UNIVERSITY OF THE WITWATERSRAND
AFRICAN CENTRE FOR MIGRATION AND SOCIETY

UNDERSTANDING ILLNESS AND TREATMENT-SEEKING BEHAVIOUR AMONG CONGOLESE MIGRANTS IN JOHANNESBURG

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A thesis submitted to the Faculty of Humanities, University of Witwatersrand, in partial fulfillment of the requirements for the degree of Master of Arts in Forced Migration Studies

Johannesburg, February 2011

DECLARATION

I, Dostin Mulopo LAKIKA, do hereby declare that: "*Understanding Illness and Treatment-Seeking behaviour among Congolese Migrants in Johannesburg*" is my own unaided work. It is submitted for the degree of Master of Arts in Forced Migration Studies at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other university.

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(Name of Candidate)

_____day of_____, 2011

DEDICATION

To you, my beloved sister Henriette KUPA, for your love and support.

ABSTRACT

South Africa has received different categories of migrants from the African continent and beyond. Among these migrants some left their home countries because of violence. In the host country (South Africa), they face challenges of integration and present some health problems.

Much research has been done, exploring challenges faced by migrants in accessing documentation, employment and healthcare in South Africa. However the implications of these challenges to their health have not been studied. In addition, less attention has been given to understanding the extent to which the traumatic experiences lived either in the country of origin or in the receiving country may have on the health of migrants.

This study focused on Congolese migrants living in Johannesburg who were affected by political violence in the Democratic Republic of Congo, and currently live under harsh socio-economic conditions in South Africa, and present some health problems. The aim of this report is to explore whether the traumatic events this group of migrants experienced in the DRC or the harsh living conditions in South Africa shape the perception or understanding of their illnesses. The study also aimed at examining the help-seeking behaviour used by Congolese migrants in response to their health problems.

Data collected have shown that both pre-migration and post-migration experiences were contributive to health decline of Congolese migrants who participated in this study. Participants used alternative ways of help-seeking behaviour depending on what they believed to be the causes of their illnesses. This case study brought a holistic and complex understanding of suffering from the views of participants. This holistic and complex understanding included physical, emotional, cultural and spiritual meaning of pain which was beyond biomedical approach of illness.

ACKNOLEDGEMENTS

I am grateful to God, Almighty Father, for the grace given to me in undertaking this programme and for giving me strength and the gift of life.

Dr Lorena Nunez Carrasco, my supervisor, deserves many thanks. Without your support this work would not have been achieved. It was an absolute privilege for me to have you as my supervisor for this study. I really learnt a lot from you. You were always there for me. You even used to sacrifice your holidays and your rest to go through my work and send me your solicitous comments quickly. I learnt from you how to commit myself in helping others. Thank you so much.

How can I forget you, Dr Joanna Vearey? Since your appointment as my co- supervisor, you have always been there to help. You used your time to critically read my work and give thoughtful comments and ideas, especially on the literature around social determinants of health. As I said to Lorena, I learnt a lot from both you and I will always be pleased to work with you in future projects.

I would like to express my gratitude to the participants of this research who dedicated their time and accepted to open their hearts and share their painful experiences of suffering with me. I don't forget my classmates, particularly Jessica, Elsa, Brittany, Femi and Melekias for your advice and support shown to me since the beginning of this research journey. Jessica and Melekias deserve to be thanked in a special way for dedicating their time to sit and read my proposal, suggesting thoughtful ideas to sharpen my study. Thank you very much.

I would like to say thank Peter Kankonde, my brother and my elder in FMSP, now ACMS, for advice and encouragement. You advice was always considered and helped a lot in producing this report.

I do not forget Bazolakio's, Malobo's, and Ciaba's families for their prayers, support and encouragement.

I am also indebted to my family for the support they have given me all the years that I have been studying. Special thanks go to my elder brother Jean-Pierre Lakika and my younger brother Matthieu Lakika and all my sisters, nephews and nieces.

I would like to express my gratitude to you, Deogratias Bikopo and Willy Mbelenge for dedicating your time to go through some pieces of this study and providing me with your insightful ideas. Special thanks to you Bikopo for offering me space in your house and staying up, many times, with me to edit this work. May God bless and fulfill all your desires.

My thanks go to Terry Sacco for recommending me to ACMS to complete this programme. May you and your family find here my gratitude.

Last but not least I would like to thank my wife Heureuse Kidima and my son Samuel Lakika, for your faith and support during this hard time.

To you all who always express to me love and support, I would like to say thank you from the bottom of my heart.

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CHAPTER ONE: INTRODUCTION

South Africa has a long history of in-migrancy, receiving different categories of migrants from the continent and beyond (Vearey, 2008:5, Landau and Wa Kabwe-Segatti, 2009). In this study the term migrant means those holding a range of temporary residence permits, in South Africa, including inter alia, refugees and asylum seekers, and those without documents. The 2007 Community Survey, a national representative survey conducted by StatsSA, states that the total number of foreign migrants in South Africa is over 1.2 million or 2.79% of the total population (StatSA, 2008). In contrast to these estimated statistics, the study done by Landau and Wa Kabwe Segatti (2009) on '*Human Development Impacts of Migration: South Africa Case Study*', underlines that "no one knows how many international migrants are in South Africa, how long they have been there, how long they stay, or what they do while they are in the country" (Landau and Wa Kabwe-Segatti, 2009:9).

Much research has been done outlining the challenges faced by migrants in accessing healthcare in South Africa (HRW, 2009, CoRMSA, 2009, Pursell, 2004, Pophiwa, 2009, IOM, 2009, MSF, 2010, Junghanss, 1998, Vearey, 2008). These studies show how migrants in South Africa are often denied access to healthcare despite the presence of legislative and policy documents such as the South African Constitution. However, less attention has been given to the influence of the harsh living conditions in the host country on migrants' health (Bhugra and Becker, 2005, Nunez, 2009, Greenburg and Polzer, 2008). In addition, few studies have focused on the influence of the home country as well as the host country on migrants' health. Scant attention has been give to understanding the extent to which the painful events experienced either in the home country or in the receiving country may have an impact on the health of migrants.

This study will focus on Congolese migrants living in Johannesburg. A significant number of Congolese migrants in South Africa have been affected by political violence. Some witnessed the killing of their relatives and others were victims of torture and persecution, and this might affect their health. Furthermore, in South Africa they are confronted by socio-economic challenges which may expose them to distress as well. I focus on the understanding of illness among

populations that fled conflict and war, and have been experiencing some health problems, with particular attention to their perceptions of illness which involve cultural understandings of this subject. Being a Congolese myself and aware of the effects of war on populations in my country, I decided to choose a community that I know well and that I have the cultural and linguistic competence to study.

While it is a known fact that migrants including Congolese from the Democratic Republic of Congo (DRC) in South Africa are faced with challenges in accessing healthcare (Amisi, 2006, Apalata et al., 2007, Pursell, 2004, Vearey, 2008), we do not know much about their perception of illness. Inadequate attention has been given to the cultural, religious or emotional understanding of illness and the treatment-seeking behaviour of Congolese migrants in South Africa. Very little is known regarding the extent to which traumatic experiences affect their current health conditions as well as their perceptions or understandings of illnesses.

This study focuses on the understanding of illness and treatment seeking behaviour of Congolese migrants in Johannesburg. It tries to retrace the migrants' perception of different events or situations lived either in the DRC or in South Africa that may shape their understanding of the current health problems they may be having. The study is based on the subjective understanding of ailments and would like to bring new insights to the cultural dimension of health that may influence help seeking behaviour and determine the healing process.

In a sense, the understanding of the cultural dimension of health needs a close knowledge of life stories to give insight on how Congolese migrants perceive illness. Life stories may be the key explanations to the health problems of Congolese, specifically how they perceive their illnesses as well as their experiences and beliefs concerning disease causation and illness. Taken from this angle, it can be argued that their help-seeking behaviour is influenced and depends on their perceptions of illness.

As Congolese migrants constitute the target group of this research, I present in the following, an overview of this group of migrants and justification for their inclusion in this research in South Africa.

1.1 Overview of Congolese migrants in South Africa

Since the fall of Mobutu in 1997, the Democratic Republic of Congo has been mired in a bloody war which broke out in 1998 and led to political instability and economic crisis. Baruti and Ballard (2005:1) call it "Africa's world war causing deaths of around three million people." The living conditions in DRC, which were already challenging from the time the country was under Mobutu's regime, worsened with the war. The war in DRC, as indicated above, resulted in millions of dying. It fuelled unprecedented high cases of internal and cross-border migration as people sought peace and safety within and outside the borders of DRC.

The number of migrants including Congolese living in South Africa is not known. The 2003 baseline survey of refugees in South Africa estimated that 24,000 legally recognized refugees residing in South Africa were from the DRC (Steinberg, 2005:25). Steinberg (2005) maintains that South Africa is reputed to have a good education system and a developed economy. It is easier to access than Western Europe and North America, and its legislation is far more welcoming of asylum seekers. It is, from this vantage point at any rate, a natural destination for young, educated people fleeing a war-ravaged economy.

Quoting Belvedere and colleagues (2003), Steinberg highlights that the category of Congolese migrants coming to South Africa is primarily middle class, young and male. The average age of Congolese refugees is 32; 43% are single and a further 23% do not live with their spouses. Congolese refugees in South Africa are well educated; 47% have a tertiary education and a further 33% have Matric; 36% were students in the DRC, 20% were skilled professionals, and just 4% were unemployed.

In stark contrast to near ubiquitous prejudice, Congolese refugees in South Africa represent an influx of a solid block of valuable human capital. In the next section, I present the living conditions of the Congolese in South Africa and the challenges they face with in the host society.

