A detainee rarely receives information about legal rights or when he or she will be released. Detention is a profoundly disorientating experience, particularly if a person has been imprisoned in his or her home country” (R.C, 1993, #11:2).

Case study 3.5 About systematic reports to the police

Marc: *I applied for my political asylum at Dover in 1993. I was kept there for a night. The following day I was given a Hotel address in Bayswater to stay and was told to report once a week at the nearest police station. For two years I reported regularly each Monday until I went to court to be heard.*

A.N.N: *How did you feel whenever you went to report to the police?*

Marc: *It is a traumatic situation. You never know what will happen at the police station. There are some who, as soon as they got to the police station, were detained and deported. This is the case of two fellows who lived in the hotel next to ours.*

It was between 1991 and 1993 that a good number of Congolese were subjected to the discipline of reporting systematically to the police. Anyone who had to report to the police was assigned a particular time and a day in the week to present himself/herself at the police station. As Marc's account points out, as in the case of detention, this is a moment of uncertainty. One can be either detained or deported. The police acted upon the decisions given to them by the immigration officers. In fact, it was part of the pastoral practice in *la Alpha* Church to offer moral and legal guidance to those who during the following week had to present themselves to the police. Often, the church provided friends who accompanied them so that in the case either of deportation or detention, the church was informed of what happened.

The Labour Government's approach to addressing the backlog of asylum seekers (R.C, July, 1998:4) has been interpreted by the Congolese as some liberation from some aspects of the inhumane conditions of their existence in Britain. Though under Labour the situation is far from improved, an important number of Congolese, those who have been here more than seven years, have been granted an Exceptional Leave to Remain. The danger of being deported, reporting systematically to the police and being detained has decreased. However, it should be mentioned here that the drastic measures of the new Immigration and Asylum Bill of June 1999 have worsened the conditions of many Congolese asylum-seekers. To illustrate, however the length of their stay in Britain, asylum seekers are no longer beneficiaries of Local Educational Authority grants. Those who have applied for asylum inside the country (outside of the ports of entry) depend on the restricted diet of vouchers as imposed by the new immigration and asylum bill (A.A, 1999). In fact, Labour policies in dealing with Congolese refugees represent 'another reworking of social inequalities' (Gamarnikow & Green, 1999: 60) in the history of Congolese existence in Britain. The main characteristics of this new Bill are summarised as follows:

"Part VI of the Immigration and Asylum Bill introduces a new support scheme for asylum-seekers. The scheme is intended to be so harsh as to deter applications for support. Under the new scheme, asylum-seekers including families with children will no longer be entitled to receive welfare benefits but will receive food vouchers and be forced to subsist at a level of income 30% below Income Support levels. Asylum-seekers will also be sent to live in areas of the country where there are no support services for refugees, such as legal advisers, specialist medical and counselling services, interpreting services, community groups etc" (A.A, U.A, Oct/Dec, 1999).

In fact as far as Congolese asylum-seekers are concerned:

"The Home Office has stated that it will begin returning failed asylum seekers to the Democratic Republic of Congo (former Zaire) and Angola. This is despite serious concerns for the safety of returned asylum-seekers in these clearly war-ravaged countries" (A. A, 1999: 3).

3.4.6 Considering the validity of Congolese refugees' grounds for exile

Studies by institutions such as the Medical Foundation (1995), the Refugee Council (1993), Asylum Aid (1995) and Amnesty International to which I have referred in section 3.4.3.2 (p.78) suggest the extent to which Congolese claims of asylum fall into the category of the UN 1951 definition of a refugee in terms of fear for persecution (section 3.4.1; p.72). I concur with their findings, as demonstrated in section 3.4.3.2 (p.78), on the basis of counselling observations conducted in *la Alpha Church* in 1993. I mentioned the nature of persecutions to which many of the Congolese exiling in London were subjected. For this reason Schatzberg has not hesitated, in his analysis of the socio-economic and political conditions of the Congo, to describe Mobutu's regime as 'bandit' (Schatzberg, 1991: 52). For persecutions (tortures) in the Congo were useful tools for the aggrandisement of the kleptocracy. The establishment of a tyrannical regime in 1965 imposed a culture of total submission. Persecutions or tortures were not only physical. They involved the Congolese in their wholeness. This autocratic culture is an unending tragedy for Congolese. It is presently manifested through abusive multiple arrests and civil war (A.I, #28; 1998). Hence the significance of Turner's thought according to which:

“...it is not merely the survivor of torture who suffers and in fear may be driven into exile. The systematic and repressive nature of the violence affects all people who share an ethnicity, religion, or political ideology with the immediate victim” (Turner, 1995:56-7).

Thus, I dispute the description of Congolese seeking asylum in Britain as bogus economic migrants or refugees. They are refugees in the sense given by the 1951 Convention on Refugees and the Universal Declaration of Human Rights. Congolese seeking asylum in Britain fall into the category of those whom the Geneva Convention describes as people without the protection of their own country (Mole, 1997:13). To express it in Fanon's terms, they are 'the wretched of the earth' (Fanon, 1963). Consequently, the bogus economic migrants discourse with which Congolese refugees are greeted in British social circles should give place to the pedagogy of articles one and fourteen of the U.N

Declaration of Human Rights to which the United Kingdom is a signatory. This is the practice of the ethic of justice and moral imperatives.

In fact, in the light of arguments on the identity of poverty (section 3.4.1; p.72-73) and the *raison d'être* of Congolese refugees in London (section 3.4.3; p.75-80), the theory of 'bogus economic migrants' blurs the whole process of addressing the main causes of the contemporary phenomenon of refugee. Instead of using a demeaning discriminatory language, host countries should focus on the main causes. To illustrate, Western host countries like the United Kingdom should learn from such views as Kung's theological political reflections, according to which he claims that:

"We have failed, because we have caused wars and not exhausted all the possibilities of devoting ourselves to mediation and reconciliation. We have excused wars and often too easily justified them.

We have failed, because we have not questioned decisively enough the political and economic systems which misuse power and riches, which exploit the natural resources of the world only for their own use and perpetuate poverty and marginalization.

We have failed, because we have regarded Europe as the centre of the world and have thought ourselves superior to other parts of the world" (Kung, 1991: 65-6).

On the basis of the Human Rights declaration and the causes of poverty, it would follow that fundamental rights such as health and education of Congolese refugees should be safeguarded by the British Government. Assisting refugees on issues of health, education and housing is guaranteed by the twenty-fourth article of the 1951 United Nations Convention of Refugees and the twenty-fifth article of the Universal Declarations of Human Rights. In fact, the self-evident status of these basic human needs as human rights is conspicuous. Not to meet these needs is to jeopardise people's whole existence. For they are intrinsically related to the fact of being human. This concurs with the Ottawa

Charter's views on the prerequisites for health (Baric, 1995). Thus the significance of Weil's thought according to which:

"The object of any obligation, in the realm of human affairs, is always the human being as such. There exists an obligation towards every human being for the sole reason that he or she is a human being, without any other condition requiring to be fulfilled, and even without any recognition of such obligation on the part of the individual concerned" (Weil, quoted, in, Hausermann, 1988: 131).

The ethic of justice and moral imperatives would constitute, to use Turner's words, 'a positive and enabling approach' (Turner, 1995: 69) for the Home Office to Congolese refugees. It aims at a total eradication of traumatising, marginalising and oppressive policies. The pursuit of justice in Home Office policies towards Congolese refugees falls into the category of what Kung describes as one of the requirements of contemporary society (Kung, 1991: 67).

While vindicating the rights of Congolese refugees on the basis of the 1951 Geneva Convention of refugees and the Universal Declaration of human Rights, the following can also be said. No critical gaze at the historical political development of the Congo would support the applicability of the bogus economic discourse to Congolese exiling in London. This is the case of the accusatory discourse mentioned in section 3.2 (p.67-68). Instead, they would speak of Congolese refugees as being victims of policies conceived and structured in the higher loci or fora where Congolese interests are jeopardised by the egocentric discourses (Ela, 1986:139) of the powers that be. They are the outcome of perennially inhumane, amalgamated policies of colonialism, neo-colonialism, cold war and capitalism. This can be sustained given the fact that the reasons resulting in exile of most Congolese in Britain are hardly related to ethnic conflicts. I, therefore, concur with the Asylum Aid conclusion on the Home Office policies towards Congolese refugees that:

"Fair decisions cannot be possibly made whilst officials act on the principle that refugees are seeking primarily to evade immigration controls and that the majority are 'bogus'. The assumption that refugees are inherently mendacious has no place in a fair asylum procedure. This can be seen by the readiness of the Home Office to

reject even people who have clear marks of torture, or who have given convincing, even documented, accounts of having been imprisoned for political reasons” (A.A, 1995: 29).

3.4.7 Congolese refugees and Education

Congolese, like any other group of refugees, have a right to education (Carey-Wood et al., 1995). While there are adults who have never registered for studies, most Congolese refugee children attend schools. There are some families whose children have not been able to attend schools, for a term or two, for reasons related to distance and housing. The question of temporary accommodation, be it in a bed and breakfast environment or a temporary house has been evoked by Power et al (1998:39) to have an impact on the education of refugees’ children. Schools endeavours to assist refugee children to acquire linguistic skills have equipped Congolese families with communicative power. As will be seen in chapter seven, children have become the most relevant translators and interpreters between doctors, social workers and members of their families.

However, my fieldwork shows that a significant number of Congolese adults have not been able to pursue academic studies for essentially financial and status related reasons. With regards to fees, the policies of grants as encapsulated by the Refugee Education and Training Advisory Service in the table below, bear witness to my reasoning (WUS, UK, October 1997).

Table 3.4. Table showing the legal status and educational entitlements for refugees and asylum seekers.

LEGAL STATUS AND EDUCATIONAL ENTITLEMENTS

LEGAL STATUS	BENEFITS	COURSE FEES	GRANTS
ASYLUM SEEKERS	If eligible-receive 90% Income support (and other benefits) if studying part – time.(1)	Currently pay overseas student fees unless 'ordinarily resident'.(2) From September 1998: overseas fees, even ordinarily resident.(3)	Ineligible regardless of the length of their residence in the UK.(2)
EXCEPTIONAL LEAVE TO REMAIN (ELR)	Job seekers Allowance + Housing Benefit for part-time study.	Pay home student fees. (5)	Must be 'ordinarily resident' in UK for 3 years before start of course. (2) and (5)
REFUGEE STATUS	Job Seekers Allowance + Housing Benefit for part-time study.	Pay home student fees. (5)	Eligible for a mandatory award.(5)

Source: RETAS, WUS, UK, (1997,p.1)

Notes related to table 4.4.

1. **Part-time study:** Courses up to 21 hours per week for Higher Education or ESF funded-courses or 16 hours per week for Further education are usually considered to be part-time. Asylum seekers who are single parents, receiving disability benefits or attending government training may receive Income Support whilst studying full-time if entitled to benefits. Since February 1996, "in country" asylum applicants, and those appealing against refusal of asylum, are no longer eligible for state benefits.
2. To be "**ordinarily resident**", you must have lived in the UK lawfully, for a settled purpose other than full-time education, since the 1st September 3 years before the start of the course. An additional criterion, requiring "**settled status**" as well as 3 year's residence, has come into effect in September 1997 for Mandatory Award eligibility, and will be coming into effect from Autumn 1998 for home fee entitlement.

3. Some universities and colleges may agree to charge asylum seekers at the home rate of fee for part-time courses. Asylum seekers receiving state benefits qualify for **concessionary fees**.
4. Mandatory Awards are only available for full-time first degree courses, HND's, DipHEs and some part-time postgraduate teacher training courses.
5. The wife/husband and children refugees and those with ELR have the same entitlements to home fees and Mandatory Awards as their spouse or parent. (*Information from the RETAS leaflet, WUS, UK, October 1997*).

The content of the RETAS table indicates that the access of many Congolese refugees or asylum seekers to education is problematic. For, though many Congolese could fall into the category of Home students, the question of funding to ensure their fees remains one of the major barriers. This is what is demonstrated by Mpemba's account below:

Case study 3.6 Mpemba's account about studying

A.N.N: *Mpemba, what are you studying?*

Mpemba: *I would like to pursue my studies but this does not seem possible.*

A.N.N: *Why not? You have a right to study.*

Mpemba: *I already have a first degree from the Congo. What I want is to do some studies in psychology in one of the Universities. Four years ago I went to the W.U.S who deal with those in my category of asylum seekers. They advised me to wait for three years. I went last year to be told that grants were very limited. I do not know what to do. They advised me to try with my Local Education Authority. I went for the interviews but no grant was found for me. I am very despondent and disoriented. I do not know what to do.*

A.N.N: *Why not to take vocational or some other courses which do not require much money?*

Mpemba: *Do I have an option? This is what I have been doing since I have been here. I know that there are those who have obtained grants for studies but, things have not worked out yet for me.*

A.N.N: *Keep hope...*

Like Mpemba, to avoid an intellectual lethargy most Congolese refugees have opted to continue English or vocational courses. For in some schools with these courses, the acceptance of refugees and asylum-seekers has become a tradition. The consequence of this is outstanding on the social, physical and psychological aspects of Congolese refugees.

A number of Congolese have been accepted in higher education. These are among those who have loans or grants from the government or the LEAs. The table below applies this education reality in the context of both *la Alpha* and *la Beta* Churches.

Table 3.5 Members of *La Alpha* and *la Beta* Churches attending Colleges and Universities. 1997 M= Male F= Female G.T = General Total

Churches	Number of Adults studying		Further education Colleges		Higher education		G.T
	F	M	F	M	F	M	
Alpha Church	26	18	26	13	-	5	44
Beta Church	49	34	47	27	2	7	83
Total	75	52	73	40	2	12	127

3.4.8 Congolese refugees and employment

Though six months after their application, refugees can apply for a work permit, unemployment is endemic among them (Carey-wood et al, 1995: 29). Neither expertise nor education can easily serve as a means for their upward social mobility. Downward mobility is their general condition and social security and casual jobs remain their main economic income sources. Most Congolese who are employed have jobs that range from cleaners, drivers, security guards, care assistants, and builders. In 1997, 216 (54%) of the 400 members of both *la Alpha* and *la Beta* Churches were working. This reality has expressed itself as follows: 32% work as cleaners, 6% as manufacturers, 6% as security guards, 2% paper distributors, and 8% work as mini-cab drivers. Congolese assume that their triple status of non-English speaking, Black, and asylum seeker (bogus economic migrant) is the most disadvantaging factor for their upward social mobility. This is what is expressed by Pele and Mavakala 's account:

Case study 3.7 Pele' s account of finding a job

Pele: Five years after my arrival in Britain, I had the chance to go to London University where I got a degree in economics. I have ever since tried to find

work relating to what I have studied. I had more than twenty-five interviews. All my efforts have been in vain. I have decided to do some cleaning jobs. The money I got from that helped me to have driving courses. I am now working as a mini-cab driver.

A.N.N: Do not worry. To find a job is not easy for everybody not just for the Congolese.

Pele: I know, nevertheless, have you ever seen a Congolese with a good job in London?

A.N.N: This is not impossible.

Pele: Tell me where are they? Most of us, regardless of our studies or background, never work in an office.

Pele's account seems to be sustained by Mavakala's.

Case study 3.8 Mavakala's account of a job

Mavakala: I graduated from London University. I have a degree in Economics and Anthropology. After my degree I hoped to find a job that would help me to use what I have studied. Unfortunately, I have returned to the same job I did before going to University. I am distributing newspapers from door to door.

A.N.N: Why do you think you do not have a job relevant to your studies?

Mavakala: Some time ago I thought it was due to language. I have done my best to improve my English. Do not forget that I taught English in the Congo. It is hard to say. I do not know why we cannot get a good job.

A.N.N: Things will change one day. Keep hoping.

Mavakala: They will change but maybe for our children whose process of integration to this society is prepared by our experience.

A.N.N: Ah, do you think that integration is a condition to getting a good job?

Mavakala: Yes, integration is very important. You must speak, walk and think as somebody from here.

A.N.N: What does it mean?

Mavakala: It means a lot. For a Congolese to find a good job in London would depend on many factors. Look at Mr Kilanda, he is a nurse and dentist. He has many years of experience in the Congo. When he arrived here, he was told to do training to re-evaluate/upgrade his diploma. Do you know what he does as a job? Looking after old people in nursing homes. At least, he is quite lucky to have such a job. For about three years, he never worked days, only nights.

It would follow from these accounts that Congolese refugees experience, in Coulby and Jones' terms, 'quite isolated economic and marginal lives' (Coulby & Jones, 1995: 121). It must also be pointed out that, an ambivalent attitude towards the employment sector is expressed by the two accounts. Studying are not necessarily a means of social mobility or viable employment. The lack of this possibility generates pessimism. Nevertheless, there is a degree of

optimism as to the children's future (Yule, 1998:90). This optimism is grounded on their children integration into British society. A cultural integration which most of the parents affirm not to have undergone.

3.4.9 Congolese refugees' concepts of the Home Office policies

Congolese refugees' experiences of detention, deportation, and backlog have led them to view British immigration systems and policies as oppressive and repressive institutions. They are repressive forms of control. As expressed by Santu, '*Biso bangunda awa na United Kingdom tozali na Lubuaku. Tozali na Kafela*' (Ling). To translate, 'we asylum seekers in this country are in prison. We are in Kafela'. Fwala a former detainee at Gatwick puts it '*Kozala na detention mpe kokende na la police mpo na ko signer ezali na risque mingi. Mpe ezali likambo na mpasi mpe lokumu te.*' (Ling) Translated into English: Being in detention and reporting to the police systematically are great risks. It is a very dehumanising experience.

The translatability of the concept *Kafela*, as previously indicated, a lost island in the Equatorial forest where Mobutu sent most of his political opponents, and the use of the term '*boloko*' '*Lubuaku*' (Ling) (prison), disclose their concepts of the British treatment of asylum seekers. The British policies of immigration to Congolese refugees are seen as vicious. They control the whole Congolese existence in a repressive and oppressive way. The Congolese asylum seeker is condemned to be what they want him/her to be. Either being deported or being accepted in the country where all his/her existence is submitted to the repressive and dehumanising gaze. The policies of backlog, detention and reporting systematically to the police oppress the Congolese asylum seeker psychologically, morally and physically. In fact, the Congolese refugee is no longer master of his/her life. Yet, this oppressive gaze does not limit itself in this penitentiary or carceral realm. It is diffused throughout the social, educational and health institutions where the Congolese is often singled out and addressed

as a bogus economic migrant. The Congolese asylum seeker or refugee's view of Home Office policies as oppressive can be seized with Ngimbi's account:

Case study 3.9 Ngimbi's predicament

A.N.N.: *Mr Ngimbi, I have been told that you are married. I have never seen your family where are they?*

Ngimbi: *We do not have a choice, do we? I spent six months in Haslar detention. Whether to die or to live that was their decision. Thank God that I walked out from it (detention). I have been waiting for two years to hear their final decision. Whenever I go to the DSS they ask me about the Home Office final decision. When I tell them that I am still waiting, they tell me they need more evidence from Home Office in order for me to get Income Support. When I bring them the solicitor's letter, they do not even care. Thus, every time my Income Support Book finishes I go to the Home Office to ask for this evidence. Otherwise, I will not be paid. I do not have a choice, do I? I have no work to live on. My existence depends on them. Whether death or life, this is up to them. Yes, whenever I see a GP or a doctor, whenever I register for a course or whenever I am looking for a job, I am singled out as a political asylum seeker, and I am treated accordingly. I do not want to talk about my wife and children from whom I have no news. I cannot write to them. I cannot bring them over. The law does not allow it. This is a prison for me. I escaped from a dictatorial oppressive regime to repressive and inhuman conditions of being an asylum seeker. I do not know what to do. (he cries...)*

3.4.10 Social Stratification in the Congolese Refugees' context

Social stratification within and among Congolese refugees determines the nature of (their mutual or intra-community) relationships. Two factors create this social stratification. The logic of sameness and the symbolic factor. The logic of sameness derives from the fact that all Congolese in London are supposed to be asylum seekers or refugees (*Ling: 'ba ngunda'*). This implies an equal existence *vis-à-vis* the British institutions. This social stratification discourse is encapsulated by Lukombo's following words:

Case study 3.10 Lukombo's view on social stratification

Lukombo: *All Congolese in Britain are equal. Within our community nobody has been sent here for studies. Even those who came for studies, they have joined our condition of asylum seekers. I know many of these people. They include former diplomatic families and 'bandeko ya'⁶. This is to say relatives of those who have economic and political power.*

The second factor is the symbolic dimension. This is to say that social public responsibilities and seniority regulate modes of relations. Pastors, orators and old people have some exceptional respectability because of their role within the community. Economic factors are not quite important within this community. The rationale is that expressed with the logic of sameness vis a vis the British institutions. All refugees are treated equally badly by British institutions and yet all of them are dependent either on income support or on menial and casual jobs.

The Congolese refugee community is mainly characterised by the presence of Congolese Churches and cultural or political community groups. Relationships that exist in the Congolese refugee community can also be rightly scrutinized on the basis of Weber's concept of 'communal and associative relationships' (Weber, 1947: 136) and Tonnies' concepts of '*Gemeinschaft* and *Gesellschaft*' (Tonnies, 1955: 17). In the Christian Congolese churches or groups, relations held can be interpreted as communal and open (Weber, 1947). No one is excluded on any basis. As such, Congolese Christian communities fall into the category of what Tonnies calls *Gemeinschaft*/ community. For in this type of community people are united and help one another despite cultural, educational, social and political backgrounds (Tonnies, 1955: 74). In addition, not all the Congolese refugees cultural or political groups can be understood as *Gesellschaft*. For *Gesellschaft* implies the idea of market relations. As Tonnies puts it, in this *Gesellschaft*/ association:

“...nobody wants to grant and to produce anything for another individual, nor will be inclined to give ungrudgingly to another individual, if it be not in exchange for a gift or labor equivalent that he considers at least equal to what he has given” (Tonnies, 1955: 74).

3.5 Conclusion

The following reflections need to conclude this chapter. First the UN statement that: 'Everyone has the right to seek and enjoy in other countries asylum from persecution' (Article 14, UN Declaration of Human Rights, 1948) is far from being a reality in cases of Congolese refugees in London. The country of exile

is for many Congolese an arena in which, to use Turner's expression, they 'experience further traumatization' (Turner, 1995: 69). Thus, the Home Office, as will be discussed in chapter six, is not without responsibility to the ill health of Congolese refugees. The Home Office denies fundamental rights to Congolese refugees through its policies which determine the way Congolese refugees are treated in many social spheres of their life in Britain. Based on the 1951 UN Convention on Refugees and the Universal Declaration of Human Rights (Weis, 1994), justice and moral imperatives should, therefore, be the grounds for the Home Office's actions towards the Congolese community. This would mean the recognition of the validity of Congolese claims to asylum.

3.6 Notes

¹ This is a card, which was given to Congolese who were seen as having adopted some Western ways of living.

² Equateur is Mobutu's region.

³ Dialogue with Mr Benga on Congolese and the phenomenon of exile, September 1999.

⁴ A reminiscent attitude or discourse is found among many Congolese who at the independence were over ten years.

⁵ An expression meaning that before you apply for a political asylum you must be well advised.

⁶ The expression '*bandeko ya*' is the plural of '*ndeko ya*' mentioned in section 3.3 (p.71).

Chapter IV. Contemporary discourses on health

4.1 Introduction

This chapter discusses current theories of health. My arguments are that current prevailing discourses on health are, to an extent, a critique of biomedicine, and reflections on therapeutic options. The two main critiques against biomedicine are encapsulated by discourses on disciplines and reductionism (Worboys, 1997:249). The emphasis is upon the issues of biomedicine as a tool of control and the idea that health transcends the biomedical model. Therapeutic options, I argue, have two bases, namely culture and notions of risk. These arguments, in final analysis, constitute the two main sections of this chapter.

As stated in section 1.6 (p.26), this chapter aims at providing hermeneutic keys to scrutinise both the grounds of Congolese refugees' therapeutic options and their conditions in relation to Home Office policies of immigration. Therefore, criticism of theories to be discussed in this chapter should above all be constructed on the basis of subjective Congolese therapeutic experiences as well as their understanding of British immigration policies.

4.2 The critique of biomedicine

4.2.1 Biomedicine as discipline

The uniqueness of the biomedical gaze (Foucault, 1973: 136) and the discovery of curative interventions have given Western medicine a high status second to none (Ityavyar 1992: 45). As a matter of fact, since the nineteenth century, Western medicine has been globally extended at the expense of local or cultural curative systems (Fassin, 1997: 83) to such extent that its empire has been established (Ityavyar, 1992:51). However, this biomedical hegemony is no longer unchallenged. Currently, local or cultural therapeutic systems are being rediscovered (Douglas, 1996a; Sindinga et al., 1995: 182) and re-habilitated. Thus, biomedicine is compelled to relativise its claims and views itself as one rational therapeutic system among many (Douglas, 1996a). The rationale supporting this

resurgence is the main critiques against biomedicine. Biomedicine has been designated as disciplines, which is hegemonic, and reductionist (incomplete or one-dimensional).

The critique of biomedicine as disciplines is associated with Foucault. To grasp the nature of his critique, a synopsis of Foucault's account of biomedical developmental history must be given. Foucault sums up his biomedical discourses with the concept of gaze (*Fr. le regard*) (Foucault, 1963:8,14,121,137). The gaze is the condition *sine-qua-none* for medical knowledge. The gaze constitutes two levels that characterise the two developmental historical moments of biomedicine. The age of the clinical gaze (*Fr. le regard clinique*) (Foucault, 1963:108-109,122) and the age of the eye of the clinic (*Fr. l'oeil clinique*) (Foucault, 1963:121-123).

The clinical gaze which prevailed in the seventeenth and eighteenth century (Foucault, 1963: 138) constituted classificatory medicine. Its features are the decipherment and the classification of illness or disease from the symptoms (Foucault, 1973:4, 122). Sight as its sole anatomical atlas imposed a diagnostic distance between the patient and the doctor. The atlas is the medium which allows interpretation of the body in analysing its conditions (Armstrong, 1993: 56). The patient had to submit to the doctor's atlas or art of classifying disease prior to any contact with his or her body for therapies to be administered (Foucault, 1973,4).

The second level or period of the gaze came into existence at the end of the eighteenth and the start of the nineteenth century. In contrast to the first gaze, the eye of the clinic, known also as the glance or pure gaze (Foucault, 1973:107,124), transcended the external visible part of the body to the internal universe of the body. This gaze imposed a diagonal reading of the body that (Foucault, 1973:129) no pathology was hidden from the doctor. Through its trinitarian atlas, the sight-touch-hearing trinity, (Foucault, 1973: 164), death and the body were demythologised to become fundamental sources of medical knowledge. The traditional diagnostic distance between

the patient and the doctor yielded to a new nosological or aetiological approach. The body could be touched, dissected and bound together by virtue of medical knowledge. This is the birth of the anatomy-clinical gaze, which according to Foucault is the decisive moment of biomedical history (Foucault, 1973:146).

Provided that the medical gaze is the source of medical knowledge, the latter falls into the category of what Foucault calls the '*disciplines*' (Foucault, 1975:161). He defines disciplines as any meticulous method of control that makes the body docile and useful (Foucault 1975:161). According to Foucault the consequences of disciplines are pathological. They create a mechanistic, controlled and dependent existence, which he expresses through the metaphors of docile bodies (*Fr: les corps dociles*) (Foucault, 1977:135; 1975:160) and panopticon (Foucault, 1977:195). The metaphor of docile bodies implies the idea of being created by the disciplines and acting according to their demands. (*Fr: Est docile un corps qui peut etre soumis, qui peut etre utilise, qui peut etre transforme et perfectionne*) (Foucault, 1975:160). This view which reflects Foucault's concept of disciplinary power has resulted to the view of an 'individual as invention' (Butchart, 1998:14). In applying Foucault into the context of the African body, Butchart states that:

"Each time it enters the surgery to invite clinical examination by the doctor, or is physically inspected and radiographed in the mine medical examination, the African body is not found but fabricated by these socio-medical micro-powers, not so much as their discovery as an invention of their power" (Butchart 1998: IX).

Disciplining power is repressive and oppressive. Confronted to the power of disciplines (Ball, 1990:5), human being acts like a robot that automatically obeys the principles of disciplines that are now normalised (Marshall, 1990:26). This leads to Foucault's metaphor of panopticon, which implies the idea of a constant surveillance, which ultimately creates an attitude of self-surveillance (Foucault, 1975: 236) to comply with the ethos of the disciplines. The device of surveillance being interiorised, the individual becomes an overseer of itself (Sarup 1993: 67). Therapeutically, there is the medicalisation of life (Illich, 1976: 47). The body and the social body are

subjected to the demands of the disciplines through regimes of systematic intervention and regular control such as vaccination and hygiene (Foucault, 1980:174). The 'anatomy-politics' (the disciplines) generate a 'bio-politics' of the population (the control of the population) (Foucault, 1976a: 139).

Foucault's concept of disciplines questions any form of knowledge (Ball, 1990:5) or any relation that involves the use of knowledge (Marshall, 1990:22). Knowledge, of any kind, implies repressive and oppressive power that extends from the social body to the individual. Consequently, any type of therapeutic, educational and penitentiary arena is repressive (Foucault, 1975: 239). It is a 'bio-power' (Foucault, 1976a: 140) whose activities are achieved through the application of strict subjugation and surveillance. Hence, medical knowledge as power is the basis for domination and alienation (Paul, 1978: 24; Petersen and Bunton, 1997: XIII).

The idea of disciplines as tools of control permeates Foucault's mind as his *Dits et Ecrits* (1985), Volume 2, demonstrates. As a tool of control, disciplines, as exercised through different institutions, have two major functions (Foucault, 1985:615). They control the temporal dimension of individual lives so that an individual's time is at their disposal. Their second function is their power over the body or individual's whole existence (Foucault, 1985:617). Institutions such as hospitals and schools, which are the locus of the application of disciplines, extend their control beyond their domain. Hence Foucault's revolutionary and lamenting statement:

"Why is it that in schools we do not only learn to read but we are told to take a bath? This is the polymorphic, polyvalent, indiscriminate, indiscrete, syncretistic characteristic of this function of control of existence.

(Fr: Pourquoi dans les écoles n'apprend-on pas seulement à lire, mais oblige-t-on les gens à se laver? Il y'a ici une espèce de polymorphose, de polyvalence, d'indiscrétion, de non-discrétion, de syncretisme de cette fonction de contrôle de l'existence"
(Foucault, 1985:618)

Foucault's critique is not only about the one-dimensional and hegemonic gaze of the disciplines, which, by virtue of their existence, exclude equal dialogues between those involved within any power-knowledge relationship. His concern is also about the absolute effectiveness of the disciplines and their invasion of the body or the individual. In other words, the gaze that makes the body dependent on it and its principles. It is the very existence of the disciplines that he questions. I would disagree with Petersen and Bunton's view that Foucault's medical gaze is not to be comprehended in any violent or authoritarian sense (Petersen & Bunton, 1997: XIII). Douglas concurs with my view that Foucault describes the medical gaze and, therefore, its practices, as 'an authoritative, distancing, masculine style of looking (Douglas, 1998: 25). A view that is also shared by Marshall (1990:26). It invades the body by creating it. Thus, for Foucault, biomedicine, as his analysis in *Dits et Ecrits* (1985) shows, is an alienating dynamic with creative power. Lupton, to my view, has also undermined this complex dimension of Foucault's concept of power. For referring to Foucault's statement of the creative mechanism through which power operates, she claims that Foucault's concepts of power 'emphasise the positive and productive rather than the repressive nature of power' (Lupton, 1997:98). The picture that comes from the three fundamental texts, the body of the condemned, docile bodies and panopticon (Foucault, 1977), of Foucault's concept of power does not provide any possibility to interpret power otherwise but repressive. Rather than extrapolating on the complexity of Foucault's concepts of power, it should be asserted, in Marshall's words, that: 'Foucault's failure to articulate this theory makes its application very problematic' (Marshall, 1990:23).

The complexity of Foucault's concept of power echoes in the African context. To illustrate, while Mudimbe uses it (the concept of docile body) to explain the mechanism of civilizing the African (Mudimbe, 1997), and recommends it as a hermeneutic paradigm to interpret the Western-African encounter, Butchart questions its use in the African context. He presents the following scenario:

“How should this theory of power be read, especially in Africa, where every day sees the mob against the spectacular might of the army police, where conventional history or even the last decade is punctuated by burning barricades, brutal acts of violence and waves of ‘ethnic cleansing’? Certainly, this speaks to societies that are not ‘disciplined’ in the sense of consisting in people who mechanically obey the dictates of the state and meekly conform to their politically and economically allocated place in the social order. But, and precisely because this notion of a ‘disciplined’ society reflects the idea that certain groups could hold power and exert it over others, this has no bearing upon whether Africa societies are or are not disciplinary societies. ...African societies have at least the turn of the twentieth century been constructed and organized in ways that starkly reflect the programmatic structure of the Panopticon, conforming that while not ‘disciplined’ they most definitely are disciplinary societies.

What then is to be made of the resistance to colonialism that constituted so great a part of the African past? Surely, in refuting the tactics of repression and subjectification aimed at inducing acceptance of their place as the ‘dominated’, black Africans have given lie to discipline? Such critique assumes that resistance is contrary to disciplinary power, that where there is resistance there is no power,...”(Butchart, 1998:31)

Recognising these complexities about the translatability of Foucault’s concepts of power in the African context, in section 4.4 (p.125-126), I will indicate the extent to which I apply Foucault’s notions of power as far as Congolese health issues are concerned.

4.2.2 Biomedicine as reductionist

4.2.2.1 The incomplete gaze of biomedicine

The critique of biomedicine as reductionist or a therapeutic system with a limited gaze prevails in the scholarship of sociologists and anthropologists. This critique has three levels.

The first level incarnates the lay concepts theorists’ views. These views are expressed through such works as those of Blaxter (1994) and Aggleton (1990). The lay concepts of health stress the fact that the definition of what constitutes health is subjective and relative. It varies on the basis of individuals, cultural groups, social classes (Helman, 1984: 91) and many

different factors or variables. The meaning of health ranges across such views of health as absence of illness or disease, 'commodity, personal strength or ability, basis for personal potential' (Aggleton, 1990:10-11). It would follow that, for lay concepts theorists, the biomedical concept of health is only one of the views about health.

The second level of critique of biomedicine in terms of reductionism is that which focuses on the relationality of being human. This is the case with Douglas (1996). Though, in contrast to Foucault, she recognises the necessity of a certain degree of power or discipline (Douglas, 1996a: 23), she criticises biomedicine for being reductionist or possessing a limited gaze. She views it as a one-dimensional therapeutic approach that fragments the person. Its gaze is so limited to the body that it is incomplete. It is not holistic in the way that alternative medicine goes beyond the 'clinic to embrace the whole person in the whole universe' (Douglas 1996a:25). Biomedical diagnoses and therapies are incomplete in that only the physical body constitutes their *terminus a quo* (starting-point) and *terminus ad quem* (ending point). Hence Douglas' statement:

"Consult her (the doctor) about a swollen shin bone, and she immediately anticipates a thrombosis; go to her with ear ache and she warns against the danger of a tumour on the brain; call about your feet and she suspects possible parkinsonism" (Douglas, 1996a: 23).

A human being exists not only in terms of body, mind and soul but also in terms of social and cosmic relationality. It is the existence to the self, to the neighbor, the environment, to that which is visible or invisible however, to which a person is ontologically or socially related. Thus, Douglas confronts the reductionism of biomedicine. She views health as the restoration of social, physical and ontological equilibrium (Douglas, 1998).

There is no doubt that Douglas constructs her critiques of biomedicine from an anthropological and religious background. The anthropological dimension in her criticisms is substantiated from her encounters with African societies, mainly the Lele, who consider the understanding of humanity as

ontologically caught up in the social and cosmic web (Douglas, 1975). There are also some religious elements in Douglas' critiques of biomedicine. Her personal Christian faith (Catholic) and anthropological scrutiny of the Bible (Douglas, 1996a: 202-212; 1996b) enrich her views of the holistic dimension of the human being.

The third critique of biomedicine in terms of reductionism derives from theorists of health promotion. Their critique transcends those already evoked. It is Lalonde who is said to have been the first to use the concept of health promotion in 1973 to indicate the non-medical or biological origins of ill health (MacDonald, 1998: 10). The concept of health promotion has been used and actualised among academics and by international health bodies such as WHO (Bright, 1997: 11) ever since. Tones (1992) and Tannahil (1992) have stressed the main rationale of health promotion to be individual (self-) empowerment. In fact the prevalent definition of health promotion, derives from Tannahil' s model which is a reflection on health education, health prevention and health protection (Downie et al., 1992: 57). On the basis of his reflections, it is argued that:

“Health promotion comprises efforts to enhance positive health and prevent ill-health, through the overlapping spheres of health education, prevention, and health protection” (Downie et al., 1992: 57).

The Ottawa Charter of 1986 indicates five areas that are intrinsic in any health promotion therapeutic activity. These are healthy public policies, supportive environment, community action, personal skills, and reorientation of health services (Bright, 1997:12). The prerequisites for health are defined by the Ottawa Charter to include such issues as ‘peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity’ (Baric, 1995: 40). It would follow that:

“Health promotion is directed towards action on the determinants or causes of health. Health promotion, therefore, requires a close cooperation of sectors beyond health services, reflecting the diversity of conditions which influence health. Government, at both local and national levels, has a unique responsibility to act appropriately and in a timely way to ensure that the total

environment, which is beyond the control of individuals and groups, is conducive to health” (Baric, 1995: 38).

For health promotion theorists, the biomedical discourse on health is only an aspect of what constitutes health. For defining health requires a holistic approach (MacDonald, 1998:5).

Thus, drawing on the multidimensionality of human existence and the multicausality factor of ill health (Seedhouse 1986: 62-63), health promotion discourses reject the hegemonic and reductionist biomedical discourse (Lupton, 1995: 50). Above all, health promotion theories insist that ill health does not only derive from physiological, ontological and social ruptures or disorders, but also from political and economic obstacles. Jones has described the health promotion therapeutic approach as a ‘salutogenic approach’ (Jones, 1997: 32). It combines both biomedical and social approaches. It goes beyond the clinical domain to make of the patient, the family and the entire community co-health-workers in the therapeutic quest. It is everybody’s business according to which:

“A surgeon will remove a tumor, a health visitor will improve the housing conditions for a family, and an educator will attempt to remove the obstacle of ignorance and work to develop power of reasoning and reflection” (Seedhouse, 1986: 64).

The concept of health deriving from health promotion discourses is that of health as wellbeing. This also constitutes its critique of biomedicine’s concept of health. This definition concurs with the post-war definition as proposed by the World Health Organisation. According to this definition, health is ‘a state of complete physical, mental and social wellbeing and not only the absence of disease and infirmity’ (Helman, 1994: 108). Health promotion’s focus on wellbeing leads to the understanding of health as a continuous process of eradicating obstacles to an individual’s life. A continuous or a constant involvement in life-sustaining actions. Thus, the concept of health as the ‘foundations for achievement’ (Seedhouse, 1986: 61). This view is more explicit in the words encapsulating the reflections of the WHO Europe at Copenhagen. For they state that:

“Health promotion represents a mediating strategy between people and their environments, synthesising personal choice and social responsibility in health to create a healthier future... Health promotion is the process of enabling people to increase control over, and improve, their health... Health is, therefore, seen as a resource for everyday life, not the objective of living; it is a positive concept emphasising social and personal resources, as well as physical capacities” (Baric, 1995: 37).

Critiques of biomedicine by health promotion discourses in terms of wellbeing resonate with current theological or Christian thoughts. Gusmer (1974) speaks of the re-discovery of the authentic biblical ministry of healing by the Church. It is humanity in its wholeness that is the object of divine healing (Gusmer, 1974: 126). To heal, is therefore, to care about all dimensions of person’s life (Dehaes, 1994: 414). Thus, in the context of the practice of healing ministry in Africa, Ma Mpolo could argue that:

“Some of us in Africa interested in pastoral care and counseling and related pastoral studies are less preoccupied with the development of methods intended for spiritual healing, that is, techniques which dwell on healing only through religion. Rather we are looking at healing in the wider context of African spirituality, which incorporates all dimensions of human and cosmic life. Healing through prayer alone would impoverish the pastoral ministry and witness of the Church in Africa and isolate it from the mainstream of forces that should contribute to the development and the development of the African people” (Ma Mpolo, 1994:15).

The current theological mind, therefore, criticises any form of therapeutic system that undermines or ignores addressing humanity in its wholeness. Health transcends the anatomy or the physiology of the physical body. Ecological, political, social as well as economic issues are viewed as part of discourses on health. The logic of health in terms of wellbeing advocates and sustains the impossibility of *‘mens sana in corpore sano’* within the context of *‘atmosfere poluto’* (MacDonald, 1998:15). This is why on the global scale, the ‘duties discourse’ (Petersen & Lupton, 1996:13) or the participatory imperative is part of health promotion discourse. This is encapsulated by the WHO’s European Charter on Environment and Health. Individuals are not only to be cared for. They have a caring role towards each other as well as to their environment (Petersen & Lupton, 1996: 13).

The theological meaning of health in terms of wellbeing is expressed by the Johanine concept of life in abundance (*Fr: la vie en abondance*) (Jn 10:10) and that of prosperity in all aspects (*Fr: prosperite a tous egards*, 3 Jn 1: 1). This view opposes the biomedical reductionist concept of health. This is what Appiah-Kubi (1979) illustrates with an account of an African patient according to which:

“They (i.e. the doctors) listen to our heart beat but they have little time for our worries. They check our blood pressure but they do not care about our daily pressures. They take our temperatures but they do not talk to us. They care of our illness but they are not interested in our whole person. They check our proteins and vitamins and tell us ‘you are suffering from kwashiorkor’ but they do not ask us whether we are employed or not” (Appiah-Kubi, 1979: 26).

