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'THE FOOD WE EAT HERE WEAKENS US': FOOD PRACTICES AND HEALTH BELIEFS AMONG CONGOLESE FORCED MIGRANTS IN SOUTH AFRICA – A CASE STUDY OF YEOVILLE IN JOHANNESBURG

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ABSTRACT

This study explores the cultural context and relationship between food, health, and illness amongst Congolese forced migrants in Johannesburg, South Africa. It specifically seeks to understand Congolese migrants' perceptions of South African foods and the importance of Congolese foods in treating and preventing illnesses. Since the beginning of the political crisis in the D.R. Congo (DRC), more than eight million people were killed and thousands forced to leave their country to seek safety in foreign countries, including South Africa. Congolese who migrated to other countries experienced various ruptures which included not only the loss or separation with their relatives but also the change related to their eating patterns. The absence of traditional dishes and the consumption of food of the host country are believed to have a negative effect on their health. The significance of this study is to explore indigenous knowledge regarding food, herbal drugs and the health and wellbeing of refugees, and by so doing to promote a better understanding of their health beliefs and healing strategies. It specifically emphasises the perceptions or meanings that Congolese refugees living in South Africa have about food from the DRC and food eaten in the host country. Since food is part of identity construction, it is argued that land and the mode of production contribute to the quality of food consumed in the foreign land, which is believed by the refugees to be harmful to their bodies in South Africa. The study employs Kleinman's model on the three sectors of health care systems to analyse and understand the impact of foreign food on Congolese refugees' health in South Africa. Thematic analysis was employed to analyse and interpret data collected. Drawing on case study material based on semi-structured interviews and focus group discussions with ten Congolese refugees living in Yeoville, a suburb of Johannesburg, South Africa, findings reveal how Congolese refugees link their health problems to food consumed in their receiving country, believing that change in diet has led to them being weakened physically and in losing 'supernatural power' to defend themselves. More importantly, findings reveal that participants rely on their traditional food from the DRC, which they believed to be organically healthy, as a remedy to treat and prevent physical diseases. While the results of this study cannot be generalised to the entire Congolese people, they stress the importance of foodstuffs in the knowledge system of people, particularly in refugees' communities.

Key words: food security, food practices, health beliefs, forced migrants, DRC, South Africa

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INTRODUCTION

This study explores the cultural context and relationship between food, health, and illness amongst Congolese refugees in Johannesburg, South Africa. The impact of foodstuffs on migrants' well-being has started receiving critical scholarly attention [1, 2, 3]. However, little has been done to explore the impact of South African foods on Congolese refugees' health and factors affecting their dietary decisions and beliefs. The objective of this study is to analyse and understand indigenous knowledge from DRC regarding food, herbal drugs, and the wellbeing of refugees particularly in terms of their health beliefs and healing strategies. It specifically emphasises the perceptions or meanings that Congolese refugees living in South Africa have about food from home, the Democratic Republic of Congo (DRC) and food eaten in the host country. Since food is part of the identity construction, it is the argument of this study that land and the mode of production contribute to the quality of food and that food eaten in the foreign land is believed to be harmful to refugees' bodies in South Africa.

Drawing on case study material based on semi-structured interviews and focus group discussions with ten Congolese refugees living in Yeoville, a suburb of the city of Johannesburg, this study highlights how these refugees link their health problems to food consumed in their host country and how they use traditional food from the DRC, which they viewed as organically healthy, as a remedy to treat and prevent diseases resulting from the change in diet. These diseases, according to participants, have significantly contributed to their physical and spiritual weaknesses.

The challenge facing people who migrate is that they seldom find their homeland traditional dishes and are compelled to adapt to the new environment and to new eating patterns. While this adaption may work for some, many struggles to adapt and struggle with foods available to them in the receiving country. In this context, eating familiar food releases people from disconnection and provides comfort [4]. However, in the foreign land, delicacies that are native to refugees become a luxury and they find it difficult to access those kinds of foods because of scarce resources.

While it is assumed that people will purposely choose foods that contribute to their long-term physical wellbeing by reducing their risk of chronic diseases, few researchers have attempted to explore how food is perceived as contributing to promote or deteriorate the believed healthy diet of refugees. Ikeda [5] contends that citizens from developing countries who move to developed nations often possess little knowledge that some foods are more nutrient-denser than others. In the same way, Crush [6] underscores that access to income is a critical determinant of healthy diet intake. Without undermining income as crucial in enabling people to afford food in general, there are additional questions to be posed for refugee communities regarding what is eaten and, more importantly, what their perceptions are on the effects of what they eat, particularly the effects of the food they eat on their bodies, as well as the customs, values and behaviours that inform these perceptions.

These perceptions led participants in this study to raise concerns surrounding food, and illness causation; the discussion also gave rise to topics of food with medicinal properties

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by looking to explore their perceptions of the South African foods as well as the way they make use of some of the foods produced in the Congo to deal with some of the health problems they link to the South African food consumption.