Some of the Congolese migrants in South Africa have been exposed to persecution and other forms of abuse within the DRC and in South Africa. Others have lost their families, belongings

and means of livelihood and become uprooted. The war has also left the survivors in the DRC with no access to basic rights such as the right to education, housing, decent employment, health care, freedom of expression, and physical and human dignity.

1.2 General living conditions of Congolese migrants in South Africa

The living conditions of Congolese migrants in South Africa can be summarized as difficult. Migrants in general and Congolese in particular, struggle on a daily basis. Despite their skills and high levels of education, a significant number of Congolese migrants in South Africa, like others in the same category, are unemployed.

Most of them are engaged in the informal sector and are identified by specific productive activities that often do not coincide with their skills and qualifications (Vearey, 2008, Steinberg, 2005, Blaauw, 2005). Quoting Statistics South Africa (2003), Blaauw (Blaauw, 2005:5) defines the informal sector as "unregistered business, run from homes, street pavements or other informal arrangements". Informal employment in South Africa, as well as in the rest of the world, comprises diverse activities. These include street trading and hawking, shoemaking and repairing, barbershops and hairdressing, security industry and car guarding and the provision of transport services such as taxis, as well as productive activities like manufacturing (Muller, 2003:20-21).

Involvement in informal activities is motivated by challenging socioeconomic living conditions in South Africa and the challenge of finding a job corresponding to one's qualifications. Steinberg (Steinberg, 2005:26) says that "While 4% of Congolese migrants were unemployed in the DRC, 29% are unemployed in South Africa. A further 50% are in work they describe as unskilled – street vending, cutting hair, washing and guarding cars – while just four 4% are in what they regard as skilled work."

The impact of access to housing on the health of migrants has been stressed in several studies (Greenburg and Polzer, 2008, CoRMSA, 2009, Landau, 2006b). These studies point out that South Africa does not provide public accommodation to migrants. Most of them resort to private

rental and are completely excluded from accessing housing subsidies made available to South African citizens (Greenburg and Polzer, 2008:9). Renting from a private landlord often presents many difficulties for migrants. The first challenge is proper documentation. Landlords require only South African identity documents and an employment contract to engage in a lease. Refugee status and asylum seeker permits are not accepted. This means that many migrants have few options but to informally sub-lease, leaving them vulnerable to exploitation and without any formal tenants' rights. Furthermore, taking advantage of migrants, landlords, in the private sector, fix the rent higher than normal, regardless of housing regulations in South Africa. Migrants face wide-spread discrimination and xenophobia on the part of the landlords. As result, a lack of adequate housing provision leads to overcrowding and unsanitary and unsafe living conditions. This, in turn, can lead to public health hazards affecting the wider urban community, places unplanned loads and strain on available infrastructure, and makes it difficult to plan for infrastructure upgrades in line with real housing needs (Greenburg and Polzer, 2008:16). The 2008 FMSP report stresses that 77% of the private rental accommodation accessed by migrants in Gauteng is sublet from other tenants (Greenburg and Polzer, 2008:13).

The 2008 FMSP report maintains that volatility is another key characteristic of housing histories. Many migrants and refugees describe histories of continuous displacement from one temporary form of accommodation to the next. Churches and shelters provide places to migrants unable to pay rent. It is also important to mention migrants are sometimes victims of scams after giving their deposit to people who are not the real managers of some buildings in Johannesburg.
Foreigners in Johannesburg are sometimes victims of violence and harassment from the Police in the area. In one of the interviews done on integration of migrants in the City of Johannesburg, one participant stated, "police consider foreigners as the ATMs from where they can withdraw money without any deposit" (Landau, 2006b:134). When the service of the police is requested, they seem not ready to help even when migrants are clearly in a dangerous situation (Landau, 2006b).

Most of foreigners carrying asylum permits or are refugees encounter difficulties to renew permits at Home Affairs offices. Corruption has become the only way of getting one's permit extended (Greenburg and Polzer, 2008, Polzer, 2010, CoRMSA, 2009, Landau, 2006b, Landau, 2006a) and as it was reported to me by many friends.

Accessing healthcare services in public hospitals is challenging for Congolese migrants and other non-nationals (Moyo, 2010, MSF, 2010, CoRMSA, 2009, HRW, 2009, IOM, 2009, Vearey, 2008, Pursell, 2004). Access to healthcare for all in South Africa has constitutional sanction. The section 27 (1) of the Republic of South Africa Constitution consecrates the right to health care, food, water and social security to all, citizens and foreign nationals alike (RSA, 1996). Section 27 (3) of the constitution goes on to state clearly that no one regardless of nationality or residence status may be refused emergency medical treatment. The section 27 (g) of the refugee Act 130 of 1998 reinforces these obligations, stating that refugees are "entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive time to time". In spite of the legislation, the reality on the ground is radically different. Practice does not follow the legal disposition (Landau, 2006a).

Moyo (2010) states that for some frontline workers, providing healthcare to migrants is seen not as a right they are entitled to, but rather as a form of generosity on their behalf. In addition, those migrants who go to public hospitals are not satisfied with the quality of service. In addition to this, the language barrier makes the communication between health workers and migrants difficult (Moyo, 2010).

Private hospitals and pharmacies are very expensive and migrants are unable to afford the costs (Mosselson, 2007). Consequently, foreign nationals, including Congolese, rely on self-medication, using drugs and indigenous medicine from their home countries. Relying on self-medication and some foods from DRC as medicine is not only due to the challenges they encounter in accessing public healthcare service, but mainly because they are used to them and it is part of their culture and beliefs (Thomas, 2010, Dyck and Dossa, 2007, Menjivar, 2002).

These difficult conditions, including access to housing, violence, police harassment and access to healthcare imposed by the country of origin and country of refuge may affect people's well-being and take a toll on their health. This is what I seek to explore in the present study. The following section discusses the research question that will guide the study.

1.3 Research question and objectives

The study is based on the perceptions of illness and help seeking behaviour among DR Congolese migrants. It therefore seeks to answer the following questions:

- What are Congolese migrants' perceptions and understandings of illness?
- What alternative ways of help-seeking behaviour do Congolese migrants use in responding to illness?

In order to answer the research questions posed above, the study pursues the following research objectives:

- To examine to what extent fundamental ideas, belief system and culture interplay in Congolese migrants' perception or understanding of illness;
- To understand whether previous experiences lived in the DRC or the current living conditions in South Africa shape Congolese migrants' perceptions of their prevailing health problems;
- To identify the cultural and religious understanding of health and illness by Congolese migrants living in Johannesburg through their illness narratives;
- To understand, through Congolese migrants' perceptions, factors that influence their help-seeking behaviour, and
- To explore how social networks influence in alternative ways of help-seeking behaviour.

1.4 The study's rationale

I will begin to state the rationale of the study by identifying myself as a Congolese, refugee, living and sharing life experiences with my countrymen. I have several times witnessed discussions around living conditions of Congolese migrants in South Africa and their comments around illnesses and the alternative ways of seeking healing. In addition, as an English facilitator at the International Community Centre (ICC), an adult learning centre where many Congolese come to learn English, I have established rapport with them and share their concerns. We share

our life experiences. Sometimes, they ask me to direct them in dealing with some difficulties such as rejection of their applications at home affairs or interpreting for them in some offices. From my interaction with them, I discovered participants in this study faced political violence in the DRC, the reason that pushed them to leave the country, and they were presenting a diversity of health problems. However, while there is a vast literature on issues of political violence and health (MSF, 2010, Groleau and Kirmayer, 2004, Bhugra and Becker, 2005, HRW, 2002, Koss et al., 1993, Pratt and Werchick, 2004), I realized that not much attention has been given to understanding the effects of the war or violence on the health of people from the DRC in SA. This motivated me to research these issues. The fact that I am a member of their community, sharing the same suffering and anxieties, and the fact that I speak the same language and have a meaningful cultural capital to assist in gaining the confidence of respondents, proved to be a crucial advantage in the study of this community. Furthermore, being a teacher of English at ICC helped me create rapport and confidence with them as they always presumed that I could be an adviser, a guide, somebody who could direct them in looking for solutions to their struggles. I therefore decided to research on Congolese migrants in order to bring out the cultural dimension of their illnesses, how the effects of political violence in the home country and socioeconomic hardship in the host country shape their understanding of their current illnesses.

The report is framed within the broader South Africa-Netherlands Research Programme on Alternatives in Development (SANPAD) project at Forced Migration Studies Programme (FMSP). SANPAD is a collaborative research programme that has been implemented by the Netherlands Ministry of Foreign Affairs since 1997 in South Africa (SANPAD, 2004).

The SANPAD funded research project, through African Centre for Migration and Society (ACMS) (former FMSP), conducted inquires about the types of psychosocial problems that (forced) migrants and displaced populations develop in the host societies and the approaches being used in the host country to assist migrant populations. The SANPAD research also inquires about the extent to which migrants' worldviews, socio-cultural and political realities as well as traditional forms to confront conflict and recovery practices are incorporated into models adopted for psychosocial assistance. In this regard, my study is nested within SANPAD project and explores the cultural dimension of illness brought by Congolese migrants living in Johannesburg who cope with the effects of political violence of the home country and the

challenges of integration and acceptance in South Africa (Nunez, 2010). The last section of this chapter presents the structure of this research.