4.2.2.2 The dialectics of health: reconsidering the question of meaning

Discussion about lay concepts of health as well as health promotion discourses in section 4.2.2.1 (p.108-113) has indicated the multiplicity and the complexity of the concepts of health. There are three main observations worth mentioning.

First, medical and lay views of health are held simultaneously by people (Radley, 1994:9). Secondly, the whole discussion of concepts of health suggests a tension between the two main views of health that are the view of health as subjective, relative and contextual, and the view of health as wellbeing. The third observation is that the concept of health in terms of wellbeing is not fully convincing. For what constitutes wellbeing and how to fully achieve it, is beyond human words and experiences (Curtis & Taket, 1996: 30). Health in this context can be argued as a reality experienced in the context of an optical illusion or a mirage.

In fact, defining health as wellbeing is criticised as being wide in scope, utopian and idealist (Baggott, 1994: 1; Bright, 1997:2; Curtis & Taket, 1996:30). As such, the critique of the biomedical conceptual paradigm of health, as an absence of disease, is not the enthronement of the concept of health as wellbeing. The human experience of the possibility for the

fulfillment of wellbeing remains distanced from reality. Health therefore falls into the category of what is described as a 'dynamic state of necessitating infinite resources' (Dines & Cribb, 1993: 22). There is a continuous search for that which is required to maintain the stability of existence. The possibilities for clean water, for harmonious social relationships, for economic self-sufficiency, for mental and physical fitness do not guarantee the tomorrows. In addition, there are, within an individual's life, contingencies as well as tensions between the haves and the have-nots. Consequently, the whole discourse of health as wellbeing becomes very complex (Dines & Cribb, 1993: 22). Aggleton (1990) has expressed this complex reality as follows:

"There are many words that we think to understand until we begin to question what they mean. Health is one of them. At the first sight, the word looks quite straightforward. It identifies a state of being to which most of us aspire—a blessing, a desirable quality, but one, which we are often told money, cannot buy. But if we pause for a moment to think just what health is, the picture becomes more complicated" (Aggleton, 1990:1).

Seedhouse argues that the paradox of health as a universally desired goal with different meanings can be addressed in philosophical terms (Seedhouse, 1986: 10). He constructs his concept of health as 'a foundation for achievement' from Wittgenstein's functional principles of philosophy as a rational activity that serves to elucidate concepts. Despite the elucidative and discursive function of Wittgenstein's principles¹, I argue that the therapeutic tension about health can be addressed from a theological therapeutic dialectic.

The theological therapeutic dialectic stresses the finitude of humanity and its eschatological completeness or fulfillment. According to the Christian holistic concept of health, there is a therapeutic tension. This is the tension of the 'now and the not yet' (*Fr: le deja/maintenant et le pas encore*). It consists of its ephemeral earthly human nature and an eschatological complete realisation. Commenting on the nature of the Christian healing ministry, Gusmer expresses this therapeutic dialectical tension as follows:

“The desired goal of this ministry is a wholeness or healing of body, mind and spirit, which, however, can only find relative fulfillment in this life. Healing is a sign of the Kingdom of God already inaugurated, but the Kingdom will be fully revealed only when Christ comes again at the end of time” (Gusmer, 1974: 126).

Not succumbing within the theoretical perspectives of fatalism or determinism, the Christian concept of health recognises the impossibility of its complete fulfillment in the visible realm of here and now. It is a realistic discourse that considers the vulnerability of human nature, human histories and contingencies (Jn 16:33) and anatomical nature (Ps 31: 9-10). Consequently, health as wellbeing is only imperfectly or partially experienced before its full realisation in, the *parousia*, the Second Coming of Christ. That is the moment of full restoration of humanity. This is the moment according to which Christians believe that the ‘older order of things has passed away’ (Rev, 21:4), for neither death nor crying or pain will be experienced. This theological therapeutic tension can be enhanced through Luther’s concept of righteousness. It is a discourse grounded in an epistemological reality of faith, which Luther calls the *Fides Christi* (Ansaldi, 1989: 45). It points to the eschaton, the Second Coming of Christ, as its *terminus ad quem*. The present experience of the Christian is the actuality of the existential tension of ‘*Simul justus et simul peccator/ semper justus, semper peccator*’ (Lat) which means ‘*always righteous always sinner*’ (Luther’s Works, Vol 34, 1536: 152-153).

Thus, like the earthly existence of the redeemed sinner that is continuously immersed in the process of sanctification, such is the experience of health. It requires constant multi-therapeutic actions which in the language of the reformed theologian Schwobel would fall into the category of the ‘ethic of createdness’ (Schwobel quoted in Gunton, 1997: 229). The vulnerability of human existence makes it an imperfect reality that calls for a constant multidimensional therapeutic approach. Hence, the significance of the biblical stress on the earthly welfare of human existence. This is demonstrated by numerous biblical accounts of bread and fish (Mat 6: 11,

Jn 6, 1-14; Mat 9; Lk 5), water (Ex 15: 22-27), as well as the recorded physical (Jn4, 9), psychological and spiritual restoration (Jn 8: 1-11).

4.3 Therapeutic options

4.3.1 Cultures as grounds for therapeutic options.

Cultures and the concepts of risk constitute the basis of people's therapeutic options. Like the concepts of health, therapeutic systems are products of cultures (Douglas, 1975:10; Morin, 1991). They are invented according to people's cultures, which in final analysis express their views on reality (Douglas, 1998:14; Illich, 1976; Janssens, 1992). This understanding of culture, as the basis for therapeutic options, applies also for social stratification and its economic inequalities as encountered in different social contexts. For in different traditional contexts, culture determines also social position and economic welfare.

Douglas argues that culture influences or defines the treatment of the body (Douglas, 1996a: 69), gender-relations (Douglas, 1975:10), and seniority and youth relationships (Douglas, 1987:10). The self-evident truth is that reality is socially constructed (Douglas, 1975:122). Thus, healers work with their diagnostic cultural codes and therapeutic options are made according to cultures' nosology and aetiology. There is a 'cognitive energy' in 'public memory' (Douglas, 1987: 72). This cognitive energy is created and reinforced in institutions which incorporate ideas or views held in a given community. This life-giving dimension of ideas as celebrated through rituals and ceremonies enables transmission from one generation to another. It would follow that for Douglas, choice of any type is primarily based on culture. The importance she gives to culture in question of choice can be grasped in her analysis of environments at risk. For in this particular context she asserts that:

“Ultimately any forms of knowledge depend on principles of classification. But these principles arise out of social experience, sustain a given social pattern and themselves are sustained by it. If this guideline and base is grossly disturbed, knowledge itself is at risk” (Douglas, 1975: 245).

Douglas' thinking on choice as based on culture synchronizes with Bourdieu's (1979, 1994) concepts of capital and habitus, and Morin's (1991) concept of cognitive capital. For Bourdieu, the social space or any human community has capital. Capitals are either cultural, social, economic and symbolic. They generate a particular habitus or worldview on which basis choices are made (Bourdieu, 1994: 224). Yet, choices or options vary according to the particular capital in question (Bourdieu, 1993: 260).

With regard to therapeutic issues, Bourdieu's theories of capitals and habitus suggest that any therapeutic option is an outcome of either of these capitals and habitus. Symbolic and cultural capitals would be directly related to therapeutic options. Thus symbolic capital, like any therapeutic system, implies the idea of power whose authority is recognized and obeyed (Bourdieu, 1994: 116, 161). Cultural capital on the one hand, implies the idea of acquired knowledge or power (Bourdieu, 1980: 215, 228) in any reality such as the art of healing. Social capital and economic capital are also influential in question of choice. They ensure the possibilities for opportunities and affordability. Bourdieu, like Douglas, concurs with Morin's notion of the ecology of ideas (*Fr: l' ecologies des idées*) (Morin, 1991: 11) and cognitive capital (Morin, 1991: 17). Morin argues that ideas of any form have a cultural basis. This is the 'ecology of ideas'. It produces a cognitive capital, a sort of cultural worldview imprinted in individuals (Morin, 1991: 29). This is the basis on which people in each society deal with realities and make their various choices. However, Morin notices that ideas or views are not static. There is a cultural soup (*Fr: les bouillons de culture*) (Morin, 1991: 28) among individuals which is the co-existence of various 'cognitive capitals' as encountered mainly in multicultural societies. Therefore, inherited or imprinted views can be challenged, transformed and abandoned (Morin, 1991: 29).

Douglas, Bourdieu and Morin's views discussed in this section have shown that options do not derive from a vacuum. They are not creation *ex-nihilo*. They are based on cultures whose ideas are at work in people's minds.

Foucault's concept of disciplines as defined through the metaphor of 'panopticon' would also explain the truth about culture as discussed through Douglas, Bourdieu and Morin. For, culture being imprinted represents the same automatic mechanisms of actions as those of panopticon. The choice is made according to the information already received, digested and absorbed. There is normalization.

4.3.2 Risk as grounds for therapeutic options

Therapeutic options should not only be grasped as an outcome of culture or capital but also as resulting from the concepts of risk. The emphasis on prevention or awareness discourse in present times, as will be discussed later in this section, makes the therapeutic arena the place where the discourse on risk prevails. In fact, it is argued that:

“The notion of risk is crucial to any debate about modernity because the process of modernization involves an intensification and multiplication of social risk, both at the level of the individual and at the level of social collectivities” (Turner, 1995: 219).

It would be understood through Turner's statement, that biomedicine, being a brainchild of modernity is also to be assessed in terms of risk discourses. Nevertheless, reflections on therapeutic options result in consideration of three types of discourses on risks. The discourse on risks as associated with therapeutic systems. The discourse on risks as related to the re-discovery of the body and the discourse on risks as manufactured and enigmatic.

4.3.2.1 The discourse on risks as associated to therapeutic systems

Any therapeutic system presents risks. However, these risks are not only from side effects associated with therapies. They are also risks from the way the body is approached. Exponents of this trend are Illich (1976) and Douglas (1996a). As far as Illich's clinical iatrogenesis thesis (Illich, 1976) is concerned, diagnostic errors, accidents during the course of treatment and the side effects of medical therapies constitute threatening risks to individual's lives. Thus, the individual is caught up in a self-surveillance system to safeguard his/her health. Any therapeutic option is preceded by serious considerations of its advantages and disadvantages.

This unprofessional self-scrutiny considers each therapeutic system's nosology, aetiology and pharmacopoeia. In fact, Illich' concepts of social iatrogenesis and cultural iatrogenesis express other forms of risks associated with Western medicine. They express the fact of being disempowered and becoming dependent on professional medicine (Illich, 1976:127).

For Douglas biomedicine presents a triple risk on the grounds of which people decide on 'the option for gentleness' (Douglas, 1996a: 21,24) that is, alternative medicine. The first risk is a risk of an incomplete or partial healing. Being a one-dimensional therapeutic approach (Douglas, 1998:26), biomedicine neglects different human dimensions that need to be addressed. The second risk is that of 'harm'. She speaks of biomedicine as being more, physical, materialist or violent than any other therapeutic system (Douglas, 1996a: 24-25). The third risk of biomedicine is that it violates the individual's privacy. Douglas encapsulates her triple critique in the following comparative observations:

"A word about the term 'gentleness' is in order. Of course it is relative. Some forms of complementary medicine are pretty brutal, like chiropractice, and some traditional medication is painless. But surely we can agree that cutting up flesh and bone or drawing blood are violent therapies compared with remedies coming in the form of perfumes and oils, and that manipulation is less intrusive than the surgeon's knife. Acupuncture involves needle pricks sited away from the painful region, which do not hurt or even draw blood. Laying on of hands relieves pain without so much as touching the sufferer' skin. These are the new styles of therapy, light oils from flowers and seeds to pamper the tired muscles, hypnotic trance to unknot deep worry, infusions of herbs to invigorate the spirit. As to diagnosis, it does no violence to the patient's bodily privacy. Because the state of whole is manifest in its parts, the patient does not need to undress. The global condition can be assessed through the eye, or the foot. Though there is the possibility that the therapist too is kinder and more sympathetic, this will not do for an explanation of the preference. Much more relevant is the kind of theory that the therapists will invoke- global, holistic, and spiritual, rather than local, partial and physical" (Douglas, 1996a: 22).

For Durkheim, institutions whose components are social facts or collective manifestations constitute the sole basis for comprehending individuals' actions (Ayisi, 1979: 2). Drawing from Durkheim, Douglas' theories of risk are primarily a cultural perception of risk. Individuals always perceive risks in the light of the social and cultural backgrounds (Douglas & Ney, 1998:136). As she has explicitly argued:

“Each culture is founded on a distinctive institutional base, which gives it interest to protect, and its own conventional way of doing things. Consequently each culture allocates blames to different sectors, and they vary according to the amount of blaming that they tolerate. In this perspective the risk signals for which the social amplification researchers are looking could be features of the systems of accountability in each cultural type” (Douglas, 1999: 226).

It is worth noting here that because of this distinctiveness of Douglas' discourse her works are said to have bridged views of 'classical anthropology and the cultures of late modern societies' (Gabe, 1995: 6) as will be discussed further.

4.3.2.2 The discourse on risks as related to the re-discovery of the body

Against the puritan society that stressed the salvation of the soul, contemporary consumer society preaches the salvation of the body. The consumer society is that which makes the body the marker of social status. The body as the most precious object becomes the individual's capital. This is a view widely shared among scholars (Petersen & Lupton, 1996: 23-26). Thus the constant quest for eternal youth, beauty and strength. The body requires extravagant treatments to keep it beautiful, juvenile, virile or feminine (Baudrillard, 1970: 200). The inevitability of the cycle of life and the passing of time (aging) are some of the risks against which the postmodern person must react in using a multi-therapeutic approach. As he puts it:

“If you do not do your corporal devotions, if you sin by omission, you will be punished. All that you suffer is because of your irresponsibility to your own salvation” (Baudrillard, 1970: 202).

Baudrillard's view of postmodern concepts of risk corroborate with Radley (Radley, 1993: 4) and Featherstone (1991). For the maintenance and

appearance of the body (Featherstone, 1991: 171) requires a therapeutic approach that challenges different risks including the natural process of getting older which has become one of the present epoch's concerns. For as it is witnessed:

“The vast range of dietary, slimming, exercise and comestic body-maintenance products which are currently produced, marketed and sold point to the significance of appearance and bodily preservation within late capitalist society. Consumer culture latches onto the prevalent self-preservationist conception of the body, which encourages the individual to adopt instrumental strategies to combat deterioration and decay (applauded too by state buraucracies who seek to reduce health costs by educating the public against bodily neglect) and combines it with the notion that the body is a vehicle of pleasure and self-expression. Images of the body beautiful, openly sexual and associated with hedonism, leisure and display, emphasises the importance of appearance and the look” (Featherstone, 1996: 170).

Consequently, the individual is kept in a context of continuous self-surveillance to avoid being blamed for looking ill. This is the new health consciousness whose moral imperative (Crawford, 1994: 142) is a constant gaze upon diet, fitness and other threatening risks.

4.3.2.3 The discourse on risks as manufactured and enigmatic

Giddens and Beck are regarded as the most influential on 'the nascent sociology of risk' (Petersen, 1996:45). For both, late modernity has ended nature and tradition to generate manufactured risks. Human socialisation has invaded and ended tradition to generate 'new types of incalculability' (Giddens, 1994: 59). This is the end of the cybernetic model of society (Higgs, 1998: 177). Thus, existence within this era is recognising the existence of these manufactured risks or uncertainties (Beck, 1998: 12) from which nobody escapes. Manufactured risks are ecological, manifold, incalculable, unpredictable (Beck, 1994: 8; Franklin, 1998:16), and remain hardly identifiable (Giddens, 1998: 28). They permeate all spheres of human existence. Giddens and Beck substantiate their thoughts by referring to such complex issues as BSE and other ecological crises. There are ambivalent views on ecological issues. While scientists remain split (Giddens, 1999: 60; Franklin, 1998: 24), the ecological or environmental issues remain a threat.

Yet, the options about food challenge tradition to become a matter of life or death. Neither a scientist nor a lay person can adequately advise how many hamburgers or at what time beef-eaters might develop CJD (Beck, 1998: 13). This is one of the complex or ambivalent characteristics of risk society about which no one is a specialist yet everybody is (Beck, 1994: 9). Thus, manufactured risks become the grounds for life or death decisions (Franklin, 1998: 8). This is what Beck calls 'the mathematical ethics of the technical age' (Beck, 1992:99). Giddens (1999) explains this complexity in the following way:

"All of us live in a more 'interrogatory' relationship with science and industrial innovation than used to be the case. New express ways, rubbish incinerator plants, chemical, nuclear or biotechnical factories and research encounter the resistance of the immediately affected population groups. That, and not (as in early industrialisation) rejoicing at this progress, is what has become predictable. Decision-making in these contexts cannot be left to the experts, but has to involve politicians and citizens. In short, science and technology cannot stay outside democratic processes. Experts cannot be relied upon automatically to know what is good for us, nor can they always provide us with unambiguous truths; they should be called upon to justify their conclusions and policies in the face of public scrutiny" (Giddens, 1999: 58).

Giddens's and Beck's views on risk imply that the person in late-modernity is characterised by a degree of anguish urging him/her to choose on the basis of existent and unavoidable risks. The importance of the issue of risk has led Lupton (1995) to develop views that link with those that are intrinsic to health promotion discourse. Health promoters' awareness of risks as causative factors orients their actions. A view shared by Green and Thorogood (1998:49). Nevertheless, Lupton identifies three different origins of risks (Lupton, 1995: 77). The external causative factor that relates risks to environmental hazards such as pollution, nuclear waste and toxic, and chemical residues. This view is similar to Giddens's and Beck's concepts of risk. The second factor is the internal causative origin that relates risks to individual life styles. The third causative factor, which Lupton considers of less importance, relates risks to the conditions of socially disadvantaged

people. Risks in this context might be of external or internal origin. The disadvantaged people represent an 'at-risk' category.

The whole discourse on risk as discussed in this section is argued to have a twofold meaning: 'Accountability and responsibility' (Petersen & Lupton, 1996: 96). Thus, individuals are invited to reflect on the conditions of modern society and to act accordingly. There is a constant self-surveillance therapeutic gaze directed against manifold risks whether known (Heyman, 1998:40) or unknown. Diet, gymnastics, aesthetic and preventive attitudes are not only means of avoiding risks but also become forms of therapeutic system.

4.4 A critique of discussed theories

The translatability of these theorists' analyses into both the Congolese home and exile contexts needs much caution. This is due to the social, cultural, economic and political particularities of Congolese in the Congo and those in exile, of which some of these theorists are unaware. In the context of Congolese refugees in London, Douglas' s (1975; 1987) anthropological works on the Lele will be used to grasp the continuity of cultural understanding of health among the Congolese refugees and the grounds for their therapeutic options.

Foucault's critique of biomedicine as 'disciplines' needs to be scrutinised with the same level of caution over the translatability of concepts and theories. To my view, Foucault is an exegete of Europe's early modernity institutions. His thoughts on disciplines have generated a re-thinking of discourses in human and social sciences, especially the sociology of health and illness (Petersen & Bunton, 1997: IX; Green & Thorogood, 1998: 23). Foucault's thoughts provide a hermeneutic tool, which can be used in the analyses of the different Congolese/African traditional therapeutic systems.

As a matter of fact, the need for a Foucauldian critique of African traditional medical systems is obvious. Some studies, whether by Africans or not, fall in the category of the quest for cultural *renaissance* which is a reaction to

modernity or Western cultural hegemony. Quenum, an African medical doctor and former director of the World Health organization particularly incarnates this trend. He is grounded in the works of fathers and exponents of *la negritude* (Fr) such as Senghor and Cesaire. As he puts it:

“It implies that it is up to us to rehabilitate African traditional medicine as part of Negro-African civilization, for obvious reasons: first of all for moral reasons, that is to say, those of human dignity, since we cannot remain beggars for ever, and then for economic reasons, in order to make the best use of our local resources, including the traditional pharmacopeia and traditional healers, and finally, for cultural reasons, in order to make our contribution to universal civilization” (Quenum, 1985: 286-7).

Not undermining the relevance of this reasoning, Foucault's concept of disciplines and his analytical account of biomedicine allows scholars on African cultures the opportunity to re-read the traditional African therapeutic systems. Such an exercise would enhance rich comparative studies on therapeutic systems. Foucault's concept of disciplines, implying the notion of 'the gaze', (*le regard*), would be an ineluctable significant starting point of such an enterprise.

In the context of my research, I use Foucault's concept of disciplines in three ways. First to grasp relationships between healers, the pastor, the doctor, the patients and the therapeutic management group. Foucault's concept of disciplines suggests that the patient is a passive container or a passive recipient of medical observation (Armstrong, 1993: 61). However, as discussed in section 4.2.1 (p.108), in the light of Butchart's thoughts, Foucault's concepts of disciplines or power are very complex in the African setting. According to Butchart, this is due to African political and cultural responses to Western ethos of colonisation and imperialism. These responses exclude the picture of the passive African. In the context of this research, I will discuss the translatability or applicability of Foucault's concepts of powers in chapters five (p.141 & 147; 151-152; 163-164) seven (p.200) and nine (p.255).

However, it should be mentioned that scholars such as Armstrong argue against the continuity of the picture of a passive patient in the current practice of biomedicine. He draws from a constructivist position, according to which such a passive identity of the patient ended at the beginning of the twentieth century with the birth of social medicine (Armstrong, 1984: 48).

The argument goes as follows:

“Clinical medicine from the late eighteenth century involved an interaction between clinician and pathological lesion. The patient as a person, had only existed within this dyad as a repository or, at most, as a rather unreliable translator for the lesion. In effect, the patient was no more than a passive physical object. In the new public health of the twentieth century, however, which stressed the importance of both the physical and the social relationship between bodies, the individual was constituted as more active physical and social being. Personal hygiene addressed this individual because it required commitment to certain activities, particularly those involving the sanitation of body interfaces such as skin, mouth, ears, teeth, bowels, etc., to prevent the transmission of disease from one person to another. The reconstruction of patient identity through the new public health towards a more active and acting object was however only one part of this transformation medicine. The other component of the new personal hygiene was the recruitment of the patient to the medical enterprise. In the nineteenth century the public health official alone could monitor and control the dangers of the natural environment. The new hygiene however could not rely on these officials as its agents of surveillance, instead it demanded involvement of patients themselves” (Armstrong, 1993: 63).

Armstrong’s view implies that such therapeutic trends as health promotion, whose philosophy empowers individuals as self-health promoters, shifts the patient from passive being in any therapeutic process. The patient becomes, instead, a co-participant in the surveillance system of health promotion. S/he is not restricted within an anatomic framework of investigation. S/he is invited to take part in joint endeavours for health promotion (Baric, 1995). Thus in using Foucault to study the nature of rapport between those involved in therapeutic quest processes, I will be exploring the nature of their respective participation. The question is of diagnoses, aetiologies, nosologies and therapies administered.

Secondly, I use the concept of disciplines to study the policies or the mechanisms applied making biomedicine and Christo-spiritual therapeutic systems acceptable to the Congolese. Biomedicine and Christianity were introduced to the Congolese within the colonial context of repression, oppression and exploitation. For this reason, Foucault's concept of disciplines, as expressed through the metaphors of docile bodies and panopticon, whose hallmarks are repression, non-negotiation (non-dialogue), and intrusiveness, can be relevantly applied in the Congolese or African context.

The third way Foucault is used in this research is in the application of disciplines' theories in the context of Congolese refugees' experiences in the British health care sector. This is what will be discussed in the concluding chapter (p.255).

Health promotion is not exempt from criticisms. As a therapeutic approach aiming at the wholeness of a person, health promotion is more invasive and intrusive (Jones & Naidoo, 1997) than biomedicine. With discourses of lifestyles and risks, health promotion generates a twofold disciplinary power. The first is the self-surveillance or disciplinary regime that makes an individual a self-health promoter. Individuals should monitor risks through constant self-surveillance and self-help disciplines (Petersen 1996: 55). The second disciplinary power is the unilateral surveillance by which health promoters have access and control over individual lives (Armstrong, 1984: 46). This even through ways that could be regarded as 'intrusive, discriminatory or paternalistic' (Petersen, 1996:56) in other contexts. This therapeutic imperialism concurs with Illich' social iatrogenesis (Illich, 1976). Social iatrogenesis is the invasion of individual lives in the dismantling process of multi-dimensional pathological causes or determinants of health. For Airhihenbuwa (1995), health promotion programs are still carried out within Western paradigms. Though health promotion recognises the importance of respective cultural perspectives, it fails to integrate them in its practice. This is what he means in the following statement:

“Progressive discourses/theories of today-postmodern, postcolonial, feminist and cultural studies -have challenged classical paradigms by advocating representation, or what Stuart Hall (1991) calls the ‘third space’. However, these theories/discourses have failed to address health adequately as a cultural production. To invoke the centrality of culture in public health and health promotion activities is to challenge health promotion and disease prevention to overlook or downplay the importance of history, politics, and education in shaping the landscape of cultural production.

Further, it is to deepen and extend the possibilities of progressive approaches, such as critical pedagogy and cultural studies that centralise culture in their theories and practices. The accomplishment of these tasks requires the deconstruction of existing systems of dominant values in a manner that challenges the very foundations of the social and cultural order” (Airhihenbuwa, 1995: XII).

However this criticism of health promotion, its emphasis on wellbeing as a critique of biomedicine will be explored to see its applicability in the Congolese contexts. In addition, health promotion constant gaze on that which threatens human wellbeing is life sustaining. For as noted by Green and Thorogood:

Health promotion might then be seen as the ‘propaganda’ wing of public health, the outrider putting public health policy into practice. How then are we to reconcile this tension between the good intentions of public health/health promotion and the unintended regulatory consequences? First, it should be made clear that this is a false dichotomy. The two aspects are not separable, the one implies the other. The public health discourse implies that a ‘reservoir of disease’ is a normal part of the social world, but it must therefore be constantly monitored so as to be controlled and prevented (Green & Thorogood, 1998: 45).

Bourdieu’s discourses of capital and habitus enlighten the analysis of therapeutic option in both the Congo and the Congolese refugees’ context. For the question to deal with is that of the place or the role of these different capitals in the quest for therapy in the two different contexts. However, their translatability in both contexts requires prudence since the environments in which the therapeutic options of Congolese refugees occur are different to those in the Congo. Bourdieu’s discourses on capital can also be relevant to the study of the grounds on which social stratification in the context of the

Congo and that of exile is constructed. Morin's thoughts on *bouillon de culture* help us to grasp the extent to which there is a cultural challenge in Congolese refugees' therapeutic options. For the Congolese refugees in London are in a multi-cultural setting whose dynamics are not to be ignored.

4.5 Conclusion

This chapter has shown the complexity about the concepts of health. None of the scholarly trends discussed in this chapter provides a concept of health which is beyond question. It is on this basis that I have introduced the notion of the theological therapeutic tension of now (yet/ already) and not yet (*la tension du déjà (maintenant) et du pas encore*). Health is a dynamic reality whose complete realisation according to Christian thought is an eschatological event (Revelation, 21). Its realisation in the here and now consists at continuous intervention to sustain human wellbeing. In addition, I have argued that, however complex is the concept of health, present literature on the sociology of health and illness shows that culture and concepts of risk consist the main basis for therapeutic options. I have, however, also argued that to translate concepts such as disciplines and risks into the Congolese contexts requires much caution. In addition, the applicability of this view in the Congolese refugee therapeutic context depends on the analyses of the data in subsequent chapters.

4.6 Notes

¹ For Wittgenstein: 'Philosophy aims at the logical clarification of thoughts. Philosophy is not a body of doctrine but an activity. A philosophical work consists essentially of elucidations. Philosophy does not result in 'philosophical propositions', but rather in the clarification of propositions. Without philosophy thoughts are, as it were, cloudy and indistinct: its task is to make them clear and to give them sharp boundaries' (quoted in Seedhouse, 1986:11).

Chapter V. Congolese concepts of health and therapeutic Options

5.1 Introduction

Considering the analyses of chapter four, section 4.3.1 (p.116-118), that concepts of health and therapeutic options are also related to the notion of culture, it is therefore important to examine the issue of concepts of health and therapeutic options in the context of the Congo. In addition, a deep analysis of Congolese refugees' concepts of health and health issues must be made in relation to present thoughts on health in the African context. Reasons for this is the fact that traditional therapeutic approaches are being given significant weight in the WHO strategies for meeting the challenge of promoting the health for all by the year 2000 (Jansens, 1992: XXVI; Fontaine, 1995).

5.2 Defining the three therapeutic systems

Three forms of therapeutic systems characterise the history of the Congolese therapeutic quest. These are: the traditional Congolese therapeutic systems (Devisch, 1990; Devisch, 1981) the modern medical system (Janzen, 1978), Devisch, 1993, Ma Mpolo, 1976) and the Christo-spiritual therapeutic systems (Devisch, 1996, MacGaffey, 1983). An adequate understanding of these three therapeutic systems first entails their clear definition.

5.2.1 Congolese Traditional therapeutic systems

By Congolese traditional therapeutic systems should be understood as the overall therapeutic practices and knowledge whose source is Congolese culture. This definition corresponds with the definition of traditional medicine proposed by the WHO (Kabangu, 1978:19). This reasoning advocates the existence in African societies of therapeutic knowledge or ethnomedical systems prior to the presence of biomedicine and the Christo-spiritual therapeutic systems in Africa. African ethnomedical systems which are not imported have, therefore, been described as traditional, indigenous or African (Iwu, 1986; Sindinga, 1995).

However, referring to African ethnomedical systems as traditional or indigenous has not been without difficulty. This complexity is encapsulated by Hours in the following statement:

“African medicine is probably a better name than ‘indigenous medicine’ which, though it indicates the indigenous character of this branch of medicine, also gives it an undesirable colonial flavour. The worst description is ‘Traditional medicine’ which sets up traditional as if it were some abstract, unchanging corpus of practices and knowledge-practices and knowledge which we today know to be evolving in a dialectical relationship and competition with what is called ‘modern’ (that is to say Western) medicine. African medicine, then, is the medicine practices by Africans before the arrival of Europeans and the brutal transformations associated with the colonial rules” (Hours, 1986: 43).

While Hours’ analyses can be justified, on the basis of cultural transformations that characterises Africa, therapeutic systems deriving from African cultures are ceaselessly described as traditional (Last, 1986:3; Kabangu, 1988; Larrey, 1994: 38-39). The use of this term is methodologically relevant. It serves to distinguish these specific ethnomedical systems from exported therapeutic systems that can in some contexts be described as African in such a way as there is an African theology (Marrey, 1995), African Christianity (Hastings, 1979), African psychology (Azibo, 1996), etc. Scholarly literature on African therapeutic systems suggests that the question at the heart of reflections on African traditional medicine is twofold. It is about the position, identity or status of African traditional medicine vis a vis biomedicine and, how can traditional medicine be used and improved to address African health issues (Janzen 1978; Last 1986; Nchinda, 1976; Fontaine, 1995).

5.2.2 Biomedicine

The concept of biomedicine refers to therapeutic knowledge and practices whose origin is in Western culture (Nutton, 1995: 494). It is argued that in terms of the history of Western medicine, biomedicine represents the pinnacle of Western medical knowledge (Foucault, 1973:146). For having been grounded in and disentangled from the medical observations of Hippocrates whose

aetiological discourses affirmed 'that disease was due to some disorder of the four humours -blood, phlegm, yellow bile and black bile' (Rhodes, 1976: 14; Nutton, 1995: 24), modern Western medicine as practised around the globe is associated with the discoveries and ideas that came into being since the end of 18th century (Worboys, 1997: 249). Its main features as discussed in section 4.2.1(p.103-105), consist, on the one hand, in its physiological and nosological knowledge and, on the other, in the techniques as well as the pharmacopoeia it develops. Thus, disease, which biomedicine defines as a biological or anatomical reality (Foucault, 1973), is subjected to its scrutiny and therapeutic framework (Magner, 1992:336).

5.2.3 Christo-spiritual therapeutic systems

The phenomenon of healing in African Christian churches has attracted the minds of many scholars. However, scholars have overlooked its theological distinctions. Terms such as 'charismatic healing churches' (Devisch, 1996c: 555), healing churches (*Eglises de guerison (Fr)*) (Devisch, 1998: 59) or faith healing (Devisch, 1996c: 567) do not necessarily imply a Christian dimension. There are, in the Congo, religious denominations (Dehaes, 1994: 408; Hegba, 1994:419) practising healing sessions that are not Christian. One of these denominations is '*l' Eglise d'Ebale Mbonge*'. In addition, missionary hospitals or church dispensaries (Janzen, 1978) and clinics are viewed to some extent as an extension of the Christian ministry of healing. This view would concur with ideas of Ma Mpolo (1994), Dehaes, (1994) and Gusmer (1974) as discussed in section 4.2.2.1 (p.112).

I prefer to use the term 'Christo-spiritual' to emphasise the intrinsic distinctiveness of the cardinal features of healing practices as observed in Congolese Christian churches. The use of the term Christo-spiritual refers to the theological dimension. This would include such aspects as the use of the Bible, the name of Christ, prayers. Nonetheless, I do not underestimate the fact

that dialogues, rituals such as dance, fasting and other symbolic elements including water (Martin, 1975) are also components of this mode of healing.

5.3 The emergence of African discourses of health: beyond the colonial and Western paradigm

Acknowledging existing differences among Africa-Sub-Saharan peoples, scholars on Africa have underpinned intrinsic cultural similarities of African Sub-Saharan societies. To illustrate, Taylor has noted the existence of a basic worldview among Africans of the southern Sahara (Taylor, 1963: 27). The same is asserted by Evans-Pritchard (Evans-Pritchard, 1965: 315). Mbiti's thoughts as a reaction to colonial hermeneutics of African cultures sum up this discourse of cultural similarities in what he terms as African ontology (Mbiti, 1969: 106). His concept asserts an African common *Weltanschauung*. This is a common understanding of the origin of existence and its destiny. The epistemological consequence of this reasoning is noticed in the proliferation of African cultural studies with titles such as African concepts of health (Fontaine, 1995: 84; Ma Mpolo, 1976, (Afrika, 1993) *African philosophy* (Eze, 1977; Kalumba, 1966; Hountondji, 1996; Wright, 1984, Okere, 1983), Bantu Philosophy (Tempels, 1949); African religions (Mulago, 1973), etc.

A number of factors have precipitated present discourses on African concepts of health. First of all, tendencies for proper African hermeneutics of health are related to the political history of African liberation. In their search for political independence, political movements such as '*la negritude*', stressed the rediscovery of African cultural elements that were thought to have been swept away by the implantation of Western civilisation (Senghor, 1964; P'Bitek, 1971) long before the nineteenth century. Quenum (1985), one of the proponents of the integration of traditional knowledge into the practice of Western medicine in Africa, argues that African philosophy as expressed through '*la negritude*', remains the unshakeable source for relevant African medical systems. This is due to the traditional concepts of humanity and community (Quenum, 1985: 287). For Quenum, African political liberation must also be concerned with the

restoration of African traditional medicine to its rightful context (Quenum, 1985: 289).

As a scholarly trend, the necessity for rediscovering and re-evaluating African cultures had its impetus with the emergence of African theologies of inculturation in the mid-sixties. In fact, the African theological trend known as the school of the theology of inculturation (Martey, 1995: 68-69) incarnated this logic. Though it was a prolongation of thoughts expressed through '*la negritude*', it was partly encouraged by the conclusions of the Second Vatican Council. The latter recognised the place of indigenous cultures in expressions of Christian faith. Thus, like views about God, African people have medical systems prior to their encounter with the Western world (Nchinda, 1976).

As mentioned in chapter four, nineteenth century' achievements of Western medicine gave it a trans-cultural or a *passe-partout* identity. Lyotey, a French military doctor in the colony had this to say: 'the doctor is the unique excuse for colonisation' (quoted in Arnold, 1988: 3). The Western medical achievements of the enlightenment condemned the non-Western therapeutic systems as backward (Arnold, 1988:7). In fact, as stated by Worboys:

"During the nineteenth century European medical practitioners increasingly dismissed other systems as primitive and dangerous. This new attitude derived in part from new medical ideas and in part from wider political policies that demanded the imposition of Western language, culture, and technology on subjects people. Western medicine increasingly based its claims to exclusivity on its preventive and therapeutic effectiveness, its power to describe and classify diseases, its grounding in testable scientific truths, and its overall progressiveness, especially its openness to critical evaluation, revision, and improvement.

Other systems, along with older Western beliefs, were dismissed as dogmatic, speculative, and ineffective. They were described as offering mere metaphorical descriptions of disease, whereas the new Western medicine gave literal accounts, grounded in observation and investigation" (Worboys, 1997: 256-257).

It is against this discourse that within the African setting, the two trends, negritude and the African theology of inculturation, referred to constitute the challenge to the uniqueness of Western medicine as introduced to the continent within the context of the expansion of Western civilization. For, as works by Douglas (1996a), Lambo (1963, 1977) and Aireherembuwa (1995) show, the view that Western medical perceptions of health and health care systems are unique and the only global therapeutic paradigm is being questioned. This is what should be grasped in Nchinda's apologetic statement about the uniqueness of healers. For he claims that:

“Even the general term of ‘witch-doctor’ given to them is now outmoded as it is inappropriate in describing practitioners of an ancient art whose skills in handling certain types of medical problems is unsurpassed by Western trained doctors” (Nchinda, 1976: 133).

It would follow on the basis of analyses above, about negritude and the theology of inculturation, that the emergence of African discourses on health is a political and cultural expression. Nevertheless, five other factors would explain the reason for African authentic discourses on health. They include consideration of the issues of the availability, accessibility, affordability, acceptability, and effectiveness of African traditional medicine. Scholars such as Iwu (1986), Nchinda (1976), Githagui (1991) and Sindinga (1995) and institutions such as the WHO (1978) have stressed these factors. The WHO has expressed this in the following terms:

“Since traditional medicine has been shown to have intrinsic utility, it should be promoted and its potential developed for the wider use and benefit mankind. It needs to be evaluated, given due recognition and developed so as to improve its efficacy, safety, availability and wider application to low cost. It is already the people's own health care system and it is well accepted by them. It has certain advantages over imported systems of medicine in any setting, because, as an integral part of the people's culture, it is particularly effective in solving certain cultural health problems” (WHO, 1978: 13).

Nchinda has asserted the same reasoning as follows:

“Traditional medicine, while largely filling the vacuum of shortage and insufficient outreach of Western medicine to the general population, has the advantage of proximity to people. Also, the practitioners approach the people with warmth, consideration, and sympathy that is often lacking in hospital staff.

The traditional practitioners not only treat and counsel using therapeutic practices that are consonant with the cultural practices of the people, but also speak with authority using the dialect and idiom of the people. Thus, to the people, traditional medicine fulfils the four criteria of accessibility, availability, acceptability, and dependability” (Nchinda, 1976: 134).

The availability and accessibility factors can be understood with the fact that is common in many third world countries. Africa is like Mexico, where there is a maldistribution of biomedical human health resources (Baer, 1987: 1). It has been reported that in Ghana only 15% of the population benefit from the 85% of National health resources (Appiah-Kubi, 1981: 3). To address their health issues, rural populations in particular depend on ethnomedicine (Iwu, 1986:9, 11). For, traditional medical systems are available where the modern are absent. In fact, each African village has its traditional healers (Mbiti, 1969: 162).

The affordability factor (Sindinga, 1995: 5) can be associated with the fact that healers do not charge beyond the cost required to access to modern medical systems. In fact, in countries such as the Congo healers or those with traditional therapeutic knowledge would include friends or relatives. In this case no charge might be required.

The acceptability and effectiveness factors are advocated against biomedicine, which is said to have failed to take into account the traditional African perceptions of health (Appiah-kubi, 1981: 3). For the effectiveness and acceptability of the African traditional therapeutic systems are fundamentally related to their holistic approach (Janzen, 1978, Ma Mpolo, 1976). Traditional African medical systems have been said to address humanity in its wholeness.

5.4 The Congolese concepts of health: health as wellbeing

Section 3.2 (p.65) has described the Democratic Republic of Congo as a mosaic cultural space of different ethnic groups. Differences between these ethnic groups are so salient that a particularist approach might be necessary. However, as discussed in section 5.3 (p.133), striking cultural similarities between Congolese ethnic groups result into the making of a Congolese concept of health. For, despite striking respective cultural differences, different Congolese ethnic groups views of health transcend the biomedical discourse of health as an absence of an organic pathology. Health is defined in terms of wellbeing that is possible through the maintenance of the social, physical and cosmological relational dynamic balance. Based on his pastoral therapeutic experiences, the Congolese Protestant theologian Ma Mpolo (1976) encapsulates the Congolese concept of health as more social and cultural than biological (Ma Mpolo, 1976:5).

The construction of a Congolese concept of health as wellbeing is an outcome of pastoral (Ma Mpolo, 1976), anthropological (Janzen, 1978; 1992; MacGaffey, 1983; Devisch, 1983, 1996; Douglas 1996, 1998) and medical observations or enquiries (Janssens, 1992: XXVII-VIII). At the centre of this concept of health is the view of the human being as a biological, social, and cosmic/spiritual being. Thus, the quest for health or the therapeutic implication implies the recognition of these different spheres of the individual's existence. It is a work of restoring this relational network or ontological web. As such Devisch (1993), like Ma Mpolo's definition in the last paragraph, has aptly expressed the Congolese concept of health in stating that:

“Being in good health therefore means being whole, that is, being integrated in a meaningful way into the relational fields of body, group, and life world” (Devisch, 1993: 31).