THEORETICAL FRAMEWORK

This study employs Kleinman's [7] model of the three sectors of healthcare systems. The use of the framework is motivated by the social scientists' argument that microscopes and stethoscopes are not enough to provide an analysis of the way medical institutions, practitioners and the lay person respond to health problems. According to this model, treatment for a disorder can be sought in one of the three sectors that form a healthcare system. The first is the professional sector, dominated by biomedicine. The second is the folk or non-professional; specialist sector, ranging from osteopathy to faith healing. The third segment is the popular sector which comprises "the lay, non-professional, and non-specialist arena" [8]. This lay sector includes health maintenance activities such as diet and home remedies [8] and it is considered the domain where "ill-health is first recognised and defined and where health care activities are initiated" [9].

Scholars using Kleinman's [7] typology have often focused on only understanding one of the sectors. Thus many studies exist documenting the activities of traditional healers [10, 11, 12], while others examine modern medical professionals and their activities. However, located in the third segment of Kleinman's model, the focus of this study is to examine how migrant populations manage their health concerns and consider among alternative helpers based on their various beliefs including food consumption. Various factors such as the nature of the land and the mode of food production could be used to explain illness causation as well as different methods of combating it.

The 1996 World Food Summit defined food security as a state in which "all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preference for an active and healthy life" [13]. Food security is commonly conceptualised as resting on three pillars: availability, access, and utilisation of food. Emphasising the food security's characteristics identified by the Food and Agriculture Organisation (FAO) such as availability, accessibility, affordability and acceptability, Wahlqvist [14] contends that a "Connected Community Household Food-Based Strategy model (CCH-FBs) could help to address unresolved nutritionally-related health problems. The authors suggest the improvement of infrastructure to allow communities and households to be usefully connected and operate with CCH-FBs. In most of cases, food insecurity, with regards to migrants, is justified in terms of "limited income and financial commitments to relatives in their homeland" [14].

While this study acknowledges the merit of this literature, it also argues that it is limited in terms of migrants' food beliefs, food habits and the advent of some diseases arising from food consumption in a foreign country. This study argues that assessing food insecurity only in terms of food access or an availability perspective is insufficient. When coping strategies are used as indicator of food insecurity, they need to be "culturally relevant and focus tested" [15]. Food security should take into account the food security governance: a systematic literature review approach [1]. It intends to look at migrants'

dietary patterns and the way they interpret their ailments after consuming the foods of the host country, in this case, South Africa. Pollard *et al*. [3] present a framework of food choice in relation to fruit and vegetable consumption, emphasising that food choice is influenced by many factors, such as sensory appeal, familiarity and habit, social interactions, cost, availability, time constraints, personal ideology, media and advertising, and health [3].

Some scholars have examined factors influencing dietary changes among migrants [2, 16]. In a study exploring dietary changes among migrants moving from a low-income to a high-income country, Burns found that "religion, availability or non-availability of foods and relative income increase influenced the change of dietary in the host country" contributed to the symptoms of overweight or obesity among the majority of Somali women refugees in Australia [2]. While the author admitted that some dietary changes were beneficial in increasing energy, she affirmed that these changes contributed to an altered nutrient density. Burns further argues that the diet of Somali women in Somalia was "nutritionally more appropriate" and concludes that migrants should "maintain the best aspects of the diet of their homeland and embrace the best foods and food habits of their host country" [2]. While the author contends that the majority of Somali migrants living in Australia were obese, she did not interrogate this group about the cultural meaning of stoutness and thinness in Somalia since thinness may be considered a sign of poverty and a difficult life in some cultural contexts while plumpness may symbolise economic prosperity and power.

In the same vein, Mellin and Wandel argue that "today these factors do not seem to be the most predictors of dietary change but rather act in combination with other factors" [16]. Their study revealed a multitude of culturally specific beliefs and attitudes that influenced people's dietary habits.

Koenig *et al.* analysed the dietary health meanings for Asian Indians living in the United States saying that "community members' dietary health meanings operate discursively through a dialectic tension between homogeneity and heterogeneity situated within culture, structure, and agency" [1]. Homogeneity was justified by the fact that dietary health meanings were the embodiment of a sense of continuity of people's identity, while differentiating them from others. Discursive heterogeneity showed dietary health meaning differences between members of the community due to other membership affiliations. Koenig *et al.* further argue that the meaning of diet analysis should be based on a culture-centred approach which postulates that "structure and agency are embedded within culture and proposes the notion of voice" [1]. Culture is understood as the "accumulated knowledge, values, personal and social behavior, customs, language, and religious beliefs of an ethnic group that are learned and passed from one generation to the next" [17].