1.5 Structure of the research report

The research report is structured in six chapters. The present chapter introduces the research and gives its aims and background. The second chapter reviews the literature on illness narrative and informs the theoretical and methodological approach taken in this study. It also includes the concept of help-seeking behaviour and the various factors that influence this behaviour. Chapter three describes the methodological approach employed in the study including a summary of the socio-demographic data of the migrants interviewed and presents the interviewing process as well as the limitations of the study. Chapter four presents the findings of the research by looking at different events that shape the understanding of the current illnesses affecting Congolese migrants. Chapter five presents the analysis and discussion of the findings by highlighting the key themes generated from the findings. Chapter six concludes the study.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The study's effort is to analyze the perceptions and understandings Congolese migrants attach to illnesses and help seeking behaviour. Various factors can influence these perceptions and understandings. Through illness narrative, migrants bring insight on different events that can be linked to their perceptions of the current illnesses. This chapter examines the existing literature and comprises eight sections. The first section presents the illness narrative understood as different events that may impact on migrants' health status. The second defines the perception of illness which involves the beliefs and cultural dimension of people. The third explores the concept of the explanatory models through which human beings identify the correlation between cause and effect in explaining illness. The fourth discusses the idioms of distress which focus on different circumstances of meaning that people ascribe to illness. The fifth examines the issue of migration and health to highlight various challenges faced by migrants, which may influence their health. The sixth section presents the help seeking behaviour to stress alternative methods of care seeking that people may use in responding to illness. The seventh points out the health worker and patient relationship that may also influence the way of seeking care. This interaction is important in showing whether the relationship between health care providers and patients is of power- domination or cooperation, especially in the way of perceiving illness. The last section examines migration as a factor which influences health highlights culture and societal value in the way people understand illness.

2.1 Illness narrative

Narratives have been used to gather people's experiences of violence and suffering (Uehara et al., 2001). The illness narrative is a way of storytelling about an individual's experience of suffering, how it started, its course, and the search for diagnosis and cure (Good et al., 1994:101). The narrative finds its essence of sharing, i.e. expressing pain by reconstituting the event. Good and colleagues (1994) stress that illness narrative is not a simple story of illness, but it is how people reconstruct their lives through past events used in their current understanding of suffering. In

storytelling, ones' good or bad memories come back to mind as one tries to show how those memories have contributed to relieve or worsen one's pain. Sharing experiences relieves and reassures solidarity and trust. Solidarity implies benefit in community compassion and support and consideration by the individual who has suffered. Life experiences are only shared with those they trust in terms of beliefs and confidence. Stressing the evidential role of narrative, Kleinman, in his book entitled "*The Illness narrative*", attempts to influence medical practitioners to listen more carefully to how patients, their families and members of their social network "perceive, live with, and respond to symptoms and disability", i.e., a process in which illness is viewed specifically as the "lived experience of monitoring bodily process such as respiratory, wheezes, abdominal cramps, etc" (Kleinman, 1988:3-4). However, Kleinman's study is primarily concerned with patients suffering from chronic disorder, such as cancer, terminal illnesses, and so on. The author acknowledges the patients' abilities to use local or cultural idioms. Nunez (Nunez, 2009:5) stresses that "a cultural idiom is clearly more than a language in the restricted sense of the term…It can also express dimensions of the new reality in which migrants are living". This concept is relevant to this study and will be developed further. The understanding of self and the body, and an explanation of how the different contexts in which practitioners obtain information from patients influence the narratives provided (Campbell, 2000:111).

Eastmond (2007:251) underscores that "Story-telling in itself, as a way for individuals and communities to remember, bear witness, or seek to restore continuity and identity, can be a symbolic resource enlisted to alleviate suffering and change their situation." If an individual does not receive such solidarity from others and does not trust or is not trusted, they will suffer a lot and will seek help in other places where they can be heard and believed. Illness is described or linked with culturally based narrative and culture supports the construction of its meaning (Mattingly and Garro, 2000, Good et al., 1994, Kleinman, 1988, Eastmond, 2007). Narrative accounts are based on 'what is known and what is remembered' (Mattingly and Garro, 2000:72). People reconstruct events that affected them in the past and that may be linked to the current health situation. Culturally available knowledge about illness and its causation can also be seen as a resource that may guide the interpretation and reconstruction of the past experience (Ibid). In

going beyond a recitation of what happened, these accounts point to meaningful connections among events and states of affairs.

Migrants' narratives

Coker's (2004:17) statement that "In the refugee's experience the future, present and even the past become the unknown terrain that must be relearned. Cultural narratives and scripts must be recreated from chaos, a chaos that is first and foremost experienced on the bodies of the individual actors" is instructive to this study. In the words of Eastmond, "Narratives have become interesting for what they can tell us about how people themselves, as experiencing subjects, make sense of violence and turbulent change" (Eastmond, 2007:249). Both these statements have salience with regard to marginalization and limitation of access to certain social advantages in the host society.

Illness is an individual experience of suffering and in the individual's narrative, the individual expects the society's capacity to apprehend and respond to that suffering (Uehara, 2007:350). My preliminary informal interactions with the migrant community under study here suggests that Congolese migrants are embedded in lived traumatic events caused by war such as imprisonment, torture, persecution, looting, bereavement, uprootedness. Narratives of Congolese are based on previous traumatic experiences in their home country and the current challenges of integration in South Africa, characterized by attitudes of violence, xenophobia and negative perception of foreign nationals, bringing anxiety and affecting the well-being and quality of life (Thanh and Roosevelt, 1986, Figueiras and Alves, 2007). However, modern society considers cultural perceptions of illness as old fashioned and as "disturbing phenomenology" (Uehara, 2007). In the host country, this perception of illness poses additional problems for both migrants and health providers. As illness is a personal experience, involving a certain set of beliefs and cultures, it becomes problematic for sick migrants as their perceptions of illness are alien to healthcare providers in the host country.

Narratives are told and used for different aims. Sometimes, sharing suffering may bring a certain relief. In this research, Congolese migrants selected as participants shared their stories with me, not only as a member of the same community, but mainly as a researcher willing to contribute to the body of knowledge relating to migration and health. Struggling on a daily basis and looking

for some kinds of support in the host country, participation in the research can be considered as an occasion of raising their voices in a language that is quite easy for them, in anticipation of support or assistance from South Africa. Some of the participants participated in order to talk about their previous experiences in the DRC and their interaction with the local community. This is demonstrated in the interview with one of the participants who stressed that "*kwabenda nkulu kwa mutshi*[1]" (meaning to be in a foreign land is like someone who is on the tree. Following this example, for this person, the host society is not a 'healthy space', but an unsafe, imbalanced and unsecured place. However, this is one individual's point of view which can be challenged by other positive experiences of migration to South Africa and elsewhere. Issues related to service delivery in the host country and migrants' cultural awareness in constructing illness and seeking help will also be raised (Davies et al., 2006). The meaning of illness that will be constructed in this study will be the result of the interaction between the researcher and participants and will highlight the collaborative nature entailed in meaning making (Koschmann, 1999).

This study is focused on meanings that participants attach to their current illnesses and the alternative ways of seeking healing. The illness narrative allowed for interaction between the researcher and participants and will helped identify different events that had contributed to the onset of illnesses experienced. As such, the researcher's role was to guide this narrative in order to lend meaning to the participants' health problems. The researcher's role was also to pay particular attention not only to what participants said, but also what they did not express clearly.

Drawing from the narratives with patients suffering from chronic pain and/or dysfunction, Good and colleagues (1994), describe the way in which individuals recreate their illness histories. The stories typically start by establishing the genesis of the illness through the context of a particular explanatory model, a concept that I introduce in the following section.

[1] This saying is in Tshiluba, one of the national languages of the DRC, mostly spoken in the province of Kasai.

2.2 Explanatory Models of Illness

The explanatory model of illness involves patients' beliefs which are different from the common understanding (Good, 1994, Uehara, 2007). Explanatory models (EMs) refer to causal attributions of a specific episode of illness held by patients, their family or practitioners. They affect treatment preference and outcome (Ghane et al., 2010:1). Good (1994) comments that illness models are studied in formal, semantic terms, with little attention to their intellectual context. In the context of the Peruvian Andean population, Darghouth et al(Darghouth et al., 2006:273-274) 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. It is important to note that migrants use their own explanatory models to understand their illness and health. These explanatory models are socially, economically, physically, emotionally, culturally and spiritually constructed. A single precipitating event or factor is usually identified, although frequently the contribution of other factors is also detailed. The next step covers the period between the genesis and the realization that the physical symptoms are a major disruption in the person's life. The following stage is the search for diagnosis and this ends with the acceptance of the health problem by individuals. On that score, (Gilbert et al., 2002:21) point out that

> *critiques of biomedicine have argued that it is essential to recognize that lay people have their own valid interpretations and accounts of their experiences of health and illness. For treatment and care to be effective these must be readily acknowledged. The sociology of health and illness argues that socio-cultural factors influence people's perceptions and experiences of health and illness which cannot be presumed to be simply reactions to physical bodily changes.*

Similarly, Campbell observes that accounts which fail to take the culture, beliefs and behaviours of individuals presenting with an illness seriously, cannot adequately address the cultural significance of the illness (Campbell, 2000).

This concept of Explanatory models will be applied in this study to understand how Congolese migrants explain their illnesses, the meaning they give to their symptoms, which lead them to the choice of treatment seeking behaviour.

The causes of illness may be natural or supernatural. An individual is always in relation with his environment. The causes of illness may come from his environment and be understood as natural or supernatural. In the following section, I present other causes of illness as believed by people.