The evoked definitions of Ma Mpolo and Devisch suggest that for Congolese, health transcends one's individuality and physicality. It is a state of collective harmony rather than a proper functioning of organs only. It is defined on the

basis of the conjunction of personal and relatives' social, physical, spiritual and material conditions. Thus, a crisis in one of these areas amounts to a crisis of health. To fully grasp the Congolese concept of health, it is important to investigate their view of what does not constitute good health and its causes (aetiologies).

Any ill health is any negative reality or condition that distorts one's life. It is any manifestation of *'le mal'* (Fr), evil (Buakasa, 1988: 3). Thus, ill health manifests itself through such reality as disease, suffering, want/lack, unsatisfied desire, impotence, sterility, mental disorders, etc... MacGaffey (1983), an American anthropologist on Kongo cultures, concurs with this thought. He indicates that for Kongo people the term disease defies the biomedical meaning to include all sorts of afflictions whether social, physical, material or spiritual (MacGaffey, 1983: 148). This Kongo aetiological discourse would concur with the South African Inyanga's (a healer) reflections to Kholer, a Western medical doctor. As he puts it:

"The trouble with you (Drs) is that you are too full of germs in your head. If you have not found the germ you will not even treat the patient. Doctors were looking for germs for centuries while people were dying from bleeding gums at sea. You have found no germ to this day" (Gumede, 1990: 38).

For Congolese, any ailment is symptomatic of a conflictual state. It is the undermining of the individual's cosmological and social structures (Devisch, 1991a: 289). The patient's body is a victim of an unhappy relational condition (Buakasa, 1988: 4). Causes that provoke conflictual relations are attributed to either the patient personally, to the community or to other entities in the patient's surrounding as understood in their cosmology. Both the patient and the community can be blamed for an offence, immorality or witchcraft. In this case the aetiological discourse falls into what Brown calls 'the evils we do' implying the logic that any evil human action can generate 'both societal and personal misfortune' (Brown, 1996: 62).

Congolese traditional thought never fails to distinguish a natural cause from a supernatural one. Natural causes would include factors such as overwork, spoilt food, injuries, ecological or climate conditions and all factors related to the physical conditions and activities of people. In relation to these factors, people organise forms of prevention and develop therapies to be applied when one gets sick as a result of overwork, solar radiation, etc.

Supernatural causes, on the other hand, include spiritual powers. These are, in the Kongo society, believed to be essential and influential in the physical part of the universe. They include witchcraft, evil spirits and the dead. In fact, any illness or disease that is not easily cured would be seen as having a supernatural origin. The Kongo in this case will speak of the *Kimbevo kia mbeni* (or *Kia tantu*) or '*Kimbevo Kia muntu*' (*Kik*). These terms indicate the non-natural origin of one's disease or illness. A headache might be seen as an outcome of solar radiation or overwork but its persistence or regular occurrence in one's life, gives it a non-natural cause or interpretation.

It should, however, be stressed that despite this aetiological taxonomy of disease and illness, the beliefs in supernatural causes prevail. They fall into the category of what Airhihenbuwa describes as the 'ultimate cause' (Airhihenbuwa, 1995: 51) of illness or disease. For the Congolese, like the Azande of Sudan (MacGaffey, 1983: 148), trying to explain one's malaria as caused by a mosquito bite is an unsatisfactory explanation. A satisfactory explanation is that which speaks of the mosquito as sent either by a person (jealousy) or by God (offence to societal norms) (Iwu, 1986:15). The biological or naturalistic answers are constantly defied by constant questions such as: Why am I sick? Why me and not another person? Why at this particular time? Why is one dead? Why only him/her/us? These questions are the request of an aetiological diagnostic discourse that would address the issue within the accepted traditional Congolese framework. Here, the natural cause is viewed as a mechanistic cause whose cause *par excellence* is the efficient cause (Sow,

1978: 56). At this level, what is expected from the doctor or the therapist is the revelation of the hidden causes.

The view of health as wellbeing is held in different parts of Sub-Saharan Africa (Horton, 1967:155; Janzen, 1992a: 211, Lambo, 1963: 9). For the Akans of Ghana health is also a holistic reality. Good health is a marker of social and ecological harmonious relation. Goodness, blessing, beauty and all that sustains life is part of their health discourse (Appiah-Kubi, 1981: 2). Likewise for the Zulu, for whom good health is not only a physical fitness but also good condition in every aspect or dimension of life (Ngubane, 1977: 27). Its restoration implies the dynamics of confessions which would restore more than physical health.

5.5 History of therapeutic systems in the Congo

This section discusses how these three therapeutic systems that are the Congolese traditional therapeutic systems, biomedicine and the Christo-spiritual therapeutic systems came to be accepted by the Congolese.

5.5.1 The Congolese traditional therapeutic systems

To apply theories of cultures discussed in chapter four, Congolese traditional therapeutic systems have to be seen as culturally endemic. This is what has been demonstrated by Douglas' concepts of 'cognitive energy and public memory' (Douglas, 1987: 72), Bourdieu's concepts of cultural capital and habitus (Bourdieu, 1979) and, Morin's concept of 'cognitive capital' (Morin, 1991). Being anterior to the presence of any other form of therapeutic system in the Congo, Congolese traditional therapeutic systems' aetiologies and nosologies are culturally based (Douglas, 1998).

In the postcolonial period, in contrast to the colonial, the relevance of traditional therapeutic systems has been recognised (Devisch & Persyn, 1992: 133) in two ways. Traditional therapeutic systems have been considered as part of the

national health systems (Janzen, 1978: 58-9). Hence, different attempts to incorporate them into the Department of Health. Secondly, traditional healers are viewed as promoters and guardians of cultural achievements. This explains their association with the department of Art and Culture. These socio-cultural and therapeutic factors are argued to be the *raison d'être* of their continuity through time and history (Devisch, 1993: 26; Janzen, 1978: 229).

Nevertheless, the history of traditional therapeutic systems in the Congo has to be understood in terms of 'extreme tolerance and repression' (I.D.R.C, 1980: 22). The whole activity of healers, mainly in urban areas, presents a power-knowledge scenario in which those who for reasons of accessibility, acceptability, availability, affordability and effectiveness depend only on healers are the victims. Here repression or oppression has to be grasped in Foucault's terms. For, like Foucault's concept of docile bodies (Foucault, 1977), the healer must submit to the selfish demands of the authorities as a condition to his or her therapeutic activity. In his/her turn, the healer submits to his/her egocentric demands the patient who cannot afford the cost of Western medicine.

As a consequence of this scenario, due to the lack of an effective co-ordination and supervision of these systems, the profession of healers has become quasi-ineffective, exploitative and a tool of control. Anyone can become a healer for lucrative motives. For rather than generous donation or honorarium, as in the past (Laman, 1962:80), healers are presently charging patients. There is what Kolie calls the 'perversion of traditional African medicine' (Kolie, 1991: 137). Attempts by the Zairian government to co-ordinate research in the field of traditional healing systems remained unproductive. The unique positive achievement is the creation of a network of traditional healers. They include such bodies as the 'Union of Congolese healers' (*Union Nationale des Guérisseurs du Zaïre. Fr*) and the Association of Traditional Practitioners (Devisch, 1993:299-300).

According to the Belgian anthropologist, Devisch, the failure of an adequate co-ordination of traditional therapeutic systems by the Zairian health department was due to its leaders' deficient knowledge of these systems (Devisch, 1993: 27). One could question this view for the Zairian politics of authenticity (*Fr: retour a l'authenticite*) in 1971, had promoted an awareness of these practices. In addition, many of the then regime's exponents and Christian leaders used traditional therapeutic systems (Ma Mpolo, 1976). The failure, in my view, is due to the egocentric and exploitative ethos that characterised the Zairian regime.

Moreover, this failure to co-ordinate, or incorporate in a structured governmental organisation, traditional therapeutic systems has also educational and ethnic reasons. The possibilities of dialogues between healers and government representatives are hardly found in rural zones. In the rural areas, the degree of illiteracy is higher and traditional therapeutic practices in their magnitude serve first and foremost the wellbeing of a family, clan and ethnic group. Thus, the politics of structuring traditional therapeutic systems are likely to be limited within urban major cities. Nevertheless, this does not underestimate the necessity of organising the activities of traditional healers. However, any attempt at such dialogues should consider the question of illiteracy, therefore education, and the issue of ethnicity.

5.5.2 Modern medical system in the Congo

Western medicine was introduced in the Congo during two main periods. First in the 15th century through the Portuguese and missionaries in the former Kingdom of Kongo. It is reported that in 1526, the Kongo King, Mvemba Nzinga wrote to the King of Portugal, Joao III, requesting medical doctors. This request was 'not exclusively for his own use, but also for the struggle against paganism' (Axelson, 1970: 67). The whole project of the Kongolese King was to replace the traditional therapeutic system by the new. Nzinga's request is said to have received few or no answers (Axelson, 1970: 79).

The last half of the nineteenth century is the second period of the introduction of Western medicine in the Congo. As in the first period, missionaries (Duncan, 1958), traders and administrators played an important role. At the Berlin Conference the issue of eradicating endemic and tropical diseases was discussed (Tshibangu, 1976: 72). To successfully carry out the colonial work, creating medical services in the Congo was an imperative (Janssens, 1992). Hence, the creation of the first Congolese Hospital in Boma in 1889. This was followed by the creation of a medical laboratory in Kinshasa (then Leopoldville) in 1889 (Cornevin, 1963: 212). Medical laboratories for the study and prevention of tropical and endemic diseases were created in the main towns. These included E'vil¹ (*recherche bacteriologique et virologique, preparation antivariolique*), Bukavu (*rikketsdioses*), Stanleyville² (*Fievre Jaune*), Coquilatville³ (*typhus murin and therapeutique de la lepre*) (Cornevin, 1963: 213). These laboratories were supervised by the School of Tropical Medicine of Brussels, which was created in 1906 (Cornevin, 1963: 212).

The medical activities of missionaries in the second half of the nineteenth century was associated with the work of evangelisation. Missionaries were 'pastors' or priests' who carried with them medicine that they were able to give to indigenous people. Nevertheless, a formal medical missionary activity in the nineteenth century began with the *Svenska Missionsforbundet's* (Sweden Missionary Society) creation of Mukimbungu's hospital in 1891 (Janzen, 1978: 15). The second and the most important medical achievement by missionaries (Protestants) was the creation of the Evangelical Medical Institute (IME) in 1950 (Janzen, 1978: 27).

In spite of conflicts and polemics in the process of accepting Western medical practices, the *savoir-faire* and techniques of Western medicine have been accepted, learnt, and disseminated by the majority of Congolese (Duncan, 1958:15). This is partly due to the achievement of Western medicine in the history of combating endemic diseases like sleeping sickness, leprosy and

other tropical diseases that threatened and claimed the lives of many Congolese during the first three decades of the twentieth century (Janzen, 1978:15). The acceptability of the effectiveness of Western medicine in the Congo can also be seen in the highly acclaimed programs of health education such as those developed by Dr Courtejoie. His programmes for health education permeated all Congolese social spheres. They were easily accommodated both in rural and urban sectors. This is what is demonstrated by the following account about a Congolese rural teacher's approach to health education.

“A newly graduated teacher was walking with his friends. Suddenly, the teacher stopped. He took a knife from his pocket, and pierced the empty sardine tin thrown on the street...His friend could not understand why such an act. Just to be told: 'Don' t you know that the rain season is approaching? Mosquitoes will come to make their eggs on the stagnant water in this tin and that will cause malaria” (Courtejoie, 1969:14).

Furthermore, it must be admitted that the modern medical system with its corpus of knowledge provides a massive anatomic knowledge of the human body (Foucault, 1973: 129) that remains unknown in the traditional Congolese systems (I.D.R.C, 1980: 26). This knowledge associated with the growing medical technologies and pharmacopoeia was very appealing. This can be relevantly demonstrated in the encounter at the beginning of the twentieth century of the British Baptist Missionary doctor nicknamed '*Bonganga*', meaning the medical practice and his Congolese evangelist nurse, with the villagers whose undisputed traditional healer was Kanga. The following can be quoted for the purpose:

“Gently Bonganga examined the boy in full view of the curious villagers. So many suffered from the same complaint, yet it was one that could easily be cured with modern drugs. If he could only treat one patient, if this child could be cured, perhaps others would come for treatment.

He looked at the flat, uncompromising, doubtful face of the mother, her skin scarified by tribal markings. The strongest emotion of these people was their love of children. He held out a finger, but the curly-headed boy, with his protruding stomach, the navel pulled out by the

mother and distended into a hernia as a sign of beauty, turned his head away. The mother's arms tightened, the child whimpered. If only Bonganga could inject, the horrible sores on the child's boy would soon begin to heal. He took his syringe from its case.

The mother's arms clutched her son so that he shouted with pain. "It will kill", she cried.

Bonganga smiled. "No, it will cure your child."

The fear remained on her face. The watching villagers muttered among themselves. Kanga, the witch-doctor, remained silent and impassive, ready to leer with triumph if Bonganga failed. The child, sensing itself to be the centre of the disturbance, began to howl with rage.

I will show you that your child will be safe, Bonganga promised, and instructed Lotoba to sterilize the syringe. This he filled with water. Then he rolled up his sleeve, and plunged the needle into his own arm.

You see? he asked the mother. It does not kill me, and it will not kill your boy. I have powerful medicine that will soon make him well.

He knew that the injections would have to be continued for a time, but the first would give obvious, quick results, and the mother would be encouraged to let him treat her son again.

Almost reluctantly, with a fearful glance at Kanga in case he should not approve and cast some evil spell on her family because of her action, the mother held the child forward. Lotoba prepared the buttock. His syringe charged this time with the proper drug, Bonganga injected. The child let out a yell as the needle pierced his flesh, but the villagers were curious now. Eagerly they crowded round. They watched fascinated, as he took their blood pressures, and let them listen through his stethoscope to the beating of their own hearts. Bonganga could do little more than make a census of their illnesses, and they went away muttering because he had not used "the needle" on them all.

Finally Bonganga turned to Kanga. This was the most impressive examination. He tapped and listened to the hairy black chest, peered down a throat guarded by huge, ugly teeth, drew a spot of blood and permitted the amazed witch-doctor to look down the microscope at the wriggling little parasites which had shown no favouritism, and invaded his body as those of the people he dominated.

Kanga peered suspiciously into the microscope, then looked angrily up at Bonganga. That's not my blood, with all those snakes in it!

Bonganga removed the slide, and showed it to the witch-doctor. There could be no doubt that the blood was his. Let me see it again, Kanga demanded. Bonganga pushed the slide back, and once again, Kanga lowered his head to examine his own blood.

He stood up sharply. It is the white man's magic, he stormed. Knocking over a chair in his fury, he stalked over to where his enormous family was waiting. With rage stiffening his moments, and his ornaments clanking, the grotesque figure disappeared into the forest, his entourage hustling after him" (Duncan, 1958: 16-8).

Despite the nature of the language used by Duncan, nevertheless, the importance of his work is its content regarding the acceptability by Congolese of the relevance of biomedicine. Therefore, whatever criticisms against Western medicine (Iwu, 1986: 10), with its views on the body, aetiology, nosology and pharmacopoeia, Western medicine does not contradict the quest for health that is inherent in Congolese traditional therapeutic systems. For the Congolese patients these are not seen as conflicting but complementary therapeutic systems (Janzen, 1978: 215). This issue is the core of Janzen's work as encapsulated in his last two chapters. In fact, Janzen has observed that the '*Kisi-nsi*' (traditional medicine) and '*kisi-mundele*' (biomedicine) (*Kik*) (Janzen, 1978: 37) co-exist in Congolese therapeutic history to the extent that they are simultaneously used in the process of addressing one disease. As a matter of fact, a healer will refer to biomedical practices when patients are thought to suffer from diseases whose causes can be addressed by biomedicine. Janzen's observation unveils that:

"Inspirational diviners such as Mama Marie have begun to refer to the hospital cases which, like the child coughing and spitting phlegm, required immediate medical attention. Said Mama Marie to the mother, "No! The child's condition has not been 'caused by somebody in the family.' It is an illness the dispensary can best treat, so get the child there at once" (Janzen, 1978: 227).

Thus, a pluralistic therapeutic approach, that which combines different therapeutic systems, is part of Congolese therapeutic discourse (Ma Mpolo, 1976). The rationale or the explanatory theory to this concomitant co-existence

is that each of these systems has a particular contribution to the quest for health. The uniqueness of biomedicine is recognised in terms of its efficacy in addressing the natural disease (Iteyavyar, 1992: 45) while the traditional remains the sole system for addressing the 'why' question. The Kongo express this view in a metaphoric language. The medical doctor is the '*Nganga Nseke*' (the doctor of the land) and the traditional healer is the '*Nganga Maza*' (the doctor of the water) (Janzen, 1978: 229).

On the basis of views expressing reasons of the acceptability of biomedicine in the Congo as discussed in this section 5.5.2 (p.143-147), Foucault's notion of power, implying the idea of docile bodies, is a problematic concept in accounting for the conditions of acceptability of Western medicine by the Congolese. The acceptability of Western medicine in the Congo depended largely on the Congolese self-assessment of biomedical effectiveness. Thus, interpretations of the acceptability of Western medicine should go beyond Foucault's theoretical paradigm of the disciplines (Foucault, 1977) which suggests the absence of dialogue. The encounter of the Bonganga, the Baptist Missionary (Duncan, 1958), to which I referred earlier in this section is very illustrative.

However, this does not undervalue the fact that the acceptability of Western medicine has served as a tool of control, repression and oppression of the Congolese. On this issue, my argument concurs with the triple hermeneutic discourse of histories of biomedicine in the African continent. This is history of biomedicine as achievement, function and repression (Butchart, 1998: 2). Its recognised uniqueness lends to it becoming a valuable means for control and claims of sovereignty over the Congolese. Consequently, Foucault's concept of disciplines as tools of control cannot be easily exhausted within the Congolese context of encounter with Western medicine. For the latter, associated with capitalism and imperialism, remains an excellent tool of control. It is a tool, in

the service of the politically powerful, used for sustaining a dehumanising social stratification (Foucault, 1985:496).

The Belgian government is attributed with the creation in the Congo of the most prestigious health system in the history of modern medicine in Africa (Lashman, 1975: 85; Kivits, 1992: 151). Their supervision restricted by and to Belgian experts gave them an exclusive European flavour that contributed to their deterioration in the post-independence era (Lashman, 1975: 85). This corroborates the view that the colonised and colonisers had no common medical facilities (Winsome, 1993: 80). On the independence there was not a single Congolese doctor, only auxiliaries nurses and dentists. Nevertheless, the state, the churches and parastatal organisations constitute the main channels of modern medical systems (Devisch & Persyn, 1992: 133). Based on information gathered by the Protestant missions, Lashman (1975) presented the following statistics regarding the then recorded modern medical infrastructure.

Table 5.1 Health Facilities in Zaire

Types	Protestant	Catholic	Government	Private	Total
Hospitals	64	31	82	27	204
Dispensary/Maternity	74	184	20	*	278
Dispensary	290	38	8	5	341
Sanitarium (TB)	2	2	2	-	4
Leprosarium	9	1	5	-	15
Training Schools	14	20	7	4	45

Note: * denotes unknown

Source. Lashman (1975). p87.

Table 5.1 indicates that Protestant missions were the largest health care providers. They had 439 health facilities and 14 health medical schools (Lashman, 1975: 107). In response to the alarming deterioration of health

systems, particularly those in the public/government sector, there were, in the 1980s, attempts by Christian organisations to create clinics, medical centres and hospitals. The most recent and prestigious being the Kimbanguist Hospital of Kimbanseke⁴.

5.5.3 Christo- spiritual therapeutic systems

The Christian spiritual therapeutic systems in the Congo are as important as the traditional and Western medicine (MacGaffey, 1983: 150). They have been particularly associated with the recent rise of independent African churches (Devisch, 1996c). Nevertheless, the presence in the Congo of Christian therapeutic systems can be dated from the 1920's with Kimbanguism (Devisch, 1996c: 556). They represent a reaction to mainstream church theologies (Konde, 1994: 13) as well as the uncertainties of social (MacGaffey, 1983: 79) economic and political life. However, healing in these churches is to be grasped not only in somatic terms but also in a holistic context. For these churches address situations and anxieties arising from daily life (De Rosney, 1992: 129-130).

It is also important to note that the Christo-spiritual therapeutic systems are not to be restricted to the African independent churches. They are also practised in mainline churches where they operate within the context of God's holistic salvation for humanity as a whole (Gusmer, 1974). The difference, between the mainline churches and the African independent churches, is in the emphasis. In the African independent churches much emphasis is put on healing (Devisch, 1996c). For this reason, this section will be devoted to the discussion of healing in the independent churches.

The aetiological discourses of independent churches have given them the credit for rehabilitating the traditional Congolese concept of health. As a consequence, they have attracted masses regardless of their social backgrounds (Dehaes, 1994: 411). They have become, in particular, the

therapeutic *locus par excellence* of 'the have nots' of the despotic regimes (Devisch, 1996c: 556; Buakasa, 1996: 44-5). In their massive numbers these churches have acquired from their users a status similar to hospitals. For some leaders of these independent churches apply the same policies of organisation, registration and hospitalisation as those found in the biomedical settings. Yet, like in the case of healers' practices, as discussed in section 5.5.1 (p.141), these churches operate also within the framework of tolerance and repression. Hence, there is also in this healing arena, the disciplinary cycle of exploiting and being exploited for selfish lucrative as well as therapeutic gains. A view expressed in London by Ngengi, a former leader of one of these churches in the Congo.⁵ Another analogy to that evoked in the context of healers is that these churches attract even the wealthy members of the kleptocracy.

While factors of accessibility, affordability and availability would partly justify reasons that healing is sought in these churches, the presence of those who can afford the cost of Western medicine leads to consider the acceptability and effectiveness factors. This is related to their spiritual/religious or cultural reasons. For God whom they worship in these independent churches is believed not to exclude the Congolese traditional views. Thus, the social dimension, symbolism and rituals, kinship, household and friends, the dead and the living are given a prominent place in diagnoses and healing. In addition, reacting against the social and political instabilities, these churches operate with the logic of creating among them a '*sanctorum-communio*' (a community of the saints) (Oosthuizen, 1979: 12; Martin, 1975: 168) which replaces the broken families and kinships.

It would therefore follow from what is discussed in the last paragraph, that the Christian idea of God being the originator, the sustainer and the destiner of human life, is one of the reasons that the Christian spiritual therapeutic systems are accepted in the Congo. The acceptability of the Christian therapeutic systems have resulted to their use alongside biomedicine and traditional

healing systems. This synchrestic or integrative approach, as can be evinced through the work of the late Congolese neuro-psychiatrist doctor Parsekle, is part of the current therapeutic quest in the Congo (Janzen, 1978). Converted to a Charismatic Christian movement in the early eighties, in Kinshasa, doctor Parsekle became the archetype of the current medical profession for Congolese doctors. Exorcism, fasting and other Christian rituals were part of therapeutic interventions in his surgeries⁶.

5.6 Therapeutic activities in the Congo

5.6.1 The traditional therapeutic systems

Considering the Congolese concept of health discussed in section 5.4 (p.137-140), it would follow that at the heart of the traditional Congolese therapeutic activity is the concept of gaze (Douglas, 1998: 26). This traditional gaze implies nosology, and therefore the configuration of diseases. Provided the view that, as stated in section 5.4 (p.138), the individual body is the medium, the image or the victim of the state or conditions of the social body, the trajectory of the Congolese traditional healer's gaze goes from symptoms to the social body. The social body is not only made up of living beings but by the dead as well. Thus, in relation to the quest of health, the Congolese healer has a triple gaze. The gaze of the body, the gaze of the community (the living and the departed) and the gaze of the cosmic forces.⁷

Differences between the Foucauldian and the Congolese traditional healers' concepts of the gaze lie in their geometry and the object of the gaze. For Foucault, the gaze is seen as that by which medical knowledge is acquired (Foucault, 1973: 9). It is an anatomical physiological gaze. It penetrates the physical body to scrutinize the tissues and cells (Foucault, 1973). In this gaze, medical knowledge is not pre-given or finite. Medical knowledge is a constant quest.

In the Congolese traditional context, the gaze of the healer does not penetrate the body to make of tissues and cells objects of medical knowledge. In this traditional Congolese therapeutic setting, the internal space of the body is quasi-unknown. Thus, the gaze of the healer is an affair of pondering symptoms on the observable parts of the physical body in relation to dynamics of social and cosmic forces within the universe. In fact, gazing on tissues, which include the opening up of the corpses for medical knowledge (Foucault, 1973) contradicts the traditional philosophy of personal immortality. This is the philosophy according to which one's life goes beyond the hereafter (Mbiti, 1969: 25-6). This justifies reasons for proper burial and all funeral rites by the community of the living after one's death. However, Foucault's gaze (Foucault, 1976b: 2) for mental illness would have some similarities to the Congolese traditional gaze. The reason for this is its focus on the patient history. Nevertheless, the Congolese traditional gaze attributes to both mental and organic pathologies the same symptoms and aetiologies. For, while causes for particular ailments are to be investigated, aetiological and therapeutic knowledge is finite. The healers investigate causative factors that have to correspond to the accepted traditional nosological and aetiological taxonomy for legitimate traditional forms of cures.

Like the 19th century medical systems, the Congolese traditional systems of health have an anatomic atlas that is made up of sight, touch and hearing. This atlas accompanies the divinatory and therapeutic function of the diviner and healer. Grounded in the traditional worldview, its uses differ from that described by Foucault. For, as previously mentioned, this atlas touches and observes the physical and the social body as well as cosmic forces. Healers, as will be discussed further, will investigate members of the family (even friends), whether alive or dead, near or far. This is part of the healing therapeutic process.

The traditional therapeutic systems are organised around healers classified into four groups that consist of the pure-herbalists, herbalist-ritualists, ritualist-

herbalists and spiritualists (I.D.R.C, 1980). Common to all of them is divination without which diagnosis is impossible. Divination is that art by which, gazing through the visible and the invisible, healers speak of the causes and suggest the therapy. Objects such as horns, statuettes, fly-chasers, Kola nuts, and mirrors are usually found on the healers' table for divination. These are media that healers use for divination. These media are also said to have 'therapeutic efficacy' (Kolie, 1991:137). The extent to which divination is used differs from one group to another. With regards to therapies, herbalist-ritualists and ritualist-herbalists use plants and rituals in a quasi-simultaneous or alternative manner. The distinguishing feature of the ritualist-herbalists is the predominance of rituals over herbal therapy. An emphasis that is reversed in the approaches of herbalist-ritualists.

The exercise of distinguishing one group of healer from another can to some extent be largely academic. As in Kinshasa and Lower-Congo, the first three mentioned groups of healers are commonly known as *Banganga* (Ling & Kik) (healers). The spiritualists in these two regions would be called *Ngunza* (Ling & Kik) in the case of male healers, and *Mandona* (Ling & Kik) when female healers. The ability of the spiritualists to disclose hidden secrets led Kongo people to deploy another significant term, that is, '*Nganga Ngombo*' (MacGaffey, 1983: 283) to mean the diviner or the one who discovers secrets.

It is through divination and the cosmological hermeneutics of disease that healers establish their diagnosis (Iwu, 1986: 30), the rhythm and the nature of the treatment. Divination is the only traditional and the most sophisticated technique by which the process of uncovering ultimate causes is possible. In fact, as asserted by Lartey:

"Divination is a form of revelation. It goes beyond mere diagnosis, the examination of the patient and the knowledge of natural cures and remedies, to include the analysis of dreams, the restoration of mental hygienic balance and the dynamics of human and supra human relations" (Lartey, 1994: 41).

Divination enables the healer to address relevantly the aetiological fundamental question of 'Why me/him/her/us? Though the art of divination is the paramount tool of diagnosis that each healer should possess, the '*Nganga Ngombo*' (Bockie, 1993: 68) are the chief diviners. Their major function is to disclose the ultimate cause of disease, illness or any unfortunate experience (Laman, 1962: 75). Consequently, they suggest the healer be consulted for the appropriate treatment.

Congolese traditional healers, in similarity to the Azande from Sudan (Lyons, 1992: 196), are the most knowledgeable about the use of traditional medicine. Nevertheless, most families would have common knowledge about traditional medicine that they use without consulting a professional healer. There are also those with specific gift of knowledge on a particular disease but who do not fall into the category of professional healers. They use it whenever need occurs. Moreover, although healers in general are consulted to address any type of ailment (Buakasa, 1980: 249; Rhodes 1976: 14), the issue of expertise or specialisation of healers is paramount. Some healers are renowned for dealing with particular issues such as madness (*Nganga bulau*) (Janzen, 1978: 195), sterility, marital problems, employment questions, etc. Therapies given can be medicinal, involving the use of plants, or ritualistic using religious symbolism: incantations, water, or traditional songs (Devisch, 1996a).

In relation to the view evoked in section 5.5.1 (p.142) that healers in rural areas are ethnically oriented, in urban areas the ethnic/regional factor is dominated by a national or multi-cultural vision. People regardless of their ethnic or social backgrounds consult any healer. However, the healer's nosological and aetiological basis remains grounded in his/her ethnic background (Devisch, 1993; Ma Mpolo, 1976). This explains why in urban areas healers would first attract patients with whom they share a common ethnic background. The logic implied is that healers would be more aware of the reasons for pathologies of patients with whom they have a common cultural cosmology.

Despite the existence of distinction among traditional healers (Janzen, 1978: 194-195), another striking common point in their therapeutic approach is their therapeutic linguistics and liturgies. These are the incessant use of traditional proverbial expressions and metaphors (Janzen, 1992c: 123) through songs and constant dialogue between the patient's relatives, the patient and the healers. In fact, any traditional healer would incarnate three distinct roles in his/her therapeutic processes. To translate these into modern therapeutic vocabulary, a traditional healer acts as a:

Psychologist: To grasp the patient and close relatives' states of mind is paramount to the traditional healer. The healer raises the patient and the relatives' psychological spirit to the level where there must be an agreement about the diagnosis and therapies. Moreover, using the techniques of family counselling, healers grasp the social dimensions of the conflicts that are often believed to be the chief causes of one's illness or disease. In fact, this is the first role of the healers. As Hours has observed where the biomedical system 'looks for the causes of functional disorder, a sick African will see the sign of some non-organic, human, social cause' (Hours, 1986: 48). Thus, it is as a psychologist that the traditional healer will rehabilitate (Devisch, 1983: 30) the patient in his or her social contexts through the dynamics of confessions, forgiveness and reparations carried through rituals and ceremonies.

Psychoanalyst: The healer uses both the techniques of questioning and the art of divination. The healer brings patients and their families to remember hidden broken taboos, rules and duties in relation to the history of their genealogy. It is a work on the subject's conscience in order to disclose hidden aspects that might be suspected as the cause of unfortunate experiences. The work in this arena is on the concept of 'Vital force' (Mulago, 1973: 121). It unites, vertically and horizontally, kinsmen from time immemorial through beliefs, rituals, ceremonies and taboos. Vital force is that which nurtures the longevity of genealogy. Its distortion is believed to be a source of various predicaments.

Medical doctor. The healer treats the afflicted body whose organic malfunctioning, as said in section 5.4 (p.138), reveals the social and cosmological imbalance (Hours, 1986: 48). In fact, it should be stressed here that the emphasis on African Traditional therapeutic systems as being mainly effective for social, psychological ailments (Hours, 1986: 47) could be misleading. For the body is of great importance. It is that through which existence in its wholeness is experienced. The healer as a medical doctor uses his/her cosmological understanding of herbs and plants which, s/he might have acquired either by special initiation (training) or by a special innate gift (Iwu, 1986: 22).

To paraphrase what has been said in this section, unless this three-dimensional function is encapsulated and noticed in a healer's profession, any suggested diagnosis and therapy are subjected to doubts. Healers success and prestige are related to the effective combination of psychological and social skills (MacGaffey, 1983: 149) in order to restore the patient's correct balance (Tchetche, 1996: 133). This is at the core of the healer's practice. For the healer (*nganga*) must, in one way or another, be seen by people as 'the expert, the technician or operator, the priest or the magician' (Janzen & MacGaffey, 1974: 6).

5.6.2 The modern medical system

Though acceptable, the practice of Western medicine in the Congo is not always available, accessible, affordable and effective. This is due mainly to the socio-economic and political insecurities that prevail in the Congo since the *coup d'etat* of 1965, when Mobutu came to power. These conditions have not spared the churches and other main channels, evoked in section 5.5.2 (p.142-143), of modern medical systems in the Congo. In addition, modern medicine has mainly been limited within urban cities where economic and social capitals (Bourdieu, 1979) are the factors of its accessibility. The quality of treatment due to the lack of medicine (Kamandji, 1998) makes the practice of Western

medicine in the Congo ineffective. There is no sustained significant research into local health and illness (Alo & Lukunga, 1993: 175). Private clinics where viable treatment may be possible operate with the principle of money before treatment. The effectiveness discourse determines the therapeutic option in terms of the aetiological discourse. It does not guarantee accessibility for biomedical interventions. In fact, while the current government is said to be struggling in order to disrupt the social capital discourse *ndeko ya (Ling)* as a condition of accessibility, the economic capital discourse (Bourdieu, 1979), '*mbongo ezali te, kisi ezali te*' (*Ling*) (no money and no treatment), reigns. This is what can be grasped from the following account:

"A clinic in Ngaliema does not hesitate to separate the newborns from their mothers until the hospital cost is paid. We have heard that in one clinic, those who have not been able to pay the costs have been arrested with their babies. One of these women has been kept for eight months while, another woman has been kept even three months after the death of her baby" (Kamandji, 1998: 64-5).

This whole picture of biomedical practice in the Congo is encapsulated in the following words:

"At the hospital, the patient must bring his/her own medicines and food. It happens for patients to be kept in till they have paid their bills. Mental patients and drugs addicts go out on the street in search for food" (Devisch, 1998:67).

It would follow with such a scenario that the biomedical therapeutic option is relegated to oblivion. As mentioned by Mampuya, a Congolese refugee in London, the popular discourse puts it well '*Ya kolia kutu ezali te, bongo oya kisi ekomonana*' (*Ling*) (How can I have money for biomedical treatment, when I do not even have some for food). The continuity of disastrous political episodes in the Congo, makes the country's medical care system as a domain in which all needs to be reorganised '*tout est a refaire*' (Devisch, 1998: 59). For as observed by Masiala, a final year student at the University of Kinshasa, the quasi-familiar slogan '*Sante pour tous pour l'an 2000*' (*Fr*) (Health for All in year 2000) does not remove the inhuman and demonic spirits that invade the Congo's medical ethos.⁸

5.6.3 The Christo-spiritual therapeutic systems

Therapeutic sessions in the Congolese independent churches such as the *Mpeve-A-Nlongo* (Holy Spirit) evolve around two main factors. The *Mbikudulu (Kik)* (prophesying) and *Lusalusu (Kik)* (the cure/therapy) (Devisch, 1996c: 563). The prophesying or divination is carried out by the priest/pastor whose gaze transcends the afflicted body to all the networks of the individual's existence. This is an important aspect of the existence of these churches. For:

“The leader, pastor or prophet has a central place; he is a corporate personality, a metaphysical centre, he is the classical personification of the dynamic expected future.

In him the expectations are symbolized, God has become through him a merciful father” (Oosthuizen, 1979: 11).

Thus, the pastor or the leader's diagnostic gaze discloses the origins of afflictions and determines the therapeutic modes. Dreams and visions are also part of the diagnostic approach within these churches. Members speak of their dreams or visions whose interpretations are also the domain of the pastor and other charismatic leaders (Devisch, 1996c). Diagnoses often relate an individual's predicament or bodily ailment to social conflicts.

While therapies include different religious rituals, confession/repentance and restoration of social ties are the very much stressed. Rather than focusing only on divination and family palavers, independent churches base their therapeutic approach on New Testament teaching. Such texts as James 5:13-16 and Mark 16: 15-18 are constantly evoked. The laying on of hands, the application of oil, fasting, the use of water and exorcism are also commonly used therapeutic techniques (Devisch, 1996c). The use of water carries the symbolism of purification '*(kosokola (Ling) (to take bath)*'. This is a necessary therapeutic ritual that is carried out either by the priest or other members of the church whose therapeutic allegiances are recognized.

It should be added that different symbolic elements such as water, salt, earth, staff as used in therapeutic sessions are believed to function *ex opere operanto*. This is to say that having been prayed for and submitted to different ritualistic performances such as dances, singing and prayers, they are distributed and kept by people who use them whenever there is an ailment of any form (Martin, 1975: 174; Hagenbucher, 1992: 97). Moreover, while most healing seances take place in the church setting, places like shrines, rivers, and bush are also seen as symbolic healing arenas (Oosthuizen, 1979:9).

5.7 Health protection: the quest for health promotion in the traditional and Christo-spiritual contexts

Discussions of the traditional Congolese therapeutic systems and the Christo-spiritual systems indicate that life in its wholeness is their focus. Thus, the concept of protection as a component of health promotion (Downie et al., 1992:57) would precisely describe some of the practices in these two therapeutic systems. For health protection as defined:

“...comprises legal or fiscal controls, other regulations and policies, and voluntary codes of practices, aimed at the enhancement of positive health and the prevention of ill-health” (Downie et al., 1992: 51).

The idea of ‘protection’ evokes the necessity of a constant awareness of risks. Thus, protective and preventive measures are to be adopted against potential dangers that threaten human existence (Laman, 1962: 77-78). In the traditional Congolese setting, individuals protect themselves against any form of misfortune or experience. This is either to prevent the misfortune, ailment or disease from re-occurring or to eradicate its expansion (Downie et al., 1992: 49). This is the case with chickenpox and death, etc. In addition, people would consult healers in order to be protected against witches (Buakasa, 1988; 1980: 249).

Protection in the traditional context includes also consideration of such issues as the self-control attitude and the nutritional imperative. To protect oneself against ill-health, morality and nutrition are respected. The logic of the self-control attitude implies caution in terms of relationships. For as evoked in section 5.4 (p.138), one's evil actions and words (Brown, 1996) can be causes of poor health. Thus, harmonious relationships are to be nurtured to enhance good health (Dehaes, 1994: 411, Douglas, 1998). This constitutes the moral dimension on which one's life is regulated daily. To illustrate, hatred, quarrels, misbehavior to elders, sexual misbehavior, robbery, excessive work and lack of hygiene have to be avoided for good health. It would follow that health protection in the traditional context is first and foremost an ethical orientation. It is the pursuit of virtue *coram mundo* (Lat) (in relation to the world), *coram hominibus* (Lat) (in relation to fellow human beings including the ancestors to whom libation is to be systematically offered), *coram Deo* (Lat) (in relation to God) and *coram meipso* (Lat) (in relation to oneself).

The nutritional factor emerges from the Congolese physiological knowledge that the body has to be physically nurtured or sustained to achieve the right balance of health (Ulimwengu, 1998). The lack of rich nutritive discipline is believed to expose the body to various pathological conditions. In this context, as can be observed in the traditional Congolese societies, people have a massive corpus of dietary knowledge (Gisaangi, 1980:16). In this traditional context, the consumption of food is carefully balanced according to the particular contributions each type of food brings to the body. Mampuya's thoughts and analyses reported in section 5.6.2 (p.157) imply that the socio-economic and political climate of the country has made the maintenance of such a dietary balance impossible. Many experience food as a mirage rather than a reality.

The Christo-spiritual therapeutic systems share much with the Congolese traditional concept of health protection. They have a common understanding of the presence of malefic forces. This is reinforced by the Pauline statement

according to which human existence is a constant struggle against the powers of this dark world and the spiritual forces of evil in the heavenly realms (Eph 6: 12). Thus, in the Congolese independent churches, such ascetic rituals as fasting are seen as important means for health protection. Fasting, for instance, is viewed as an arsenal against destructive powers or influence.

The concept of 'protection' as defined in this section constitutes one of the levels on which Congolese concepts of risk should be apprehended. For risks are not only physical or material in nature. They are also spiritual or invisible. They are a threat to the individual, the family, the village and the society as a whole.

5.8 The therapeutic managing group: its role in therapeutic options

Given the logic that disease or illness is a way towards total social poverty (Buakasa, 1988), the patient in Congolese society is the focus and the concern of everyone. The patient is the symbol of potential familial misery. Therefore s/he is a person to be cared for in order to dismantle the impoverishing process. The search for therapy is thus a collective imperative.

It is Janzen who has coined the term 'therapeutic managing group' (Janzen, 1978: 4). It has been recently used by Douglas (1996a: 34) to speak of those who search for healing alongside the patient. The existence of this group stresses the social concept of disease and health. This social basis of illness and health implies the prevailing rationale of community suffering with the patient. The therapeutic managing group in its solidarity is made up of kin from paternal and maternal sides as well as of friends. Prior to consulting the healers, the therapeutic managing group has a preconceived statement of the true cause of one' suffering (Janzen, 1978:4; Fink, 1989: 33). In this case, recognizing the exceptional expertise of the healer, the latter is consulted to confirm what the therapy-managing group holds as true to start a therapeutic process. The group discusses and rejects the validity of the healer's diagnoses

when they do not concur with theirs. This is to say that the diagnoses that incarnate the healer's power might be rejected if they are viewed as trivial or contradictory to the fundamental beliefs or aetiologies of the therapeutic managing group (Janzen, 1978:142). Hence, the beginning of the process of uncovering truth from other healers' opinions.

The same attitude is adopted in regards to options for biomedicine or Christian therapeutic systems. A reference is made to a medical doctor when the illness or disease is thought to have a natural cause. The choice for Christo-spiritual therapeutic systems is always referred to whether the case is thought to have natural or supernatural cause. This is justified by the logic of God's omniscience and omnipotence.