Drawing on field observation for this study, we notice that the role of traditional medicine and folk beliefs in addressing various health needs of the Congolese community in South Africa has remained prominent. Despite the change of environment and the development of western medicine, research among migrants in various locations suggests a cultural

understanding of health problems and a high use of the traditional sector in the management of individual's health needs [18, 19].

Another concept relevant to this study is the concept of explanatory models deriving from Kleinman's [20] analysis of the cultural construction of illness helps to understand the way people ascribe meaning to their health problems. Explanatory models sometimes implicate supernatural agents as the cause for illness [21] and structure how individuals operating within various cultures understand health problems. Explanatory models refer to causal attributions of a specific episode of illness held by patients, their family or practitioners. They affect treatment preference and outcome [22]. Illness is described or linked with culturally based narrative and culture supports the construction of its meaning [20, 23, 24, 25]. As such, Darghouth *et al*. [26] attribute illnesses to five causes: (1) supernatural (devils, spirits, stars, ghosts and dead persons); (2) natural/environmental (excessive heat, cold, and winds); (3) interpersonal issues or conflicts with family, community or spirits; (4) biological/biomedical explanations; and (5) socio-political accounts that may underline situations of poverty and lack of financial and material resources and/or social support.

We use this framework in this study investigating refugees' perceptions of foreign foods and illnesses affecting migrants in a host country. Different causes enumerated by these authors could be used to explain different health problems they encounter since these problems could be interpreted as being mystical, environmental due to the change of location, social or organic.

CONGOLESE ENVIRONMENT, FOOD PRACTICES AND HEALTH BELIEFS

The overview provides a context of the broader food environment and the eating patterns of the population in DRC in order to help understand the respondents' views.

The DRC consists of thousands of square kilometres of evergreen lowland forest [27] where most people are engaged in a subsistence economy through hunting, fishing, farming and breeding activities. Although the country has enormous rivers and lakes endowed with different kinds of aquatic life, fishing is rudimentary and expensive because of the difficult conditions. This compels households to rely on imported meat and saltwater fish (commonly known as *thomson*). While meat is part of the diet, the way of eating it is regulated by religious principles precluding the consumption of the meat of an animal which was not slaughtered in a particular way. Meat-consumption also depends on financial constraints. There is a belief that meat stored in a cold-room loses its nutritious values and could become harmful to the body, exposing it to some diseases like cancer or gout, the painful inflammation of joints. Many Congolese are driven by the belief that suffering from cancer is the result of foodstuffs containing unnatural substances which are produced by industries [28, 29].

The country is endowed with an organically rich soil and many crops and vegetables are produced organically without requiring fertilizers to enhance yields. Usually people consume foodstuffs derived from their home gardens [30]. In many markets, greengrocers use this expression in Lingala as a way of marketing and attracting clients:

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'*buka lelo lamba lelo*' (literally translated as 'reap today and eat today'). As electricity is difficult to access in many areas including in big cities, cold rooms are not often used to preserve foodstuffs. Perishable goods are not preferred as the foods become spoilt. In some areas (mostly rural), people rely on alternative and traditional methods of preservation such as drying and smoke-drying to conserve perishable foods.

Another important element of the Congolese landscape is the presence of fruit trees. For inhabitants of Kinshasa, the fruit trees bring shade in a city with warm climatic conditions and provide food and income [31]. Income generated by the selling of fruit and vegetables from home gardens helps to supplement consumption and income, as well as to pay for the school fees. As Heywood [30] argues, an estimation of a billion people depends, for their survival, on the products of home gardens, supported by subsistence agriculture.

DRC is also endowed with different edible insects such as locusts, crickets, termites, ants, grasshoppers, worms and a variety of mushrooms which are food for many people. Bukkens [32] maintains that edible insects provide high protein and minerals and vitamins; their amino acid composition is better than that of grains and legumes and often the insects complement the protein content of staple diets among the indigenous population. Bukkens [32] reports that the consumption of caterpillars in the DRC complements cereals, which are a lysine-poor staple food.

It is held that cultural specificity influences food choices in many African societies. For example, people from Asaba in Delta State in Nigeria forbid soup made from *ogbono seed* (Irvingia gabonensis) because it is used for spiritual purification, which in local parlance is known as *ife-ahu*[1].

The *Bayaka*, a Bantu-speaking ethnic group located in the Kwango District, in the Province of Bandundu in the DRC, do not hunt animals like the hyena and birds such as owls (*fungu*) whose sound they believe announces bad news to the society. Similarly, Women in this society are forbidden to eat meat from snakes (*nyoka*) or turtles (*kafulu*) which they believe negatively affect their fertility [33]. Other communities in the DRC are banned from eating things like escargot, crocodile, snake, and monkey, which their customs consider as totems and revered for symbolising a clan or society and are often used in atonement rituals of healing. Others are given some food constraints because of their adherence to magical or supernatural practices. Koenig *et al* [1]. found that many people "were imbued with dietary restrictions conceived as an important aspect of their cultural identity and a daily form of social action with flow of effect on every day aspect of routine dietary behaviour".