Supernatural threats as causes of illness

Garro's (2000) study conducted in Pichataro, Mexico and in Anishinaabe in Manitoba, Canada, brings new insights on illness and suffering. The individual is always linked to his community. His/her relationships with people of the community who are alive or dead are never broken. A human being's relation with a living person or a dead person can expose him to illness. Therefore, we can talk about the first explanatory framework of "bad medicine" and "witchcraft". Bad medicine can be used to covertly influence other people, objects, or events in order to benefit the user or to harm others. Jealousy, envy, anger, laziness, greed, desire for revenge or retaliation, desire to avoid privation, and lust are seen to motivate individuals to resort to bad medicine. In the illness case histories collected in Garro's study, misfortunes ultimately attributed to bad medicine took myriad forms and included flat tires, equipment and vehicle malfunctions, losing a talent contest, a house fire, relatively minor physical problems, striking alterations in an individual's behaviour, loss of a spouse's affection, seemingly accidental injuries (ranging from a broken finger to quite serious injuries incurred in a car crash), acute and prolonged illnesses, twisted mouth, a miscarriage, and a couple of sudden deaths (Garro, 2000:326).

Although a diviner conveys information about the cause of illness, there is a general proscription against divulging the source of bad medicine. Even when sufferers feel certain they know who is responsible, confirmation and elusive element of doubt remains.

The second major explanatory framework links illness and other problems to transgressions that lie outside the realm of everyday and observable interactions between normal living humans.

Everyday difficulties do not necessitate the assistance of other-than-human persons; such problems may be addressed through human means (Garro, 2000:327).

The following section introduces the concept of illness perception.

2.3 Perception of illness

Perception of illness is, at the same time, individual and culturally constructed. It is linked to the life experience of an individual (Amstrong, 2000, Darghouth et al., 2006, Good, 1994). This section defines first the concepts of illness, disease and sickness.

Illness, Disease and Sickness

These concepts need clarification to reveal how they are deployed in the present study. Several studies have focused their attention on the definition of these concepts by highlighting the difference between them (Boyd, 2000, Gilbert et al., 2002, Kleinman, 1988). However, this study considers the differences between the three concepts as propounded by Gilbert and colleagues (2002).

Gilbert et al. (Gilbert et al., 2002:8) stress that "disease is a physical concept linked mainly to the body, and illness is a psychological concept linked to the individual, sickness is a sociological concept, and as such linked to society." Value, judgment and social norms have played a role, not only in defining health, but also in defining illness (Boruchovitch and Mednick, 2002). In this regard, the study focuses on illness considered as a psychological concept linked to personal experience and embedded in people's culture, which becomes central in the illness narrative. This narrative begins with the patient's experience of suffering and the main emphasis is on the patient's own model of their condition (Weinman and Petrie, 1997:1).

Good (Good, 1994:38) stresses that Culture is asserted as a central feature of human response to illness. However, the author argues that lay beliefs are false propositions, juxtaposed to medical knowledge, and the clear implication is that correcting folk beliefs is a first priority for public health (Good, 1994:40). Changing people's beliefs supposes failure to understand them and in this case medical care may not be adapted and meaningful. Paul (1955) cited in Good (1994:26)

points out that "if you wish to help a community improve its health, you must learn to think like the people of that community". The knowledge of a community includes the understanding of its culture, attitudes, knowledge and beliefs that lead to their health care seeking and become a key point in responding to migrants' health needs. The perception of illness is useful and helps to determine the interpretation migrants give to their own suffering (Nunez, 2009). Illness is an individual experience of suffering and in his narrative, the individual expects the society's capacity to apprehend and respond to that suffering (Uehara, 2007:350).

This study examines the perception held by Congolese migrants who were exposed to political violence in their home country, the DRC and continue to face socio-economic challenges in the host country, South Africa. In this context, different events such as persecution, looting, bereavement, uprootedness can be used as previous events constituting the reason for leaving the DRC, and the harsh living conditions in South Africa which bring anxiety and affect their well-being and quality of life (Thanh and Roosevelt, 1986, Figueiras and Alves, 2007). This study will explore the perception of illness among Congolese through cultural factors that influence help-seeking strategies. In the host country, this perception of illness poses additional problems for both migrants and health providers. As illness is a personal experience, involving a certain set of beliefs and cultures, it becomes problematic for sick migrants as their perceptions of illness tend to be alien to healthcare providers in the host country (Moyo, 2010, CoRMSA, 2009, Nunez, 2009).

The next section of this chapter discusses a crucial concept to this research, the idioms of distress.

2.4 Idioms of distress

Many factors can shape the perception of illness (Nunez, 2009, Risør, 2009). Risør (2009) argues that the explanations are determined by context, setting and space, and some are limited to clinical encounters while others are related to patients' everyday life. But one should first of all ask what an idiom is exactly. I would like to use the definition proposed by Whyte (1997). According to Whyte (Whyte, 1997:23), idioms are "guides to action that are in common currency

in a community (shared, like a dialect), that convey meaning and are understood like a vocabulary, and that constitute a situation in a particular way." The use of an idiom within a specific cultural context, where parties have a common reference, seeks to obtain mutual understanding (Risør, 2009). The study among patients with *'Medically Unexplained Symptoms' (MUS)* in Danish primary care, stresses that the creation of meaning in the patient's everyday life is based on four different explanatory idioms (Risør, 2009): (1) the symptomatic idiom; (2) the personal idiom; (3) the social idiom and (4) the moral idiom.

The symptomatic idiom refers to an effort to find a treatment when faced with the bodily experience of suffering caused by a physical disorder. In this case the informants visit presumed experts of the symptomatic idiom, such as a general practitioner. However, this does not stop patients with MUS to seek knowledge and exploring embodied experiences through social contacts.

The personal idiom asserts a person's liability to illness as certain personal characteristics or profiles, as aspects of the psyche and as the connection between emotions and body. These aspects are also causes of the patients' sufferings. The social idiom emphasizes the environmental factors, working situations and social life constraints or the challenges in accessing basic needs. Often stress is attributed to external factors such as certain social conditions or work conditions. In the view of this idiom, one can argue that for migrants, the fact of being uprooted, coming from a war environment after witnessing cruel murder and facing the challenges of accommodation, unemployment and lack of social assistance, or working in painful conditions can be source of suffering.

Finally, the *moral* idiom is engaged, as the patients evaluate their illness situation and try to add meaning and coherence to it. The *moral* idiom also deals with the attempt to consider what is good for an individual's life and why. The moral idiom seeks to promote values that orient people's behaviours. Risør (Risør, 2009:518) stresses that these idioms are interchangeable in their use and can be concurrent.

This study seeks to explore different idioms used by Congolese in the creation of meaning of their suffering and the influence of the host society in using idioms of distress (Nunez, 2009).

Idioms will be used as a way of communicating or understanding suffering. This understanding of suffering will be embedded in various factors which affect Congolese migrants' lives and the "past and present effort to overcome poverty" (Nunez, 2009:5). In addition to the four idioms, the study will also explore intangible threats (supernatural) and migration as other idioms in explaining and understanding human illness.

2.5 Migration and Health

Migration should be considered as a social determinant of health for the specific challenges it poses to migrants throughout the migration process as well as in the host country (Davies et al., 2006:18). It is generally assumed that people migrate for different reasons including to escape persecution or to seek economic opportunities in the host country (CoRMSA, 2009). What they find in the host country is not always protection, safety and job opportunities (Junghanss, 1998, Landau, 2006a, Pursell, 2004). The phenomena such as xenophobia, discrimination and stigma contribute to bring isolation and anxiety, and to heighten suffering. (WHO, 2003:9) makes a salient point that "we need friends, we need more sociable societies, we need to feel useful, and we need to exercise a significant degree of control over meaningful work. Isolation and exclusion from social life lead to premature death." This section examines different challenges faced by migrants in the host country that may affect their health. It also highlights some problems affecting migrants' access to healthcare and social services in South Africa.

2.5.1 Migrants' conditions in South Africa

As highlighted in the introductory chapter, migrants living in South Africa are faced with many challenges. The country struggles to respond to its inhabitants' needs expressed in terms of employment and service delivery and the estimated unemployment rate is 24%[2]. The country also faces the challenge of corruption (Polzer, 2010) that overwhelms the system. Thus, the South African government finds it difficult to positively respond to the needs of its citizens before thinking of migrants' needs. Despite the constitutional guarantees ensuring access to basic

[2] http://www.indexmundi.com/south_africa/unemployment_rate.html

and socio-economic rights to all, cross-border migrants are often denied access to basic rights such as healthcare (Moyo, 2010, MSF, 2010, CoRMSA, 2009, HRW, 2009, IOM, 2009, Vearey, 2008, Pursell, 2004). Health workers consider the provision of healthcare to migrants optional and not as the rights they are entitled to (Moyo, 2010, Polzer, 2010).

The social and economic conditions of migrants in South Africa are generally poor and may impact on their health (Amisi, 2005). The literature reviewed so far in this study mentions some of the problems encountered by migrants and refugees in the host country (McCarthy et al., 2009, Apalata et al., 2007, Vearey, 2008) and these mostly include health. Despite the South African government's policy, for example, on refugees' access to social services (Health, 2007), the situation on the ground is different and alarming (CoRMSA, 2009, Landau, 2006a, Vearey, 2008).

2.5.2 Employment

Some commonly held opinions support that cross-border migrants leave their country of origin in search of livelihood opportunities in the host society (Kenworthy, 2010). In one study, Vearey (2008) points out that few of the skilled migrants holding residence documents are employed in the formal sector, in South Africa, while the majority of them are involved in informal activities. While under employment is a factor of poverty, it also affects human well-being and health (Bhugra and Becker, 2005). Migrants may be skilled in various domains, but struggle to find opportunities to apply their knowledge in the host country. Susceptibility to illness and complication in the recovery process need an assessment to highlight the links between individuals' health and issues such as low income, high level of stress, job insecurity, food insecurity, poor housing and social isolation (CNA, 2005:5, King, 2002:437, Bhugra and Becker, 2005).