Conflicts between the therapeutic managing group and the healers' diagnostics or therapies (effectiveness) are not the only reason for moving from one healer to another or from one therapeutic system to another. For as argued by Janzen:

“The therapy-managing group must achieve internal cognitive agreement and social consensus in order to be an effective decision-making body. This does not happen by itself, for decisions reached by a minority among the sufferer's caretakers may be invalidated by a dissenting majority; resolutions made by laymen may be shifted after consultation with specialists; or specialists' recommendations may be amended or ignored by laymen; and so on” (Janzen, 1978: 139).

It would follow that the therapeutic managing group is a cluster of individuals where democratic principles must operate for therapeutic options. Hence, the relevance of the '*lukutukunu Iwa dikanda*' (the clan council) (Janzen, 1978:135) to maintain the harmony required for therapeutic purpose.

5.9 The question of power in Congolese therapeutic settings

The notion of power is paramount in the Congolese therapeutic settings (I.D.R.C, 1980: 21). In the traditional therapeutic context, it discloses the nature of the relation that exists between the groups involved in the quest for therapy

and the patient. The Ghanaian scholar, Lartey, has understood this in stating that:

“The traditional healer may exercise social power -the power channeling, resolving or utilising social conflicts embedded in the tribe or community. They often function as conflict experts who detect the active agents of conflict situations and exercise the power to control or direct them. The Nganga in Zaire is seen as a great peacemaker and the guardian of the community. He has wide knowledge of such things as the history of family lineages, the origin of villages, the relationships among clans, the roles and psychologies of each member of the community. He uses these data to restore or maintain the necessary equilibrium in community relationships” (Lartey, 1994: 41).

Healers' power is structural or hierarchical (Laman, 1962: 176) and functional. The healers possess power by virtue of their function. Having the cultural capital for therapeutic needs, they also possess a symbolic capital (Bourdieu, 1979). Thus, healers are socially elevated and respected (Mbiti, 1969:, 171, 188). To accept their diagnosis is to act according to the authority of their knowledge. The healers' power exercises a control over the patient and the therapeutic managing group. Their discourses and practices regulate the acts and behaviours of the patient and of the therapeutic managing group. The power of the healers '*logoi*' discourses becomes inherent and permanent in their minds so that healers' instructions and restrictions on sexual intercourse, sleeping positions, places to go, people to talk to, what to eat, are observed for the sake of the rehabilitation of the sick person. Such is the power of the healers which is manifested in what the Kongo would call '*minsiku mia nganga*' (*Kik*), healer's restrictions.

It must, however, be stressed that healers' restrictions are accepted in so far they are the language of the process of recovering and breaking the power of what is held as the ultimate cause of one's predicaments. In this particular context, Foucault's concept of disciplines that would suggest an oppressive unilateral form of relationship between the healer and the patient does not apply. The patient and the therapeutic managing group, as indicated in the last

section (p.162), do not act as docile bodies or panopticon (Foucault, 1977). Their relationship with the healer is based on legitimate therapeutic grounds. For, as mentioned in the last section, in cases of disagreement between healers and the therapy-managing group, there are possibilities for consulting other diviners. This is the stage where extended familial palavers become so important in avoiding the division of the family. For, the family is regarded as the first therapeutic circle. Foucault's concept of docile bodies does not reflect the traditional dynamics of the Congolese relationship with the healer. The traditional context is that of dialogue and contest. Yet, the patient and the therapeutic management group are not wholly ignorant of that which is being suggested to them.

Pastors and doctors are also invested with symbolic capital (Bourdieu, 1979). The reason for this being that they also share the required cultural capital for therapeutic purposes. However, this does not exclude a counter-discourse from the therapeutic management group or from the patient when there is disagreement in terms of diagnoses, therapies and other policies involved in the therapeutic process. This constitutes the basis of migration or exodus from one church to another by many members of these Congolese independent churches.

5.10 Conclusion

This chapter, about concepts of health and therapeutic options in the Congo, has provided a basis to comprehend some aspects of health issues and therapeutic options in the Congolese refugee community. The chapter has shown that there are three therapeutic systems in the Congo. The Congolese traditional therapeutic systems, biomedicine and the Christian therapeutic systems. In addition, the chapter has indicated that the Congolese concept of health is as complex as the health promotion discourse. Health is understood in terms of wellbeing emphasising all aspects of human existence. Hence, the eagerness to combine the three therapeutic systems mentioned in order to

address the human being in its wholeness. The use of such therapeutic systems as biomedicine and the Christo-spiritual therapeutic systems, it has been argued, do not conflict with the Congolese concept of health in terms of wellbeing.

However, though biomedicine as a therapeutic system is acceptable by Congolese, the social, economic and political conditions prevailing in the Congo do not make it accessible, available and affordable to many. Yet, even when it is accessible and affordable, its effectiveness is questioned by the lack of medicine. Thus, biomedicine, it has been argued, is not an option for many Congolese. In addition, the pre-eminence of socio-economic and political instabilities has also an impact in the practice of Congolese traditional and the Christo-spiritual therapeutic systems. In these arenas, the repressive culture of exploiting and being exploited is at work. Consequently, both the Congolese traditional therapeutic systems and the Christo-spiritual therapeutic systems function as necessary means for lucrative or selfish needs. These issues which characterise the histories of quest of health in the Congo, as well as the practice of therapeutic systems as shaped by the socio-economic and political conditions constitute the comparative analytical basis with issues of health in the Congolese refugee community. The question will be that of exploring continuity and discontinuity in Congolese refugees' quest of health in London.

5.11 Notes

¹ Presently known as Katanga (Lubumbashi)

² Presently known as Kisangani

³ Presently known as Mbandaka

⁴ Kimbanseke is one of the most populated zones of Kinshasa. Its inhabitants are in majority very poor.

⁵ A dialogue with Ngengi on healing in the Congolese independent churches, September 1999.

⁶ I personally met Dr Parsekle and heard his lectures on '*Les maladies psychosomatiques*'

⁷ I had dialogues with Professor Douglas on the concept of gaze in the traditional Congolese context. As a result of these dialogues, she agreed on May 20th 1998 to deliver a paper on the anthropology of the body at the Institute of education.

⁸ Information obtained through Email on 27/07/99

Chapter VI. Concepts of health and the impact of Home Office policies on Congolese refugees' health

6.1 Introduction

This chapter discusses Congolese refugees' concepts of health and the impact of the Home Office policies of immigration on their health. Analyses in this chapter draw from the fieldwork data and theories discussed in chapters four and five. In so doing, the chapter establishes whether there are similarities between concepts of health in the context of exile and the views held in the Congo. The impact of the Home Office on Congolese refugees' health is studied by examining the fieldwork narratives in conjunction with available literature about the pathological effects resulting from conditions of exile.

6.2 Concepts of health among Congolese refugees: health as wellbeing

Four indicators have been used to study the Congolese refugees' conceptualisation of health. As will be shown further in this section, Congolese refugees define health in terms of wellbeing (Devisch, 1993). The first is that all responses to the question one of questionnaire I '*What does it mean for you to be in good health*' (Q1 of QI), considered the social, spiritual, economic as well as biological aspects of their life. The second indicator is the observations and participation in therapeutic quest sessions, which I have indicated in sections 2.3.3.1(p.43) and 2.3.3.3 (p.45). As will be discussed in sections 6.2.1(p.168), 6.2.2(p.171) and 6.2.3 (p.177), the Congolese refugees' aetiological theory relates some of their illnesses, disease or ailments to social and extra-physical breakdown. The third revelatory indicator is the observation and analysis of responses to the common greeting '*Ozali malam/ Bozali malam?* (*Ling*) How are you? I have noted, during the practice of fieldwork that responses to this common greeting would include experiences and relationships, so that a definition of their concept of health becomes very complex. The last indicator is the analyses of Congolese refugees' self-rated perceived health status. These analyses derive from data of question 18 of questionnaire I. Two observations

are noted about responses to this question. Health was neither defined in biological terms nor was it defined as an achieved reality.

The analyses of my data suggest two types of discourses expressing Congolese refugees' concepts of health. The prevailing discourse stresses the wellbeing factor while the second speaks of health in tri-partite terms. Their tri-partite discourse on health speaks distinctively of different aspects of a person's life. This discourse stresses distinctively the health of the body (*malamu ya nzoto*) (Ling), the health of the social body (*malamu ya libota to bandeko*) (Ling) and the person's economic, spiritual and political health '(*malamu ya bomoi*) (Ling). This distinction is only semantic. It indicates the pathological dimension of the wholeness that needs to be addressed. Thus, a tri-partite discourse is only a diagnostic discourse. The data analysis confirms that all these human dimensions are inherent and an indivisible unit of what I would call the Congolese refugees 'mono-discourse' of health. As further analysis proves, this is what prevails and orients their therapeutic quest. In fact the tri-partite discourse bears witness to the complexity of their concept of health as wellbeing (Buakasa, 1988; Devisch, 1993). An individual's account of his or her health state transcends the geography of one's physical body to include the social body, considering existential, economic and spiritual daily experiences. Health is accounted for on the basis of personal, relatives' and close friends' conditions as disclosed in their greetings. Hence, therapeutic approaches to be adopted would reject the prevalence of a biomedical or a dualistic concept that would undermine their traditional aetiological table of imbalance and extra-natural causes.

6.2.1 The question 'What does it mean for you to be in good health?'

The analyses of the seventy-two responses to the question above (Q1 of QI) have observed the following. 43.06% or 31 of respondents defined health as a state of happiness, 37.5% or 27 of respondents defined health as socio-economic and physical balance, and 19.44% or 14 respondents defined health

as being psychologically, socially, spiritually and physically strong. 65% (20 persons) of those who responded viewing health as a state of happiness are women, whereas most men defined health in terms of balance and strength. I wonder whether the higher rate of Congolese women's concept of health in terms of 'happiness' has something to do with women's concepts of health in terms of coping with biological and social factors. These views are sustained by scholars such as Oakley (1993); Bendelow & Williams (1998: 265) and Miles (1991: 59). For, as advocated by Miles, though men and women are co-habitants of the same world their unequal experiences of health make them of and from different worlds (Miles, 1991: 1).

Despite theories on women's perceptions of health, what can be stressed is that the analysis of Congolese refugees' concepts of health overlap and stress on a single reality, which is wellbeing. Happiness, through which health is being evoked, is consequential on stability in different aspects of life. The following interviews would confirm the scrutiny of these respondents' discourses.

Case study 6.1 The Kabongo's family views on health

A.N.N: *Kabongo, what does health mean for you? Mpo na yo kozala na 'sante' malamu ezali nini? (Ling)*

Kabongo: *Please, can you fully translate your question, mainly the term 'Sante', in Lingala? (Okoki kotiya motuna nayo nionso na Lingala, sante, elingi koloba nini na lingala?)*

A.N.N: *What does it mean for you to be in good health?*

Kabongo (Kabongo's immediate reaction) *Do you realise that the word 'health' does not exist in Lingala? That is the problem. Let me tell you, the word 'health' which is often used to speak of the bodily/physical health in biomedical circles does not explain what I am taught and believe of health. For me health includes all the conditions of my existence. It includes my body, studies, my wife, my children, my relatives, my job, immigration. Also my relations with my ancestors. Do not forget God though I do not go to church any longer. These are the things I think about when I consider health.*

A.N.N: *Do you not see that it is impossible to fully achieve all this? You cannot have a type of an idealistic view of the world as if things will always be fine for you?*

Kabongo: *You see where your Bible is leading you? You see. Believe what you want to but, this is what my family, my friends, and I believe what to be healthy means.*

A.N.N: *If this is your interpretation of what it is to be in good health, your life will be a continuous experience of being sick.*

Kabongo: *Whatever. A.N.N, do not get corrupted.*

Case study 6.2 The Mayangi family views on health

A.N.N: *What is health for you?*

Wife (Kiese): *It is a hard question. What do you think, 'Mayangi' (the husband)?*

Husband (Mayangi): *The question is first put to you Kiese, deal with it.*

Wife: *I think health must be accounted for in three or many different ways. There is the health of the body (when we need a doctor), spiritual health (when your relationship with God is no longer harmonious), social health (when there is a difficulty of any form among friends and relatives). This can also include the economic and political situation of any form to which one is directly related. Let us not forget mental health which is also a direct consequence of that which we cannot cope with. In fact bodily health and mental health can be a result of rupture or non-satisfaction, though naturally our bodies are not immune from variations, decomposition and death. I do not know whether my husband has any comment...*

These two interviews came from couples with an academic background. On this basis, I wanted to grasp their views on health as a universal reality. However, as their responses suggest they could only respond according to their cultural and social context. This is what is meant by Kabongo's sentence '*this is what my family, my friends, and I believe what to be healthy means*'. This stresses the view that health is a social and cultural construct as the lay concepts of health discussed in chapter two have shown (Aggleton, 1990; Blaxter, 1994). Yet, these two interviews carried out separately and from couples of different ethnic backgrounds are similar in terms of concepts of health. Kabongo's definition of health in terms of conditions and relationships is similar to the Kiese's family as expressed by his wife (*Mayangi*). The body, studies, jobs, immigration, family and God are the variables through which they account for their health. A holistic account of health which Kabongo sums up in terms of '*toutes mes conditions d'existence (Fr)*' (all my conditions of existence).

6.2.2 Observations and participation in therapeutic quest sessions

The pathological histories or accounts, diagnoses and therapies encountered during therapeutic sessions are revelatory of their concepts of health as wellbeing (Devisch, 1993). The following cases demonstrate this reality. The first case is about a couple in a therapeutic quest against sterility. The second is about a person diagnosed with HIV. The third is about issues around alcoholism and miscarriage.

Case study 6.3 The Charles' predicament

Charles: *We are so pleased to meet with you. We know how very busy you are but this is the nature of your work.*

Jacques (one of the Pastors in la Beta Church): *That's fine. We are also very pleased to meet with you. What can we do for you?*

Charles: *This is Nkengi my wife. We have known each other for almost fifteen years now. She was eighteen and I was twenty. We flirted for six years during which time she got pregnant twice and we aborted without our parents knowing. We did so because we were very young and it would have been a shame for her parents who in fact would not have accepted me getting married to her. After my secondary studies we decided to get married against the will of her parents. They said that I did not deserve their daughter. Because I loved Nkengi, against her parents will, she came to live with me. We have been together thirteen years now. Unfortunately, she never got pregnant again. I went to reconcile with her parents. My family paid what we had to but the situation has never changed. We consulted many doctors but still the same. She never conceived. The doctors' diagnoses have everywhere been the same. Medically, the problem is with her not with me. They all confirm that it is treatable. However, the situation never changes. We have spent a lot of money on this. We, therefore, only look at God to help us. Perhaps, the blood of the children we aborted voluntarily still cry. We want God to forgive us.*

Nkengi (the wife): *I always suspect that the problem is with my parents. Mainly my father' side. I tried to reconcile myself with my parents but I realise from my situations that they have not forgiven. They never wanted me to get married to him. Look at my age now. What more can I do? What my husband has not told you is that because of this sterility situation he got another wife without me knowing. I just found out lately. He has got two children with her. I can understand him but what about me?*

Case study 6.4 A dialogue with a patient with AIDS

Sima: We are pleased to meet with you. My friend has been told recently that he's got HIV.

Folo: (The HIV Patient): I cannot understand. I cannot understand why only me?

Mvualu (The Alpha pastoral team leader): When were you told of this sad news?

Folo: Mbuta Mvualu, about one month ago.

Mvualu: What have you been doing ever since?

Folo: I am following the therapy that has been prescribed to me.

A.N.N: How do you understand the whole situation?

Folo: I am not the only one who goes out with women.

A.N.N: You assume that you have contracted the virus by going out with women?

Folo: Yes

A.N.N: Do you know which one of the women it might be?

Folo: It is hard to say but I can suspect.

Mvualu: How do you want us to help you?

Folo: I need your advice and prayers.

Case study 6.5: Nzumba and her alcoholic husband's misbehaviour

Nzumba: Ba ndeko (Dear Friends), we are not doing well in this house.

Zoka (a deacon in la Alpha church): What's wrong?

Nzumba: (she calls all the children). Look at this one (a girl of thirteen years old). For no reason, her dad has beaten her half to death. All the children (four of them), including the eldest son, intervened on behalf of their sister by beating their dad. The police came and he was arrested. He spent a day at the police station.

A.N.N: Where is their dad now?

Nzumba: He just came back. He is sleeping.

Zoka: May we talk with him?

Nzumba: Let me call him.

The man came down to the living room.

A.N.N: What's wrong Mr Kalala?

Kalala: Mbuta A.N.N, I never understand. These are my children. I love them to death. However, I do not know why this often happens to me. Whenever, I drink, I want to beat my children. I started to be angry with my wife, my first son and now my daughter. I do not understand why. I need help.

Zoka: Does it happen to you only when you are drunk?

Kalala: Yes. But I have been drinking for some time. This has never been the case. It is only during these last few months that I began feeling this.

Nzumba: His family curses him. He has just been cursed at home. The reason being that he has not intervened in the death of his father.

A.N.N: Who do you drink with and where?

Kalala: Whether I drink alone at home or outside with friends it is just the same. I feel like being possessed by a spirit to harm my children, my beloved children.

(At this, the whole family started crying the children kissed their dad in tears). I need help.

Nzumba' s traditional prayer *(She turned her back on her husband after spitting on him and beating the ground): I have married you but we are not of the same family. My family is my children. If your family wants to harm you but not my children. I also have a family. I am sending a letter to my parents and uncle to look after this problem. What's wrong with your family? Tell them to pay attention. Otherwise, let us divorce now.*

Zoka: *Okay, Nzumba, calm down. It will be fine.*

Nzumba: *Mbuta A.N.N, the problem is a serious one. Six months ago, I miscarried. Before it happened I had a dream in which my husband's dad sat on my womb. I told my husband but there was no reaction from him. How is it that I must have such a dream about his dead father...*

These three cases in their distinctiveness carry the hallmark of the Congolese concepts of health and traditional aetiologies. Though not neglected, the medical diagnostic is not seen as disclosing the ultimate cause of the pathology. The Charles' family (case study 6.3; p.171) as well as Folo (case study 6.4; p.172) suspect, and are fully convinced of, the external social origin of their ailments. Witchcraft and curse are suspected. The same is suspected in the case of Nzumba's alcoholic husband where she refers to her dream of six months ago. Her dream is meaningful for she comes from a context where:

“Erotic dreams augur evil (ndosyambeembi) in that they prefigure an encroachment or mixing of conjugal spaces; or they underscore exogamy or incest prohibitions in that men and women may use charms to free themselves from dreams where that are visited in bed by a close relative” (Devisch, 1993:98).

Devisch' s interpretation of dream in the Congolese context would justify Nzumba' s triple action of beating the earth, spitting on her husband and turning her back while speaking angrily to him. For in the absence of traditional charms, Nzumba' s triple action indicates the condition of a person who thinks to be bewitched and who must expose and exorcise the evil action through the performance of a socially unaccepted behaviour. Nevertheless, to apply Sow (1978) and Airehembuwa' s (1995) thoughts discussed in chapter five, her husband's alcoholism is not the ultimate cause of the family's predicament. In fact, his alcohol addiction is a pathological consequence of a curse, which

according to the theory of these scholars is the efficient, or the ultimate cause. Just as his wife pointed out ' *his family curses him. He has just been cursed at home*'. The Folo's case (case study 6.4; p172) refers to the philosophical aetiological question 'why me' evoked in chapter five. The biomedical diagnostic or discourse seems not to convince Folo. His statement is very explicit. *I cannot understand, I cannot understand why only me?* These questions are not imaginary or hallucinations.

Neither Charles nor Kalala's ill health can be interpreted as *maladies imaginaires*, like Moliere's (Prat, 1994), nor can Folo's question be seen as hallucination. All of these cases express a reality that can only be grasped through a cultural lens as Janssens would put it (Janssens, 1992: XXVIII). Any therapeutic response, '*prise en charge*', like the pastoral counselling, would have to avoid Fanon's error of proposing to his Algerian patients a therapeutic mode *a la francaise*. Not taking into account their Arabic *Weltanschauung*, Fanon imposed European solutions on Moslem problems. The failure of such a therapeutic approach was outstanding (Mpolo, 1991: 92). My observations of the mentioned cases and the many non-mentioned have shown that despite the degree of acculturation of Congolese in London, in moments of crises the traditional Congolese aetiological theories prevail over the biomedical discourse. In addition, the pre-eminence of Congolese *Weltanschauung* should not only be restricted in medical settings. It needs to be taken into account in different social spheres where conflicts have to be settled. This is what can be understood in the following case.

Case study 6.6 Elikia's escape from her husband

Elikia, with her five children, run away from her husband in Belgium for reasons she said to be of witchcraft. She settled in London with her five children. It happened that they could not sleep at nights. Each night they heard voices, which she interpreted to be those of her husband who came to bewitch them. Every time they heard these voices, they cried so much that neighbours could not sleep. Neighbours informed the police who, more than three times, visited the family in order to find out what was going on in the middle of nights. The mother used some Congolese interpreters to tell the police what they were experiencing. Nevertheless, the more they dialogued, the more they

misunderstood each other. It is in this context that a Congolese pastor was invited to deal with the family. (Fieldnotes, February 1999, Appendix I, p.275)

My observations about the pre-eminence of Congolese *Weltanschauung* among Congolese refugees in London concur with those of Lambo (1963) in his medical practice among Nigerians in London. Commenting on the existence of traditional concepts of health and traditional aetiological discourses among educated Nigerians, he states:

“I found innumerable examples among Westernized professional Africans and also among our students in England at the university level. I found in 1950 that over 60% of the patient population of a large General Hospital in Western Nigeria received ‘native treatment’ in one form or another during the time they were being treated in the hospital. In psychiatry, the percentage would probably be much higher” (Lambo, 1963: 8).

A British psychiatrist, Anderson, practising in London has also encountered the prevalence of traditional African concepts of health among her patients. Two of her observations need to be quoted.

“A Nigerian student consulted me with palpitations. Having ascertained that his heart was normal I tried to reassure him, but he returned almost daily complaining not only of a persistence of the palpitations, but of increasing lethargy, inability to concentrate, and general body weakness.

A initially healthy looking student soon looked haggard. He said he did not suffer from insomnia, and it was not until I eventually asked him how many hours sleep he had in each of the last few nights that he told me of his fears.

He explained: ‘In my tribe we believe that the soul resides in the heart, and when the heart starts bumping about it is the soul trying to fly away. I must therefore stay awake so that if it tries to fly out I can catch it’.

He then went on to say that the belief was that if it flew away while he was sleeping he would die, although he did not believe that this would happen he could not quite risk himself to go to sleep, so that he had been pacing his room night after night in an effort to stay awake” (Anderson, 1992: 158).

Her second observation is more explicit:

“A post graduate Ugandan student brought his wife to the Health Centre because she had become unable to speak. Having excluded any medical cause for this and made a diagnosis of conversion hysteria I found it difficult to know how to proceed from there. Only after mentioning on their second visit that I had worked in Uganda did the student feel able to tell me that his wife’s illness was due to witchcraft. She had left two young children behind in Uganda when she came to join her husband in England. They had been left with her sister-in-law who had made it very clear that she did not want them, and who was also jealous of the patient coming to London. After a short time in England she became very home sick and missed her children a lot. She felt guilty about leaving them, and anxious lest her sister-in-law maltreated them.

She started getting symptoms of depression, insomnia, loss of appetite and headaches. She then received a letter from another relative at home telling her that her sister-in-law was so angry that she had had a curse put on her. The patient immediately recognised that the symptoms she was already experiencing were the effects of the witch doctor’s poison, and she went dumb. At our next meeting the wife came alone. She was no longer totally aphasic, but produced little more than occasional mumbles” (Anderson, 1992: 160-161).

Anderson’s accounts are analogous to those of many Congolese as heard in the pastoral setting. For in this particular environment where the pastor is himself a Congolese, Congolese in the quest for health would not hesitate to unveil their understanding of the origin of their ailments.

Morin’s *‘bouillon de culture’* (Morin, 1991) seems not to apply to Congolese refugees in London. To illustrate, while in case study 6.5 (p.172) the English friends and neighbours of Kalala’s children blame Kalala as a troublemaker, his family points to the ultimate cause that he is bewitched and cursed. Yet, Kalala’s family transcend the ultimate cause to what is described as the ‘structural causalist way of reasoning’ (Devisch, 1991b: 113). This structuralist aetiology, operates only when individuals relate their ailments to their misdeeds as in case study 6.5 (p.172). This is the place where theory that speaks of misconduct in traditional African setting as the social natural cause that precipitates curse or witchcraft can be grasped (Horton, 1970: 136). Kalala’s

misdeed brought witchcraft or curses into play. In contrast, Folo, case study 6.4 (p.172), seems not to have reached the level of a structuralist aetiological discourse yet. He claims not to have disturbed the social order as Kalala did. Thus, he is investigating for the ultimate cause which, as explained by the theories of Sow (1978) and Buakasa (1988), is *the terminus a quo* of any unfortunate experience. This ultimate cause might be invisible powers, witchcraft, jealousy, etc. Beliefs in invisible powers and witchcraft prevail among Congolese living in London. This can be verified with my observations and dialogues within contexts of bereavement where most of deaths have been suspected as originating from witchcraft. Hence, the massive use of gastronomic metaphors such as '*balie ye*' (Ling), '*badidi*' (Kik), to literally mean that the dead has been eaten by witches (Bockie, 1993).

Kalala's family, unlike their friends who put the blame on the father, has what Levi-Strauss calls as 'a common capital' (Tchetché, 1996: 126). In reference to theories discussed in the second chapter, this constitutes for Bourdieu the 'habitus' (Bourdieu, 1979) which Morin has called as 'cognitive capital' (Morin, 1991). The existence of this capital among Congolese refugees organises the practice of pastoral counselling. Considering their *Weltanschauung*, their aetiologies as Ma Mpolo (1991: 93), and D'Almeida (1974: 19) would put it, are the unavoidable first step of any therapeutic process. To deny or despise the concerned pathological discourse, embedded in metaphors on witchcraft and possession, would reduce the relevance of the whole therapeutic counselling practice.

6.2.3 Observation and analysis of responses to the common greetings

Common greetings are the most revealing indicators of the Congolese concepts of health. They are symbolic rituals through which the social equilibrium or people's health are assessed (Fontaine, 1995: 84). Expressions and verbs used in greetings are a liturgical synopsis of their concepts of health as wellbeing.

The validity of this thought can be assessed through the following reported dialogues.

Case study 6.7 A visit to the Nsungu family

A.N.N: Hello, Mbuta Nsungu

Mbuta Nsungu: Hello Mbuta Ngudi

A.N.N: How are you? Comment vas-tu?

Mbuta Nsungu: Not well, I am afraid. I am not in good health (Kiena mavimpi ko. Ki siemi ko)(Kik)

A.N.N: What's wrong?

Mbuta Nsungu: Johnson, my nephew has been deported.

Case study 6.8 A visit to the Nsala family

A.N.N: How are you? Bozali malam (Ling)?

Nsala: Mbuta Ngudi, we are not well. (Mbuta Ngudi, tozali malam te (Ling); Katuena mavimpi ko (Kik). (We are not in good health).

A.N.N: What's wrong?

Nsala: My sister has miscarried for the third time. Her husband has put her out from their household. (She started crying...). We are not in good health, Mbuta Ngudi...

Case study 6.9 A visit to the Ndandu's family

Ndandu: Welcome Mbuta Ngudi!

A.N.N: How are you doing here?

Kuka (Ndandu's wife): Ah, please sit down Mbuta Ngudi. We do not know what to say. We have never been fine in this household. (Katukolanga ko, Kik)

A.N.N: What's going on?

Kuka: It is about my husband's sister, a lady in her early thirties now. She has studied but has never married. Just yesterday another man has let her down. This is the seventh time for the poor lady in the last five years. What wrong have we done, we do not know. I do not know whether Ndandu has something to add.

Ndandu: Mbuta A.N.N, I am very exhausted and I do not know what to do and what to say. We are not well in this family. (Tozali malam te: ling). This last two years have been a time of accumulation of sad events. Nobody knows the whereabouts of the youngest of our family. He vanished just like that. My wife's father was kidnapped in 1996 by Mobutu's security over a field affair. The Home Office has rejected my appeal. The DHSS does not assist us any longer. Just yesterday my sister's fiancé turned her down.

Case study 6.10 A visit to the Kibonga family

A.N.N: How are you doing?

Kibonga: We are not doing fine. (We are not in good health/ Tozali malam te) My child is sick. We just came from the GP.

A.N.N: How long has he been sick?

Madiya: This is the second week for Claude. But, it started with their dad about a month ago. The household is really tormented. We are not well.

The four cases sustain my view that greetings are indicators of the Congolese concept of health. They are done in such a liturgical way that all different aspects of life are being brought to the knowledge of the other. In addition, they sustain the view that health is not only wellbeing but also a collective reality. A view that has been stressed in chapter five with relation to Janzen's concept of 'therapeutic management group' (Janzen, 1978).

Observations show that even when a singular form such as '*Comment vas-tu (Fr), Ozali malamu(Ling)? Mavimpi wena (Kik)?*' (Case study 6.7; p.178) has been used, people often ignore the individuality to embrace the social body. In the first case the Nsungu's account of health is given on the basis of his nephew's arrest. The second case accounts health on the basis of Nsala' s miscarriage. The third case grounds the account in the basis of the husband' sister incessant 's broken relationships and the horde of unfortunate social experiences. The fourth is based on the child's biological pathology. In fact, an etymological inquiry about the terms used to express their state of health discloses that Congolese terms, '*Kola (Kik), mavimpi (Kik), siama (Kik), malamu (Ling)*' encapsulate the idea of '*Force vitale*' (*vital force*) (Tempels, 1949) that is the hallmark of the Congolese concept of existence. As explained by the following etymologists, *Kola* or *kodila (Kik)* indicates good health, being, better, strength (Laman, 1936: 300); *mavimpi (Kik)* means health (Laman, 1936: 510); *siama* or *sikama (Kik)* refers to the idea of being awake and strong (Laman, 1936: 896; Swartenbroeckx, 1973: 305). *Malamu (Ling)* means wellbeing (Everbroeck, 1985: 107; Turnbull & Pashi, 1994: 126). These different analogous definitions of the terms stress the whole reality of health as wellbeing, which implies the realisation of happiness, strength and ultimately the authentic being.

6.2.4 A self-rated health status

The fourth indicator in comprehending the Congolese concept of health was the analysis of their self-health assessment. Responses to question eighteen of questionnaire I (Q18 of QI) 'How would you assess your health? Very good, good, fairly good, poor, very poor,¹' revealed that no answer was recorded as very good. All responses were given in terms of what I have called previously the tri-partite discourses on health. Responses included such expressions as good despite, fairly good despite, poor because, very poor for or because of. The following table shows the nature and repartition of these answers.

Table 6.1 Congolese refugees self-rated health status

	<i>Responses</i>	<i>Why/Reasons for these responses</i>	<i>Number</i>	<i>%</i>
<i>Very good</i>	-	-	0	0
<i>Good</i>	<i>Physically good despite</i>	<i>Economic and social conditions</i>	8	11.1
<i>Fairly good</i>	<i>Fairly good despite</i>	<i>Economic and social conditions</i>	38	52.8
<i>Poor</i>	<i>Poorly good for/because</i>	<i>Physical, social and economic conditions</i>	12	16.7
<i>Very poor</i>	<i>Very poor because</i>	<i>Physical, social and economic conditions</i>	14	19.4

Table 6.1 shows that Congolese refugees' assessment of their own health indicates aspects of their wellbeing that need to be addressed. 11.1 % assessed their health status as good despite of economic and social conditions. The same reasons are advanced for the 52.8 % who assessed their health as fairly good. 16.7% spoke of their health as poor on the basis of their physical, social and economic conditions. 19.4% assessed of their health as very poor because of their deficient physical, social and economic conditions. As it has been stated in the context of the analysis of their common greetings (section 6.2.3; p.177-179), respondents have assessed their health not only on the basis of their personal conditions but also on the basis of conditions of those to whom

they are related. Some of the social conditions evoked include deportation, refusal of asylum, the death of a relative or a friend, unemployment and education.

6.3 The impact of Home Office policies of immigration and the conditions of exile on Congolese refugees' health

Having discussed Congolese refugees' concepts of health, this section discusses the impact of Home Office policies of immigration upon the Congolese refugees' health. To study the impact of Home Office policies of immigration is also to deal with the social and economic conditions of Congolese refugees. For these conditions are determined by the Home Office policies of immigration as mentioned in sections 3.4.5 (p.85-89).

The crises of identity and of personality are some of the consequences of the Congolese refugees experiences of exile and their conditions in Britain. The crisis of identity results from the loss of their authentic identity. This is a 'cumulation of loss' (Rutter, 1994: 89) which Turner calls 'a consequential loss events' (Turner, 1995: 65). It is the loss of one's genuine name, date of birth, and at times marital status and country of origin. For Congolese exiling in Britain, the need to adopt a false identity for exile purposes is frequently imposed once again when after arrival in Britain, an application for asylum is rejected and the threat of deportation looms. Thus, the experience of changing identity can occur many times in the course of applying for asylum as the following table indicates. In 1997, it was identified that 78.6% (110 persons) of members of *la Alpha* Church had changed their identity and 62% (68 persons) of these changed it more than once. Within the context of *la Beta* Church, 91.5% (238 persons) had another identity and 66.4% changed it more than once. The statistics are reproduced in the following table.

Table 6.2. Indicating the phenomenon of changing identity for reasons of asylum in *la Alpha* and *la Beta* churches. 1997.

Churches	Number	Changed identity		More than once	
		F	M	F	M
<i>La Alpha Church</i>	140	32	78	13	55
<i>La Beta Church</i>	260	96	142	45	113

The following accounts give a full portrait of changing identity in different circumstances encountered by Congolese refugees.

Case study 6.11 Makela's problem

Makela: I have been in Britain for four years. In order to get here I travelled with documents that were not mine. When my appeal failed, I had to re-apply for political asylum with another name and another date of birth. Many letters from my parents and relatives never got to me because of my name. They used my real name, which for reasons of exile I have abandoned long ago. My true date of birth is 19/09/65. The first card with which I applied for my political asylum showed my date of birth as 14/02/58. On my present identity my name and date of birth are also different. This is my situation.

Case 6.12. The Ngoma couple.

The husband: We are officially married in the Congo. We have got three children. I was the first to come in exile. When I got here I applied as a married person. A year after my application was refused. I had to re-apply this time I applied as a single person. My wife and children arrived six months after my refusal. She applied as a single mother. Since they were given a big house, I moved to their place. Vis a vis the British institutions we are partners (boy friend and girlfriend). This situation makes us sick.

The wife: Ah God knows! I have never wanted to think about it. What a situation! What a hell! Having names and date of birth which are not ours is a very sad situation. I never know how to celebrate my children birthdays. My children suffer much about this. How to solve this problem remains a mystery. To try is to undermine the whole claims of exile. (The husband comments: What Mobutu did to us is not to be forgiven).

The crisis of personality derives from experiences within various spheres in which individuals are regularly caught up as refugees or asylum seekers. Widely used labels such as 'bogus seekers' (Cohen, 1994: 83) have generated

among many Congolese the feeling of having been dispossessed of their humanity. This is what the following account shows.

Case study 6.13 Lopi's crisis of identity

Lopi: I have never wanted people to know that we are refugees. I have instructed my wife and children about this. This categorisation brings inhumane experiences. While studying English at Westminster College, I had good friends from France and Belgium. As soon as they realised that I was a refugee, they started looking down on me. This has also been my experience at work as well as at the DHSS. This name of being a refugee is not a good one.

The crisis of personality implies that like any other refugee, Congolese refugees' prime or fundamental concern is the restoration of their dignity. A dignity that is being denied to them by issues they face in the land of exile. In responding to the characteristic portrayal of asylum seekers in the media, the following has been stated:

“Asylum seekers have been presented as bogus because their travel documents sometimes are. The truth...is quite the opposite. It is precisely the persecuted who are mostly likely to use false documents. The act simply criminalises without distinction. The official insistence that the genuine refugees are not affected is unconvincing” (Cohen, 1994: 83).

The impact of the backlog, bogus economic migrant discourse, detention, deportation, reporting systematically to the police upon Congolese refugees is noticeable. The impact is social, psychological, and physical. It has an impact upon the whole being of the Congolese refugees. As case study 6.13 mentioned above has shown, the relational dimension towards non-Congolese is pathologically ambivalent or enigmatic. In their relations with public institutions there is the impossibility of concealing their identities as refugees, which they frequently hide in their regular social encounters.

The health repercussions of Congolese refugees' conditions manifest themselves, as in the case of many other refugees, in terms of depression and anxiety (Rack, 1991: 150; Carey-wood et al., 1995:81) as well as other illnesses. The most common are stress, migraines, and violent headaches. The

following tables that result from *la Alpha* and *la Beta* Churches' observations of eighteen stress case studies in counselling pastoral between April and September 1993 can substantiate this. These cases come from three couples, seven men and five women.

Table 6.3 Indicating principal causes of stress among Congolese refugees. *La Alpha* and *la Beta* Churches, April and September 1993.

Causes	Number concerned 18	%
<i>Uncertainty about Home Office decisions</i>	17	94.4
<i>Financial Problems</i>	17	94.4
<i>Multiple Causes</i>	16	89
<i>Prejudices on Refugees</i>	8	44.4
<i>Education Related Problems</i>	8	44.4
<i>Housing Problems</i>	7	38.8
<i>Refusal Case</i>	6	33.3

Table 6.4 Indicating the pathological effects caused by issues facing Congolese refugees in London. *La Alpha & la Beta* Churches, April and September, 1993.

Pathological Effects	Number 18	%
<i>Insomnia</i>	16	89.9
<i>Loss of Weight</i>	15	83.3
<i>Depression</i>	15	83.3
<i>Loss of Appetite</i>	13	72.2
<i>Suicidal Ideas</i>	8	44.4
<i>Self-Dislike</i>	6	33.3
<i>Social-Withdrawal</i>	3	17

Table 6.3 shows that the highest rate (94.4%) of complaints were related to uncertainties of Home Office decisions and financial issues. Yet, the table shows that about 89% complaints were multi-cause related. These are causes including different aspects of their experiences in Britain to realities in the Congo. Table 6.4 indicates that pathological effects were expressed in terms of insomnia (89%), loss of weight (83.3%), depression (83.3%), loss of appetite (72.2%), suicidal ideas (44.4%), self-dislike (33.3%) and social withdrawal (17%). The issue of the impact of Home Office's policies on refugees' health is

important among other refugees as well. To refer to Tubb' study, one of her respondents stated that:

“When you have worries about immigration it can make you feel more ill, I get headaches, chest pain and dizziness when I get worried” (Tubb, 1996: 42).

As mentioned in section 3.4.3.2 (p.78), pathological experiences among Congolese refugees are expressed also in terms of Post Traumatic Stress Disorders. This results from particular experiences that led them into exile. The most common Post Traumatic Stress Disorders express themselves in terms of anger, hatred, and nausea. This can be evidenced with the following cases.

Case study 6.14 Samba's family ethnic hatred

Samba is married with two children. He worked as a secondary school teacher in Kinshasa. In 1986 their neighbour, a member of Mobutu's ethnic group, decided to confiscate a vast space of their compound. Samba reacted and was arrested. He spent seven months in a prison where nobody could visit him. It was on his transfer to the central prison of Makala that he met a chaplain whose relations with his family arranged for his exile. For him and his children born in exile, any person belonging to Mobutu's ethnic group is dangerous and must be avoided. (Fieldnotes, October 1997, Appendix I, p.275)

Case 6.15 Why the Clement's family does not eat meat

Clement spent three years in Makala. Mobutu's soldiers systematically abused him. For more than two years Clement, with his fellow prisoners, was subjected to what he said the soldiers called: cannibal disciplines or cannibal diet. The only alternative to this diet was 'assassination'. With his fellow prisoners, he was forced to eat dogs and cats as the weekly compulsory special menu. In 1990, at the beginning of the decline of Mobutu's regime, he was helped to escape after his family paid a large amount of money. He has been in exile for six years. No one in his household eats meat or fish. He never watches the Rolf Harris weekly broadcast program on the Veterinary practice. Whenever he does, he gets sick. He and his family still go through regular counselling sessions. (Fieldnotes, January 1999, Appendix I, p.275)

These narratives which find analogies in the narratives provided by one of Mobutu regime' s ministers (Ngunza, 1982:54-62) are common among Congolese in London. As the two cases above show, the effects of Post Traumatic Stress Disorders are obvious among the children born in exile

6.4 Conclusion

The analyses of the four indicators (p.168-181) I have used to study the Congolese refugees' concepts of health suggest that Congolese refugees define health as wellbeing. Referring to the thoughts of Buakasa (1988) mentioned in section 5.4 (p.138), it can be stated that for Congolese refugees, health is not only a biological or anatomical reality. Their concepts of health challenge the biomedical theory of interpreting health in the restricted anatomical terms. Congolese refugees have, to use Ma Mpolo's expression, 'a holistic concept of illness' (*Fr: une comprehension totalistique de la maladie*) (Ma Mpolo, 1976: 58). Any unfortunate reality is viewed as threatening wellbeing and falls into the category of pathology. This is what is implied by the terms '*mavimpi*' (*Kik*) and '*malamu*' (*Ling*) that transcend the physical conditions of the individual body to the social body (Douglas, 1996b: 69) to make it a collective rather than a personal reality.