METHODOLOGY

This study combined case study, semi-structured interview and focus group discussions. First, the study inspired by the field work carried out in Johannesburg from July to November 2010 with Congolese forced migrants and victims of political violence.

[1] https://www.vanguardngr.com/2015/10/onishe-ahaba-why-asaba-people-forbid-ogbono-soup/

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The initial case study concerns a 35-year-old married woman with children, a refugee in South Africa. Linda was forced to leave the DRC for fear of persecution, entered South Africa in November 2007, and was granted asylum along with her six-year old son and her four-year-old daughter. Two years after her arrival in South Africa, she noticed a lump on her right breast. Linda sought medical help from a clinic in Johannesburg. After a medical examination as recommended by the doctor, the results revealed that the lump was a symptom of breast cancer for which she went through operation. Espousing the view of many Congolese that that cancer is contracted within the family lineage, Linda explained that being diagnosed with breast cancer, particularly in light of her beliefs, was strange to her, saying, "In my family, I've never seen somebody among my parents, my aunts or my sisters or cousins developing the symptoms of breast cancer" (Interview, Linda: October 2010).

Linda argued that breast cancer was due to South African food which contained chemicals. She also added that the doctor concurred with this view that in the DRC, there is a diversity of fresh vegetables, a variety of food which protected people from illnesses. Linda's perception was that food eaten in South Africa contributed directly to her health problems as she believed that breast cancer was a hereditary or genetic disease but could also be caused by consuming food that contained chemical additives or were produced with chemical inputs. This perception of South African food is what most participants reported on in the findings section.

Apart from the breast surgery she underwent, Linda reported that she almost stopped using the tablets prescribed after surgery to avoid being intoxicated. In her view, drugs also were chemical products and she sought to find alternatives to drugs. She narrated that her family members and friends supported her in searching for different remedies able to cure cancer, including some food types from the DRC. Linda was of the view that the appropriate medication for her treatment was not in the hospital, but in the use of natural plants and foodstuffs from the DRC, a view that was held by her physician who gave a list of foods to eat and a list of foods to avoid eating.

Explaining the importance of food from home, which was provided by her family members in the DRC, Linda reported that she monthly received between 20 or 30 kilograms of DRC foods from her mother. These included smoked fish, prawns and soybeans and believed these foodstuffs significantly contributed to her healing.

In addition to foodstuffs, Linda also reported that she relied on traditional medicine, using particularly two plants: *Artemisia* and *Pandanga*[2] (see pictures in appendix). She reported that since confiding in family members and friends about the medical report, she received unconditional support from her siblings who were all involved in the search

[2]*Pandanga* (in Tshiluba, one of the local languages of the DRC) is a medicinal plant discovered by herbalists or ordinary people in the forest of DRC. It is used to treat many illnesses, particularly cancer. Its bark is removed and soaked in a container of water for 24 hours. It then completely changes the colour of the water. This liquid produced is drunk by the patient. It is very bitter and some say the bitterness of *pandanga* contributes to the healing of the ill person

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for solutions for her illness and who discovered these plants. Artemisia has the reputation of curing many diseases including breast cancer. According to Linda, the recommendation she received from her family was to use the *Pandanga* as tea, which was an efficient treatment for breast cancer. Linda regularly received *Pandanga* from her mother and explained that the two plants (*Artemisia* and *Pandanga*) were bitter; believing that their bitterness was what brought healing.

In addition, nine other Congolese residents in Yeoville were interviewed, including two sessions of focus group discussions (FGD) were conducted with four people (two males and two females who were all adults, with an average age of 36 years) in November 2012 to complement the case study. The focus group discussion was unstructured and based on Congolese forced migrants' experiences of the South African foods. The two women who participated in the FGD were married and had children; one man was also married, while the other one was single. The participants had been living in South Africa as asylum seekers for more than five years. The FGD took place at one of the women's home.

The discussion concerned foods from Congo, knowledge about South African foods, health problems related to food intake and how they thought that food eaten in South Africa improved or deteriorated their health. There was no questionnaire prepared in advance and participants' selection was not based on any specific criteria, rather on their Congolese identity as well as their availability and willingness to share their knowledge about problems related to food practices. They all lived in Yeoville, a suburb in the city of Johannesburg, and were selected through the first researcher's social network. In order to avoid any bias that could be caused by the influence of the social networks, the first researcher (who is also from the DRC) decided to move out of his social networks to randomly interview five more Congolese refugees in Yeoville (three men and two women) who were all in their forties in November 2017, and compared the different opinions about food beliefs. All interviews were conducted in Lingala (one of the most spoken local languages in the DRC) and translated into English. For the analysis and interpretation of data we relied on thematic analysis, a method aimed at "identifying, analysing and reporting patterns (themes) within data" [34].