2.5.3 Access to documentation

In South Africa, access to employment, social welfare and health care services in public hospitals is sometimes denied to migrants who do not possess documentation (Vearey, 2008, McCarthy et al., 2009, Landau, 2006a, CoRMSA, 2009). A case in point is access to antiretroviral treatment

(ART). CoRMSA (2009) also makes the point that documentation status is related to barriers to accessing healthcare. The provision of ART, in public hospitals, is restricted to holders of South African identity documents (Vearey, 2008, McCarthy et al., 2009). While the South African Constitution holds in high esteem the right to healthcare to all (RSA, 1996), South Africans and foreign nationals – in practice, lack of a South African identity document jeopardizes migrants' access to healthcare and ART. Both documented and undocumented migrants often find it difficult to access ART (CoRMSA, 2009).

2.5.4 Language

The adaptation or integration of migrants into the host society is possible when they speak the language of that milieu. Speaking one language of the host society reduces anxiety and brings a greater sense of psychological well-being to this group of migrants (Thanh and Roosevelt, 1986). In South Africa, language barriers contribute to the failure of treatment among migrants for whom English is not the first language (Apalata et al., 2007). Apalata and colleagues suggest the use of translators in public hospitals to avoid inappropriate treatment being provided (Apalata et al., 2007). But sometimes the use of interpreters is contested as it does not offer privacy for sensitive health issues (Hadziabdic et al., 2009). Language barriers give rise to negative interaction between migrants and health professionals and contribute to poor quality of health (Moyo, 2010, CoRMSA, 2009).

The situation is tougher for migrants (refugees, asylum seekers and undocumented) who find themselves in a new environment and face the challenges of adapting and being accepted by the local community. It may be argued that dire conditions, upon arrival in the host country, such as unemployment, lack of accommodation, difficult access to schooling, and discrimination can take a toll on their health (Anthony et al., 2009).

I agree with Anthony et al. (2009) that migration *per se* is not a risk to health. Rather, conditions surrounding the migration process can increase the vulnerability to ill health (Davies et al., 2006:7). When people cross borders to a new place, they may be faced with the challenges of leaving their home country and those of adaptation in the host society. This may contribute to enrichment or impoverishment of their health conditions. Migrants seek to create what (Dyck

and Dossa, 2007:699) call their home 'healthy space'. Home may no longer be the country of origin depending on the opportunities it might or might not offer. Regarding healthy space, the focus is not only put on the physical but also on the ability to be accepted and integrated in the new society as an 'appropriate cultural body' (Dyck and Dossa, 2007:700). This seems to be the most prominent challenge facing migrants and affecting their well-being. The following section presents the help seeking behaviour and highlights different factors that may impact on the choice of treatment seeking.

2.6 Help Seeking Behaviour

2.6.1 Definition

According to (Jain et al., 2006:140) help-seeking behaviour "refers to those activities undertaken by individuals in order to keep healthy in the absence of symptoms." The holistic understanding of care utilization of a community involves paying much attention to the meanings and life experiences ascribed by people to an illness and complex relationships these meanings have on people's behaviour (Bailey, 1987). "The meanings and values that people associate with particular treatments and contexts is therefore of central importance in understanding the help-seeking behaviour and outcome among communities" (Thomas, 2010:6).

2.6.2 Factors Influencing the Choice of Treatment care

There are many factors that influence individuals' choice of treatment seeking. The most important factor that is of high relevance to the present study is culture. Quoting Luckman (1999), (Gupta, 2010:13) defines culture 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". In the same vein, Olafsdottir and Pescosolido (2009) introduce the concept of cultural map. Cultural map is defined as various choices individuals have at their disposal regarding health care providers. The choices made depend on the individuals' beliefs regarding illness and the way society perceives and responds to it. These

authors emphasize culture as values, attitudes and beliefs where the believed causes and consequences of illness lead to an appropriate or a particular choice of treatment (Olafsdottir and Pescosolido, 2009). When individuals believe that an illness, for instance, is the result of a spell, they resort to a kind of treatment able to respond to this particular case. A case in point is brought by Englund (1998) who explored the cultural issues amongst Mozambican refugees in Malawi who preferred spiritual solutions to their trauma. The author concludes that "for refugees with traumatic experiences, spirit exorcism is a therapeutic practice within a meaningful existential and aesthetic framework" (Englund, 1998:1172). (Lie, 2002:422) also identifies the need to highlight trauma in a cultural perspective given that "the cultural values may affect psychological responses and adaptations to trauma'

On the other hand, Biddle and colleagues (2007) bring new insights by presenting a framework based on the Cycle of Avoidance referring to the reasons for not seeking help. The social meaning attached to illness and stigma is the main cause of avoiding help-seeking. Illness should be understood as a situation that can happen to anybody. An individual suffering from any illnesses should not be discriminated or stigmatized even though the illness results from his misconduct or behaviour (Biddle et al., 2007:1000).

The *Centre for Suicide Prevention (CSP)* identified some barriers to not seeking help such as age, gender, socialization, embarrassment, stigma and fear (C.S.P, 1999).

2.6.2.1 Age

Age can be an important factor in people's willingness to seek help. Adolescents are often particularly resistant to seeking counseling. However, resistance to help-seeking among elderly may not relate as much to their age as to fear of losing their independence, of being publicly exposed and not seeing a need for intervention (Biddle et al., 2007).

2.6.2.2 Gender and socialization

Bossart (2003:353) stresses that "during illness episodes, women receive less nursing care than men in the household sample, most likely because they themselves are responsible for nursing

duties". A study on Guatemalan immigrant women in the United States found that women maintain acquaintances with their families and communities and use networks and medical treatment from their home country through "ties that heal" (Menjivar, 2002). Similarly, a study done among women living in a rural, medically underserved county in south-western Ontario, Canada, found that women who perceived the lack of support and care in their relationships with providers, actively sought such assistance relying on the personal connections with others who spent time to discuss their concerns (Wathen and Harris, 2007:647).

An important element of analysis in the case of the Congolese is the role of 'others' in the treatment seeking as mentioned in the studies by Menjivar (2002) and Wathen and Harris (2007).

2.6.2.3 Embarrassment, shame, fear, stigma and blame

A study attempting to explain non-help seeking among young adults with mental distress found that low rates of help-seeking for mental disorders were based on sociological concepts (normalization and stigma) (Biddle et al., 2007:998). Similarly, Bossart found that patients with mental or emotional health problems were only helped by their close family members, but the afflicted family hid the information from others. Furthermore, people living with HIV/AIDS avoided other people, including their close family members and hid their HIV-positive status in fear of social discrimination (Bossart, 2003:355). This shows the need to offset clinical and lay perceptions when attempting to determine an appropriate illness (Biddle et al., 2007).

In addition to these barriers, there is the issue of language which represents an important aspect in seeking help as it is the vehicle of an individuals' culture (Apalata et al., 2007). Thanh and Roosevelt (1986) stress that speaking one language of the host society, reduces anxiety and brings a greater sense of psychological well-being to a group of migrants. It was observed by (Apalata et al., 2007)) in their study done in Durban, that language barriers contribute to the failure of treatment among migrants for whom English is not the first language.

The present study seeks to examine all these factors with a group of Congolese migrants living in Johannesburg in order to understand their perception of illness and alternative methods of seeking help, as well as the factors that influence the choice of treatment. In the same context,

the relationship between health worker and patient is crucial in the choice of a method of care seeking. The following section briefly examines this relationship.

2.7 Healthcare Provider – Patient Relationships

Communication between health workers and patients is a key component of treatment success (YS Wong and Lee, 2006). The assumption is that in this relationship, there is not a master and a disciple, or an actor and spectator; or between somebody who knows and the other who does not know. Much research has focused on the importance of good communication in the interaction between sick people and health professionals (Kuper, 2007, Wathen and Harris, 2007, YS Wong and Lee, 2006).

Health workers should demonstrate their ability to elicit and respect the patients' concerns, provide patients with appropriate information, demonstrate empathy, and develop patients' trust. These are shown to be the key determinants of good compliance with medical treatment in patients (YS Wong and Lee, 2006). In practice, it has been shown that health workers express lack of care and respect for patients' opinions. There is also the lack of time by doctors and the dismissal of patients' concerns (Wathen and Harris, 2007). In some cases, patients are called names because they ask many questions and are considered troublesome (Andersen, 2004). In Canada, women declare they are not allowed to contradict doctors for fear of being given a bad name (Wathen and Harris, 2007:644).

Other scholars argue that health workers' attitudes towards patients may find their roots in the stressful conditions in which they work (Moyo, 2010). Andersen supports this claim and adds that health workers work under "very difficult circumstances and they struggle for a decent standard of living" (Andersen, 2004:2011). Thus, doctors' non- supportive attitudes towards patients can be attributed to lack of basic infrastructure in public hospitals, understaffing, the large number of patients waiting to consult and poor salaries. All these may frustrate and stress health staff. In many public hospitals, especially in African countries, doctors and other healthcare providers work under difficult conditions. Hospitals are understaffed and lack minimum working conditions and suffer from shortage of skilled medical labour (Moyo, 2010, Andersen, 2004). This leads to the argument that "physician satisfaction with their professional

life can also be an important determinant of a good doctor patient relationship" (YS Wong and Lee, 2006). To some extent, it is acknowledged that conditions can affect doctors' attitudes and their relationships with patients but not in all the cases. If it happens, unfortunately, in this case, patients suffer.