To apply theories of health concepts as discussed in chapter four (section 4.3.1; p116-118), the following can be argued. The Congolese refugees' cultural world is a microcosm of Congolese cultural world in its entirety. There is a cultural continuity on health issues between Congolese refugees in London and those in the Congo as discussed in chapter five (section 5.4; p.137-140). Their traditional worldview is not disrupted by the factor of distance as I suggested it in my hypotheses in section 1.5 (p.25). There is what Douglas has called 'a cognitive energy' (Douglas, 1987) in the Congolese refugees memory. Their traditional concepts of health are imprinted in their minds (Morin, 1991) that any health issue is primarily given a cultural interpretation. In other words, any ailment is subjected to their cultural aetiological discourse which in final analysis is their habitus (Bourdieu, 1979). Its continuity among them is assured as long as it is meaningful to Congolese refugees (Douglas, 1987). In fact, the concept of health and the existence of traditional Congolese aetiology are also discerned among Congolese children². This can be understood in the sense that the attribution of causes to external, social, economic and cosmic factors

has often been made in the presence of children. This can be illustrated with case study 6.5 (p.172). Moreover, in many circumstances, the traditional therapeutic approaches that are adopted involve the participation of the children. Congolese children, even those born in the U.K, are therefore being made acquainted with ideas such as curse and witchcraft.

Morin's triple challenge of '*les bouillons de cultures*' (Morin, 1991) as discussed in chapter four, does not eradicate their traditional views of health. In contrast, present discourses on social evils (Seedhouse, 1986) as causative factors of ill health strengthen their views of health as wellbeing. For as observed, while complaining about his lack of income support, Henrie insisted: '*Ndenge nini nakozala na sante malamuru tangu mbongo to eloko ya kolia ezali te*' (Ling) to mean, how do you want me to be healthy when I have got no money and no food.

This chapter has also shown (p.181-185) the extent to which Home Office's policies of immigration, which determine Congolese refugees' conditions of exile, have an impact upon Congolese refugees' health. This confirms, to some extent, Turner's thought that escaping the state of persecution for exile may only serve to increase the problem (Turner, 1995:65). It would therefore follow that the recognition of the validity of Congolese refugees' claims to asylum is urgency. This recognition has a therapeutic dimension. It rehabilitates the Congolese refugees' confidence to engage in process of recovering the lost dignity. Rather than victimising and marginalising the Congolese refugees, by recognising the authenticity of their claims, the Home Office releases their process of psychological healing.

6.5 Notes

¹(French) *Comment-évaluez-vous votre sante?* (Lingala) *Nini okoki koloba mpo na malamu na yo, mpo na sante na yo? Malamu penza, Malamu, Malamu moke, Malamu te, Mabe penza.* (Kikongo) *Nki lenda zabisa mu diambu dia mavimpi maku keti mavimpi wena? Mbote beni, Mbote, Mbote fioti, ka mbote ko, Yambi beni.*

² Dialogues with the leaders of *la Alpha* and *la Beta* Churches, September 1998.

Chapter VII Therapeutic systems and therapeutic options among Congolese refugees in London

7.1 Introduction

In chapters one and two I indicated the three therapeutic systems that exist among Congolese refugees. These are biomedicine (Western medicine), the Congolese (African) traditional therapeutic systems, and the Christo-spiritual therapeutic systems. This chapter discusses two main issues. The first is the history of these therapeutic systems among Congolese refugees. The second concerns the choice-making process for Congolese refugees; what is the rationale underpinning the therapeutic options they choose? Based on the findings of the fieldwork, this chapter uses some of the theories discussed in chapter four to explore the nature of the relation that exists between Congolese refugees and the British health care sector.

7.2 Biomedicine among Congolese Refugees

Congolese as any other group of refugees are entitled to use the resources of the British National Health Services (Carey-wood, et al., 1995; Rutter 1994). Congolese refugees' first encounter with British health care starts once they arrive. A compulsory medical inspection is often carried out by the immigration services on arrival. This is followed by registration with a General Practitioner according to the regulations of the National Health Services. G.Ps' surgeries are the most frequented area of the British health services by the Congolese.

The joint efforts in 1993 by *la Alpha* and *la Beta* Churches to disseminate information about available resources in the health care sector uncovered the unequal use by Congolese refugees of existing resources. Dentists, opticians, and related welfare or health resources such as psychologists, psychotherapists, and nutritionists services were among the least consulted by Congolese refugees. This was due to the lack of information on how to get in touch with these services. The table resulting from this observation is as follow:

Table 7.1 Health care resources used by Congolese of *la Alpha and la Beta Churches*. June 1993.

<i>Churches</i>	<i>Number</i>	<i>G.P</i>	<i>Dentist</i>	<i>Social worker</i>	<i>Optician</i>	<i>Psychologist/ Therapist</i>	<i>Nutritionist /Dietician</i>
<i>Alpha Church</i>	<i>M=45</i>						
	<i>Users</i>	45	2	39	0	0	0
	<i>%</i>	100%	4.4%	87%	0%	0%	0%
	<i>F=72</i>						
	<i>Users</i>	72	4	69	4	0	7
	<i>%</i>	100%	5.6%	96%	5.6%	0%	9.7%
<i>Beta Church</i>	<i>M=96</i>						
	<i>Users</i>	96	0	87	12	2	0
	<i>%</i>	100%	0%	90.6%	12.5%	2%	0%
	<i>F=130</i>						
	<i>Users</i>	130	6	128	28	0	13
	<i>%</i>	100%	4.6%	98.5%	21.5%	0%	10%

As it will be argued further in section 7.5.1 (p.214-215), the accessibility to any therapeutic system cannot only be grasped in terms of its availability, acceptability, affordability, and effectiveness. For, accessibility depends also on three important factors: the willingness of health care professionals to provide the required care, the users' knowledge of the availability of resources as well as their determination to use them, and the acceptability of services provided. The lesser use of health care resources has been confirmed by my fieldwork. This has been made possible by obtaining and analysing the Congolese refugees' views on their experiences within the British health care sector. The investigation has considered a number of issues related to the use of these health services. They included frequency and reasons for medical visits, attitude of the health care professionals, communication, and finally the question of diagnosis and

therapy. Considerations of their views on some medical interventions were also important. For instance, I also considered their reactions to caesarean sections in my analysis of grasping reasons for their lesser use of available resources in the British health care sector.

7.2.1 Frequency and reasons of consultation

To investigate the frequency of the use of health care systems, respondents were asked to indicate the number of times they have used health care resources in the last year prior to the reception of my questionnaire. The feedback to question 10 of questionnaire I (Q10 of QI *How often do you see a doctor, a dentist, a nutritionist, a psychologist? When is the last time you saw your doctor? How many times did you see your doctor this last year?*) indicates that women's use of health care resources, for reasons to be explored below, was more frequent than men's. 41.7% of responses were by women (30 women) who have seen GPs in comparison to 18.1% of men (13 men) who have seen the GP in a year. Of the 72 respondents it seems that 40.2% (29 persons), 2 women and 27 men, have not seen the GP within the year. This does not mean that Congolese refugees are not registered. All of my respondents declared themselves to have been registered with a GP. 86% (62 persons) had local GPs while 14% (10 people) had not found local GPs for reasons such as the GP's list was full or they had just moved into a new area.

The main reasons for medical visits included children's health, personal health issues, antenatal clinical, postnatal clinic, and general health control. Based on the findings of Q7 of QI (*What are the main reasons for which you visit your GP?*) the following statistics have been provided.

Table 7.2 Indicating reasons for visits to the doctor' surgery, December 1998

<i>Reasons for consultation</i>	<i>Men</i>		<i>Women</i>	
	<i>n 13</i>	<i>%</i>	<i>n30</i>	<i>%</i>
<i>Children/vaccination/illness</i>	2	15.4	23	76.7
<i>Related to personal sickness/illness</i>	3	23.1	9	30
<i>Family planning</i>	-		-	
<i>Antenatal clinic</i>	-		11	36.7
<i>Postnatal clinic</i>	3 (accompanying their wives)	23.1	4	13.3
<i>General health control</i>	5	38.5	8	26.7
<i>Asthma clinic</i>	-		1	3.3
<i>Cervical test</i>	-		2	6.7
<i>Breast cancer test</i>	-		1	3.3

92% of those who take children to the GPs are women. I view this as a reproduction or extension of the home context habit, which makes of mothers, by virtue of their closeness to children, the first guardians of their welfare. This concurs with theories of women as 'primary health care providers' (Oakley, 1993: 331). Yet ante and post-natal clinics as well as cervical smear and breast cancer issues raise Congolese women's rate of consulting doctors above their male compatriots. Nevertheless, inquiries into knowledge of cervical and breast cancer tests indicate that many Congolese women are unaware of their existence¹.

7.2.2 The question of rapport: the health care professionals' gaze

The question of attitude within the biomedical milieu is of a major importance. This because of the therapeutic relationship that is to be established between the doctor and the patient. Yet it is very complex since it falls into the category of discrimination that can be based on gender and race. Responses recorded are relative and very subjective. They consider experiences ranging from encounters

with the receptionist, the nurses to the doctors. McNaught (1988) and Donovan (1986a) sustain my understanding of the complexity of the issue. However like them I wholly depend on accounts given and observations made. As McNaught advocates it:

“When we attempt to determine how discrimination manifests itself in the NHS, we have a basic problem of trying to separate it from complaints about poor quality services and treatment. We have no source of regular data on allegations of racial discrimination in the NHS. In practical terms, we know from the employment field that complaints of social discrimination are extraordinarily difficult to prove. It must be doubly difficult in the field of health care provision. It is difficult to see any but a determined and resourceful individual, with substantial evidence and some specialist knowledge or advice being able to pursue such a complaint successfully” (MacNaught, 1988: 57).

The existence of racial discrimination in the delivery of health care is not disputed. Referring to scholarly works, McNaught puts it as follows:

“What we do have is a growing number of reports by people who have either experienced or witnessed racial discrimination in the health service. These include Cottle, who noted that ‘again and again I heard accounts of poor treatments, patients kept waiting, racist slurs, open avoidance of certain patients, the most minimal and often despicable treatment’ (Cottle, 1965). Wilson mentions the case of an elderly West Indian man admitted to hospital with hypertension: ‘He became increasingly lethargic, a condition not considered important by his white doctor, who dismissed it on the basis that ‘black people are known to have high blood pressure, because they’ re so highly strung, and there’s nothing you can do about it anyway’. The patient was eventually re-diagnosed as suffering from renal failure (Wilson, 1983)” (McNaught, 1988:57).

To substantiate my analyses, I am referring in this chapter to scholarly literature on the health issues of ethnic minorities in Britain. Moreover, as mentioned in section 2.4.3 (p.51), studies of Harper-Bulman (1997) Tubb (1996) and Torkington (1991) are here necessary. Their relevance is that they are concerned with health issues and health experiences of Black Africans in the British biomedical milieu. Nevertheless, it would be relevant to note on the issue of individuals’ views of biomedicine that:

“Studies tend to find that at a general level, people have a great regard for Western medicine and medical practitioners. There is an inherent and strong belief in the achievements and accuracy of medicine and considerable deference is accorded to doctors. Even when asked about particular services, such as child health or primary care, the most frequent findings are of general satisfaction from the majority of those asked. It is only when considering relationships with individual doctors, and particular consultations or illness episodes, that criticisms and dissatisfaction emerge” (Miles, 1991: 161-162).

In the same context, discussing the hegemonic nature of the doctor-patient relationship in the Britain health care sector, Torkington has noted that:

“It would be a gross misreading if what has been said so far is interpreted as a general condemnation of all doctors. Nothing can be further from the truth. Within the medical profession there are many conscientious, caring and trustworthy people. What is said here is not so much about individuals but about the structure within which they work, and the professionalism which places them above those who consume the services they provide. There is no shortage of individuals who abuse their positions of trust and rightly deserved to be labelled ‘nasty’” (Torkington, 1991: 31).

Miles and Torkington’s observations express views that are held by Congolese refugees in London. Certainly, white patients can also experience inhumane treatment in the British health care sector (Torkington, 1991:30-31). However, black experiences are unique due to factors of race, language and social background that are at play. This in fact is what Torkington acknowledges in the scenario of a clash between a white middle class woman and the white man consultant over the issue of delivery. For as she remarks:

“Mrs. X rightly refused to have anything to do with this consultant and demanded to be transferred to another doctor. It was at this stage that the problem of ‘ownership syndrome’ surfaced. None of the other consultants was willing to have her transferred to them because she was Mr. F’s patient. Mr. F was adamant that if she was no longer his patient she could not use one of his beds even if it was empty. Mrs.X informed her G.P. that she would have her baby at home rather than be under Mr.F. Luckily for Mrs.X she had her a very good supportive G.P. in her health centre who fought for her until the system gave way and Mrs.X had her baby in hospital under a different consultant. *If this happens to a middle class professional white woman, what happens when one is working class and/ or black?*” (Torkington, 1991:30-31)

Congolese refugees assert that there is a hegemonic gaze within the biomedical milieu. It is embedded within the unavoidable and often unexpected question 'Are you a refugee/asylum seeker? In fact, 84.7% of respondents (61 persons) to Q9 of Q1 (*How do you describe the surgery's receptionist, nurse and doctor's attitude towards you?*) suggest that this question occurs almost every time they use the health care systems. 'Imagine the psychological effect', as Mbimba puts it², when you are asked in the midst of many people.

In fact, this question is not asked in order to establish the required medical history of the patient. Neither is it asked on the basis of compassion to affirm common humanity. It is asked to signal and to confirm the power relations through which the therapeutic approach sought has to be established. As suggested by most of my respondents, this type of social stratification discourse is prerequisite to the diagnosis and the therapy. This question, is in fact 'the diagnosis itself as Wendo, a Congolese asylum seeker, put it in his reaction to Mbimba' statement as evoked in the previous paragraph.

The existence of a degrading gaze on refugees and asylum seekers in the health care sector can be evidenced with Tubb's (1996) and Harper-Bulman (1997)' studies. They have both pointed out the extent to which stereotyping attitudes, racism and discrimination are inherent to sub-Saharan women's experiences in the British biomedical milieu (Harper-Bulman, 1997: 4; Tubb, 1996: 3). Moreover, as pointed out by Bhatt:

"It is extremely difficult for African refugees and asylum seekers to get angry or complain about inadequate medical services when any medical assistance they receive is seen to be a favour rather than a legal right" (Bhatt, quoted by Tubb, 1996:43).

The responses of Congolese refugees about their rapport with the health care professionals can be divided as follows. 47.2% (34 responses) stressed the existence of health care professionals' negative attitude. 22.2% (16 responses)

described the rapport with health care professionals as variable and unpredictable that it is preferable to not visit the doctor surgery. 18.1% (13 responses) have described it as relatively good. 12.5 % (9 responses) have described it as good. The distribution of these inquiries suggests the following table.

Table 7.3 Indicating Congolese Refugees' assessment of the British biomedical milieu, December 1998

	Number: 72	%
Negative attitude	34	47.2
Variable	16	22.2
Relatively good	13	18.1
Good	9	12.5

Donovan's observation that a detailed scrutiny of black people's assessment of accessibility to health care reveals critical views (Donovan, 1986a: 151) has been realised in the case of the 18.1% of Congolese refugees who have described it as relatively good. It has been summarised by Kolo's dictum that: '*De fois il faut faire comme si rien n'était*' (Fr) to mean, at times do or act as if nothing was wrong.

7.2.3 The question of communication and the acceptability of services

The question of communication is the second factor through which the lesser use of health care resources by Congolese refugees can be explained. Communicating with health care professionals is a very complex issue. In fact, as noted by Torkington:

"It is difficult for anyone who has never experienced the inability to communicate to appreciate or even begin to understand the feelings of frustration, insecurity, anger and fear for those facing this problem in their day-to-day life" (Torkington, 1991:102)

A common linguistic medium as a key to accessibility of health care cannot be underestimated (Nazroo, 1997:119). This concurs with the view that linguistic performance in dialogue with the medical staff is an important factor for an

effective use of the health service (McNaught, 1988: 57). In their medical *rendezvous*, Congolese with a negligible proficiency level in English find it hard to dialogue with the personnel. To address the issue, interpreters have been used. Interpreters are provided either by Congolese themselves or by doctors. In many cases, Congolese use friends, relatives, spouses, and children. This has been proved in relation to the findings of Q10 of QI regarding the thirteen men and thirty women who saw the doctor in the last year from the time they received the questionnaire. For the purpose the following table is drawn.

Table 7.4 Indicating the types of interpreters used in the bio-medical milieu, December 1998

<i>Types of interpreters used</i>	<i>13 Men</i>	<i>30 Women</i>
<i>Spouses</i>	-	3
<i>Children</i>	-	9
<i>Known person (friends, relatives)</i>	-	7
<i>Unknown person</i>	4	3
<i>No interpreters needed</i>	9	8

It should be emphasised that Congolese children's performance in English is outstanding. The age of those who have been mostly used for translation or interpretation purposes varies between twelve and sixteen.³ These are children born in the Congo but who arrived here while still young. Their integration into their host country through schools and friendship remains the key for such a linguistic achievement. Some of these children have often served as interpreters for relatives or friends dealing with medical or social security issues.

Nevertheless, communicating through interpreters is not without difficulties and consequences. Three risks can be identified. Firstly, there is the risk of misunderstanding. For as noted by Torkington, the interpreter might neither be fluent in English nor able to grasp the medical terms (Torkington, 1991:92). The second risk is that of cultural sensibilities or destroying the cultural order. The third risk is the fear of one's medical history being unveiled beyond the clinic and household domain. The following case study bears witness to the complexity related to the issue of using interpreters:

Case study 7.1 Makaya's verbal fight with her GP

I had a severe back pain. An appointment was made with my GP for the next morning. My thirteen years old son came with me to serve as the interpreter. This he always does in our household. As the GP started his diagnosis, he asked me to lay on the clinic bed to examine my back. I was more prepared for that and did it. He told me to sit down. He continued his examination still with my boy as the interpreter. An unexpected question came to me which my son was not at first very able to grasp. The GP graphically explained to my son what he meant. He said ask your mother when did she have her last period. I forgot that I was sick. I pointed out my finger to the GP asking him whether that's what he had been taught at school to tell a son to ask her mum when did she have her last period. I shouted at him and came out from her office. It was a panic in that surgery on that day. He will never again try to do that to another person. He could easily ask me to undress before my son. I had to change my GP.

Such an incident has been recorded among siblings and friends of opposite genders within different medical circles⁴. It generates within the Congolese refugees' mind the view of the biomedical milieu as a risk milieu. To avoid such a risk some Congolese change GPs. Those who can speak French or Swahili have either found a GP who speaks French or East-African GPs (Pakistanese and Indian GPs) who speak Swahili.

7.2.4 The question of diagnosis and therapy

One of the striking findings of the fieldwork is the 'Congolese discourse on common or familiar therapy'. They claim that whatever one's pathological symptoms, 'paracetamol tablets' are the most prescribed medicines by the GPs. Investigation on the issue (Q15 of QI *How do you define your GP' s medical assistance?*) shows that 43.1% (31 respondents) of Congolese do not prefer to

attend GPs' surgeries because they know in advance what will the GP's prescription be. As Nsimba's wife sums it up '*Bapesaka kisi mususu te, kaka paracetamol*' (Ling) to mean, they never prescribe other medicine than paracetamol.

Reasons why GPs develop such a therapeutic approach to Congolese refugees are hard to know. Nevertheless, Congolese advance their conditions and status of 'refugees'; derogatorily described as bogus economic migrants, to be the basis of such a therapeutic approach to them. Yet, besides the issue of the same prescription in every visit, respondents to Q14 (*What are the most common diagnoses and prescriptions of your GP?*) and to Q15 (*How do you define your GP's medical assistance?*) of QI have indicated that in most of cases no full explanation has been provided for therapies to which they were subjected. They had to mechanically obey the doctor's instructions. McNaught also mentions this problem in his study of health issues among ethnic minorities in Britain (McNaught, 1988: 57). One of the case studies reports this problem as follows:

Case study 7.2 The Blaise family

My wife and I have decided not to consult our GP any longer. Instead we speak to Mr Makuala, a former nurse in the Congo, whenever we have some physical ailments. His diagnoses are more relevant than those by many of the GPs to whom we go. The reason why we find it inappropriate to consult a GP is what happened with my boy and my wife. When we consulted our GP for my boy, before we finished explaining our son's pains, a prescription was already established. We found ourselves humiliated. It seemed that the doctor did not want to talk to us. The prescription was only for painkiller. The same with my wife when she started complaining of rheumatism. As soon as we got at the surgery, the nurse told us, here is your prescription. There is no need to see the doctor. What is the point of having and consulting a doctor. We do not bother any more. We only pray God to give us good health.

The question of attitude, communication, diagnosis and therapy are the fundamental bases on which Congolese refugees will always assess the British health care sectors' approach towards them. Despite the particular experiences and conditions of Congolese refugees on these issues, there are some analogies with Blaxter and Patterson's observations in their study of three different

generations of Scottish women. For, as I have observed among Congolese refugees, Blaxter and Patterson noted that:

“The amount of time the doctor had to spare for a consultation was a salient feature of service for both generations. Grandmothers, particularly, defined a good doctor as one who could offer his time, and a bad doctor as one who has the prescription written out before you’ve even spoken” (Blaxter & Patterson, 1982: 166-167).

Misunderstanding between Congolese and doctors has often resulted in the rejection of the suggested diagnosis and therapy. This is what the following event, at which my presence was required as interpreter to clear the misunderstanding, shows.

Case study 7.3 A Post-natal clinic conflict

Mafuta attended the postnatal clinic where she was told that her seven month-old boy was overweight. The doctor required medical investigations to grasp the causes. Mafuta refuted these investigations since her son, she said, had no problems. The doctor insisted and Mafuta refused stating that ‘I look at my son very well. I feed him well. How on earth can you suggest that something is wrong with him?’

The following week I attended the clinic with Mafuta to serve as the interpreter. The doctor explained how he thought that a seven-month-old baby like him was overweight and that some clinical examination was necessary. Mafuta told the doctor how reluctant she was to agree to this clinical examination since her child had never had any medical problem and that as a caring mother she was looking after him. After fifteen minutes of discussion, Mafuta decided to find a new doctor and she told me six weeks later her son had never been subjected to the proposed medical investigation based on the view that the baby was overweight. (Fieldnotes, September 1998, Appendix I, p276)

It appears that the misunderstanding between Mafuta and her doctor is due to the lack of consideration of Mafuta's views which the doctor could have had positively used for therapeutic purposes. Had the doctor explored the conditions of the bed and breakfast environment which was the child's main environment as well as the diet that was daily given to the child, the story would have had been different. There has been a lack of dialogue because of the doctor's imposition of a unilateral view. Here applies the Foucauldian theory of the disciplines (Foucault, 1977) that excludes possibility of dialogue.

The fact that the ineffectiveness of medical therapies to Congolese refugees has much to do with doctors failing to consider the socio-economic and political context of the Congolese refugees cannot be underestimated. At times Congolese refugees are given medicines which they do not require. This is what is shown by the following case.

Case study 7.4 Jean Francois loneliness

In 1996, Jean-Francois, married and a father of four, was exiled in London alone. He hardly spoke English. When he arrived in London, he was sent into a bed-breakfast hostel where, he had nobody to speak with. He lived in complete loneliness for thirteen months. Two weeks after, he started complaining of severe headache and backache. He consulted his GP, with whom he hardly communicated. He was prescribed painkiller tablets and regularly saw his GP. After three months of interrupted treatment he decided to give it up. For as, he said, it did no good but added more pain. Eight months later, another Congolese, Pierre Rene, was sent to the same hostel. A friendly relationship was established between them that Pierre Rene met compatriots to whom he spoke of Jean-Francois' situation. La Beta Church' s pastoral team was informed. Pastoral counselling sessions proved that loneliness and linguistic barrier were the factors causing his ailments. Integration into the Congolese community was the therapy that was mostly required to address his situation. Within the next two months of his integration in the community, Jean-Francois was able to go to school and join in different church activities. Ever since, he has never complained of that type of headache and backache any more. As he later put it to his church fellows his headache and backache went into oblivion. (Fieldnotes, August 1998, Appendix I, p276)

7.2.5 Congolese obstetric discourses

To the issue of 'common or familiar therapy' is added that of common obstetric discourses'. This is the observation by Congolese that between 1990 and 1995 caesarean sections were the common experience of Congolese women. Inquiries into this situation in *la Alpha* and *la Beta* Churches context proved that between 1991 and 1993, 76.2% (sixteen of the twenty-one) of women had their childbirth through caesarean section. In fact, a medical approach to childbirth is not refused. However, Congolese women have realised they are deprived of using their natural force for a natural birth. Many of these interventions, they claim, have been unnecessary and traumatising. One day after her childbirth, I

visited Sylvie, a twenty-seven-year-old young woman, at the hospital. This is what she had to say:

Case study 7.5 A visit to Sylvie

I got here to the maternity ward around 4 p.m. My husband was out. Nobody suspected that I was giving birth that day. After the examination the doctor told me that the baby was on her way and that I needed a caesarean section. I told the doctor that I did not need it because I felt myself strong enough to give birth naturally. Yet neither the baby nor myself were in a condition requiring such a surgical intervention. I had to sign documents about my decision. Two hours later I felt that now the time had really come and I gave birth without a caesarean section.

According to Verstuyft (1992), obstetrical pathology (*Fr: la pathologie obstetricale*) is associated with biologically inherited, climatic and socio-economic factors. He stresses that causes related to socio-economic factors are higher for women in under developed countries (Verstuyft, 1992: 831). Given the history and the conditions of Congolese refugees, Verstuyft's arguments can explain the use of caesarean sections for Congolese women. However, the lack of a full explanation, as argued by the Congolese, explains their reluctance. It has generated fear and adversity in many. Caesarean sections were interpreted as a potential risk to both women's bodies and procreativity in assuring the family's longevity. For Congolese refugees assume that Caesarean sections are a necessary surgical intervention when natural childbirth presents risks. When no convincing reason is provided it should therefore be avoided. This is the view expressed by Kilombo's account below.

Case study 7.6 Kilombo's view on caesarian section

Caesarean sections can only be used in cases where either the mother or the child is at risk. Otherwise, the mother should use the natural strength that God gives them. To give birth is not pathological. Being pregnant is not a disease. It is divine. Natural childbirth has to be encouraged. Our first son was born by caesarean section, I could not understand the reason. Perhaps because it was the first birth. Now I hear that most of the women I know have given birth by caesarean section. This is frustrating, said Manda his wife. -(The husband continued) To be operated on for reasons you do not know. Our ladies do not lack strength anyhow. (Batiaka yo mbeli na ntina oyebi te. Basi na biso bazangi makasi te quand meme) What about our mothers at home who have never used these techniques?

Observations in the field have demonstrated that, because of the necessity of having children, families have empowered themselves by requesting the reasons for caesarean sections. When a couple sees no convincing reason, a joint family decision is always taken for natural childbirth. Lenga, who also gave birth by caesarean section in 1996, had this to say: *'I wonder whether these caesarean sections are necessary to us because of the weather or what, I do not know.'*

Parsons et al.' study (1993) on pregnancy, birth and maternity care among ethnic minorities in Britain argues that apart from biological problems such as 'cephalo-pelvic disproportion' (Parsons et al., 1993: 69), a major reason for the high rate of caesarean sections among Bangladeshi women is the problem of communication between the patient (expectant mothers) and the doctor. Given the low level of English proficiency of Congolese women, Parsons et al.'s argument can also be applied in the Congolese women's context. When an interpreter has not been available during the 'childbirth', the dialogue between doctors and patient (expectant mothers) is virtually absent.

Much of my understanding and analyses of Congolese experiences in the British biomedical milieu corroborate Harper-Bulman's observation on Somali women.

For she recounts:

"The other women who discussed their FGM in the interviews were unhappy with the care that they had received, and three said that they had received severe perineal tears due to staff mismanagement. The reasons for this appear to have been the staff's lack of understanding of FGM and its management, combined with the poor communication afforded by the language barrier, which has exacerbated by the fact that some staff seemed uninterested and even angered by the women's attempts to advise them.

The woman who was infibulated, speaks of a labour where, as delivery was approaching, the midwife and someone who to her appeared to be junior medical staff attending to her, seemed confused and undecided as to how to manage her infibulation. The woman tried to communicate to the staff that she needed an anterior episiotomy, but was unable to, due to their lack of interest, and their difficulties with English. She was given a small medio-lateral (downwards) episiotomy, which was not sufficient, and as the baby emerged she developed a large perineal tear" (Harper-Bulman, 1997: 71-72).

7.2.6 Conclusion on the use of biomedicine among Congolese refugees

This section has shown that the restricted use of health care resources by Congolese refugees is due to their experiences in the health care sector. They include the hegemonic gaze of health care professionals, the inability to communicate, and the nature of therapy. While inequalities in health care delivery to British black ethnic minorities do exist beyond a doubt (Ahmad 1993:202,214; Torkington, 1991: 136-154), the Congolese, like Somalis, are highly disadvantaged by the two other major factors that are the components of their triple status in Britain. These are the bogus economic discourse as well as the non-English-speaking factor. Not that their existence in Britain is incognito, but the lack of linguistic cultural ties results in their presence being interpreted as an existence *ex nihilo*.

7.3 Christo-spiritual therapeutic systems among Congolese refugees

7.3.1 Healing practices in Congolese refugees' churches

Some aspects of the uniqueness of Congolese Christian communities in London with regards to Congolese refugees have been discussed in section 1.2 (p.20). Like charismatic churches in the Congo, healing is one of the main *foci* of these churches. Cases for which healing is sought varies from social, physical (anatomical), psychological to spiritual. Moreover, while in every service sick people are prayed for, there are special services and days dedicated to healing. Thus, for a people whose concept of health transcends the biomedical discourse, these communities have an important place in their therapeutic quest.

The factors enhancing their uniqueness in the Congolese therapeutic quest are triple. First, their incarnation of the traditional Congolese *Weltanschauung*. As a matter of fact, the existence of common perspectives endows them with a common symbolic capital and habitus (Bourdieu, 1979). In these two churches, the Congolese traditional concept of health, nosological and aetiological discourses are part of their therapeutic practices (De Rosney, 1992). Dreams, visions, curses, and investigations of social relationships are given a paramount

aetiological consideration. Secondly, their shared social-economic and political experiences in Britain. Lastly, the idea of God as the originator, sustainer, and the destination of human existence. God is the 'alpha' and the 'omega' (Rev 1:8).

The pastor and appointed church leaders compose the Church's pastoral team. Appropriating the biblical accounts on healing, they diagnose pathological cases that are submitted to them. In particular cases the pastor intervenes alone. The aetiological discourse in this church speaks either of '*pasi ya Nzambe*' (Ling) or '*pasi ya Satana*' (Ling). The '*pasi ya Nzambe*' refers to any ailment which is believed either natural or caused by God. When God causes it, people believe that one might have sinned. Thus, repentance and intercession on the individual's behalf is paramount. The individual is exhorted to avoid evil (*Kotika mabe: Ling*) or to not sin any longer (Kolie, 1991: 138). The '*pasi ya Satana*' refers to any ailment caused by Satan and its horde which includes witchcraft, jealousy, etc. Exorcism (*Fr: priere de delivrance*) is the most used therapeutic technique in this case.

Any therapeutic practice, including exorcism, collective prayers, and vigils, requires the collective participation of all church members. In such therapeutic sessions the whole community becomes a therapeutic or intercessory team. The rituals such as the laying on of hands are carried out by the pastoral team and those of the group called, *groupe d'intercesseurs* (Fr), the group of intercessors. There is a transfer of traditional Congolese therapeutic values and functions in these churches. In any therapeutic quest, the church takes the place of the 'therapy managing group' (Janzen, 1978). A close relationship is established between some members of the church with concerned or afflicted persons. In some circumstances, the pastor is invested with the father or the uncle role in medical therapeutic interventions. At times he is viewed as the healer. He is consulted whenever a need arises for prayer and advice. Moreover, pastors have been regularly consulted for medical advice and decisions. At times they accompany their members to their appointments with doctors.⁵

United by their common habitus (Bourdieu, 1979), 'God as the ultimate source of human existence', the liturgical linguistics of healing sessions in Congolese refugees churches are characterised by a massive use of biblical verses and songs (Oosthuizen, 1979) demonstrating the powerful healing act of God. Different spiritual gifts, (*Fr: les dons spirituels*), are manifested and exercised. The laying on of hands is accompanied by a continuous Hebraic glossolalia in which God is spoken as the '*Jehovah Raphah (Heb)* God who heals', '*Jehovah Jireh (Heb)* God the provider', '*Jehovah Shamah (Heb)* God who hears', '*Jehovah Shalom (Heb)* God of peace', '*El Roi (Heb)* God the shepherd'. At times oil is applied on the sick person. This is according to the New Testament statement; '*Is any one of you sick? He should call the elders of the church to pray over him and anoint him with oil in the name of the Lord*' (James 5:14).

Other Congolese Christian communities in London, mainly the Kimbanguist, use symbolic elements like water and earth. These elements are imported from Kamba (Martin, 1975: 158) the birthplace of the prophet Simon Kimbangu. Hence, *maza ma Kamba (Kik)* (Water from Kamba) is drunk and *ntonto a Kamba (Kik)* (earth from Kamba) is eaten while they are also applied on the body. They are thought to act in an *ex opere operato* way against any ailment.

7.3.2 The place of counselling in Congolese refugees' churches

A comparative analysis based on weekly time (*44 hours*) dedicated to the three main church activities, preaching, counselling and church meeting, within *Alpha* church reveals that 75% (*33 hours*) of pastoral activity is about counselling. In addition, members of the pastoral team of *la Alpha* and *la Beta* churches have observed that in a number of their pastoral visits, each encounter with a Congolese Refugee 'is a request for a deep pastoral counselling session.'⁶

The practice of pastoral counselling (*Fr: la cure d' ame*) has, in itself, a therapeutic value. Its effectiveness in the area of psychosocial tensions is often noted in these two churches. Its dynamics have been mainly demonstrated in the

resolutions of different social tensions and by the pastor taking on those with various traumatic experiences. This can be discerned in the following statement:

Case study 7.7 Pedro' s thoughts on pastoral counselling activity

Surely it is exhausting when you have either to visit those in need of a pastoral counselling or to dedicate times and days to listen, to advise and pray with them. However, there is a much joy when you see how people are reconciled with their particular histories and trust in Christ that He cares more than any human being would do and that He is always with them.

Depending on the case, pastoral counselling as practised in these churches is either individual or collective. Using both traditional tools such as songs, storytelling, proverbs and biblical narratives, its main rationale is to restore life dimensions that are seen as broken by integrating the individual into the society (Berinyuu, 1989: 96). In this pastoral-counselling arena Jesus Christ, as Pedro' s account has shown, is recognised as the *proto-ancestor* (Bujo, 1992: 75) whose redemptive activities are restoring, healing and assisting. Reintegrating somebody into the community is the principle that prevails in the pastoral counselling sessions. It implies the idea of being one with the other. This principle concurs with Mbiti's philosophical dictum: 'I am because You are since You are therefore I am' (Mbiti, 1969: 106). This is explicitly expressed by the Xhosa proverb according to which:

"Umuntu ngumuntu ngabantu (a person is a person through persons). This is a belief that recognises within other people the presence of the divine through which a person attains full humanity. Ubuntu involves the realisation that for better and worse we are shaped by a host of others with whom we share our lives" (Villa-Viciencio, 1995: 70).

The context of collective counselling, is an arena for 'a group therapeutic palaver' (Ma Mpolo, 1991: 94) where suggestions are made about different therapeutic options viewed as necessary. The church as a therapy managing group (Janzen, 1978) offers its social, psychological, spiritual and material support. The following case sustains what is being said about the value of pastoral counselling in this community.

Case study 7.8 Nsenga family' s predicament

'Nsenga is forty-two and his wife is thirty-seven. Both were traders in the Congo. Following the socio-economic and political conditions of the Congo in the late eighties, they decided to go to Luanda, Angola, thinking that their trade would flourish. They had three children, aged 10, 7, and 4. UNITA's failure in the election in 1992 led to civil war during which they saw their three children being assassinated by UNITA's militias. Four months later they came into exile in Britain via South Africa. Their asylum was refused two years after their application. Depressions and ideas of suicide invaded the couple. (Fieldnotes, October 1998, Appendix I, p.276)

To address the Nsenga case, a systematic special counselling program was organised by *la Beta* church. A therapeutic managing group was organised while the pastoral team was involved in the counselling activity.

The practice of counselling sessions, within the Congolese refugees setting, is a sacrificial act. In many circumstances, which is often the case, the pastor goes beyond the analytic or anthropological principles of listening and deciphering the symbolic cultural codes (Brodeur, 1996: 74) through which a pathology is being expressed. The pastor, on the basis of therapeutic necessity and the absence of family members, is condemned to perform a therapeutic sacrificial task. As previously said, s/he takes the place of the father, sacrificing time, energy even money. A task that their church ministers kindly accept.

Analyses show that the practice of healing sessions in these two Congolese churches is an extension of healing reality as stressed in charismatic churches in the Congo. This can be grasped by the fact, mentioned in chapter one, that most of members of these two churches are from a charismatic church background.

In contrast to Devisch (1996c), there is a degree of power between the pastoral team (the charismatic leader) and those in therapeutic quest. For pastors are viewed as 'the anointed ones with specific gifts' (Oosthuizen, 1979). This power dimension is important otherwise the whole ministry of healing loses its credibility. However, this power is only accepted in the context of therapeutic function. For, the pastoral team' s diagnosis and their therapeutic approach are not without criticism. When it is characterised by continuous ineffectiveness, its

symbolic capital (Bourdieu, 1979) can be questioned. Thus, the pastoral team can be accused of not having a good relationship with God. This is what is shown by the following case.

Case study 7.9 Kiebi and Kiki' s dialogue on the gift of healing

Kiebi: *I have never wanted pastor Ben and pastor Vedi to lay their hands on my children. They do not have a good testimony. In fact some of us have suspected them of being witches (Ling: Bandoki). Whenever they pray for people, they never recover. What types of pastors are they?*

Kiki: *They might not necessarily be witches (Ling: Bandoki). Maybe their relationship with God is not good. For God can give you the gift of healing but when you are not using it properly or your conduct is not good, the gift is taken away.*

Kiebi: *It might be the case. But, I still do not want them to lay their hands on my family.*

7.4 Congolese Traditional Therapeutic systems among Congolese refugees

Traditional therapeutic systems among Congolese refugees revolve around three important factors: aetiologies and nosologies, the use of traditional medicine and the therapeutic management group. Any ill health manifestation, mainly that which persists, is subjected to a traditional aetiological discourse. However, this aetiological gaze is not fundamentally a singular exercise. It is done in conjunction or communion with friends or relatives who ultimately constitute the 'therapeutic managing group' (Janzen, 1978).

In their quest for health, Congolese refugee community in London creates a therapeutic bond with relatives in the Congo to create a larger therapeutic managing group. In relation to what I said in chapter four, on the nature of relationships within the Congolese refugee community, the Congolese refugees' therapeutic management group can be understood through Weber' s concept of 'communal open relationship' (Weber, 1947) or Tonnies' concept of *Gemeinschaft* (1955). For, the therapeutic management group constituted by Congolese refugees often transcends ethnicity and political orientation.

Traditional diviners and healers are absent in the Congolese refugee community. They are, however, collectively incarnated by the collective therapeutic role of the

constituted therapeutic managing group. Divinations and forms of medicines or therapies to be used are suggested and accepted collectively. They are based on their different historical therapeutic backgrounds. Thus, their interpretations of the ailment result in a view that will be commonly accepted and commendable. Illnesses that have not responded to cures offered by medical treatments remain the most suspected. These are ailments such as accidents, nightmares, sudden death and illnesses such as *panzi* (Ling), 'lubanzi (Kik), stitch-in-the-side (Eng)' (Janzen, 1982: 108) that are not thought to be curable through medical approaches.

One of the areas in which the therapeutic managing group among Congolese refugees has been very effective is in the resolutions of social conflicts. The practice of what they call '*les palabres*' (Fr), (Palavers: Eng; *Lisanga ya mabongisi*: Ling). Palavers are a form of dialogue whereby issues or conflicts are discussed, analysed and resolved. Palavers have pedagogic and ethical functions (Ma Mpolo, 1976: 74). The liturgy of palaver sessions is characterised by a massive use of parables, metaphors, idioms and incantations. The introduction is always marked with the affirmation that whatever the nature of the conflict a solution will be found (Devisch, 1996b: 50). This is what can be discerned in the following conflict resolution cases.

Case study 7.10 A palaver at the Salomon's

Both Claire and Salomon arrived in Britain separately. The husband arrived two months before his wife. Upon his arrival in 1992, he was detained for eight months. His wife arrived with their two children and applied for asylum as a single mother. She had no idea where her husband was until five months later when she met former Congolese detainees who assured her that they had seen the man she described in detention. Accompanied by other Congolese, she visited the detention centre where she, effectively, met her husband. Three months later, Salomon was released from detention. He was given a hostel but decided to join his wife at her place. Some months later, Salomon suspected his wife of having flirted with other men while he was in detention. He based his views on close friendships his wife developed with some members of the community. Social tensions occurred in the household so that physical fighting was endorsed with his wife's friends. To avoid the worst, divorce, some close friends initiated palaver council sessions. The presence of the old men in the community was required. Though the family had never attended church, a pastor and some

church leaders of the community were invited to the session. The conflict was resolved through a massive use of Congolese traditional dialogical proverbial techniques (bingana: kik; masese:ling= proverbs: Engl). The pastor' symbolic capital was significant as a moral figure. He and his team incarnated the couple's family representatives' authoritative power. Public confessions were made, scriptures were read and prayers were said. To materialise the restoration of broken social and psychological relationships, everybody was conveyed to an agape meal. Ever since then the couple have lived harmoniously and another child has been born into the family. (Fieldnotes, July 1998, Appendix I, p.276)

The dynamics of palavers constitute the most recommended positive technique of the traditional African therapeutic systems. They are said to have been mostly applied in African psychiatry (Quenum, 1985: 289). The major influence of Christianity in the Congo, as well as the place of Congolese churches among Congolese refugees, explains the importance of the participation of Christians in the practice of such sessions. As case study 7.10, mentioned above, shows, the resolution of such conflicts is always crystallised by symbolic or sacrificial actions. The agape meal, where finally the two reconciled parties bring something to eat and to drink is a symbolic therapeutic act (Ma Mpolo, 1976: 74).