It is important to stress that this study was granted ethical clearance (protocol number H100913) by the Human Research Ethics Committee (Non-Medical) from the University of the Witwatersrand and that for the sake of confidentiality real names of respondents in all interviews including case study and focus group discussion were withheld. Those used in the presentation of the results to follow are all pseudonyms.

The discussion of the findings consists of four points. The first highlights participants' foods preferences and the challenges of finding these foods in South Africa. The second point focuses on the links that participants make between their health problems and the South African food intake. In this point we highlight some symptoms that they mention and their understanding in relation to the South African food eating. The third point discusses participants' beliefs about supernatural forces they embodied and how in their views alien foods have destroyed those 'powers' they brought from their homeland. The

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last point focuses on how participants make use of foods from Congo to prevent and even to treat some of their health problems in the receiving country.

Food preferences: 'I like *Pondo* and *fufu*':

In responding to the question about what they liked eating, participants more often referred to food from the DRC, expressing remorse as they missed eating them. Each was able to mention the food they liked, often associating the best moment of their lives when they shared food with their relatives.

Most of the participants explained that they liked eating local Congolese delicacies such as *pondu* and *fufu*. *Pondu* also known as *saka-saka* is the Congolese word for cassava leaves, and the name of a dish made from them. These leaves are pounded in a mortar and cooked with palm oil, onion, garlic, green pepper and dried or smoked fish. In their explanation, participants stressed that the ingredients such as *ndembi* (spring onion), *litungulu* (onion), *ail* (garlic), eggplant and green pepper contributed to the flavour of *pondu* and increased people's appetite to eating it. *Fufu* is dough made from boiled and ground cassava, used as a staple food in Congo and some parts of West Africa. Hence, *pondu* is served either with *fufu* or with rice. Participants also stressed that they liked eating many other kinds of vegies and dry fish from the Congo. This was emphasized by Andrews, a married man, who reported that vegies were good for building the body:

> I am more attracted by leaves or vegies (commonly called *makasa* in Lingala); I like vegetable of home called *biteku-teku*. It is very sweet and healthy (*kotonga nzoto*) (Andrew, FGD).

Eating vegies is also motivated by the beliefs that they prevent many diseases and that too much meat can cause gouts.

Participants reported that they had been unable to access these local delicacies with the same frequency as they used to do back in the DRC. This was emphasized by Andrew, a resident of Yeoville, who said he was suffering because of the inability to frequently access *fufu*:

That's our big challenge; we suffer a lot for not eating foods we are used to, like *fufu*. (Andrew, FGD).

It is important to stress that *fufu* is the staple food in the DRC. It is accompanied either soups made with meat or vegies. In many families when *fufu* is not cooked they do not consider that they have eaten especially when rice is served instead of *fufu*. Some respondents said that sometimes their family members sent them foods from the DRC but the quantity was not enough to meet their needs because at the airport these foods were not allowed to enter South Africa.

While some foods similar to those from home can be found in the South African markets, some participants stressed that their quality was spoilt and that they were very expensive

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to access. This was emphasized by Amba, a resident of Yeoville who indicated that there was a popular market in his area where many African foods were sold.

> We can also find some of our foods here at Yeoville market but they are not tastier than what we eat at home, because it takes longer to reach South Africa and this affects their flavour. But here, it is also very expensive and people don't have money to consume it (Amba, FGD).

South African foods cause diseases

Findings of this study also reveal a relationship between alien foods and refugees' diseases. Many of the participants presented some symptoms which they believed derived from eating foods of the receiving country.

Participants stated that the South African foods were affecting their health in different ways. Among the various symptoms which they linked to eating these foods, they mentioned that some were losing weight while others were getting plumped. According to them, it was the result of eating things they did not know how they were made. In the views of many participants, the South African foods were full of chemical substances because they were produced on a large scale to supply the market and make profit. As an illustration, they took the case of tender chicken which they said that the flesh often fell of the bones when it was cooked because it was bred with chemicals which were harmful to their bodies. Breast cancer, for instance, was viewed as resulting from consuming foods that contained too much chemicals.

Many participants reported that the South African foods were not healthy and exposed them to some health problems. They explained that whenever they ate these foods they noticed some symptoms. The following quotes from Denzu and Koko were taken as evidences to highlight the health problems participants linked to the South African food intake:

> One day, I was hungry at school and decided to buy pie and ate it. Yeah, the whole night I didn't sleep. My whole body was itching. The following day I decided to go to the hospital and the doctor told me never to eat pie again (Denzu interview, November 2017).

Pie is a baked dish which contains various sweet or savoury ingredients and the fact that the doctor forbad Denzu to eat it reinforced his belief that the body itching he experienced derived from the pie that he ate.