As a result of being discriminated against, some migrants hold some institutions in contempt and would do everything in their power to avoid hospitals and turn to traditional healing methods or turn to faith healing. In the same vein, the migrants in Australia from the Horn of Africa (Manderson and Allotey, 2003) are recorded as having a mistrust for the medical attention that they were given at hospitals. Due to language barriers and despite having bicultural liaison staff to help minority groups, the migrants, especially women, were frustrated by the Australian health care system which was seen as against "black babies" (Manderson and Allotey, 2003:1). Kuper (2007) highlights that "meaning to illness should be dialogical and contained in a language and the act of naming between two people allows them to create between them."

The aim of this interaction is to give the patients choices over types of treatment suitable for him after being informed about their health situation. There should be a no conflict between health professionals and sick people. Health professionals need to help patients and be sensitive to their cultural patterns regarding the perception of illness and care-seeking. The opposite may affect the healthcare outcome and lead patients to avoid the mainstream healthcare system and seek other ways of healing (Biddle et al., 2007, Wathen and Harris, 2007, Manderson and Allotey, 2003). The health system and conditions in which people are may also justify the type of treatment seeking they may resort to. In the section below, I examine the social determinants of health as factors that may impact on migrants' health status in the host community.

2.8 Social Determinants of Health (SDH)

2.8.1 Definition

The Commission on Social Determinants of Health (CSDH) (2008) observes that "social determinants are recognized as the conditions in which people are born, grow up, live, work and

age" (CSDH, 2008). The social determinants of health explore not only access to healthcare, but contribute to health outcomes which can be good or poor health. These factors depend on the society where individuals live and on their own characteristics and behaviours. In a migration context, the previous experiences lived in the home country could have shaped the understanding of the current situation in the country of destination. The selected respondents of this study live under difficult conditions in terms of unemployment, accommodation and language barrier in South Africa and this may contribute to their health deteriorating as described in the Figure 1 below.

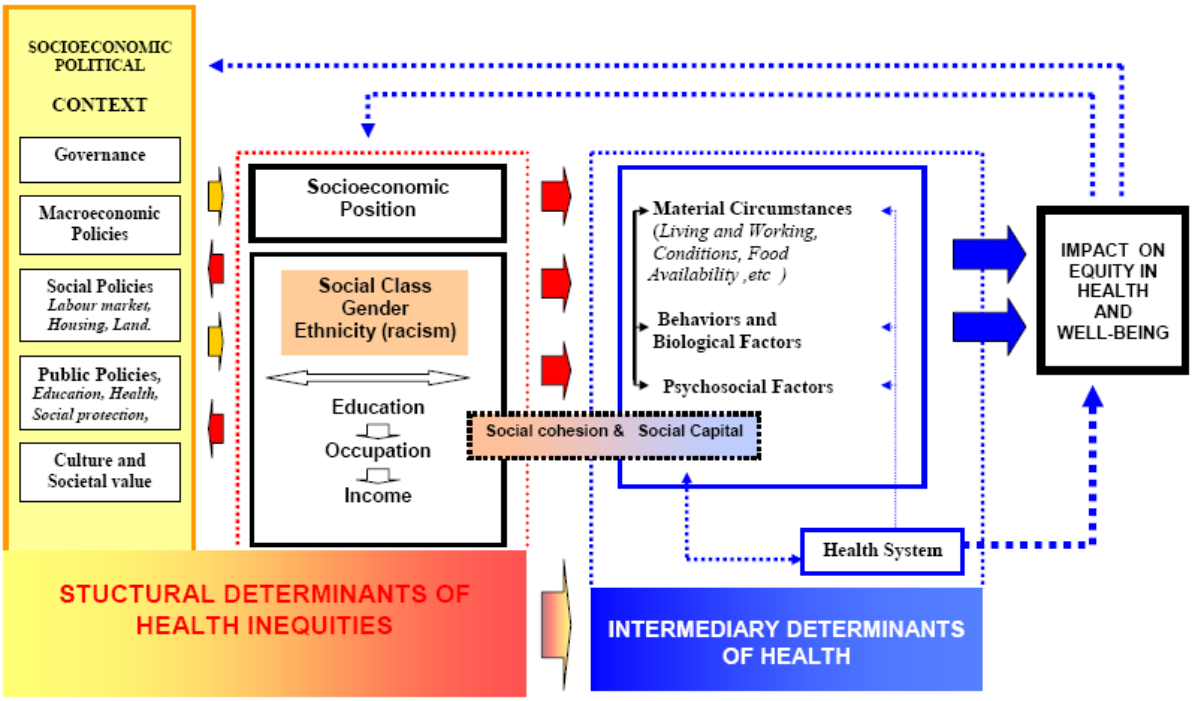


Figure 1**: Summary of social determinants of health framework.** Source**: Commission of Social Determinants of Health (WHO, 2008)**

2.8.2 Social and Economic Factors

Much research argues that only those migrants in good health migrate (Fennelly, 2005, Singh and de Looper, 2002). Studies conducted in the United States, Canada, Australia and Europe, have found that migrants are in better health than local citizens (Fennelly, 2005, Wingate and Alexander, 2006). For example, Fennelly presents the 1996 estimated cost of hospital based care

of foreign-born migrants in New York at 611 million dollars less than care for the equivalent number of U.S.-born (Fennelly, 2005). This concurs with the report produced by CoRMSA in 2009 which maintained that less than half of migrants expressed the need for healthcare in South Africa.

While some scholars mentioned above claim that migrants are potentially healthy when migrating, it is important to understand how social forces and other determinants –, behavioural, psychological, political, economic as well as biological determinants - affect changes in health (Thisted, 2003). A similar study was conducted in the Netherlands on chronically ill people, aimed at assessing the relationship between financial resources and life satisfaction of patients and the mediating role of social deprivation and loneliness in this relationship. The conclusion was that that available income correlates with life satisfaction (Rijken and Groenewegen, 2006). The study distinguished between material deprivation and social deprivation. Material deprivation refers to a situation in which people lack money to meet very basic needs, such as food and shelter. Social deprivation is a situation in which people are constrained in their social functioning because of a lack of financial means (Rijken and Groenewegen, 2008:41). In view of this, it should be noted that both material deprivation and social deprivation can result from lack of financial resources. Financial resources cannot be obtained without employment. According to the *World Health Organization (WHO),* unemployment puts people at a particular [health] risks (WHO, 2003:16). While unemployment is seen as a source of stress and ill health, WHO highlights that the social organization of work, management styles and social relationships in the workplace all matter for health (WHO, 2003:18).

There is a relationship between social determinants of health and migration in the sense that migrants who are qualified or skilled experience challenges of integration in the host country with regard to employment, housing, documentation, food, stigmatization and language barrier. All these constraints of integration force them to be involved in different livelihood strategies in informal activities and become survivalists (Steinberg, 2005, Vearey, 2008). Being uprooted and finding themselves in uncomfortable situations in the host country, some migrants may adopt alternative behaviours believed to bring relief. However, those behaviours can be harmful to the point of worsening their health. Generally, people tend to abuse alcohol and drugs to numb the pain of harsh economic and social conditions which results in high rates of suicide due to

isolation, poverty, unwillingness to seek assistance because of stigmatization, and barriers to accessing services (WHO, 2003:441, Yurkovich and Lattergrass, 2008).

The key components of the CSDH model include (1) the socio-political context; (2) structural determinants and socioeconomic position, and (3) intermediary determinants (Solar and Irwin, 2007). Though the framework does not include migration, it should be noted that migration is, in itself, a determinant of health and needs to be taken into consideration (Davies et al., 2006). Furthermore, cultural elements need to be linked to help seeking behaviour to explore alternative ways of healing seeking used by individuals when faced with illness. Health system is a determinant of health in terms of policy and infrastructure. The policy includes the way of planning and responding to people's healthcare needs. Infrastructure involves accessibility, availability and affordability (Moyo, 2010). The quality of healthcare delivery can significantly impact on people's health. This study is nested within this context and explores the issues of migration and the cultural dimension in understanding illness and seeking healing.

Theoretical Framework

The review of the literature reveals that society is constructed by and through symbols and cultural interpretations. There are webs of meaning and signification built and used by human actors, and that there are multiple realities. Each reality depends on a specific context (Schwandt, 1994, as cited in Ponterotto, 2005). The meaning is created through narrative and narrative revises different events or episodes from where the meaning gets form through historical context and lived experiences, to look for meaning and symbols that people attach to events (Eastmond, 2007). This is apt as the study's central purpose is to explore how the previous experiences in the home country and harsh conditions in the host society shape the understanding of the individual's current health problems. In this effort, the researcher's intervention is to construct the narratives so that scientific knowledge can be produced (Eastmond, 2007).