The use of herbal medicines and different rituals are common among Congolese refugees in London. Some of herbs and plants needed for traditional medicine are not available in London. This is the case of '*lemba-lemba*' (Janzen: 1982), which is cardinal in the treatment of ailments and diseases that are supposed to defy the medical therapies. They are imported from the Congo. The most common traditional medicine, whose recipes are found in London is the '*Tangawusi*'. '*Tangawusi*' is a melange of ginger, mangoes, and other plants. It is often used to treat exhaustion, impotency and related symptoms. *Hydrotherapy* is often practised. Some herbs can be mixed in the water for a special therapeutic bath. This treatment is often applied in issues such as curses, misfortunes, and failure in any aspect of life. The inhalation of steam is also part of this hydrotherapy treatment. Aromatic herbs are mixed within the water. This is used in many cases, mainly fever, bronchial congestion and headache. Traditional forms of massage are practised for those suffering from '*panzi*', (*luvati*; stictch-in-

the-side) (Janzen, 1982). Peanuts, palm nuts or palm oil are often used in these cases while incisions and incantations are made.

It can be argued on the basis of my fieldwork that the importance attached to both Christo-Spiritual and traditional therapeutic systems by Congolese refugees transcends academic hermeneutics. Whether these systems operate as a placebo in this psychotherapeutic approach defies academic reasoning. For the Congolese refugees, the fact remains that not only Job and other biblical figures were healed but the same healing power is conveyed to the church (Mk 16:15-18). Healing therefore has both scriptural and theological basis (Ikechukwu, 1998: 80). Palavers, hydrotherapy, herbal medicines are accepted as effective. Consequently, being healed through Christo-spiritual and traditional therapeutic systems among Congolese refugees is a reality that is not only accepted but also expressed through the community language: *'nazalaki na mpasi Nzambe abikisi nga'* (Ling). (I had many afflictions but God came to my rescue).⁷

7.5 Therapeutic options

7.5.1 The rationale for six therapeutic approaches

In their therapeutic quest Congolese refugees have developed six therapeutic approaches. These constitute their therapeutic options that are divided into three categories. These are the three-dimensional, two-dimensional, and one-dimensional therapeutic approaches. Referring to Ricoeur (1976) and Douglas' (1996a) theory of social meaning as stated in section 1.4 (p.22), each of these approaches is a social action carrying a particular meaning. These meanings are intrinsically related either to the issue of culture, experience in the British biomedical milieu or their concept of risk.

The three-dimensional therapeutic approach is a simultaneous or consecutive combination of Congolese Traditional Therapeutic Systems, Christo-Spiritual Therapeutic Systems and Biomedical Therapeutic System. Fieldwork discloses that this approach is used in any pathological case, whether life-threatening or

not. The rationale, as indicated by responses to Q2 of Q1 (*Why is it that the Congolese refugees therapeutic quest is a history of combining biomedicine, Christo-spiritual therapeutic systems, and traditional Congolese therapeutic practices?*), for this approach is twofold.

First, the uniqueness of physical life which has to be sustained by any viable means. The second is that each of the therapeutic systems used has a particular contribution to the individual wellbeing. Quenum (1985), Janzen (1978) and Appiah-Kubi (1981), whose works have been referred to in chapter five advocate this therapeutic syncretism or pluralism. Janzen, as indicated in section 5.5.2 (p.147), sums it up in the answer of the traditional healer Masamba to the medical Dr Artkinsta: *'ngeye nganga ku nseke, mono I nganga ku maza'* (Kik) (Janzen, 1978: 229) meaning, you are the healer of the land and I am the healer within the river. This sapiential statement indicates the contribution of each of these therapeutic systems. In fact, fieldwork suggests (Q3 of Q1 *Why is it that in some circumstances Congolese refugees insist that the participation of their relatives back home is very important in their therapeutic quest?*) that the use of this syncretistic or tree-therapeutic approach is very common. It stresses their perceptions of ailment as their responses suggest.

The second category, which I term "a two-dimensional therapeutic approach", has three forms. The first form is the combination of the Congolese Traditional Therapeutic System and Christo-Spiritual Therapeutic System. It is used in cases where the pathological case is interpreted to transcend the biomedical gaze or expertise. This is demonstrated in case study 6.5 (p.172). These are cases when curses, witchcraft and social offence are often evoked in their aetiological inquiries. The second form is the combination of Biomedical Therapeutic System and Christo-Spiritual Therapeutic System. It is often used when pathological cases are interpreted as having natural or biological causes. Nevertheless, as mentioned in chapter five, they would become suspect when the ailments last long and have fatal consequences. Observations of this approach confirm that no

medication is taken without a prayer. While following their medical cures, relatives or the concerned persons themselves ask for prayers. The reason for this state of affairs is explicitly explained in the following case.

Case study 7.11 Kopa' s views on healing

Do not be a fool. It is God who heals. Biomedicine is important. However, doctors can only treat the sick person. To heal is a proper activity of God. God only can cure. Otherwise doctors could never die and everybody would long to become a doctor to heal oneself or the loved ones. We know of people who have had the best treatment and in the best hospitals in the world. They have not been cured. Understand me, I do not mean that we do not need treatment and good doctors. We need them. For knowledge comes from God. Nevertheless, to be cured is beyond the capacity of the doctor. God nevertheless, does not want us to be inactive in a face of disease. We have to seek medical care.

Kopa's view that '*les medecins ne peuvent que soigner mais c'est Dieu qui guerit*' (Fr). (Doctors can only treat the sick person. To heal is a proper activity of God) does not exhaust their trust in the usefulness of therapeutic systems. For, as he affirmed, God is held as the source of medical or therapeutic knowledge. These reflections overlap to such a degree with those generated by the Mbundu rain maker (African traditional healer) in his conversation with the Scottish Missionary Dr Livingston.

"I use my medicines, and you employ yours; we are both doctors, and doctors are not deceivers. You give a patient medicine. Sometimes God is pleased to heal him by means of your medicine; sometimes not-he dies. When he is cured, you take the credit of what God does. I do the same. Sometimes God grants us rain, sometimes not. When he does, we take the credit of the charm. When a patient dies, you don' t give up trust in your medicine, neither do I when rain fails. If you wish me to leave off my medicine, why continue your own?" (Stanley quoted in Janzen, 1978: 40).

The third form is the combination of the *Self-Biomedical Therapeutic approach* and Christo-Spiritual Therapeutic system. The self-biomedical approach is that according to which Congolese refugees buy and use medicines without consulting their GPs. This is the most common among Congolese refugees. It is mainly the outcome of their experiences in the British biomedical milieu as evoked in section 7.2 (p.189-204). The issues of attitude, communication and diagnosis and therapy as experienced by Congolese refugees in the biomedical

milieu create such a deep psychological blockage that the biomedical milieu is completely rejected by some Congolese refugees.

Based on responses to Q6 of Q1 (*Why is it that rather than seeing the GP, some Congolese refugees prefer to consult the pharmacist and buy their own medicines?*), 75 % (54 respondents) of users of this approach refuse to attend the surgery because of the hegemonic gaze of the medical personnel, the difficulty in communication, the quality of therapy (paracetamol) and the risks presented by the use of interpreters. This implies that acceptability and effectiveness are decisive factors to understand the use of health care resources by Congolese refugees. Another significant reason for this approach is related to the 'immigration issue'. Some Congolese refugees do not consult GPs because the Home Office has rejected their cases. To avoid being identified by the Home Office, they would avoid any contact with the GPs whom they believe to work in collaboration with immigration officers. This is the reason evoked by Kiakuama in the following case.

Case study 7.12 Kiakuama's reasons of not going to see the GP

I am not feeling well but I cannot go to see my GP. For I have been told by the Immigration services that I have to leave the country. I know for certain that the Home Office is not only in touch with the social security officers but also with the GPs. I cannot try to register with GPs. They all ask for Home Office papers. The only alternative is to ask the chemist what tablets I would need for my pains and buy. For if I have to try to go to see my GP, You will hear that I am deported.

For Kiakuama, the health care sector represents a risk. A risk of being identified and being deported. Tubb will concur with Kiakuama's argument. She identifies the issue of immigration as one of the reasons why black African woman refugees and asylum seekers with HIV present themselves late at the hospital (Tubb, 1996: 41). Moreover, it is asserted that:

"Some hospitals are reported to be sending memo's to GPs to get proof from the Home Office of people's immigration status before they are referred to hospital" (Cleo, quoted in Tubb, 1997: 43).

The third category, which is the fifth and sixth therapeutic option of Congolese in London, is the 'one-dimensional therapeutic approach'. It is either the Congolese

Traditional Therapeutic System or the Christo-Spiritual Therapeutic System alone. This approach is used when there has not been success with biomedicine. When the traditional Congolese therapeutic system, like biomedicine, proves its therapeutic failure, the Christo-Spiritual Therapeutic System is the ultimate system to be used. The philosophy sustaining this is that of God as the *Alpha* and the *Omega* of an individual's existence. This can be illustrated with case study 6.3 (p.171) of the Charles family.

7.6 Lifestyles as a therapeutic option

Crawford's view that there is a birth of a 'new health consciousness' (Crawford, 1994: 142) can be verified in the Congolese refugee community in London. Different risks associated with health as portrayed by the media have created a self-therapeutic system that one can describe as life styles. Sex behaviour, alcoholism, smoking and obesity are those which have received particular attention among Congolese refugees. Representing risks, these issues generate a certain way of behaving, some lifestyles that for Congolese refugees constitute therapeutic or preventive approaches.

82% (69 responses) to question one of questionnaire *two* (Q1 of QII *how do you contribute to your personal health care or safety?*) emphasise that a self-care attitude requires a self-attention on issues of sex, alcohol, tobacco and food (obesity). However this percentage, their views on some of these issues, mainly sex, are neither publicly discussed nor discussed in depth. These are views that are held individually. They only emerged following this study. The inquiry of Q 10 of Q II (*Is sex education important for your personal health promotion? Have you ever spoken of sex education in your family or church? Are condoms essential in preventing STD such as Aids?*) demonstrates that only 7.1% of respondents (6 of the 84 respondents) have tried to deal with sex education issues in their families. Moreover, the Congolese refugees' discourses on sex behaviour stress the issue of Sexually Transmitted Disease. All responses to Q10 of QII suggested that AIDS is the most feared and the most known. Married couples and those who are

single advocate that mutual fidelity is the only way of protecting against any sexually transmitted disease. This view is strongly held by those with Christian background. A preventive sexual relation that speaks of the use of condoms is not part of their vocabulary. For any sexual relation that is extra-marital is viewed as unhealthy. This is what is shown by the following account:

Case study 7.13 Baku' sex education theory

Why should we use or encourage condoms when it is clear that for us as Christians, the matrimonial environment is the only locus for sex. Moreover, the use of condoms does not guarantee protection against the risk of being contaminated. The Christian message, therefore, remains the response to those who want to protect themselves.

It is interesting to note that some Congolese who are not churchgoers hold the same view. This is what is revealed by the following case study.

Case study 7.14 Nyanza's views on sex education theory

Fidelity (Fr: la fidelite conjugale) is the only way to avoid risk of being contaminated. It is a great risk to go with somebody who is not your real partner. You do not know his/her history. There is no trust. The whole issue of having sex with someone who is not your real partner is an affair of risk. You are never at peace for condoms do not guarantee protection. Better to protect oneself by not trying to have sex with somebody who is not your real partner.

Analyses of Q9 of QII (*Do you smoke and drink alcohol? What do you think of tobacco and alcohol?*) indicate that health rather than economic reasons are the most evoked with regards to the issue of consumption of alcohol and smoking. 73.8 % (62 respondents) think that alcohol and smoking have to be avoided for they are causes of many pathological cases. 26.2% (22 respondents) said that smoking and drinking have an impact on domestic economies. Here is an account which incarnates the essence of views about alcohol and smoking.

Case study 7.15 Belinga's views on alcohol

I do not drink alcohol and I have never smoked. Not because I am a Christian. Neither because my incomes are limited. But because drinking and smoking damage people's health. This is what I have seen of many people. Have you ever read what is written on cigarette packets. Some of them say tobacco is harmful, others clearly say tobacco can kill. Why therefore should I smoke? In my language we say 'wukitanina bonso mpe Nzambi kakutanina' (Kik) (God helps those who help themselves). Mainly the way some of our compatriots drink. Some of them do not even eat any longer. They cannot do without alcohol though their incomes are limited.

Belinga's account demonstrates the extent to which the risks awareness prevails in the mind of many Congolese. Consequently, as Baudrillard (1970) and Featherstone's (1996) theories of risks in chapter two have suggested, there is a particular self-therapeutic gaze on the body. Risks are conducive to therapeutic options or attitudes. For Congolese refugees this would include the practice of gymnastics, insistence on aesthetic and diet, avoidance of casual and extra-marital sex, avoidance of alcohol and tobacco.

As a therapeutic approach, the discourse on diet and physical exercises is very appealing among Congolese youth. Analyses of question two and four of questionnaire II (*Q2 Does food and drink contribute to your health? Q4 What types of food and drink do you take and avoid? Why?*) have revealed that the discourse of diet is very important among women.

All thirty-eight responses that came from women have spoken of avoiding certain types of foods (fatty foods) that might lead to obesity. Also to keep in shape (*la forme*), the body is to be submitted to certain physical exercises (Q6 and Q7 of QII. *Q6 What type of bodily exercises or activities do you think contribute to your health care? Q7 What do you think the body needs to be kept in good condition?*).

While 89.5% of women (34 of 38 women of QII) speak of dance '*Fr: la danse*' (Q6 of QII) as the most common option of Congolese young ladies, 83% of men (38 of 46 men of QII) opt for sports that involve much physical exercise. These are basketball, football and karate. These views are reflected in young girls and boys. The following has been noted among two Sunday school children, a boy and girl, who are from the same family.

Case study 7.16 Melissa and Poly

Melissa (13): *Gymnastics is very good for the body. I go for my dance classes every Saturday. I feel very good. I also do swimming whenever I can. Other sports such as football, basketball, Judo, Karate are masculine. Perhaps, when I am sixteen, I will start be going to the gym for my body (work).*

Poly (15). *My sister might be right. But I do not see swimming and dancing as sports. Everybody can dance. Everybody can swim. We go swimming after we have played basketball.*

Both Poly and Melissa portray a view of what the division of sports is in many Congolese refugees' households. While exercising the body is seen as contributing to one's health (Q1, Q6 & Q7 of QII), there is a clear understanding of what is appropriate in relation to gender. Moreover, while the discourse of diet is prominent among Congolese women (Q4 of QII), the rate of women practising sport is lower. In fact, the world of sport is relatively reserved to Congolese young males, for the most part, for adult males are rarely actively involved in regular physical exercise. As far as this issue of physical exercises is concerned, local council gymnasia are given a prominent attendance because of the possibility of financial exoneration.⁸ Risk theories have also shaped their approach to the issue of conceiving. As Ngelima pointed out:

Case study 7.17 Ngelima's views on Congolese women and conception

One of the outstanding realities of Congolese women in London is that the rate of conception has decreased in comparison to Congolese women at home. While at home the gap between conceptions or children is hardly of two years. I am delighted to see Congolese women in London to have three, four or five years gap between children. This I assume is not related to our limited income but to our new awareness that there can be a relation between our health and the number of pregnancies we have had.

One of the issues mentioned in responses to Q1 of QII was hygiene. In fact, there is a discourse of aesthetic among Congolese refugees which is associated to their discourse of hygiene. Regardless of their limited incomes, Mankenda's family assumes that: 'it is an imperative to fight other risks, in looking after our bodies and home, despite our limited financial means'. (Fr: *C' est plus qu' important de combattre d'autres risques en soignant son corps et sa maison avec le peu des moyens que l'on dispose*). As can be seen, the imperative of lifestyles as a self-therapeutic approach is a very complex matter involving a financial cost that is beyond their income. This might also be the reason why many adults in the Congolese community cannot go to gymnasia. In addition, fieldwork (Q3 of QII *How is your household diet like?*) proves the existence of a

quasi-monotonous non-balanced dietary regime among most Congolese in London. This is not related to cultural factors but economics. This would confirm the view that malnutrition is a real problem within refugee communities in London (Rutter, 1994:133).

7.7 Conclusion

This chapter has dealt with health issues among Congolese refugees in London. It has been argued that Congolese refugees have six therapeutic options. These options are based either on their culture, concepts of risk and experiences in the biomedical milieu. The three-dimensional therapeutic option which, combines biomedicine, the Christo-spiritual and the Congolese therapeutic systems, sustains the logic of benefiting from the uniqueness of each system. This approach is mainly used on ailments that are biological. Secondly, there is the two-dimensional approach which offers three options disclosing a particular rationale or reason. For instance, the use of Congolese Traditional Therapeutic Systems combined with Christo-Spiritual Therapeutic Systems would imply that the ailment, which might be biological, transcends the biomedical gaze or expertise. When the Biomedical Therapeutic systems are combined with the Christo-Spiritual systems, the ailment is understood purely in anatomical terms. The Christo-Spiritual Therapeutic Systems are brought in, because of their beliefs that 'doctors can only treat but to heal is God's activity' (Case study 7.11; p214). The third option, in this two-dimensional therapeutic approach, is when Congolese refugees refuse to consult doctors. Instead, they buy medicine from pharmacists and take them with prayers. I have called this option as the Self-Biomedical Therapeutic and Christo-Spiritual Therapeutic approach. Reasons for adopting this option included their negative experiences within the British health care sector as studied in section 7.2 (p.189-204) and the risk of being identified and deported (Case study 7.12; p.215). The last therapeutic option among Congolese refugees is the one-dimensional therapeutic approach. It includes either the use of the Congolese Traditional Therapeutic systems or that of the Christo-Spiritual systems. It is used in cases where biomedicine or Congolese

Traditional Therapeutic Systems have shown their ineffectiveness. The rationale in this is the idea of God being the Alpha and the Omega of human existence.

In section 7.5.1 (p.214-215), I have stressed the fact that Congolese refugees' therapeutic option is not only conditioned by their traditional aetiology, which relegates some predicament to extra-natural power or to self-evil deeds, but also by their multiple experiences within the British biomedical milieu as mentioned in section 7.2 (p.189-204). Thus, a therapeutic approach to Congolese refugees should consider their experiences in exile as well as the bases of their therapeutic options, as discussed in this chapter. To distinguish the social from the political, the religious and the economic, or to isolate the individual from the collective, in the process of promoting the Congolese refugees' health, is misleading (Lambo, 1963: 9).

Moreover, I have pointed out in section 7.6 (p.216-219) that their awareness of multiple risks creates another therapeutic approach to the body. These are lifestyles adopted in order to avoid potential risks.

Having refused a reductionist discourse on Congolese refugees' concepts of health (Section 6.4; p.186-187), on the basis of my fieldwork, theories attributing the use of traditional systems and the Christian spiritual systems in the Congo (and Black Africa in general) to social and economic factors (Iwu, 1986; WHO, 1978; Nchinda 1976; Sindinga, 1995) should be disputed. However relevant these theories might be, the factors of the availability, affordability, accessibility, acceptability and effectiveness of biomedicine do not eradicate the importance attached to traditional (and Christo spiritual) therapeutic systems. The use of traditional therapeutic as well as Christo-spiritual therapeutic systems by Congolese refugees is no compensation for the recreation of the psychological balance given their multiple losses. This view, based on my fieldwork, deconstructs my second hypothesis outlined in section 1.5 (p.25). The effectiveness and acceptability discourses that are inherent in their

Weltanschauung remain the most important factors explaining their use of traditional (and Christo-spiritual) therapeutic systems.

7.8 Notes

¹ Dialogues with ladies of la Alpha Church, April 1998.

² Mbimba speaks of his *rendez vous* at the surgery as a very sad one. He was asked while others standing near whether he was a refugee or not, June 1999.

³ Dialogues with parents and Sunday Schools children at *la Alpha* church, May 1998.

⁴ Dialogues with Pastoral teams of *la Alpha* and *la Beta* Churches, February 1999.

⁵ Idem.

⁶ Statements made by leaders of '*les groupes des intercesseurs*' and pastoral visits groups of *la Alpha* and *la Beta* Churches, April 1998.

⁷ A phrase often produced during what they call in these churches as '*les moments de temoignages (Fr), tango ya matatoli (ling)*,' moment of testimonies.

⁸ Based on conversations with Sunday School children at *la Alpha* Church, May 1998.

Chapter VIII. The schools' role in the promotion of Congolese refugees' health

8.1 Introduction

In this chapter I discuss the significant role of schools regarding the issue of promoting health in the Congolese refugee community. I substantiate my views, on this specific role of schools, with data collected in the practice of my fieldwork. Moreover, reflections in this chapter are not to be isolated from current thoughts on the ineluctability of the schools' role in promoting people's health. In the particular context of Britain, such reflections are epitomized by discourses on schools' pastoral care, personal, social and health education and citizenship education.

The chapter has two main sections. The first deals with views on the unique role of schools in promoting health as articulated in current scholarly discourses. The second section applies these thoughts in the Congolese refugee context.

8.2 Present thoughts on the role of schools in promoting health

8.2.1 Schools and pastoral care

The outstanding argument of theorists on schools pastoral care is that according to which there is no school without pastoral care activity (Hamblin, 1978:XV). This argument is nurtured by the view of students as human beings whose multiple needs require a particular attention. This is cardinal for an effective pedagogic impact as well as for the children 'meaningful life' (Davis, 1985: 13). Teaching is thus intrinsically related to pastoral care activities. In fact as stated by Haigh:

“...it remains a fact that every new entrant to the teaching profession is persuaded of the need to accept the dual role of academic and shepherd. It is widely assumed that the two roles are closely interrelated, as indeed I believe them to be, but the new teacher will find separate reminders of their existence” (Haigh, 1975: 1).

Schools' pastoral care is thus a pedagogic imperative. Through it obstacles that would hinder children learning process (Davis, 1985: 11) are identified and addressed. These obstacles can be of different nature ranging from emotional, knowledge, social, economic and physical aspects (Ryder & Campbell, 1988: 74). Haigh strongly advocates this aspect of schools pastoral care, as a pedagogic imperative, in his statement according to which:

“Pastoral care is not separate from work. To believe anything else is to misunderstand the nature of the teaching process. A teacher needs a great deal of feedback from his pupils about how his material is being received, and to help his assessment of this feedback he must know something about the thoughts and emotions of the children. In learning about these thoughts and emotions he will find out about the child's physical and emotional problems, and it would be a further denial of his status as a teacher if he failed to do what he could to help the child to overcome them” (Haigh, 1975: 6).

Hence, a school's pastoral care approach to children would encompass activities such as counselling, social actions, health education, moral or values education (McGuinness, 1998:9; Hamblin, 1986:2), human rights awareness or whatever contributes to the welfare of the children. Yet, pastoral care is not only a pedagogic imperative but it also has a pedagogic value or dimension. Its interventions provide knowledge. Thus the meaning of Marland statement:

“All pastoral care has a teaching element, and the converse is equally true: you cannot teach at all effectively without establishing some relationship” (Marland, 1974: 8).

It, nevertheless, must be pointed out that school pastoral care is not only to be restricted to teachers or the schools' staff, despite their prominent role (Hammond & Kirkland, 1996: 54). Schools do it in relation with parents and professionals from various sectors. It is the work of everybody (Davis, 1985:13). The reason of this is the fact that children's needs are of different forms. Hence, the necessity of what Jones calls a 'multi-agency approach' (Jones, 1998). In fact, as noted by Wall:

“If teachers accept their changing role to encompass the welfare needs of the child as a person rather than considering only the academic child then they must also accept the need to be a working

member of the welfare network. While some welfare problems can be effectively dealt with within the school there are many that require the specialist skills and expertise of outside agencies. The range of agencies will include both statutory and voluntary services” (Wall, 1996: 84).

Two more factors would justify the significance of schools pastoral care. The first is that schools direct contact with children gives them accessibility to pupils’ lives. Schools are therefore morally accountable to the welfare of the children. The second factor is that schools might be the only venue where children’s problems can be discerned (Davis, 1985:13).

To end this section, it should be stated that the rationale of schools’ pastoral care and its multi-disciplinary strategic intervention approach concur with the fundamental ideas of health promotion as discussed in section 4.2.2.1(p.110-113). Health promotion is about wellbeing (Baric, 1995). It is concerned with the totality of human beings. Consequently, schools through the practice of pastoral care contribute to the process of promoting children health. Through their accessibility to children, schools have a moral responsibility to the welfare of each community whose children are represented at schools.

8.2.2 Schools and the promotion of health through PSHE

Knowledge and action is at the core of the multi-dimensional activity of health promotion (Seedhouse, 1986). This corroborates with the rationale of PSHE as defined in the report of the National Advisory Group of May 1999. For PSHE is defined as:

“...all aspects of schools’ planned provision to promote their pupils’ personal and social development, including health and wellbeing. As such it is a means by which schools promote their pupils’ personal and social development” (Morris & Jowell, 1999:2).

PSHE is thus that activity through which the pupil is empowered, in the words of the Government Secretary of State for education and Employment, for ‘healthy and good decisions about their lives’ (Morris & Jowell, 1999). As such, any

issue that threatens or sustains lives is an object of reflections and actions for PSHE. This ranges from such issues as health, values, and human rights, to risks. Like the schools' pastoral care, the PSHE idea of empowering the pupil for right decisions concurs with the concern of health promotion discourses. For, like health promotion (Downie et al., 1992), the philosophy of PSHE implies that:

“An effective school is a healthy school. It promotes the physical and emotional health not only by providing access to information about factors which affect health, but by equipping children and young people with the skills and attitudes to make informed choices about health, now and in future, and to make the most of the opportunities of life presents” (Morris & Jowell, 1999: 10).

The British Labour Government is thought to have given prominent consideration to the role of schools in improving health. This is what is argued by Otten when she claims that:

“Personal Social Education was previously known as health education, a term still found in older official documents. Section 1 of the Education Reform Act 1988, restated in paragraphs 331 and 332 of the Educational Act 1996, places a statutory responsibility on schools to provide a broad and balanced curriculum which: promotes the pupil's spiritual, moral, cultural, mental and physical development; prepares pupils for the opportunities, responsibilities and experiences of adult life” (Otten, 1999:1).

For this reason, 'plans for National Healthy Schools Scheme' (Morris & Jowell, 199: 11) are being enhanced to make of each school a healthy school. Health education, therefore, is a component of PSHE (Ryder & Campbell, 1988: 123; Morris & Jowell, 1992: 2). As a matter of fact, whether health education should be part of school activity is not disputed. Indeed, it has long been argued that:

“Young children need to have knowledge as well as experiences and activity; knowledge about themselves, their bodies and the world into which they are moving in order to make important decisions which relate to their health” (Wetton & Moon, 1987: 55).

This statement concurs with the World Health Organisation understanding of the role of education in promoting health. As reported by Lloyd:

“The WHO (WHO 1969, 1984) has defined Health Promotion as the process of educating people about health issues in order to help them to increase control over, and improve, their health” (Lloyd, 1994: 2).

Knowledge as a necessary factor in health promotion explains the role of schools and all educational systems. Moreover, as expressed in the Ottawa Charter (WHO, 1986), the school constitutes a community where strategies can be considered and decisions taken to ‘achieve better health’ (Jones & Sidell, 1997: 1). The school is thus a ‘health promoting community’ (Williams, 1987: 79). For, like it was advocated in the context of school pastoral care:

“...schools have concerns which go beyond the academic and intellectual development of their pupils which include responsibility for their personal, social and physical welfare” (Williams, 1987: 79).

Therefore, issues that threaten pupils’ well being and strategies that are considered as contributing to their health promotion are regarded as pedagogic concerns. Moreover, the idea of being a network for the welfare of children remains central in PSHE (Morton & Lloyd, 1994:6; Morris & Jowell, 1999). Health questions to be dealt with are numerous. They would include issues such as lifestyles, substance use, nutrition and diet, stress, relationships (Otten, 1999). The point about this is that the schools should deal with real issues encountered and experienced by pupils (Hendry, Shuksmith & Philip, 1995: 195). With PSHE, schools go beyond the traditional paradigm of health education by considering particular experiences of ethnic minorities (Coombs & Craft, 1987: 79) as well as sensitive issues (Otten, 1999). This is clearly asserted in the recent Government draft for consultation on sex and relationship education. Stressing the nature of issues that are to be dealt with in PSHE, the third point of its introduction reads as follows:

“The new PSHE framework will help pupils to develop the skills and understanding they need to live confident, healthy and independent lives. It will play an important role, alongside other aspects of the curriculum and school life, to help pupils deal with difficult moral and social questions” (DfEE, SRE, 2000).

8.2.3 Schools and the promotion of health through citizenship education

The Crick report on citizenship defines citizenship education in terms of social and moral responsibility, community involvement and political literacy (Crick, 1998:13). Its main concern is:

“...to make secure and increase the knowledge, skills and values relevant to the nature and practices of participative democracy; also to enhance the awareness of rights and duties, and the sense of responsibilities for the development of pupils into active citizens; and in so doing to establish the value to individuals, schools and society of involvement and wider community” (Crick, 1998:40).

The notion of citizenship education implies the logic of the relevance of knowledge and actions required for common good. This knowledge covers all dimensions of human life including questions of ethics, human rights, and political histories (Crick, 1998: 51; Rowe, 1992: 60). Personal and collective rights and duties are bound and exist intrinsically in an indivisible form of relationship (Rowe, 1992: 51). Citizenship education, thus, is the process by which individuals are made conscious and concerned for right actions in regard to causes and issues within or beyond their social spheres (Heather 1992: 19) for the sake of common humanity. The individual acts for common good. Justice is argued to be the key concept of citizenship education. For, it is the criterion by which any action is assessed (Rowe, 1992). This emphasis on common good or care is intrinsic to the philosophy of health promotion (MacDonald, 1998).

The discussion of the rationale of pastoral care, PSHE and Citizenship education demonstrate that they are relevant tools or means by which the welfare of pupils can be guaranteed. The overlaps in their concern (DfEE, SRE, 2000) are symptomatic of the multi-dimensionality of pupils' existence. This bears witness to the fact of health promotion that it requires, as mentioned in chapter two, 'a cooperation' (Baric, 1995) of different techniques and *savoir-faire*.

8.2.4 Schools and the promotion of health through human rights education

Given the manifold nature of determinants of health (Baric, 1995; Seedhouse, 1986), the teaching of human rights is a cardinal action in promoting health. This explains the fact that it is one of the issues in PSHE and Citizenship education. The teaching of Human Rights is intrinsic to the activities and reflections of the United Nations and affiliated bodies. This is articulated in the twenty sixth article of the UN Declaration of human Rights. According to this article, education is not only a right, but also the significant means to expound knowledge about human rights and freedoms. In 1968 at the International Conference on human rights in Teheran, states were urged to use 'all means of education' (Claude, 1996:6) to disseminate knowledge about human rights. In 1978, to celebrate the thirtieth anniversary of the UN Universal Declaration of Human Rights in Vienna, ten articles were approved as fundamental in the teaching of human rights. Article eight and nine, to my view, summarise the importance accorded to schools in particular and education in general to disseminate knowledge about human rights. The two articles state the following:

“(Article 8) Human rights must be taught at all levels of the educational system, as well as in out-of-school settings, including the family, and in continuing education programs, including literacy and post-literacy programs. States shall strive to improve and broaden human rights education and teaching and cooperate to this end.

(Article 9) It is not enough to dispense teaching and education in the spirit of respect for human rights; human rights should also be taught as a subject integrated in the appropriate disciplines and, in particular fields such as philosophy, political science, law and theology, they should be taught as an independent course” (Claude, 1996:8-9)

The two articles quoted stress the intrinsic relation that exists between education and human rights. In fact, as argued by Sebaly:

“Since the adoption of the UN Charter (1945) and the Universal Declaration of Human Rights (1948), there has been no shortage of recommendations that teachers should be better prepared to

develop Human Rights perspectives and skills among their students” (Sebaly, 1987: 207).

The teaching of human rights has educational significance. It informs about one's rights and one's responsibility. This is what is expressed by the fourth article of the Vienna meeting (Claude, 1996:8). Education is portrayed as the most important medium in disseminating knowledge of life-sustaining issues. Thus, given the pre-eminence of education in schools, the latter are viewed as the arena, *par excellence*, for human rights education (Ray & Tarrow, 1987: 3). Every teacher is seen as a human rights' educator and promoter. His or hers is the task to implement and translate in the micro social and political context the fundamentals of the UN Declaration of Human Rights. Moreover, it should be stated that knowledge of human rights is a right in itself. This can be discerned in the preamble to the 1948 Universal Declaration of Human Rights which describes the latter:

“...as a common standard of achievement for all people's and all nations, to the end that every individual and every organ of society, keeping this Declaration constantly in mind, shall strive by teaching and education to promote respect for these rights and freedoms and by progressive measures, national and international, to secure their universal and affective recognition and observance, both among the people of Member States themselves and among the people of territories under their jurisdiction” (UNDHR, in, Davies, 1988: XVIII)

As a matter of fact, with its emphasis on individual rights and responsibilities, the teaching of human rights promotes human well being, since the fact is as pointed out by Flowers and Shiman:

“The Universal Declaration of Human Rights, for example, speaks of the right to life, liberty, and security (Art 3), to food, clothing, shelter, medical care, and the needed social services (Art 25), and to rest and leisure (Art 24). The Convention on the Rights of the Child addresses human rights of children related to abuse and neglect (Art 19), disability (Art 23), expression of opinion (Art 12), and health care (Art 24)” (Flowers & Shiman, 1997: 161).

In the light of human rights concerns, I would argue that human rights education does not only contribute to health promotion activity. It is part and parcel of health promotion activity.

8.3 Contextualizing the relevance of schools' health promoting role

8.3.1 The relevance of schools' pastoral care for Congolese refugee children

Scholars on education and refugee issues have pointed out the difficulty that exists to define and to deal with refugees' issues. For instance, in the context of the United Kingdom, Coulby and Jones have observed that:

..., it is difficult for education systems and teachers to understand the full range of obstacles that exist. Many relate to the traumatic experiences that led them to asylum seeking, some involving death and torture. Others relate to the difficulties of surviving in the UK, in making sense of the bureaucratic systems that impinge on all aspects of refugees' life here. They often feel insecure and isolated and indeed they often are. Within this environment, school is potentially one of the few secure sites in their daily lives and teachers can be critically important adults. However, for teachers to deal effectively with such issues requires training (Coulby & Jones, 1995:122).

The quotation above shows both the complexity and the relevance of schools' indisputable role to refugee children. In the context of promoting the health of Congolese refugee community, the role of the school is pivotal. This is due to the fact that schools, more than the GP' surgery, are the most attended arenas of the British social space by the Congolese refugees (Yule, 1998). Another factor that entails schools to be involved in the health promotion of Congolese refugees is the fact that Congolese refugee children, like any other refugee children, are a microcosm of their household and community conditions (Jones, 1998: 174). They carry at school the realities of their households and of their community. Consequently, schools have access to the realities of the Congolese community. This access, is an important tool for schools to contribute to the process of health promotion within the Congolese refugee

community. To illustrate the schools' opportunities in contributing to health promotion, I refer to Rutter's observation that:

"Refugees are more likely to be refused registration with a GP than other sectors of the population. In cost-conscious times someone who does not speak fluent English may be perceived as being more expensive to treat. All these factors mean that teachers and the school medical team should not assume that a refugee family is registered with a GP" (Rutter, 1994: 134)

Schools' pastoral care of refugee children is not to be limited to counselling. In other words, schools' pastoral care of these children should not be restricted to addressing psychological conditions deriving from their experiences (Yule, 1998). A school's pastoral care of refugee children should be concerned with the totality of the issues facing the refugee community (Rutter, 1994). Such an approach discloses the interrelated dimension of refugee issues and addresses their causes. For as Jones argues:

"The educational needs of refugee pupils, for example cannot easily be divorced from other out of school issues faced by many refugees families and/or individuals. Schools sometimes do become the key information point for refugees but seldom have the expertise to deal with the range of issues involved" (Jones, 1998: 174).

In the context of Congolese refugee children, school pastoral care activities would consider the impact of the asylum policies on their health. Reflections and actions on the conditions of Congolese children's household and community would be part of any school pastoral care program. The ethic of justice and moral imperatives, evoked in section 3.4.6 (p.90-92), should be the *leitmotiv* of such a pedagogic approach. In addition, the equation that the ability to learn corresponds to the quality of children's conditions should remain pedagogically cardinal. This concurs with what Freire has called an authentic education (Freire, 1972: 66). Authentic in that, with the participation of children, this type of education generates actions that are life-sustaining and humanising. Two areas of action can be identified as strategic for schools' pastoral care of Congolese refugees. These are the dissemination of relevant needed information about health care and welfare resources and counselling.

8.3.1.1 Disseminating relevant and needed information about health care and welfare resources

One of the reasons advanced in section 7.2 (p.189) regarding the lower use of various health care resources by Congolese refugees is the lack of information. Thus, identifying the needs of the refugee community, schools should provide information to children about available legal and health care resources (Rutter, 1994: 94). The need to know where to go, to whom to turn, to address any difficulties they personally encounter in their households is obvious among Congolese children. This has to be stressed considering the frequency of the abuse of children in the Congolese community. Cases of sexual and physical abuse are systematically being recorded to the extent that, as noted by leaders of *la Alpha* and *la Beta* Churches, some of them have already had fatal consequences. Thus, as Davis (1985)' argument evoked in section 8.2.1 (p.226), the school remains the main arena where such children can find help.

8.3.1.2 The imperatives of Schools' counselling to Congolese refugee children

Reference to the issue of the abuse of children in the last section underlines the importance of counselling within schools with Congolese refugee children. Scholars (Yule, 1998: 90; Rutter, 1994:96) have particularly noted the importance of counselling among refugee children in Britain. Counselling in schools has a twofold function. First, it contributes to detecting the pupil's own problem. Secondly, it helps to discover the ongoing social, economic and political realities of the children' s household and community. As stated in section 8.3.1 (p. 232), Congolese children's misbehaviour at school can reveal a range of pathological issues within their household as well as in their community in general. I would illustrate this with two case studies.

Case study 8.1 Claudette' strange behaviour

Claudette and her parents have been in Britain for four years. Her teachers and classmates admire Claudette. She has mastered English that she is the pride of her parents who can hardly make an English sentence. The relationships with her best classmates have transcended the school frontiers. They exchange gifts for birthdays and often meet for celebrations. At the day of Claudette's fourteenth birthday, she decided not to go to school. Nevertheless, her friends

and teachers came to her place with presents as they sang 'Happy birthday Claudette' surprised her.

Claudette thanked her friends and teachers adding that she did not know whose birthday it was today. Also, that she did not know whether she should accept these lovely presents on this particular day. This happened in 1997. A similar scenario was reproduced the following year (1998) and Claudette had insomnia and could not attend school for a week. It required counselling sessions, with which a Congolese pastor is still associated, to realise that Claudette strange behaviour at each time of her birthday is related to her strange identity. Her birthday is celebrated on the wrong day. Regular support from the teacher and regular pastoral counselling are hoped to spare Claudette from this regular seasonal hysteria or schizophrenia. (Fieldnotes, July 1998, Appendix I, p.277)

Case study 8.2 Romaine accused of witchcraft by her stepmother

Romaine was six years old when she joined her dad, stepmother and stepbrother in London. She was a happy little girl full of life. Within a year she was fluent in English. Suddenly, she became pale and refused to speak to anybody. The impact upon her studies was noticeable that the schoolmaster had to speak to her parents. The meeting with the headmaster ended with the parents' statement: 'let us talk to our pastor it will be fine'. Through pastoral counselling sessions it was realised that for economic and familial reasons Romaine was mistreated by her stepmother who persuaded her husband that Romaine was a witch. (Fieldnotes, May 1998, Appendix I, p.277)

These two cases clearly show the significance of counselling for Congolese refugee children in schools. This is why, basic counselling skills for each teacher are thought necessary (Marland, 1974; Haigh, 1975). However, schools should also have among their staff those with outstanding counselling skills (Lang, 1993).

As shown in the two last case studies, counselling Congolese children might require co-operation between a school's teacher, professional counsellors, and members of the Congolese community with knowledge on the issue. The school-household and Congolese community liaison is paramount for pastoral care performance. This is a view that is strongly stressed by experts on the question of schools' pastoral care (Hamblin, 1978). As in the case of interpretations within the biomedical milieu, Congolese pastors on the basis of

their vocation and uniqueness in the community can be of a major help to schools with Congolese refugee children.

Issues for which Congolese children need counselling are immense and some are similar to those of their parents as seen in section 6.3 (p.185). Nevertheless, it is worth noting that stress deriving from conditions of exile in Britain and Post Traumatic Stress Disorders due to experiences in the Congo are noticeable among many Congolese refugees children. Bolloten and Spafford's (1998) account of a Congolese schoolboy is paradigmatic, and I offer their observation:

"Paul was in a Year Two class at primary school in London. Paul's family were from Zaire and Paul had been in the UK for less than a year. Sometimes he was not picked up from school and not given any 'tuck money'. The family had been forced to leave Paul's young sister, Agnes, behind in Zaire.