Another participant reported that since he has been in South Africa, he only ate meats from animals that were not properly bred (meaning bred with chemicals), which were symptomatized in the gouts that he suffered:

> You see how I use crutches to walk. It is because I have gouts and the doctor said gout is caused by excess of eating meat. Since I have been in South Africa for the past 16 years, I only eat meat which is not properly bred (John interview, November 2017).

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This quote reveals the belief that John carried about meat consumption. While the WHO has classified the red meat and processed meats such as hot dogs, ham, bacon, sausage, and some deli meats as a probable cause of cancer and many other diseases (35) no reference was, however, made to gout. The explanatory model that John presents is informed by the popular belief of the consequence of eating meat.
Koko raised another health problem related to eating South African foods:

> I don't eat the South African pap commonly known as mielie-meal [mielie pap]. If I try it I have constipation which can take a week. My wife knows it and always makes sure that I eat *fufu* or something else. But as you know, *fufu* is expensive and it is extra expense. (Koko interview, November 2017).

Congolese refugees' views on the alien foods are not largely positive. The most common complaints include tastelessness, chemical substance additives and the use of fertilisers to increase growth. These chemical substances in the food consumed, contribute, in the views of respondents, to weakening them both physically and supernaturally. For the respondents, the way these foods were prepared was of concern. They linked highly processed foods with 'chemicals', 'additives' or of "containing high levels of chubbiness" which they identified as dangerous for their health. In their views South African foods were not produced like foods are produced in the Congo; they are based on foreign habits and values and hence not sustainable for them [33]. Some respondents indicated that they read the labels on food products to understand their composition and to check for fat content and, in some cases, additives. They all discussed their concerns about the way chickens and livestock were reared. In their views, chickens produced in South Africa were a potentially risky food, as well as the eggs derived from battery farms, mainly because of the growth hormones, viruses or antibiotics that they were thought to contain, as a result of farming methods. One participant said:

> In this country [South Africa], everything has been industrialised. Business people are always after money. They want to run businesses quickly and make money. For this aim, they resort to several artificial methods. By way of example, they make use of fertilizers to grow crops and the henhouses are full of chemicals used as a means of poultry. Everything people eat here is full of chemicals: eggs, chicken, pork, meat even spicy used in the cookery. (Buga, FGD).

Stressing the industrialisation aspect of food production, Mary also considered that her diabetes was caused by the South African foods which she believed contained too much sugar. This is what she reported:

> You know that we have two types of diabetes: hereditary diabetes and food diabetes. When I was diagnosed with diabetes in this country [South Africa] I was shocked. I searched in my family no one has ever suffered from diabetes. Then I came to understand that it was the result of the food I have been eating in South Africa. Everything here is sweet; this is the result of industrialisation. Most

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> of the additive substances are sugar-related. (Mary interview, November 2017).

Again, this quote stresses the folk beliefs that are engraved in people's minds, leading them to ascribe the cause of their ill-health to the foods consumed in South Africa. Surprisingly, while most of the participants admired the organic character of Congolese foods, one of them gave a contrary opinion. Gerard reported that every time he ate worms, he had a sleepless night. This is what he said:

> My wife can tell you. I don't touch caterpillars although they come from the DR Congo. Whenever, I tried to eat them I had serious running stomach and could not sleep the whole night. (Gerard interview, November 2017).

Renzaho and Mellor [15] differentiate between physical utilisation and biological utilisation of foods. The physical utilisation reflects the ability of a household to have all the physical means to use the available food. In contrast, biological utilisation is concerned with the nutritional effects of the food consumed in the body; in other words how the body will accept or reject the food once it is consumed. This means that indicators of unhealthy/healthy food in the long run should include components of the core measurements of the nutritional status of individuals or communities concerned [15].

Loss of supernatural power: 'the food we eat here weakens us'

Importantly, participants also reported that the supernatural powers with which they were endowed were affected by the foods they ate in South Africa.

Participants reported that they knew from the beginning that they would encounter various problems in the foreign country and got involved in supernatural ceremonies to help them to overcome these difficulties of life in South Africa. However, the results of these supernatural aids could be hindered by the consumption of some forbidden foods. In the foreign land, they noticed that they ate what they did not know. The result of this kind of eating was that they lost these powers they received before coming to South Africa. This was emphasized by Buga, a resident of Yeoville:

> The food we eat here in this country is not nutritious and weakens us. Sometimes we eat things which are incompatible with our health and many people are allergic to such food. I even saw a man who is almost mad because of this South African food (Amba, FGD).

When asked to elaborate on this claim, the response was:

> You know, I don't like to focus on these things. We are losing power because we are revealing our secrets to strangers. Don't you know that if you don't obey the instructions given to you, madness is a consequence? Maybe after his [the mad man's] initiation he ate food that was forbidden. It is like what happened to Adam and Even when they ate a forbidden fruit (Buga, FGD).