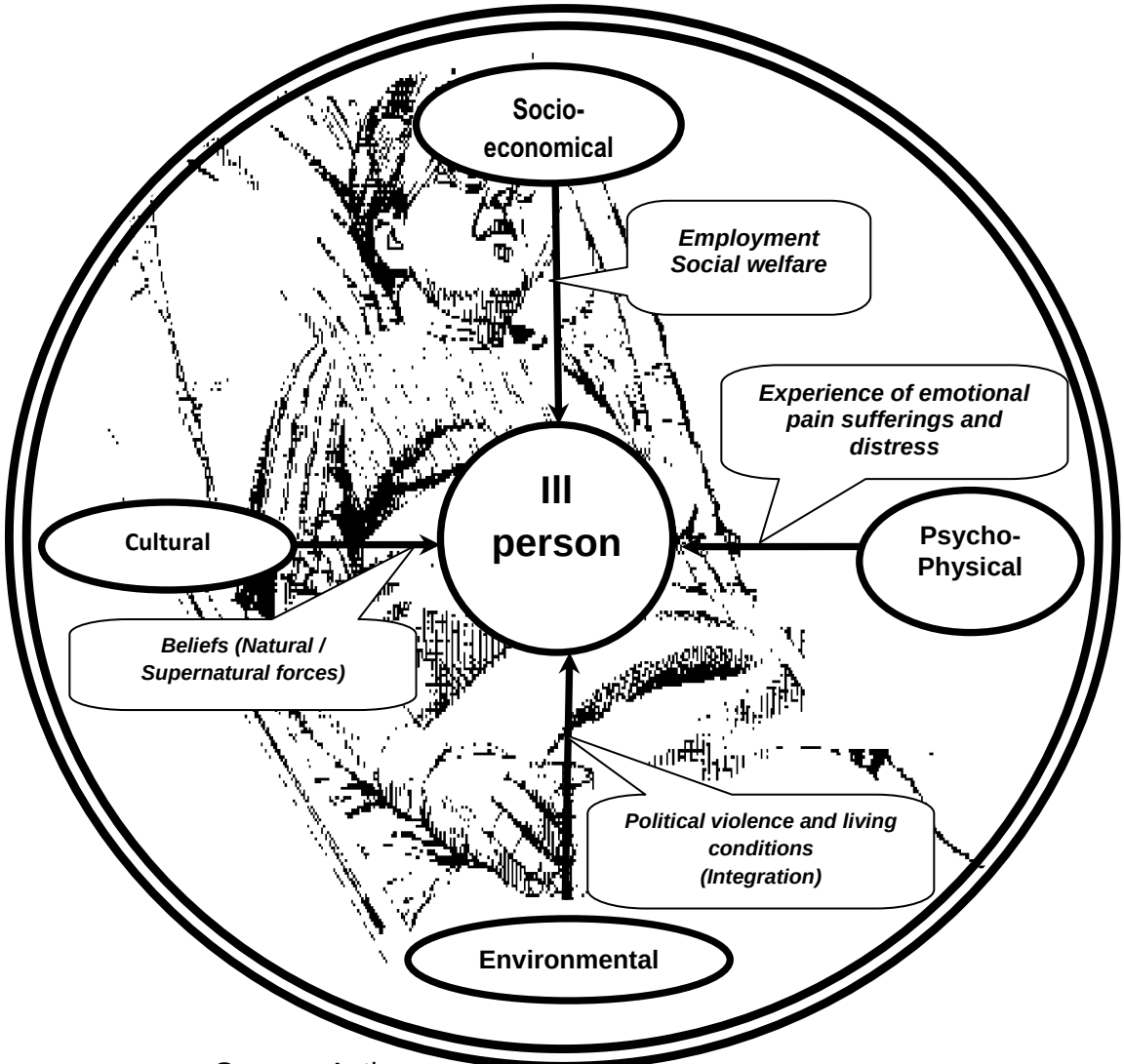
The investigator and investigated co-construct meaning (Ponterotto, 2005:129) because the researcher is not wholly removed from the process of constructing and conveying knowledge.

The lived experiences and meaning ascribed to them find their place in the Psycho-socio-environmental Model (Gilbert et al., 2002). This model emphasizes the role of people's

behaviour, what work they do and how and where they live in determining their health status (Gilbert et al., 2002). In addition, culture plays a major role in perceiving the world and dealing with illness. Cultural mapping (Olafsdottir and Pescosolido, 2009) and cycle of avoidance (COA) (Biddle et al., 2007) highlight different choices and perceptions/attitudes individuals hold in coping with ailments.

With this conceptual framework, the study, therefore, fits into the sociology of health and includes cultural and medical anthropology. An emphasis is put on the socio-economic, psycho-physical, environmental and cultural factors that influence people's perceptions and experiences of health and illness which lead them to alternative treatment care-seeking. This cannot be presumed to be simply reactions to physical bodily changes (Gilbert et al., 2002:21, Bendelow, 2006). In the following figure, I underline factors which interact each other and shape the meaning constructive narrative of people's experiences of illness and suffering.

Figure 2: Narrative of Co-constructive meaning of illness



Conclusion

This chapter examined the different studies based on health and various factors related to the subject. The emphasis was put on the narrative and different perceptions of illness through events lived in the home country, linked with current difficult living conditions in the host country. The narrative brings the meaning people attach to different events which may have an impact on their health situation. This understanding is through people's narratives which led to the perception of illness, explanatory models and idioms of distress where people identify the causal attributions of illness and different ways of dealing with it. Migration and conditions surrounding it are determining health, especially the socio-economic conditions which may impact on migrants' health. Migrants therefore look for a healthy space which not only relates to physical body, but also to their acceptance and participation as individuals with a specific culture in the local society. Help-seeking behaviour was used to emphasize alternative methods of care used by people. The use of alternative methods of care-seeking is led by the beliefs and perceptions about what constitutes illnesses and their causes. In this sense, culture is an important factor that needs to be linked to help- seeking behaviour. Finally in this chapter, I also discussed migration as a social determinant of health. This is missing in the framework of the Commission of Social Determinants of Health (SDH) but is the key component of the framework of this study as it deals with migrants.

CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

This chapter discusses the methodology used to collect data on the understanding of illness and treatment care-seeking behaviour of Congolese migrants living in Johannesburg. The research was based on a small number of participants to allow in-depth interviews and facilitate easy the follow up with each participant. This chapter is structured in eight sections. The first section focuses on the research design; the second discusses the choice of participants; the third describes the interviewing process; the fourth explores the issue of language, the fifth presents the way of analyzing data; the sixth outlines the limitations of the study; the seventh looks at reflexivity, the eighth broaches the ethical issues, and the last section is the conclusion.

3.1 Research design

This study was connected to the Forced Migration Studies Programme and framed within the South Africa-Netherlands Research Programme on Alternatives in Development (SANPAD), a research project set out to explore alternative strategies used by migrants to deal with trauma and the effects of political violence among migrants and refugees in South Africa. Trauma was the backbone of the present study that explored whether current health problems experienced by Congolese migrants in South Africa were related, in view of the respondents, to the previous violent or traumatic experiences they were exposed to in the Democratic Republic of Congo (DRC) or to the hardship of the host country, South Africa. However, psychological trauma as a concept was not explicitly used in the interviews that sought migrants' understanding of their health conditions. People themselves proffered their own understanding of their illnesses through their narratives.

The major aim of the study was to generate understanding of Congolese cultural knowledge and practice through ways of perceiving and using different resources of treatment-seeking. This study was qualitative because in relation to this study, "qualitative research is the appropriate tool to uncover the unrevealed beliefs about a disease and its preferred treatment modalities" (George et al., 2006:1318). In other words, qualitative research methods are particularly useful in

identifying divergent beliefs, attitudes, and behaviors that otherwise would remain undisclosed (Patton, 2002). The research focused on illness narrative and looked into the explanatory model of illness and methods of treatment and care. Two methods of data collection were employed in the present study: participant observation and in-depth interviews.

The methodology of my study is based on case study. Each participant is treated as a case for individual analysis (Neale et al., 2006). Case study refers to the collection and presentation of detailed information about a particular participant or small group. This frequently includes the accounts of subjects themselves. The aim of social research is always to discover "what has happened, how it has happened and as far as possible, why it has happened" (Breakwell et al., 2000:5). In this regard, qualitative research methods are very effective in identifying intangible factors, such as social norms, socioeconomic status, gender roles, ethnicity, and religion, whose role in the study issue may not be readily apparent (Breakwell et al., 2000, Smith, 1998). Quoting Henwood (1996), Lyons observes thatt the power of qualitative research is also the capacity to provide complex textual descriptions of how people experience a given research issue and provide information about the human side of social dynamics, that is, the often contradictory behaviours, beliefs, opinions, emotions, and relationships of respondents (Lyons, 2000:268).

As a form of qualitative research, the study looks intensely at an individuals or small participant pool, describing different situations that happened to them at a specific time, and the consequences of these situations in their lives. Conclusions are drawn only about these participants or group and only in their specific contexts (Neale et al., 2006:3).

3.1.1 Observation

Patricia and Peter Alder (2003) stress that "observation is the best empirical research method available because it allows us to study, first-hand, what people do, think, and believe, in their group" (Alder and Alder, 2003:42). Following this argument, (Patton, 1990:10) points out that "data from observation consists of detailed descriptions of people's activities, behaviours, actions, and the full range of interpersonal interactions and organizational processes that are part of observable human experience." Through observation, as a member of the Congolese community in Johannesburg, I interacted with different categories of people who were

caregivers, mothers, fathers, and vendors who had some knowledge and experiences in their various capacities to the information related to health and illness. From these interactions, information gathered was documented and analyzed. Relevant comments from care givers, breastfeeding women, men and others on what they thought, believed, and did with regard to health and illness relating to themselves and their family members were noted and used in this study. For example, ladies spoke about their experiences regarding maternal health, childcare or their partners' health or guidance on how to deal with such health issues. Men shared their knowledge and experiences of health. The researcher recorded and made use of this relevant information in connection with the present study. Furthermore, my role as English facilitator at an adult language centre connected me to participants and from the relationship created, they shared their multiple problems with me and this led to the selection of participants. However, the use of observation in this study is limited as I did not collect much information through this approach. I just observed how people were discussing some health issues and treating some illnesses using home remedies.