Paul's behaviour at school was at first seemingly bizarre. Teachers found him very difficult to control. However, with regular one-to-one supervision from a General Welfare Assistant, both first thing in the morning and at break times, and through plenty of extra opportunities for supervised play, Paul was able to feel more secure and settled. Although Paul was making good progress in his understanding of spoken English, he easily became frustrated when unable to express himself. He would often stutter with the effort of recalling or finding new words. Paul loved listening to stories read in class and also drew pictures to convey meaning.

In one lesson Paul drew a series of pictures about journeys. Paul's teacher encouraged him to talk about his pictures and gave him lots of encouragement and praise. Paul recalled some of his memories of Zaire.

Paul: Let me show you something (Paul collected another picture from his tray. It was a small picture of a small person climbing a tree. Paul then drew a soldier by a tree).

Teacher: OK You jump on the tree...

Paul: Yeah..

Teacher: and then what else do you do?

Paul: (stammering)(inaudible)... and then I fall d.. whooaaaaa

Teacher: You fall down?

Paul: Yeah I fall down and then I jump... water is there... and then someone get me...ad then...(inaudible)...I' m dead.

Teacher: Oh no!

Paul: Some... he push me... and then he push me... (stammer)... dead.

Teacher:... and you're dead?

Paul: Yeah.

Teacher: Can you go to hospital and get better?

Paul: Yeah I got better..... Som.... He push me he shoot me... (made shooting noise)... he shota me.

Teacher: Have you seen soldiers like that?

Paul: Yeah!

Teacher: Did they push you?

Paul: Yeah. They push me.

Paul finished by drawing a flower which he remembered was outside the door of his house. The teacher looked through the drawings. Paul numbered the pictures and agreed to tell the story of all of them.

Paul: Sometime I go in the tree.. and someone soldiers and they do get me, they push me and then tree...and I' m dead...I go strong...and then...sometimes I go home I sleep my bed...and then...(inaudible)... when I close my door I see my...(inaudible)...flower ...it's lovely flowers" (Bolloten & Spafford, 1998:116-8).

It can be said, as fieldwork has shown, that school counselling to Congolese children would not fail to see the correlation between Home Office policies towards Congolese refugees, conditions of exile as disclosed in chapter three, and Congolese children's behaviour and performance at school. Children whose parents' cases are suspected or rejected by the Home Office are likely to misbehave at school. This is what is illustrated in the following case.

Case study 8.3 Matonge' s children

The Matonge family arrived in Britain in 1995. Five months after their application for asylum was rejected. While appealing against the Home Office decision, their income support was stopped and the housing ceased paying for their house. They had to move from one's friend's place to another. The children started missing school. Yet whenever they attended they slept while others were following the teachers. The headteacher asked them to find out why they had to sleep. He decided to accompany the children at their place to discover that their home address at school was different to that where they

were now living. With the help of a Congolese interpreter, they explained the whole situation. The head teacher said to them: now I understand why, whenever they attend classes they fall asleep. (Fieldnotes, July 1998, Appendix I, p.277)

This case is one of the many among Congolese refugees. Parents' conditions and social tensions jeopardise their school performance. Children remain the most vulnerable group. My argument would concur with Rutter's comments regarding the withdrawal of welfare from many refugees families:

“Schools and other agencies are already noting the ill effects of the withdrawal of such benefits. Some children have simply disappeared from roll. It is likely that among asylum-seeking children there will be:

- an increase in malnutrition and associated health problems
- the manifestation of stress-related illness among affected children
- greater family breakdown
- little effective learning in schools”(Rutter, 1998: 31).

Rutter's observation would coincide with Gamarnikow and Green's critical concern about Government policies which overlook the relation between economic, social, and symbolic capitals in the acquisition of cultural capital (Gamarnikow & Green, 2000:17). This state of affairs, claim Gamarnikow and Green, would regenerate poverty and social exclusion (Gamarnikow & Green, 1999: 60). The performance of Congolese refugee children in schools cannot be divorced from their households and community' social and economic deprivation. In fact, their situation is not different to that of refugee children resettling in camps (Ahearn *et al.*, 1999: 224). For like refugee children in camp, the experience of severe deprivation in terms of food, medical care and shelter is a reality within the Congolese refugee community in London.

8.3.2 Promoting Congolese refugee children's health through PSHE

PSHE provides schools with numerous opportunities to contribute to health promotion in the Congolese community. Analyses of Questionnaire II (QII) indicate that questions such as diet, sex education, and other health risk issues are hardly fully discussed in the Congolese refugee households and community. Although, as I have previously mentioned in chapter six,

monotonous Congolese diet (semolina) is related to economic factors, schools can provide relevant information on reasons and possibilities for a balanced or healthy eating diet (Morris & Jowell, 1999; Otten, 1999: 63). The necessity of this issue has been stressed by Rutter who strongly asserts that:

“...it is debatable whether asylum seekers who have to survive on 90% of income support can afford a balanced diet. The school medical service must be made aware of these issues and the schools must ensure that schools meals meet nutritional guidelines and that refugee children do not miss out on health education” (Rutter, 1994: 133).

Sex education, as the fieldwork in section 7.6 (p.216) (7.1% from Q10 of QII) and dialogues on sex education with parents of *la Alpha Church* have shown, is not part of the Congolese household or public discourse. This is what is summarised by the following dialogue:

Case study 8.4 Dialogue with members of *la Alpha Church* about sex education

A.N.N: *Thank you for this opportunity you have given me to talk with you on sex education. Though many of you have expressed their views in my Q II, I still wanted to meet with you to talk on this particular issue. Considering what is happening in our community, this is a very important issue to talk about. Children are rebelling against parents in romantic affairs. The phenomenon of teenage pregnancy is increasing. Let us not forget the risk of AIDS and other STDs. However, I have the impression from your responses to my QII that you hardly speak of sex education in your household. How come?*

The representative of the women’s group stood up to respond

Maman Solika: *As the women’s group leader, I have been appointed to respond to this question after our consultation. Ah! We thank God for your work and we hope that it will be helpful somehow to address some of the serious problems we are facing in our households in particular and in our community in general. We think that it is time we started talking of what we have never spoken before. To take my own example, I am now in my early forties, no one in my family has ever spoken to me about sexual life. Not even at school was I taught about it. I sometimes ask myself how do I know what I know about it (everybody laughed)- (do not laugh she said, it is serious)- speak Maman Solika, speak!*

Now, how easily can we talk of that which we have never spoken about with our parents. What we need is to be equipped to deal with this issue. We would not blame our parents. Nevertheless, we think times have changed, our attitudes to such an important issue should also change. I do not know if one of us (ba

mamans: the mothers) has something to add. Thank you. (Everybody applauded).

Maman Bineta: *Most of us find ourselves in what Maman Solika said. I have two girls. The oldest is sixteen and the youngest is fourteen. I am worried of what I am already seeing with them. All I tell them is that they are not supposed to have boyfriends, not until they are married. They must be careful because there are many STDs. When I suspect calls from boys whom I do not know, I rebuke them (Everybody laughed). You are laughing! I have to protect my children.*

Pastor Kiembo's intervention (Please, be quite, I think we need a father's voice)

Ngoy *(The leader of the father's group). The problem is more complex with us as fathers. To begin with, whenever we talk about sex education, we always have in minds our girls. Now, if mothers (our wives) cannot easily talk with our girls, how easy is it for fathers to deal with them. To be honest, none of us has ever spoken of sex education in our households. All we do is to blame our girls and our wives. We beat them whenever we suspect something involving a sexual relation is going on with our girls (Everybody laughed) (Women above all applauded him for saying the truth). Therefore, what we need is to know how to deal with this particular issue that is real in the community. We do not have the skills and we have never spoken about it even in our church meetings. (everybody applauded)*

Ngoy's wife's quick intervention: *Oh Ngoy! how can the church talk about such an issue? (Every body laughed...)*

Dialogues with members of *la Alpha Church* proved that neither boys nor girls are successfully equipped to grasp sex issues. A puritan approach of blame rather than a dialogue on the issue is the common experience. Children's knowledge of sexuality derives from outside the household context. Hence, conflicts between parents and children. In fact, my observation of a lack of sex education within Congolese refugees' households concurs with the Government's observations. Discussing the issue of sex education and relationship within Britain's ethnic minorities it has been noted that:

"...a range of children from black and minority ethnic communities are less likely to talk to their parents about sex and relationships. Some young women and men from some minority ethnic communities may rely on schools as the main, and sometimes only, source of sex education" (DfEE, SRE, 2000).

One of the outcomes of a lack of sex education within the community is the striking phenomenon of teenage pregnancy and the break-up of households. *La Alpha* Church's pastoral team commented that during pastoral visits in summer 1998, they came across six families whose young children were pregnant. It should, however, be commented that the reluctance of Congolese parents to deal with the issue of sex education might derive from views acquired in Christian circles in the Congo. For, however the nature of theological divergence between Christian denominations in the Congo, there seems to be an agreement that discussing sex issues in the household context between parents and children is a taboo. A puritan attitude restricting the discussion of sex issues between spouses, and a culture of blame towards 'misbehaving children' have been imposed. Traditionally, however, sex issues are openly dealt with within the extended family context. This is between grandparents, aunts, uncles and grand children. In this context parents are hardly included (Ngambu, 1981: 49).

The complexity related to sex education is not to be limited to the Congolese household context. The subject is described as 'one of the most controversial and political aspects of school curriculum' (Trudell, 1993: 2). The whole issue of whether to repeal the section 28 is suggestive. This can be illustrated with the importance accorded to parents in Labour' Sex and Relationship Education guidance. Point 2.1 stresses the fact that:

"Parents, and pupils, may need to be reassured that the personal beliefs and attitudes of teachers will not influence the teaching of sex and relationship education within the PSHE framework" (DfEE, SRE, 2000).

Parents' objections to sex education in schools can have a moral or religious background, though the question of who is teaching and how it is being taught are very alarming factors for parents (Bradney, 1996:93). Moreover, parents' negative attitudes to sex education should not only be explained in terms of moral, religious and curriculum factors. What should also be considered is the fact that:

“The parents’ own knowledge of sexual matters may be lacking, even though they have produced children. They may not have had sex education at school themselves of course. They may also lack the necessary education skills, as not everyone is good at explaining things to other people” (Went, 1985: 12).

Went’s views concur with reasons advocated by ‘*Mama Solika*’ as case study 8.4 (p.239) has indicated. However complex is the issue of sex education, Congolese children have the right to know about issues related to sex. Considering the fact that dialogues on sex issues between parents and children in the Congolese refugee community are absent, schools, as indicated by point 1.24 of the government guidance on sex and relationship education, have a major role in providing relevant information to Congolese children. This does not imply an exclusion of parents from knowledge that is being disseminated to their children. In fact, together with Congolese children’s parents, school governors and teachers should develop a dialogue about what should be taught in sex education and why. As stressed by the Government:

“Governing bodies and headteachers should consult parents in developing their sex and relationship policy to ensure that they develop policies which reflect parents’ wishes and the culture of the community they serve” (DfEE, SRE, 2000).

Moreover, in consulting parents over these issues of sex and relationship education, schools must develop an approach by which they are able to discern the needs of the children. For these might be different to those of their parents. The relevance of this approach in the making of school policies and programmes of sex education and relationships has been grasped by Rutter who states that schools must be able to:

“Distinguish the young person’ needs and the concerns of those who speak on their behalf: parents, community leaders and those with particular political agendas. It may be necessary to acknowledge inter-generational conflict and internal power play” (Rutter, 1994:138).

Schools can help Congolese children on other health issues related to life styles. Issues such as smoking and drinking are vitally important. The

consumption of alcohol and other substances is a routine among many Congolese children. These are mainly children whose parents have no outstanding social occupation such as job and studies.¹ Among the thirteen families visited by *la Alpha* Church pastoral team in autumn 1999, eight had children under sixteen involved in the consumption of alcohol and other substances. Not only is the consumption of alcohol and tobacco flagrant among children from unstable families, but also a culture of *laissez-faire* is common. A total social and psychological chaos reigns in most of these families where nobody would help or control anyone. Promiscuity of any type can only be suspected.²

The other cause related to the consumption of alcohol and substances among Congolese children is the influence of society (Coggans & McKellar, 1995). Church leaders from *la Alpha* Church have stressed this fact, which they say is very damaging in the Congolese community. They spoke of parents' constant complaints over the issue of children revolting beyond control.³ Referring to experts' studies such as those by Wilson *et al.*, (1992) and Coggans & McKellar (1995), social deprivation as a contributing factor to teenagers' pregnancies, and the consumption of alcohol and other substances by the Congolese youth should not be underestimated.

8.3.3 Promoting the health of Congolese refugee children through Citizenship Education

The characteristics of C.E as discussed in section 8.2.3 (p.229) demonstrate its significance in promoting the health of Congolese refugee children. The effect of teaching human rights in CE is threefold.

First, it helps non-refugee students to understand the main political issues and their effects which have led Congolese to exile in Britain. They will be able to undermine any stereotyping and downgrading gaze towards Congolese or any other refugees. Through the teaching of human rights, such discourses as bogus economic migrants will be dismantled (Rutter, 1994). For in teaching

human rights, pupils will come to grasp the self-evident truth asserted by the Universal Declaration of Human rights that:

“Art 3 Everyone has the right to life, liberty and security of person.

Art 5 No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Art 14 Everyone has the right to seek and enjoy in other countries asylum from persecution” (UNDHR, in, Davies, 1988: XIX, XXI)

Secondly, the teaching of human rights through citizenship education would help Congolese refugee children to overcome the downgrading attitude of which their community is often victim. They would not only interpret their presence in London as a question of right in relation to fundamental texts on human rights but they would also feel understood and accepted. Thus, a degree of the lost self-esteem is recuperated. To achieve this, schools voices in defending and promoting the rights and the welfare of refugee children should be echoed.

The benefits of acting against government’s policies (regarding deportations, detentions, and welfare benefits) on Congolese refugees have considerable positive psychological and social effects for the schools and the concerned children’ households and their community. This can be illustrated by the Hazelwood Junior School, Enfield, North London, whose action against the deportation of three Congolese children in 1993 still has enormous positive effects on the family, the community and the school.⁴

The knowledge of fundamental human rights texts within the Congolese community in London is very limited. It is for this reason that one of the pastoral concerns within *la Alpha* Church, in 1993, was to assist Congolese asylum seekers to substantiate their cases with reference to fundamental text of Human Rights. The ignorance of these fundamental texts by many Congolese in London can be explained in terms of a lack of human rights education in Congolese schools. For such people seeking asylum is hardly seen as a right.

Given the relevance of education in disseminating right knowledge to shape and nurture beliefs and perceptions (Lewis, 1998:43), I would argue that Citizenship education provides Congolese refugees, through the teaching of human rights to their children, with the possibility to acquire the knowledge they need on human rights issues. This information, as already stated, would help them to interpret their presence in London in terms of rights. As such, the shame that the concept of refugee brings to them will be partly exorcised.

In this context of human rights, it should be said that knowledge of children's rights, as articulated by the United Nations Convention of Rights for Child (Hodgkin & Newell, 1998), is of a major importance to Congolese refugee children. It would constitute an asset to deal with the variety of issues that they face in the community. The nature of the patriarchal regime that prevails in some Congolese refugees' households deprives many children of self-views or opinions. Social experiences within some of these households reflect the existence of forms of totalitarian social or household culture. As reported by *la Alpha* and *la Beta* pastoral teams' members⁵, verbal and physical forms of abuse are the experiences of many Congolese refugee children. Being a patriarchally oriented community, it must be stressed that girls have been the most vulnerable or victimised. The following case sheds light on the complex experiences of Congolese girls within the Congolese refugee community in London.

Case study 8.5 Margaret forced to marry

Margaret (now 19) is the eldest of a family of four. They regularly attended a Congolese church where her parents had responsibilities. At 16, Margaret had many Congolese admirers who consulted her parents for marriage. Her parents could not accept these demands stressing that education is all they wanted for their daughter whom they said to be still very young to consider a marriage.

As demands and financial offers multiplied, Funsu, Margaret's dad, abandoned his original view and persuaded his daughter to marry. Over this decision, the family split. For neither Margaret, nor her Mum and friends could accept these demands and financial offers for letting Margaret get married. Having no knowledge on the Convention of the rights of Child, they had no basis to challenge Funsu. For as far as their cultural traditions are concerned, it was not

the first time that a father would decide a marriage for his daughter at that age. Their pastor was the only person to whom they could turn. (Fieldnotes, August 1999, Appendix I, p.277)

Thus, against despotic abusive parental attitudes, such as those undergone by Margaret, schools could equip the Congolese children with knowledge on the rights of the children as articulated by article twelve, thirteen and nineteen of the Convention on the rights of the Child, for the latter states:

“Article (12). 1 States parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article (13). The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child’s choice.

Article (19). States parties shall take all appropriate legislative, administrative and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent (s), legal guardian (s) or any other person who has the care of the child” (C.R.C, 1989; 4,6)

The third aspect of Citizenship education for Congolese refugee children is that it equips them to take part in actions not only for Congolese refugees’ benefit but for society’s common good. Citizenship education, thus, brings Congolese and non-Congolese children to work together for common causes. To illustrate, being in a multi-cultural society, students, regardless of their race, will unite against such issues as racism and xenophobia (Bulman & Jenkins, 1998: 21).

8.3.4 Some pitfalls in the schools’ approach to Congolese refugee children

While reasons for exile and conditions in the host country should be part of the schools’ concern for Congolese refugee children, the issues of gender and culture are also to be regarded as significant for a dynamic and effective practice of pastoral care in the school (Devoe, 1994: 236). Two things are worth

noting here. First, schools' pastoral care that neglects to consider cultural elements of the ethnic minority children runs the risk of enhancing and promulgating an assimilationist philosophy. In this trend, the teacher implicitly and tacitly asserts that the salvation of ethnic minorities children is by adopting the dominant culture (Ahmad, 1996: 196).

Second, ignoring the cultural element of a Congolese child can be counter-productive in the school pastoral care. The case of Romaine (p.235), would bear witness to this. Had not the school agreed with Romaine's parents '*let us speak to our pastor*', the school would have been bound to a therapeutic walk into a *cul de sac*. Moreover, though Congolese children try to adapt to British cultures, an 'over-adjustment identity' (Veer, 1998: 26) is not the case. There is the possibility of speaking of a 'bi-cultural identity' or a 'partial adaptation' (Veer, 1998: 25) among Congolese children. To illustrate the importance of this, it has been observed that newly arrived Congolese girls have found it difficult to go to swimming pools with their male classmates. Not that they could or can not swim but the idea of boys and girls swimming together has not been fully accepted yet.⁶ The same would apply in counselling processes. Though some practices of the Congolese patriarchally oriented society are to be considered as obsolete, theirs is a society characterised by a 'mechanical solidarity' (Bellah, 1973: 63). Some roles and places in their society are not questioned. Thus, a teacher would not be surprised to be told by Congolese children that in their community Congolese girls' daily activities apart from school work would include, washing up, cleaning the house, shopping and cooking while their brother's would include football and occasionally washing up. In this particular context, teachers would be advised to:

“...not make assumptions about the role of women and men in specific cultures. In every refugee community there are many personal differences in the positions adopted by men and women and ideas about masculinity and femininity” (Rutter, 1994:139).

As far as issues related to sex education are concerned, Congolese girls are not likely to be interested and motivated when the teacher is a male. Dealing

with his daughter's homework, Maketo found out that (science) was the course on which his daughter (15) did not do well. Lufimpu revealed the same when he was told by his daughter (14) that the reason why she does not do well with science is that she sometimes feel uncomfortable with its content. While school pastoral care and PSHE are vital for both the intellectual development and the welfare of the Congolese children, teachers and those involved in caring should be aware of these particularities. For, rather than being a dilemma, cultural difference can be enrichment to the art of teaching. To end my reflections on the relevance of recognising the Congolese children's culture within the schools' settings, I would refer to Burtonwood's words that:

“Cultural discontinuity between pupil and pupil or between pupil and teacher is not just a problem, but an opportunity- a stimulus to thought. A multicultural society which is open would allow, indeed require, that individuals seek intercultural understanding so as to participate fully in transforming cultural reality.” (Burtonwood, 1986: 160).

8.4 Conclusion

The chapter's focus has been on the role of schools in promoting the health of Congolese refugees in London. This role is apparent by the virtue of schools' function and their direct contact with Congolese children. I sustained this reasoning on the basis of scholarly reflections including those by the United Nations and affiliated agencies as well as thoughts on schools' pastoral care, P.S.H.E and C.E as articulated in the British context. Schools are in the front line to discern happenings (Hamblin, 1978: 81) in Congolese children's lives. Through their practice of pastoral care to children, schools have possibilities to decipher the ailments invading the community and therefore, contribute to possibilities for effective therapeutic and life-sustaining actions. However, schools must avoid an assimilationist pastoral care approach. Considering themselves as part of the needed network to address the real problems facing Congolese children, schools pastoral care approach aiming at enhancing the wellbeing of Congolese children must adopt a 'multifaceted approach' (Devoe, 1994: 242). This is an approach that considers the multi-dimensionality of

Congolese children issues in taking into account culture as well as social, economic and political conditions of their household and community. For it is a matter of fact:

“Without a more complete set of information, school staff are hampered in attempts to help the individual” (Devoe, 1994: 241)

The significance of PSHE and C.E as tools for promoting Congolese refugee children’s health remains in their ability to empower the Congolese refugee children with adequate knowledge for right actions for both personal and collective good. Through the children, schools will empower many Congolese refugees on various issues contributing to their welfare as well as responsibilities. The children, thus, become the medium through which life-sustaining information and knowledge is passed on to the entire Congolese refugee community.

8. 5 Notes

¹ Based on dialogues with the *Alpha* Pastoral team, December 1999.

² Based on information received from pastoral teams of *la Alpha* and *la Beta* churches, February 1999.

³ Idem.

⁴ See Appendix VII.

⁵ Dialogue with members of *la Alpha* and *la Beta* Churches, February 1999.

⁶ Dialogues with Sunday school children of *la Alpha* Church, May 1998.

Chapter IX Conclusion: The Home Office, the health care sector, the schools and the Congolese refugees in the promotion of health in the Congolese community in London

9.1 Conclusions

This thesis has shown that there are two major issues as far as Congolese refugees' health issues are concerned. The first is the impact of the Home Office policies on Congolese health. The second is the relationship between therapeutic options, culture, experiences in biomedical milieu as well as the concepts of risks. The impact of the Home Office policies on their health has been discussed in section 6.3 (p.181-185). Its pathological effects include such issues as the loss of appetite, loss of weight, insomnia, social withdrawal, depression and suicidal ideas. Moreover, discourses such as 'bogus economic' have generated a crisis of personality whereby the Congolese refugee is characterised by a pathological ambivalent behaviour. The Congolese exiled in London is unwilling to disclose his/her identity to anybody, except those in public services. This is a pathological self-protecting mechanism against any possibility of his/her state as refugee being discovered. Six therapeutic options have been identified among Congolese refugees (section 7.5.1; p.212-216). These options are based on their culture, concepts of risk and experiences in the biomedical milieu.

This concluding chapter has three main intentions. The evaluation of the thesis, the evaluation of the methods used for the collection of the data, and the conclusion. The conclusion offers some constructive critiques and suggest changes and improvements in attitudes, policy and service provision to maximise the benefits of biomedicine to Congolese refugees. These constructive critiques are not restricted to the health care sector. They are also extended to Congolese refugees as users of the health care services whose interventions are needed to promote the health of their community.

9.1.1 Evaluation of the thesis

The literature as well as fieldwork used in this research disclose that culture (Douglas, 1987, 1996, 1998; Morin, 1991), concepts of risk (Featherstone, 1991; Giddens, 1994), and experiences in the biomedical milieu constitute the trinity outside of which it is impossible to grasp the background of Congolese refugees' therapeutic options. They constitute the theoretical framework for any discourse on any Congolese refugee health issue. This argument has also been tested and confirmed in my post-fieldwork encounters with Congolese refugees. Adopting an ethnographical approach in my post-fieldwork encounters, I encountered familiar and unfamiliar people who expressed similar views about their reasons for therapeutic options. These have been expressed in terms of culture, racism and risk. Two families among the seven interviews conducted in the post fieldwork context have been in Britain for less than three months. Their views about the British health care sector are as similar as those by Congolese who have been in Britain longer than them.

9.1.2. Evaluating the methods

I have indicated in my third chapter that my research is both a quantitative and qualitative exercise. In fact, it is a 'bricolage' (Levi-Strauss, 1962), using sensibilities of different paradigms, research strategies and techniques proved necessary. I resisted the positivistic approach, which implies a gap between the researcher, the data and the social actors. This approach would not do justice to an enquiry into the roots of Congolese refugees' therapeutic options. Meanings can only be understood from within (Nagel, 1986). Hence, the importance of ethnography, case study and ethnomethodology. However, in the context of research among refugees, sensibilities of ethnography, case studies and ethnomethodology do not guarantee either accessibility to data or their interpretations, a view that is enhanced by Krulfeld (1994). In the context of exile of Congolese in London, three factors, I assume, would make a major contribution to the researcher's activity. A symbolic capital (Bourdieu, 1979), a common cultural and political background, and a common status in the host

country. Despite his/her symbolic capital, a researcher from outside the Congolese community has difficulty in accessing the most critical and intimate information. Yet, a Congolese researcher without a symbolic capital also has limited accessibility to information. The same applies for a Congolese researcher who does not share the same status with his/her compatriots *vis a vis* the institutions of the country of exile. The combination of these components has advantages in doing research among Congolese. This does not mean that the researcher who finds himself or herself in this position does not encounter difficulties. S/he might miss information on the basis of ethnicity, gender and his/her position within the community. Only his/her awareness of the existence of such issues can help him/her to effectively use capital which give him/her credibility and access to information that only someone in his/her position would have.

In relation to the issue of methodology, I would also point out that the place of 'habitus' (Bourdieu, 1979) or subjectivity (Kleinman, 1994; Nagel, 1986) in any research makes any scholarly work to be understood as a partial discourse. A particular genre (Atkinson, 1992: 29) that is a product of personal readability and autobiography. It would, therefore, follow that whatever the researcher's position to the community studied, the researcher has to be aware of pitfalls that might be due to his/her position. For conducting a research is to find oneself caught up in the tension thus expressed:

"We do not have perfect theoretical and epistemological foundations, we do not have perfect methods for data collection; we do not have perfect or transparent modes of representation. We work in the knowledge of our limited resources.

But we do not have to abandon the attempt to produce disciplined accounts of the world that are coherent, methodical, and sensible" (Atkinson, 1992: 52).

In the case of this research, as I argued in chapter two, not only have I examined carefully the reliability of my data and my analyses, I have also tried to see my data through the eyes of a non-Congolese researcher. This was possible by developing a stereoscopic vision that implied not only the use of the

literature but also a constant dialogue with some experts on some aspects of the questions discussed in this thesis. Yet, though theories of such scholars as Bourdieu, Douglas and Foucault have been used as hermeneutic tools in grasping issues of therapeutic options among Congolese, their translatability requires much caution. This is, as has been shown in chapters five and six, due to the specific cultural, economic and political Congolese conditions. Moreover, the applicability of some of these theories, like Bourdieu's discourses on economic, social, cultural and symbolic capitals, is different in the Congolese context of exile as compared with that of the Congo. In the Congo, economic capital and social capital are the conditions of accessibility to biomedical resources (p156-157). In London, however, the hegemonic gaze of the health care professionals, the nature of diagnoses and therapies, as well as the danger of being identified by the Home Office, as shown in chapter six, remain factors that deny the Congolese refugees the possibility of having access to health care resources.

9.1.3 Conclusion: critique and suggestions

Based on the reflections on the impact of the Home Office on Congolese refugees' health and the bases for Congolese refugees' therapeutic options, I would argue the following. Promoting the health of Congolese refugees is a question of altering policies and attitudes (the Home Office and health care sector), of taking into account their socio-cultural and political conditions (health care sector and schools), of providing life sustaining knowledge (schools) and self-involvement endeavours (by the Congolese refugee community). Since chapters three and eight have discussed what this implies in relation to the policies of Home Office and the schools' approach to Congolese refugees, the subsequent reflections will mainly be on its implications in the health care sector and the Congolese refugee community itself.

9.1.3.1 The health care professionals' gaze: the urgency of a *metanoia*

Attitude, communication and diagnosis, and therapy, as discussed in section 7.2 (189-203), incarnate the Foucauldian disciplinary gaze. The Congolese refugee in the British health care sector is an object of a disciplinary or hegemonic approach. S/he is compelled to act mechanically according to the wish of the therapeutic milieu frequented. Congolese descriptions of their own experiences suggest that this bio-medical milieu is a non-dialogical therapeutic arena. Diagnoses and therapies are to be taken as self-evident. They are denied full explanation. The Congolese patient must be a docile body. An object of discourse but not a subject of communication as Foucault's panopticon suggests. As such, for Congolese refugees, the British medical milieu is an arena of risks as discussed in terms of Douglas (1996a), Illich (1976), Beck (1998) and Giddens' (1998) views. To ask a Congolese woman about her last period through her interpreter son (case study 7.1; p.198) and not knowing reasons for caesarean sections (case study 7.5; p.202) are as threatening as going to see the doctor when decisions on deportation have already been taken (case study 7.12; p.215).

As a matter of fact, the magnitude of inequalities in the health care sector in Britain (Rack, 1993; Jacobson & Whitehead, 1988; Townsend & Davidson, 1982) entails the urgency of the ethics of justice and moral imperatives as evoked in section 3.4.6 (p.90-91). This is to understand refugees' needs of medical attention as fundamental human rights. The practice of health care requires an ethical ground. This is fundamental because health care implies the 'welfare of the patient' (Parsons, 1952: 453). It is on this basis that the welfare of Congolese refugees in London has to be safeguarded. It entails the understanding of patients, in this case Congolese refugees, as fellow human beings to establish a 'mutual trust' (Parsons, 1952: 464). This constitutes the sole grounds for any possibility of 'equity' (Ahmad, 1993: 202) in the health care sector. The absence of the ethics of moral imperatives and justice in any health care approach to Congolese refugees would not only reduce the use of health

care resources by Congolese refugees, but also, it damages psychological and physical aspects of Congolese refugees wellbeing. Moreover, to deal with Congolese refugees' patients on the basis of the bogus economic refugee discourse, as the findings mentioned in section 7.2.2 (p.195) have shown, has destructive effects on the welfare of the health care sector as well. For deprived of the ethic of justice and moral imperatives, the health care activities would fall into the category of Rabelais' statement according to which '*une science sans conscience n'est qu'une ruine de l' ame*' (Fr)(Montreynaud, 1985: 447) which I would translate as 'an art or practice without moral values is self-destructive'.

Analyses of section 7.2 (p.189-203) have indicated that the GP' surgery is the most attended area of the health care sector by Congolese refugees. The GP remains the person through whom the Congolese comes into contact with the British health care sector. Thus, the GP has a valuable opportunity and role for health promotion in the Congolese community. Given the pre-eminence of the GP's contact with Congolese refugees, it is his/her task to develop, using Jones 'expression already mentioned in section 8.2.1 (p.225), a 'multi-agency approach' whereby factors threatening Congolese refugees health are referred to those with relevant expertise. It would mean that a medical doctor to Congolese refugees has also a referential role. To play this referential role, the health care professionals must undergo a *metanoia* or a radical shift in their approach to Congolese refugees.

9.1.3.2 Developing a holistic approach towards Congolese refugees

The urgency of *metanoia* for health care professionals implies the understanding of the Congolese patient in his/her wholeness. Hence, the necessity of a dialogical therapeutic approach. In the light of health promotion discourses, such a holistic dialogical approach would be viewed as a prerequisite for any effective therapeutic intervention for any patient. However, I argue that particular cultural, social, economic and political experiences make health promotion unique to each cultural or ethnic minority group in the United

Kingdom. In fact, a therapeutic approach towards Congolese refugees within the British health care sector should be understood in the context of a 'cross-cultural medicine' (Fuller & Toon, 1988: 1). Considering cultural differences, the doctor or the therapist in a cross-cultural context must be acquainted with the social, political and economic context of his/her patients. Hence, the importance of disciplines such as anthropology, sociology, politics (Fuller & Toon, 1988:2), whose information on backgrounds and experiences of British ethnic minorities in general, and Congolese in particular, would contribute to an effective therapeutic intervention.

What is required in the practice of medicine in a cross-cultural setting is in final analysis a type of anthropological perspective to the patient (Kleinman, 1995: 44). It is an approach whereby the doctor, prior to any medical intervention, sees and interprets things through the eyes of the patient. As such, dialogue, in order to grasp the Congolese patient's particularities, should precede prescriptions or any other medical intervention (Case studies 7.2; p.199 & 7.3; p.200). In considering the Congolese patient background, *Weltanschauung*, as well as social, political, economic and psychological conditions in his/her host country, the medical doctor is equipped to deal not only with the disease or illness but also with the individual as a human being (Case study 7.4; p.201). To do otherwise can jeopardise the credibility of the doctor's practice and locate the patient in a therapeutic condition of not recovering.

Grasping of the background contributes to understanding the Congolese patient biographies. Events that characterise one's history in becoming a political asylum seeker are understood. They are scrutinised as to whether they are explanatory of the patient's pathologies, pathological discourse and attitude. Only such an approach allows possibilities of adequate diagnoses and therapies. Otherwise, the Congolese refugees will endlessly find themselves in a context similar to that thus expressed:

"When structures of domination identify a group of people (as racist ideology does black folk in this society) as mentally inferior, implying

that they are more body than mind, it should come as no surprise that there is a little societal concern for the mental health of that group” (Hooks, 1993, quoted, in Browne, 1995: 63).

However, when grounded on the ethical principles of justice and moral imperatives, the practice of a dialogical therapeutic approach would undermine the hegemonic gaze that exists within the doctor-Congolese refugee relationship.

To grasp the Congolese *Weltanschauung* would provide the possibility of becoming acquainted with his/her perceptions of pathologies and realities. The relevance of knowledge of the patient's culture within the bio-medical circle is being noted as non-negotiable (Fuller & Toon, 1988). It is an analytical undertaking that challenges the narrowness of the medical practice and dogma. It integrates other hermeneutics of illness or disease and therapeutic possibilities that would contribute to addressing human conditions and experiences (Kleinman, 1988: 153). In the particular context of mental health Torkington has noted that:

“Most medical professionals would now accept that a highly sophisticated level of cultural knowledge is an essential prerequisite to effective diagnosis and treatment of mental illness. Where such knowledge is lacking there is a danger of breakdown in communication between the patient and those who provide the services. This may lead to wrong diagnosis and unnecessarily prolonged stay in mental institutions” (Torkington, 1991: 122).

According to Zur, a German anthropologist-psychiatrist:

“Before assessing, diagnosing and treating people from other cultures, it is important to have some understanding of local theories of disease aetiology as well as the cultural forms they take” (Zur, 1996: 8).

The magnitude of multiculturalism in London impels health care professionals to possess knowledge about cultures represented in their working constituency. Dialogues with the concerned people and seminars by experts are some of the means to acquire such knowledge. In encountering Congolese perceptions, the

medical practitioner is not invited to give up his/her medical approach. However, s/he is called on to accommodate Congolese views for harmony and effectiveness in the delivery of health care. An assimilationist or hegemonic therapeutic approach is avoided for an integrative approach (Fuller & Toon, 1988:56). The Congolese patient should, for instance, be asked to give his/her views about his/her illness. Here, it undermines the hegemonic unilateral therapeutic framework suggested by Foucault's theories of disciplines (Foucault, 1977). In fact, as it is argued:

“The practitioner who goes to the trouble of discovering the culture of a minority (any different group) is rewarded by the satisfaction and sheer interest of seeing the world from a different standpoint, and is likely to find his/her own perceptions changed and sharpened. Travel broadens the mind and gives one a different outlook on one's own life and one's ethnocentric values. This is not a passive process, however” (Rack, 1982: 247).

Rack thinks that there is a pedagogic richness in engaging, for therapeutic purposes, into dialogue with patients from other cultures. It is an exercise by which the doctor like an anthropologist develops a stereoscopic vision that would challenge any self-ethnocentric perspective.

The advantages of possessing some knowledge of the patient's culture transcend the level of aetiological perceptions. They confront issues of communication and cultural sensitivities in consultation settings. Each culture attributes different meaning to different bodily or vocal expressions (Douglas, 1999). The Congolese in the consultation arena submits the language, the eye (the gaze), and the postures of the doctor to a Congolese cultural scrutiny that might suggest different interpretations. Not that the doctor's expertise is questioned (Janzen 1978) but for the Congolese any approach to the body, any prescription and any medical intervention requires a full explanation. Thus, the doctor's approach to the body requires full explanation (Case studies 7.3; p.200; & 7.5; p.202). One of the reasons for this is the fact that for Congolese, the body is not to be understood in Platonic terms of **‘σῶμα, σῆμα ἐστίν’** (Gk)

(the body is the tomb). For them, the body is a religio-physical reality that denies reduction to any materialistic interpretation. Hence, it is approached with care and devotion. Moreover, not only do the doctor's attitudes need to be explained, but the velocity by which a diagnosis is delivered needs care (Case study. 7.2; p.199). The silence of the doctor, as case studies have suggested, can also be suspected as refusal or dangerous. Frequent physical, visual contacts (i.e. frequent touching of the shoulders) can be interpreted as a sexual advance. What is required of the doctor is the ability to function 'across the cultural and linguistic divide' (Fuller & Toon, 1988: 1). This is an imperative of what is meant by doctoring in a multi-ethnic or cultural society. Had Makaya's GP, in case study 7.1 (p.198), possessed some knowledge of his patient's culture, tensions that arose from his use of graphic sexual language could have been avoided. Makaya found her personality threatened as she was asked to speak about her periods while her son was the interpreter. While the understanding of patients' culture is advocated as paramount for a positive medical intervention (Fuller & Toon, 1988:3), its relevance is not to be restricted to the medical field alone. It applies also to other social or public services that deal with Congolese refugees. This is what has been demonstrated with case study 6.6 (p.174).

An anthropological approach in a cross-cultural encounter of Congolese refugees and British doctors entails the reconsideration of the whole issue of interpretation. As noted in section 7.2.3 (p.198), the complexity of the question is triple. First, the use of any Congolese interpreter can jeopardise the question of medical deontology. The Congolese patient fears that his/her medical history might go beyond his/her intimate social circle. This explains reasons that many Congolese attending Congolese churches have always required their pastors or one of the church leaders to be the interpreter in the medical context. Secondly, when a child is used (Case Study 7.1; p.198) there is the problem of the complexity of the medical language and the issue of indecency. Thirdly, the use of a non-Congolese interpreter does not guarantee a viable communication or understanding between the patient and the doctor.

However complex is the issue of interpretation, its solution lies in the use of trained interpreters with an approved knowledge on British minorities' cultures (Fuller & Toon, 1988:36). Fieldwork suggests that Congolese pastors can be of an important help in addressing the issue of interpretation in the Congolese community. They can operate not only as interpreters but also as consultants on Congolese refugees' social and cultural issues. In addition, pastors and members of the community who are willing to do such a work should be provided with the opportunity to be trained in order to be equipped to grasp the language and the structures of the health care sector (Torkington, 1991:111). In so doing issues of confidentiality and communication which often threaten the Congolese-doctor encounter might be safeguarded.

The use of trained interpreters and Congolese pastors should not be understood as a matter for the advantage of the Congolese refugees only. Certainly, such a shift will maximise the Congolese refugees' use of those biomedical health care resources to which, in contrast to the Congo's context as discussed in section 5.6.2 (p.156-157), availability, affordability, accessibility, acceptability and effectiveness are not supposed to be the conditional factors. It is also to the advantage of the doctor and health care professionals whose encounters with Congolese refugees, as such case studies as 7.1 (p.198) & 7.3 (p.200) have suggested, often result to 'confusion, dysfunctional consultation, role uncertainty and role non-correspondence' (Fuller & Toon, 1988: 30-31).

A dialogical or anthropological therapeutic approach as is being advocated, creates a trust that binds the doctor to his patient and vice-versa (Parsons, 1952:464; Veer, 1998: 88). For as it is being argued, such an approach does not limit itself to the scrutiny of 'pathological processes and the life cycles of parasites' (Kunitz, 1994:188). It incorporates the socio-economic and political particularities of the patient. However, arguing for a therapeutic dialogical or anthropological approach towards Congolese refugees, I would appropriate Freire's words according to which:

“Dialogue cannot exist, however, in the absence of a profound love for the world and for men. The naming of the world, which is an act of creation and re-creation, is not possible if it is not infused with love. Love is at the same time the foundation of dialogue and dialogue itself. It is thus necessarily the task of responsible Subjects and cannot exist in a relation of domination. Domination reveals the pathology of love: sadism in the dominator and masochism in the dominated. Because love is an act of courage, not of fear, love is committed to other men. No matter where the oppressed are found, the act of love is commitment to their cause- the cause of liberation. And this commitment, because it is loving, is dialogical. As an act of bravery, love cannot be sentimental; as an act of freedom, it must not serve as a pretext of manipulation. It must generate acts of freedom; otherwise, it is not love. Only by abolishing the situation of oppression is it possible to restore the love which that situation made impossible” (Freire, 1972:62).

9.1.3.3 Counsellors and the promotion of Congolese refugees' health

The relevance of counselling Congolese exiling in Britain is conspicuous. Yet, viable works of such organisations as the Medical Foundations for the Care of Victims of Torture are limited in their assistance. Their major concern is to address above all psychological disorders whose causes are traumatic experiences in the country of origin. Much of the Congolese refugees' pathology, the causes of which might be related to the social, cultural, political and economic conditions in the country of exile are far from being addressed. This is the case in crises of identity, which has been clearly illustrated by the case of Claudette in chapter eight, case study 8.1(p.234), which, I consider an epitome of crisis of identity in the community. Many Congolese struggle either for the re-appropriation of their true identity (name, date of birth, marital status) or, for the reconciliation between different identities that have been generated by circumstances of exile (Littlewood & Liepsedge, 1982: 152).