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Respondents in this study view South African foods as affecting not only their physical bodies, but also destroying their supernatural powers. The supernatural power includes any rituals they performed to acquire power, knowledge, blessing and protection which required them to comply with instructions they were given by their elders in Congo in order to work successfully in their bodies. Buga's quote reveals the link between food consumption and supernatural power. More importantly it reveals the cultural understanding of madness. This quote shows how the body is a site of various forms of power and is connected to environment. While mental disorder can be explained using a combination of biological vulnerability and psychological and socio-environmental stressors, this study reveals that foreign foods have a significant side-effect and Supernatural attribution is so well established in the beliefs of people that neither educational status nor religious denomination can make a significant difference in its pattern of endorsement [19, 36].

During the discussion, Buga declared that he was weakened by the food he ate in South Africa:

> Buga: You know, when we come to South Africa, we come with our expectations. We are well equipped because we know that life will not be easy out there. We go there to fight in order to succeed. We need protection. We receive 'special blessings' from our elders. These blessings are followed by instructions to respect so that they can work (Buga, FGD).

Buga reported that he possessed supernatural powers to fight and conquer his enemies without fatigue. Some of these powers helped him to illegally and invisibly cross the border into South Africa. He was able to blind the police and pass through without being questioned, even while they were arresting illegal migrants. According to him, he was given certain instructions to follow for these powers to work efficiently, for example avoiding certain foods like eggs. Buga reported that he did not know how all the foods he started eating in South Africa were prepared, and it caused him to lose these supernatural powers. That is the reason that led him to state that the South African foods render many of them powerless spiritually, physically and mentally. He claimed that since he had been in South Africa, he kept on losing weight, whereas in Congo he was healthy. In his view, this means that the foods he ate in South Africa contained a lot of things which were incompatible with his body and health. He further stressed that sometimes they were not able to perform well as men when they were in front of a woman. Following Bunga's statement, other respondents confirmed that some people were endowed with *biloko ya bokoko*[3], or ancestral power, which could be impaired by the consumption inappropriate foods.

By emphasising that they ate things they did not know in South Africa, respondents stressed that they were not aware of the ingredients used to make the food, and that they

[3]Biloko ya bokoko in Lingala means ancestral powers passed on from one generation to the next. These supernatural powers are given through some initiations. Some do it when the child is about to travel. They believe that these powers related to a protection deity and lead to success

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did not know where it came from or how it was prepared. Questioning them about whether they knew the origin of foods they consumed in the DRC, they indicated that in the Congo they knew most of the foods they ate because the foods, particularly products of land, mainly came from local farmers who did not rely on chemicals to grow them. The issue of language also made it difficult to understand how food was produced, what ingredients were used and what the consumption suggestions were. They explained that sometimes it was difficult for them to understand food instructions in English. This was a problem especially when they had newly arrived in South Africa.

Treatment of health problems through home foods

Respondents indicated that a good way of dealing with health problems resulting from the consumption of the South African foods was to rely on Congolese foods believed to possess curative powers.

Many reported that they rejected chicken as part of their diet and sought free-range or organic varieties, or to replace chicken with alternative foods, such as fish and foods from their home country [29]. For instance, Mary narrated how she dealt with what she believed to be food diabetes:

> Since my diabetes is not hereditary the only way to treat it is to rely on food from home because it [diabetes] is mainly resulting from the consumption of too much sugar. I have decided to combat it by eating bitter foods. What I do is that I crush *fumbwa* and *ngadiadia* to the powder form. I take that powder and mix it with everything I eat. That bitterness stabilises sugar in the blood. (Mary interview, November 2017).

Fumbwa (see appendix) is wild spinach, botanically known as Gnetum Aricanum found mainly in Central Africa. *Ngadiadia* known as garcinia (see appendix) is slightly acidic and bitter, which seeds are chewed like cola nuts and used as a stimulant or aphrodisiac. According to Lyana and Manimbulu [33], fumbwa provides iron and helps to reduce excess sugar levels in the blood.

Plants, foods from home and food from family members psychologically linked the sick person to their country and family. According to Nguyen [37], the use of traditional food is often seen as a symbol in the maintenance of ethnic identity and is a cultural trait most resistant to change. However, the case of the respondent (Gerard) having trouble after eating caterpillars, a food imported from the DRC, reveals that not all the people are comfortable with the foods from home. There are always some exceptions and all depends on how the physiological system of each individual can respond whether positively or negatively to some foods even those produced in the home country or in the receiving country.

Without undermining the effect of modern medication in treating diseases, the findings of this paper stress that healing is not only about modern medication. They differentiate among functional foods, food with medicinal properties, and remedies with

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multifunctional uses and stress that these foods contribute to enhance the defence system of the body. The chemical effects of drugs were also highlighted in Georges's examination of abortion practices and meanings in three generations of married women in the city of Rhodes, in the Dodecanese, supporting that the contraceptive pill was related to "numerous undesirable 'side effects', such as breast or uterine cancer, weight gain, nausea, dizziness, loss of interest in sex, phlebitis, 'nerves' and fear of forgetting it" [38]. The side-effects illustrated are seen as the "limits of biomedical care even when it is believed as the best medicine for life in modern society" [39].

The findings by Georges [38] support Ong's [39] study on Cambodian immigrants, refugee medicine and cultural citizenship in California that food has been variously prescribed to "prevent imbalances in the body or for restoring the sick body to health" [38]. The confidence of the sick person to believe that healing is possible increases because these foods are provided by friends and family members from their homeland and in the beliefs of respondents, western medicine was not the only way of healing.

The study concurs with Peglidou's [40] findings that resistance to 'the pill' as a consequence not only of fears rooted in an increasingly dominant biomedical paradigm, but this resistance is also shaped by local cultural understandings of the body. The distinction of the inner and outer body and the proper maintenance of boundaries between the two illustrate the representation of the pill as a foreign substance to the body. Consumption of pills is also considered to result in physiological and psychological addictions, alteration of cognitive skills, transformation of personality, and feelings of malaise.

The Congolese environment provides a variety of medicinal plants including *Artemisia* and *Pandanga* that can be used to deal with some illnesses. Fruth conducted a study on the Convention on Biological diversity in the DRC as part of a broader project entitled "The *cuvette centrale* as a reservoir of medicinal plants". This indicates that, in 2009, the herbarium consisted of 6750 specimens, of which 936 species were taxonomically known, and could be assigned to 459 genera and 110 families. Investigating plants threatened by extinction within and outside the urban area of the country, Fruth [27] found that 17 markets in Kinshasa demanded, supplied and used medicinal plants, over 70% of regenerative plants was inappropriately used (sold as wood in the market) through deforestation making their recovery challenging.

In terms of treatment of illnesses, there is a combination of different methods of care. The methods used are dependant not only on the issue of language or discrimination that hinders migrants from seeking healing in public hospitals in South Africa, but also on the beliefs surrounding illness causation [18, 19]. The same beliefs were observed in Linda's perceptions of the food she received from the DRC, to the extent that she dismissed western medicine to rely mainly on food and medicinal plants for her health problems. This is consistent with Peglidou's [40] study on therapeutic practices among Greek women, demonstrating that these women went to hospitals and clinics while simultaneously (not alternatively) resorting to a healing strategy concerning food. Peglidou [40] explains that this combination of healing practices was an attempt aimed

to give meaning to sufferers' actions, to justify their visits to alternative healing systems and to express their own exegeses for their suffering.

The findings of this study reveal that health is not an individual concern but a community concern. The decision-making process on alternative ways of seeking healing does not often come from the patient alone. As Peglidou [40] indicates, the moment that family members become aware of the problem affecting their loved one, the afflicted person becomes the focal point for collective care. Therapy becomes a family affair, which mobilises relatives to search for a swift resolution. The patient is regarded as having no free will or reason, incapable of managing their own troubles [40]. The respondent in this case study was aware of the support received and considered it as indispensable. This confirmed the WHO's [41] assumption that the lack of supportive friendship during long periods of anxiety and insecurity is damaging in different areas of life. Thomas [19] underscores this value when reporting on meaning, value and place in health-seeking amongst Southern African migrants in London which shows that social support plays an important role in the process of healing. Belonging to a social network of communication and mutual obligation makes "people feel cared for, loved, esteemed and valued" [41]. In a similar line, Bossart [42] conducted a study examining the kinds of support and their sources in Cote d'Ivoire, and found that the main source of assistance comes from close family members, although in this study, Bossart [42] focused more on the financial support that the family members contribute to assist the ill-person.

CONCLUSION

The findings suggest that DRC refugees experience challenges in finding their indigenous foods in South Africa, which they link to their health problems in the receiving country. A related finding is that participants believe that the foods they consume diminish their 'supernatural powers' which they brought from their homeland. The majority of participants considered eating South African foods as "*bricolagealimentaire*" [4], which was epitomised in Lingala in the phrase "*Toliaka kaka po tosepelisa munoko*" (we only eat to please the mouth). Finally, participants believed that food from the DRC could be used to prevent and even to treat some of their health problems in the receiving country.

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APPENDIX

This photo of *Artemisia* (left) and *Pandanga* (right) was taken by the first researcher at Linda's place during the interview conducted on the 21 October 2010

Fumbwa: wild spinach botanically known as Gnetum Aricanum found mainly in Central Africa
Source: Google images

Ngadiadia known as garcinia used as a stimulant or aphrodisiac
Source: Google image