Post Traumatic Stress Disorders in the Congolese refugee community are observed among some children. These are children whose parents or themselves have been physically tortured or abused by exponents of the two Congolese regimes. Post Traumatic Stress Disorders are expressed in different abnormal behaviours. As shown in case studies 6.14 & 6.15 (p.185), the most

commonly observed abnormal behaviours include anger against a particular ethnic group, fear, nausea, reticence (Avoidant Personality Disorder) (Veer, 1998: 30). For many of those who endured traumatic experiences in the Congo, only regular dedicated and profound counselling sessions might help to provide the psychological stability needed to cope with life again. For what is needed in these cases is more than accepting what happened, but also a 'social healing which stresses reconciliation, pardon seeking, truth and justice or democratic reforms' (Janzen, 1999: 53).

9.1.3.4 The Congolese refugees' role in promoting their own health: some thoughts

Health promotion among Congolese refugees is not to be restricted to the health care sector. The Home Office as discussed in chapter three needs to adopt policies based on human rights discourses. This applies as well as for schools whose role in promoting the health of Congolese refugees, as discussed in chapter eight, is beyond any doubt. However, the role of the Congolese refugees concerning the promotion of the health of their own community is fundamental. The Congolese community has to realise that there are 'no rights without responsibilities' (Giddens, 1999: 65). This statement reinforces the logic that is intrinsic to health promotion discourses (Petersen & Lupton, 1996). Against their conflicting experiences within the health care sector, the community should, to use a Tillichian's term, demonstrate 'the courage to be' '(Fr: le courage d'être)' (Tillich, 1952) in using available health care resources. This is not a naïve attitude. It seeks dialogue and participation in whatever can contribute to the health of the community. The philosophy of 'Courage to be' will help Congolese refugees to overcome pessimism and interpret their presence in the United Kingdom in terms of human rights discourse. Such an interpretation would engage them in the personality self-rehabilitating process and life sustaining actions.

The Congolese community must seek its existence in constant dialogue, which means constant reflections and praxis (Freire, 1972: 60). Risks that are inherent

in not using the available health care resources should be stressed. Moreover, the community, through existing Congolese churches and other cultural groupings, should engage in health promotion strategies or actions (Flowers & Shiman, 1997: 174). This would include such activities as talks on health risk issues with Congolese and dialogues with local health authorities on Congolese experiences in the health care sector. Health risk and other health issues must be addressed and translated into Lingala. For as argued by Torkington:

“When people understand the situation they might be in a position to do something about it. Knowledge is power. Withholding information and thereby limiting the knowledge people have of the real situation is the most effective way of oppression and organisations in general constantly employ this strategy” (Torkington, 1991: 183)

Particular attention should be paid to young girl’s experiences. As stressed in section 8.3.3 (p.245), Congolese girls are among the most vulnerable group within the Congolese community. Thus, their involvement in creating health education projects within the community is strategically important. The community should provide individuals with interpretation and counselling skills. To provide professional counselling services, the training of Congolese is important. What is being discussed here shows that education in all its forms is a strategic element for health promotion in the Congolese refugee community.

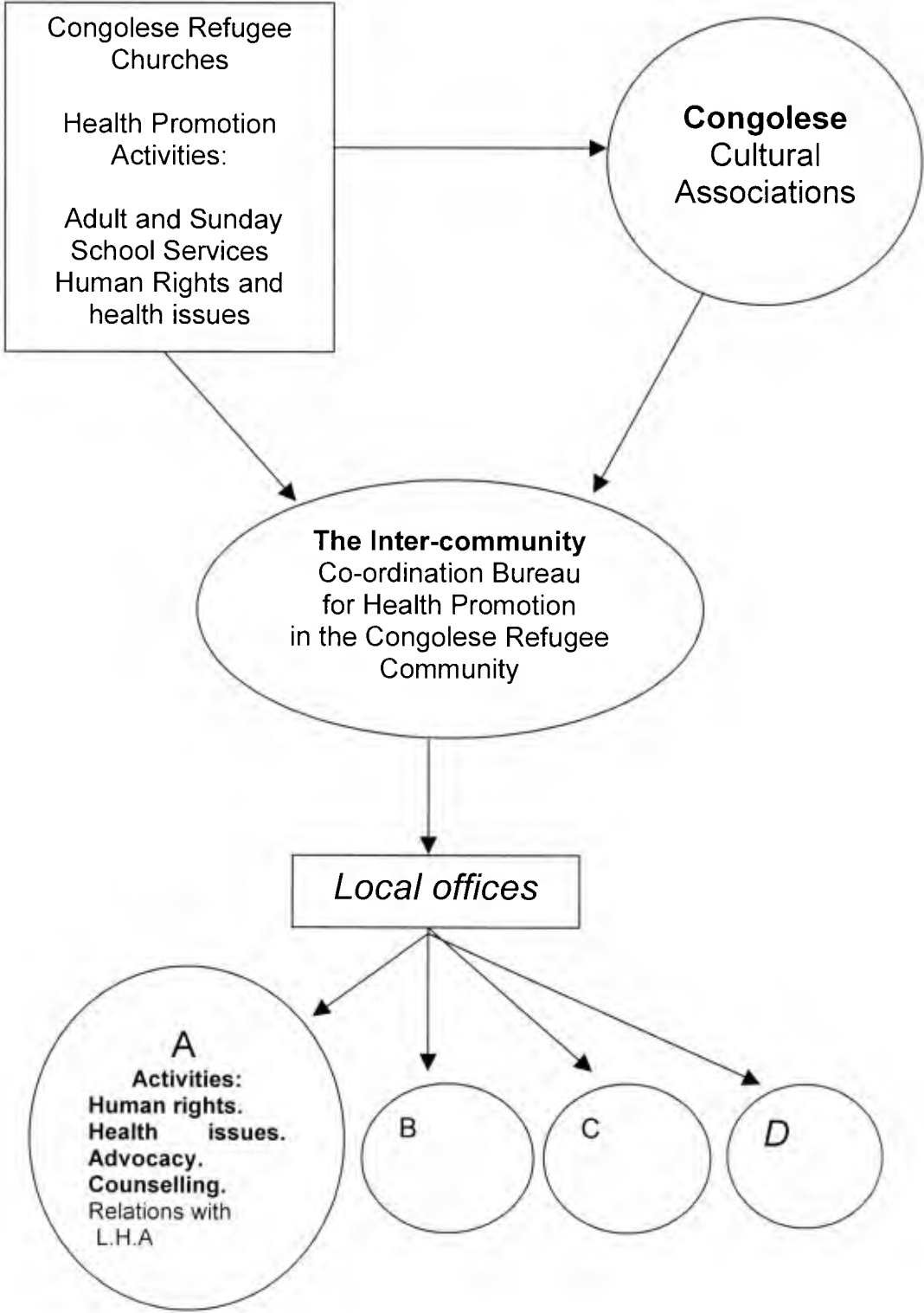
As a matter of fact, to achieve these goals or objectives, structures that would motivate Congolese refugees in different parts of London are required. These structures should start with the creation by Congolese refugees of an inter-community co-ordination bureau. Its main function is to enable Congolese refugees, wherever they are found, to participate actively and effectively in actions that would contribute to the health of their community. Congolese refugees’ churches, by virtue of their place in the Congolese refugee community, are those who can actualise the achievement of such structures. They are the role model to engage in such initiatives. As Lingedo put it during my post-fieldwork encounters: ‘We need our churches in London to create

structures that would ensure our welfare'. To advance the emergence of such structures, I would propose:

- that health promotion issues and human rights questions be incorporated in Sunday School and adult services activities within Congolese refugees churches in London,
- the necessity of regular meetings among Congolese churches leaders and leaders of other cultural associations to discuss health issues within the community,
- the creation of an inter-community co-ordination bureau for health promotion in the community,
- the creation of a regional representative office where Congolese health issues are discussed with fellow Congolese and local health authorities.

This type of structure can be graphically represented as follows:

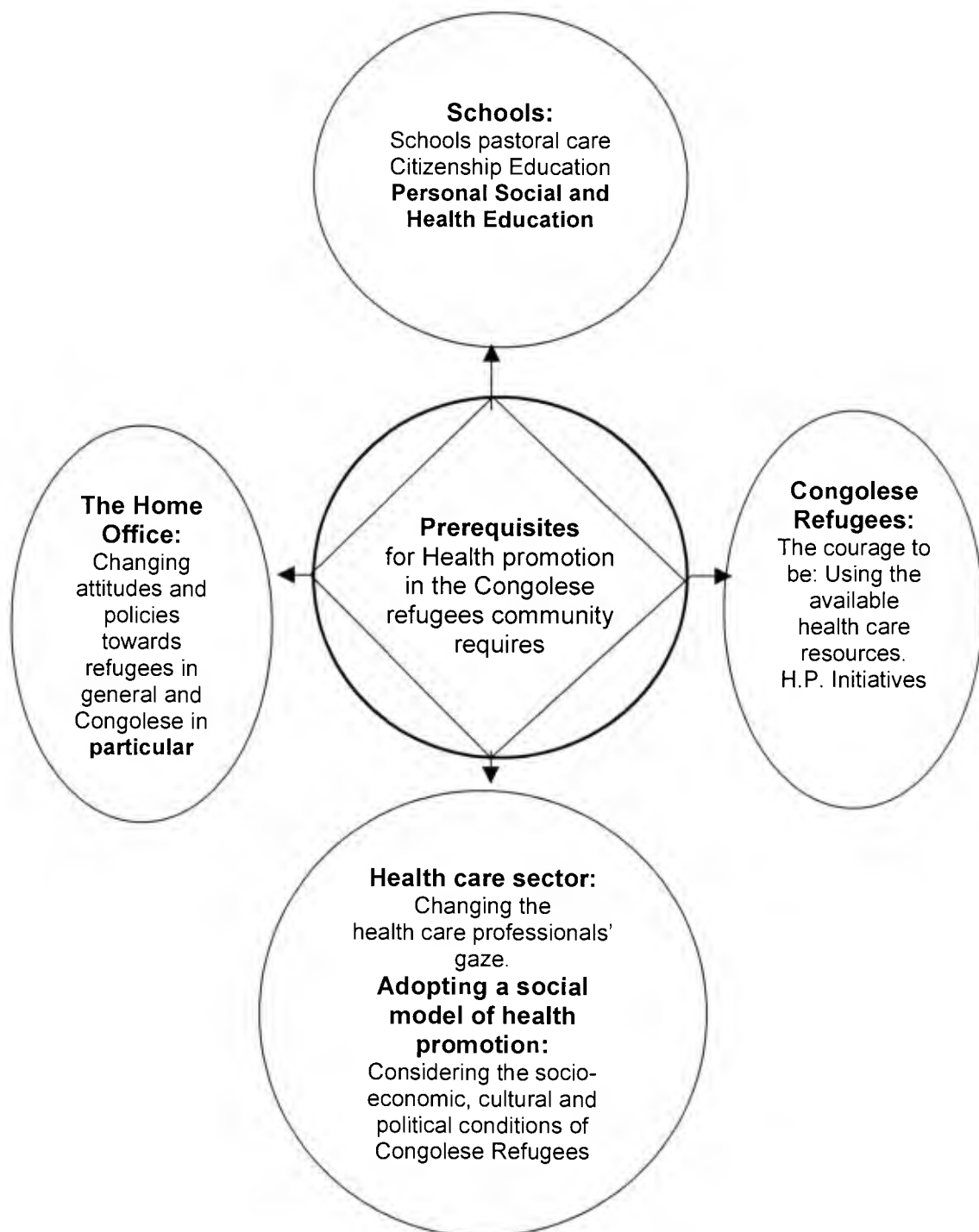
Figure 9.1 Structures of Congolese refugees' health promoting activities



9.1.3.5 The theoretical model for health promotion in the Congolese refugee community: social model

Provided the combination of efforts needed to promote the health of the Congolese refugee community, the theoretical model to which I would subscribe such action is that which is described as a social model (Naidoo & Wills, 1998: 58; Jones & Naidoo, 1997: 77-8). This is the model advocated by the Alma-Ata Declaration (WHO, 1978) and the Ottawa Charter for health promotion (WHO, 1986). It distinguishes itself from other models that are medical, educational, and behavioural or lifestyle. Its uniqueness is that it considers all aspects, economic, political, educational, social, etc... that have an impact upon the human individual's existence. As such, it refuses to reduce human being to a materialistic or anatomical understanding. Since a social model enhances the wholeness of the human being, it advocates the concept of health as wellbeing. For as expressed through the thoughts of Seedhouse (1986) and Jones and Naidoo (1997), a social health promotion model is that which uses different resources to enhance an individual's wellbeing. In this social model, past and present dimensions of individuals' conditions are gazed upon to promote individuals' wellbeing. Social model sustains a dialogical or anthropological therapeutic approach, which excludes both assimilationist and hegemonic therapeutic programs. It points out to 'upstream thinking' (Ashton & Seymour, 1988: VII) or forms of therapeutic intervention that aims at addressing the causes of afflictions. In the light of analyses of this concluding chapter, the social model of health promotion among Congolese refugees can be graphically represented as follows:

Figure 9.1 Structures of social model of promoting health in the Congolese refugee community



It is worth mentioning that pastoral counselling as practised among Congolese refugees would subscribe to the social model of health promotion. The reason being that its contribution to the health of Congolese refugees can already be discerned through its attempt to provide 'affection and social contact' (Williams & House, 1991: 155) and relevant information. In addition, pastoral counselling as practised in Congolese churches does not refrain from recommending Congolese traditional therapeutic systems and techniques when the latter are viewed as possibilities in addressing a particular issue.

9.1.3.6 The emergence of Congolese healers and the issue of social health within the Congolese refugee community

One of the most striking issues emerging from this thesis is, in my opinion, the extent to which Congolese traditional and Christo-spiritual systems are used as authentic therapeutic modes. While the Congolese refugee community does not have traditional healers, they are replaced by the collective memory and suggestions made by the therapeutic managing group. In the Christo-spiritual context, the pastor and members of pastoral team are viewed as healers and the Church as a healing community. This leads to the fact that the therapeutic arena is that in which different therapeutic systems converge to contribute to individuals' wellbeing. In this arena no universal therapeutic claim is possible. As demonstrated in this thesis, in the search of therapeutic quest, Congolese are not empty-handed. Theirs is a therapeutic system whose focus differs from biomedicine's (Douglas, 1998: 19). Their cosmology, like the Christo-spiritual, entails the consideration of afflictions whose causes are not only anatomical but also social and spiritual referring to such cosmogonic forces as spirits, the dead, witchcraft, transgression. It would follow that the history of therapeutic quest among Congolese refugees in London is that which evokes also the limitedness and the inability to address forms of afflictions whose causes cannot be detected by biomedicine. This belongs to the realm of religions (Douglas, 1990:5). In addition, therapeutic stories among Congolese refugees sustain the idea of the body being a 'microcosm' of the social, and cosmological order (Douglas, 1998).

The Congolese refugees' massive use of traditional therapies in London is an expression of the need of traditional healers in their community. Their emergence is imminent as sustained by the acceptability of the diagnoses and the therapies suggested by the therapeutic managing group. This is a dimension that should not be overlooked by those engaging with Congolese refugees in therapeutic arena. A dialogue has to be established in order to allow each system to operate within its own sphere in enriching one another. The effectiveness of health promotion activities among Congolese refugees largely depends on the consideration of Congolese culture (Airhihembuwa, 1995) Health promoters should encourage a proper use of systems that Congolese find as relevant to address certain afflictions.

This thesis has also shown that the health of the social person as applied in the context of Congolese in exile is very complex. First, reconciling with the new identities created by the imperatives of exile seems to be an unsolved problem. Key aspects of one's true identity, that is to say, name, date of birth and marital status, can be unrecoverable. For, trying to recover them undermines one's case or process of political asylum *vis a vis* the Home Office. Thus, like Claudette (case study 8.1 (p.234), psychological imbalance is the experience of many. The second complexity is the embodiment of vengeance (Janzen, 1999:48) against some ethnic groups or some individuals. Case study 6.14 (p.185) shows that hatred against certain ethnic Congolese groups is even transmitted to children born in exile. The third complexity is the social cultural imbalance as indicated by case study 6.5 (p.172). Although he is the eldest son, the realities of exile prevented Kalala from taking his social responsibility *vis a vis* his paternal and maternal families. The necessity to reflect on these aspects of social suffering is not to be undermined when considering health promotion for Congolese exiled in London. Whatever therapeutic approaches can be developed for such issues to be addressed, I, however, suspect that such values as justice and forgiveness, as well as political and cultural dimensions should be considered. Yet, since Congolese traditional therapeutic systems

deal with the social person and also ascribe some ill health to social discomfort and ruptures, their relevance in the context of exile, as being emphasised in this chapter, cannot be ignored. Traditional techniques of palavers might be an asset to reconstruct the social relations or the broken lives of many. One could argue that what is true for the Congolese refugees may also be true for other African refugee communities. Their cosmology, like the Congolese, includes beliefs in invisible powers. Also like the Congolese refugees, their stories of exile are also characterised by distorted social relations.

9.1.3.7 Suggestions for future research

Given the pioneering characteristic of this research in the history of Congolese refugees' issues in Britain, I suggest that further studies on Congolese refugees' health issues should consider expounding some of the issues mentioned in this thesis. They would include detailed analytical reflections on such themes as the role of language, Citizenship education, and personal, social, health education in the promotion of Congolese refugees' health. For these studies would have to demonstrate what is being done to promote the Congolese refugees' health. Moreover, further studies should also consider detailed epidemiological studies in the community, to examine how particular diseases such as AIDS, tuberculosis and others are experienced and dealt with in the Congolese refugee community. In fact, much needs to be done in terms of health issues and experiences of French speaking Black-Africans in Britain. My understanding of literature on ethnic minorities' health issues suggests that French speaking Black-African health experiences are not given voice. There is a tendency among scholars to favour experiences of English speaking Africans (Rack, 1991, Donovan, 1986b: 121) or countries with which Britain has some close relations. While this reflects the linguistic and colonial bond, it must also be due to the influence of the pioneering works of Lambo, a Nigerian psychiatrist scholar among Nigerians in London in the fifties (section 6.2.2; p.175). The existence of this unequal situation shows the need of research on health issues among French African refugee communities. Thus education,

whether formal or informal, has a major role in addressing this situation. It is the effective means through which health issues facing these communities are to be studied and understood to ensure that human rights have to be applied to every human being in Britain regardless of race, culture, gender and religion.

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Appendix I Tables of informants on the basis of gender, age and marital status

Chapter III: The historical background and current conditions of Congolese refugees in London

Case No	Study	Name(s)	Gender	Age	Marital Status M= married S= Single
3.1		Mpembele Berthe	M F	39 35	M M
3.2		Tshimbombo	M	29	S
3.3		Kiala	M	31	M
3.4		Zola Makambu	M M	34 37	M M
3.5		Marc	M	26	M
3.6		Mpemba	F	27	S
3.7		Pele	M	34	M
3.8		Mavakala	M	29	M
3.9		Ngimbi	M	38	M (wife and children still in the Congo)
3.10		Lukombo	F	26	S

Chapter VI: Concepts of health and the impact of Home Office policies on Congolese refugees' health

Case study No	Name (s)	Gender	Age	Marital Status M= Married S= single
6.1	Kabongo	M	27	M
6.2	Kiese Mayangi	F M	33 36	M M
6.3	Charles Nkengi	M F	48 44	M M
6.4	Folo Sima	M M	37 46	M (wife still in the Congo) M
6.5	Nzumba Kalala	F M	43 49	M M
6.6	Elikia	F	39	M
6.7	Nsungu	M	29	S
6.8	Nsala	M	32	M
6.9	Ndandu Kuka	M F	36 27	M M
6.10	Kibonga Madiya	M F	31 33	M M
6.11	Makela	M	35	M
6.12	Ngoma Kieba	M F	41 37	Married to each other at home. However, known here as non-married
6.13	Lopi	M	36	M
6.14	Samba	M	40	M
6.15	Clement	M	35	M

Chapter VII Therapeutic systems and therapeutic options among Congolese refugees in London

Case No	Study	Name (s)	Gender	Age	Marital Status M=married S=Single
7.1		Makaya	F	39	M
7.2		Blaise	M	32	M
		Alexandra	F	27	M
7.3		Mafuta	F	35	M
7.4		Jean Francois	M	36	M
7.5		Sylvie	F	28	M
7.6		Kilombo	M	36	M
		Manda	F	31	M
7.7		Pedro	M	41	M
7.8		Nsenga	M	41	M
		Disu	F	37	M
7.9		Kiebi	M	36	M
		Kiki	M	34	M
7.10		Salomon	M	36	M
		Judith	F	29	M
7.11		Kopa	M	32	M
7.12		Kiakuama	M	28	M
7.13		Baku	M	26	S
7.14		Nyanza	F	25	S
7.15		Belinga	M	32	M
7.16		Melisa	F	13	S
		Poly	M	15	S
7.17		Ngelima	F	31	M

Chapter VIII: The schools 's role in the promotion of Congolese refugees' s health

Case Study No	Names	Gender	Age	Marital Status M= Married S=Single
8.1	Claudette	F	15	S
8.2	Romaine	F	10	S
8.3	Matonge Adolphine Mujinga Georges	M F F M	44 36 9 7	M M - -
8.4	Solika Bineta Ngoy Kiemvo Jariya And other members of the church	F F M M F	38 37 37 34 33	M M M M M
8.5	Margaret Funsu Denise	F M F	20 48 47	S M M

Other Congolese refugees mentioned in the thesis

Chapter	Names	Gender	Age	Marital status M= Married S= single
3	Benga	M	48	M
3	Santu	M	31	M
3	Fwala	M	29	S
5	Mampuya	F	27	M
5	Ngengi	M	36	M
5	Masiala	F	29	S
7	Mbimba	M	36	M
7	Wendo	M	32	M
7	Lingendo	M	36	M
7	Kiyoka	M	31	M
7	Ndonzoa	M	38	M

Appendix II Questionnaire I: On the Concepts of health and the use of the three different therapeutic systems

- 1 What does it mean for you to be in good health?
- 2 Why is it that the Congolese refugees' therapeutic quest is a history of combining biomedicine, Christo-spiritual therapeutic systems, and traditional Congolese practices?
- 3 Why is it that in some circumstances Congolese refugees insist that the participation of their relatives back home is very important in their therapeutic quest?
- 4 What are the main causes of ill health for Congolese refugees?
- 5 Do the conditions of your exile affect your health? How?
- 6 Why is it that rather than seeing the GP, some Congolese refugees prefer to consult the pharmacist and buy their own medicines?
- 7 What are the main reasons for which you visit your GP?
- 8 What therapies are used within Congolese traditional and Christian therapeutic settings?
- 9 How do you describe the surgery's receptionist, nurse and doctor's attitude towards you?
- 10 How often do you see a doctor, a dentist, a nutritionist, a psychologist? When is the last time you saw your doctor? How many times did you see your doctor this last year?
- 11 How do you communicate with your doctor? What language do you use?
- 12 Do you sometimes use interpreters in your dialogue with your GP? Who are they?
- 13 How much time does your GP spend with you during a consultation?
- 14 What are the most common diagnoses and prescriptions of your GP?

- 15 How do you define your GP's medical assistance?
- 16 How often do you have access to medical or health promotion information?
(ie: information on STD, cancer, tobacco and alcohol addiction)
- 17 How do you think the issue of health among Congolese refugees can be improved?
- 18 How would you assess your health? a)Very good, b) good, c) fairly good, d) poor, e)very poor

Appendix III Questionnaire II: on risks and lifestyles

- 1 How do you contribute to your personal health care or safety?
- 2 Does food and drink contribute to your health?
- 3 What is your household diet like?
- 4 What types of food and drink do you take and avoid? Why?
- 5 Are the bases of your diet financially or culturally related?
- 6 What types of bodily exercises or activities do you think contribute to your health care?
- 7 What do you think the body needs to be kept in good condition?
- 8 Are spiritual and mental exercises important for your health?
- 9 Do you smoke and drink alcohol? What do you think of tobacco and alcohol?
- 10 Is sex education important for personal health promotion? Have you ever spoken of sex education in your family or church? Are condoms essential in preventing STD such as Aids?

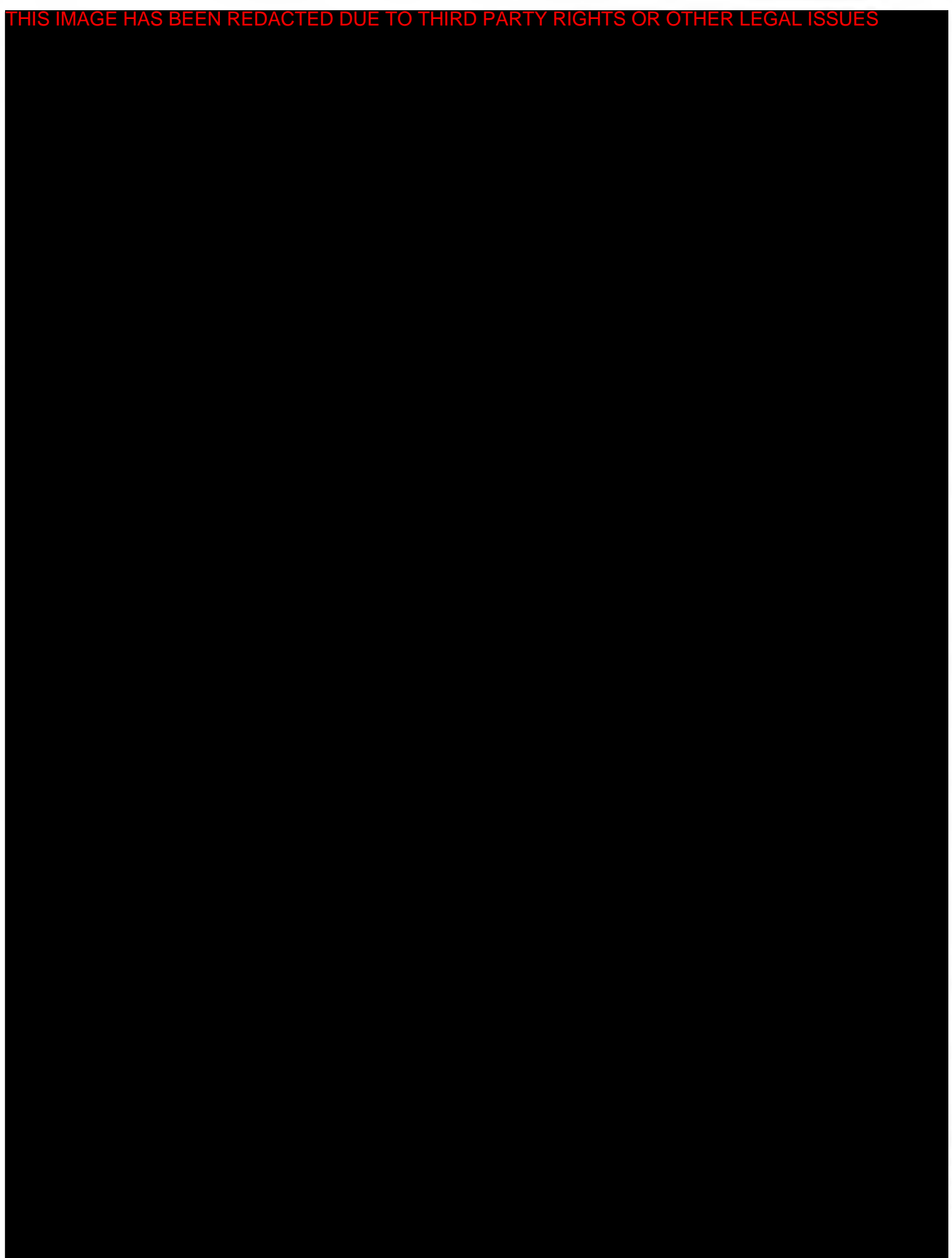
Appendix IV: Main questions used in the post-fieldwork encounters

- 1 Why is it that the Congolese refugees' therapeutic quest is a history of combining biomedicine, Christo-spiritual therapeutic systems, and traditional Congolese practices?
- 2 Why is it that in some circumstances Congolese refugees insist that the participation of their relatives back home is very important in their therapeutic quest?
- 3 What are the main causes of ill health for Congolese refugees?
- 4 Do the conditions of your exile affect your health? How?
- 5 Why is it that rather than seeing the GP, some Congolese refugees prefer to consult the pharmacist and buy their own medicines?
- 6 How do you think the issue of health among Congolese refugees can be improved?
- 7 How do you contribute to your personal health care or safety?

Appendix V: Some collected newspapers with some information about the experiences of Congolese refugees in Britain

This appendix contains some reduce sized photocopy of articles by British national newspapers on Congolese refugees.

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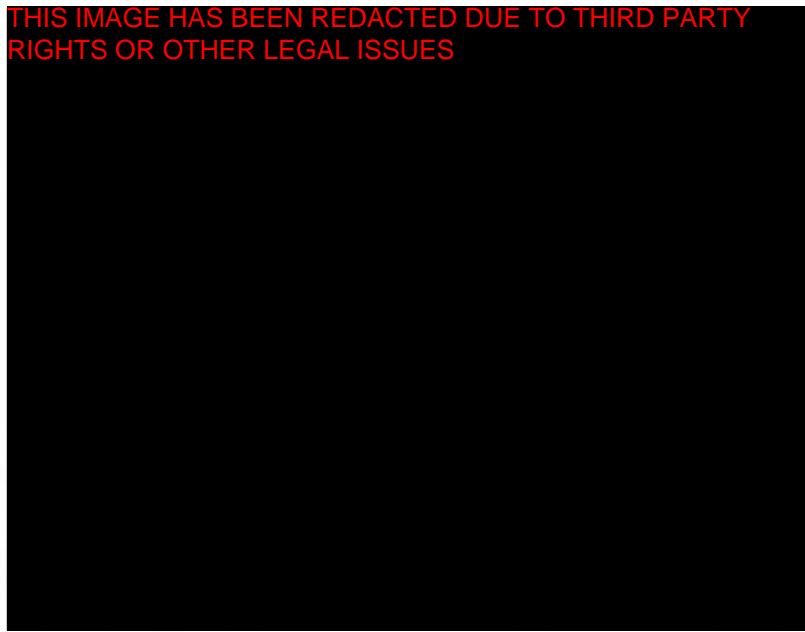
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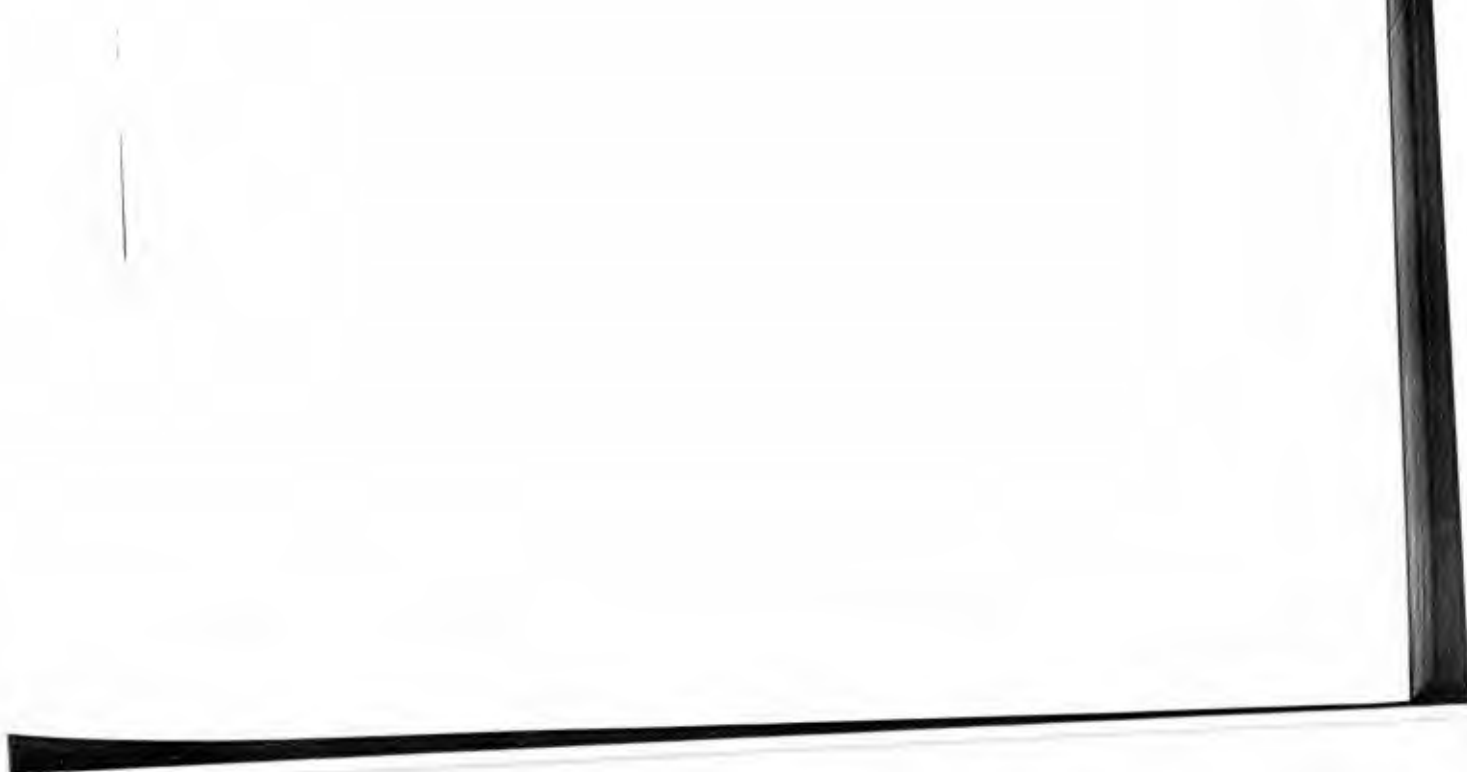
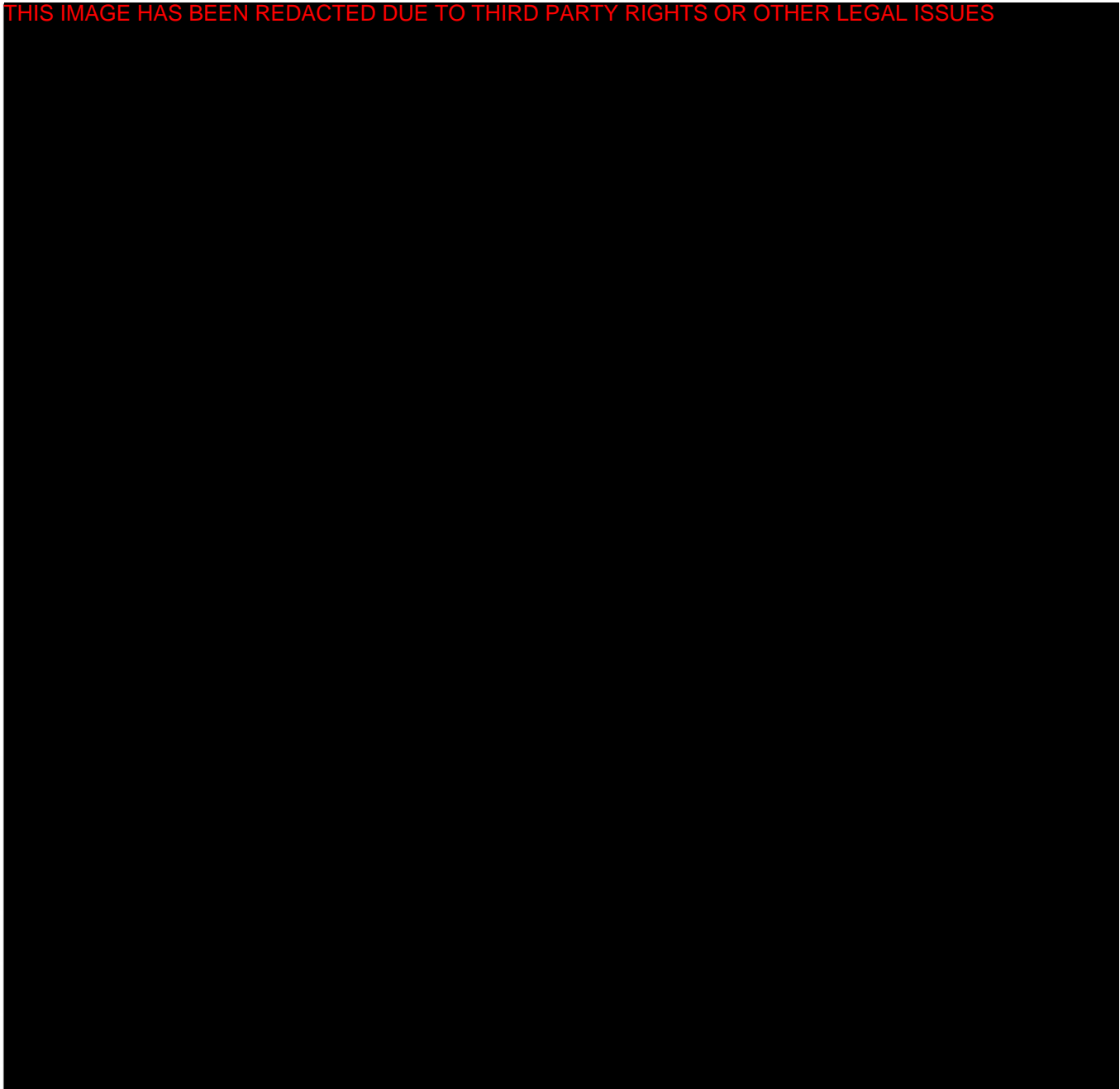


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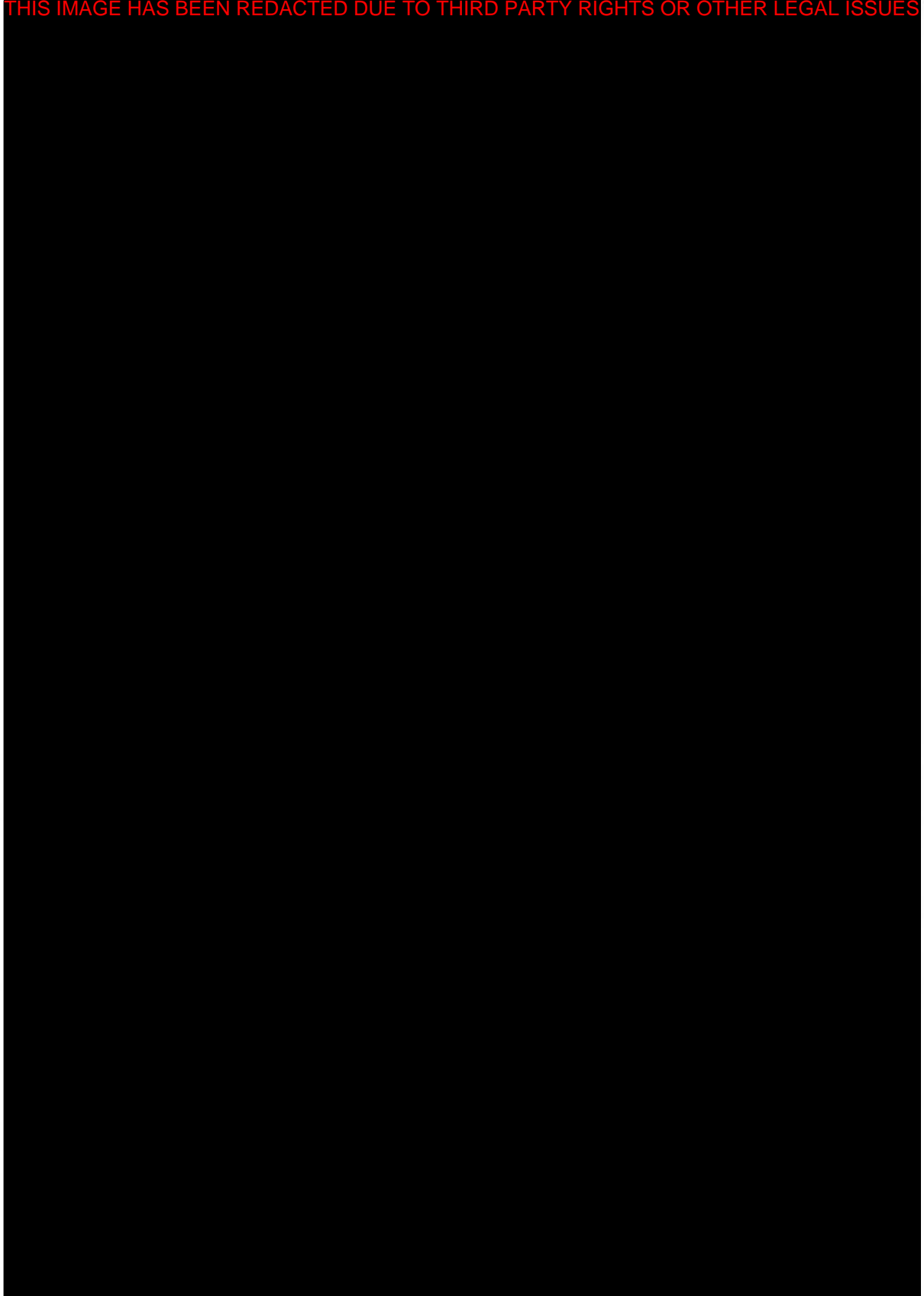
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