3.1.2 In-depth interviews

Being qualitative in nature, this study sought to bring new insights on Congolese cultural knowledge and practices around illness and treatment care-seeking. In order to obtain in-depth narratives and explanatory models of illness, five people were selected and interviewed at least three times. An open-ended questionnaire guide was used during the interviews. Using semi-structured interviews, the questions asked followed the order of the respondent's narrative. The open-ended questions helped in establishing the reasons for leaving DRC, Congolese migrants' experiences of violence and in highlighting their life conditions in South Africa. Comments were made on illness and different beliefs surrounding care- seeking. The shortest interview took 60 minutes and the longest took two hours. The interviews were held at public spaces such as Hillbrow and Yeoville Recreation Centres and at participants' residences. Participants were selected from the researcher's network at International Community Centre (ICC), an adult English learning centre. There already existed a rapport between the researcher as teacher of English and the participants who were students. From their exchanges, the researcher discovered those who were presenting some health problems. Participants already knew that the researcher

was a student and also knew what topic he was researching on. The table 1 below presents study participants and their socio-demographic characteristics. To guarantee anonymity, real names of participants were not used in the study. Thus, names used in the table 1 below are pseudonyms as indicated in the ethical considerations and promised to all participants.

3.2. Choice of participants

The study is based on a small number of participants interviewed at least three times to highlight the cultural knowledge and practice around illnesses of Congolese migrants living in Johannesburg. Five people, originally from the DRC participated in the study. Participants were selected according to criteria such as nationality (they should originate from DRC), age (older than 18 years), duration of stay in the Republic of South Africa (more than a year), and their motivation to migrate (reason for leaving DRC, mostly political violence) and their willingness to participate in the study. However, as the most important criterion of selection, the study was based on participants experiencing, at present, some physical health problems. The interaction between the researcher and participants was easy because of an already existing rapport (English teacher and students). I used my English students I knew were experiencing health problems and invited them to participate in this study. Initially, the study expected to find some respondents from a Congolese NGO, "*Women Network Against Terrorism War and Ethnic Cleansings"* (WONATWEC), dealing with women victims of war in the DRC, but this route was not successful because WONATWEC was not forthcoming with information.

Seventeen interviews were conducted with five participants, thus at least three interviews per respondent. The reason I went back to my informants three times was to verify the missing details of the information provided by them. This helped me to maintain a regular and good contact with them. In addition, I did a follow up with each participant to clarify some unclear points. Before going to conduct interviews, I set up interview appointments with my respondents. I tested my questionnaire with a participant in March 2010, before the real process. Then I discussed that interview with my supervisor to identify questions that were or not relevant. From there I finally drew up a questionnaire guideline that I used during the whole fieldwork process.

Table 1: Socio-demographic characteristics of respondents

Names	Origin	Location SA	Age	Gender	Marital Status	Education	Health Problem as reported by participants	Occupation	Means of living	In SA	Reason for leaving DRC	Num of interv	Reported Legal Status
Anne	Goma	Kensington	35	Female	Married	Lawyer	Hypertension & Trauma	Employed as a secretary in a company	Receiving monthly salary	3	Persecution	3	Asylum Seeker
Christian	Kinshasa	Yeoville	64	Male	Married	Former Soldier (Colonel)	Gout Rheumatism Hypertension Diabetes	Retired Military (Unemployed)	UNHCR monthly stipend of R1000	8	Persecution	3	Refugee
John	Uvira	Orange Groove	49	Male	Married	Historian	Cramps	Unemployed	In charge of his younger brother	2	Persecution	4	Asylum Seeker
Liliane	Kinshasa	Orange Grove	56	Female	Divorced	Geographer	Slipped Disc	Unemployed	Charity	2	Persecution	4	Asylum Seeker
Pauline	Goma	Yeoville	40	Female	Married	No education at all	Gastritis headache	Unemployed	Relies on her younger brother's support	2	War	3	Asylum Seeker
Total Interviews conducted												**17**	

Source: Fieldwork data

The above table shows that almost all participants reported to be asylum seekers in South Africa. They came from different areas in DRC such as Kinshasa, Goma and Uvira and lived in different suburbs of Johannesburg (Orange Grove, Kensington and Yeoville). They were all older than 18 years (56, 35, 64, 40 and 49). The oldest participant is 64 and the youngest, 35. The average age is 49 years old and most of them were married. Only one was divorced, and they had different university backgrounds (geographer, lawyer, historian), one was a former soldier (colonel) and one did not attend school. Their living conditions in South Africa were challenging in the sense that despite their University qualifications, most of them were unemployed and did not have a steady income to take care of their basic needs. Only one was employed in a sector different from her qualification (Lawyer). They mainly relied on the support of their family members who were professionally active and on some charity from churches and NGOs that dealt with refugee issues. These challenging living conditions in South Africa may have potential impacts on their health situation in the host country.

The above table also indicates that most participants in this study have lived in South Africa for more than one year (two, three, four and eight years), which could have enabled them to create social networks.

3.3 Ethical considerations

I complied with the university's requirements. The application to the Human Research Ethics Committee (HREC Non-Medical) was submitted and the Ethical approval of the research questionnaire was obtained from the University of the Witwatersrand Non-Medical Ethics Research Committee (protocols **H100913**). A copy of the certificate of approval is attached as appendix in this study (see annexure). This allowed the study to be carried on the fieldwork and to achieve its aims.

Stressing the vulnerable character of participants in this study, I was particularly concerned about the ethical issues by being sensitive to participants' experiences and avoiding to judge them in the way they presented their stories (Eastmond, 2007). The study was essentially based on illness narratives with each participant involved.

Before starting the interview, an information sheet, (see appendix II), explaining the purpose of the research was presented to all participants, verbal consent to participate and verbal consent for recording the interview were sought from each participant (Babbie, 2004). This verbal consent was recorded at the start of interviews. To prevent the "risk of injuring" participants in any forms such as physically, morally and emotionally, vigilant attention was paid to the planning of interviews and questionnaire design (Babbie, 2004:64).

During the fieldwork, potential problems were raised (social, physical or affective) and some participants asked questions related to their health conditions and sought advice. Respondents presenting potential health problems or symptoms of psychological distress were referred to relevant service providers for therapeutic interventions. For this purpose, the researcher had a list of referrals to free health and psycho-social support services that could be offered to all participants needing them.

3.4 Interviewing process

The first preliminary interviews were done in March 2010. The rest took place between July and October 2010. Among the participants, there were two men and three women. Women seemed to be more willing to get involved in the study than men and presented many health problems just as their male counterparts. Interview appointments were set up either face-to-face or over the phone. All the interviews were conducted face-to-face or one-on-one. On the arranged date, I always started by explaining the rationale of the study to participants. Then verbal consent for participating in the study and allowing the use of the recorder was sought. The duration of the interview was between one and two hours. I used a questionnaire guide to conduct semi-structured interviews (see Appendix I), but did not follow all of the questions in their order. Questions were open-ended and time was given to participants to gather their thoughts. The open-ended responses helped me to understand the respondents' experience and meaning of suffering through their own narratives or viewpoints. Some questions were sensitive and made some participants shed tears, which was a normal reaction to a painful or sensitive experience. In such cases, the interview was stopped for a while. Often, I changed the topic and talked about general things before coming back to the topic.Verbal permission was sought again whether to

continue or stop the interview. In many cases, participants allowed me to carry on with the interview.

Once completed, each interview was transcribed and sent to the supervisors for comments. An appointment was set with the supervision team for a discussion based on the interview material. Such discussions were constructive as they led to generating major themes which formed the core of the findings presented in the next chapter. In addition, the discussions also helped me to identify the unclear answers of the respondents. For this reason, I went back to participants for a second and third time interview for clarification.

3.5 Languages used

Given that all the interviewees were from the DRC which is a French speaking country, I mainly used French and one of the Congolese local languages (Lingala) spoken countrywide to conduct the interviews. As the socio-demographic data show, most of the participants in this study had completed tertiary education and therefore had a good command of French. However, Congolese tend to mix French and Lingala. Some of them could understand a bit of English but cannot really engage in a proper conversation conducted entirely in English. To gather rich data, it was important to use the languages that participants knew better. The respondents preferred to be interviewed either in French or in Lingala and thereafter the interviews were translated into English. However, for the sake of originality of information collected, some quotations are left in the languages used by participants to avoid any bias and distortion of the information provided.

Congolese migrants adopted French and Lingala as the languages of the interviews, though as the interviews progressed, some could also borrow some words from their mother tongues to explain their illnesses. Those words were then explained and translated into English. Few of them made use of some English words.

3.6 Data analysis

The study focused on the analysis of different cases. Each case was understood and analyzed in its particularity and from there the study compared them to identify similarities and differences, and key themes according to their explanatory models.

Responses were grouped and divided into themes. Welman et al. (2001) stress that coding is a technique used to guarantee easier recovery and organization of chunks of text to categorize it according to certain themes. Codes are based on the research question and seek to highlight the concept of explanatory model considered as a description and understanding or explanation of the onset and experience of illness (Stern and Kirmayer, 2004, Groleau et al., 2006). This helped in identifying a cause-effect relationship of the participants' illnesses; the way they perceived them, how informants felt about their bodies, when they started feeling like that, and whether there was a link between social life events and the current health problems they faced. The explanatory model helped the study in understanding the symptoms, aetiology, risk factors and treatment care of Congolese migrants from their own narratives. Stressing the perception of illness from Congolese migrants' narratives, the study used direct quotations from the interviews to highlight respondents' emotions, thoughts and beliefs in explaining and labeling illness and alternative treatment-seeking behavior. Thus, some direct quotations were cited verbatim in respondents' language in order to highlight the originality of their understanding of illnesses and experience of suffering. The notion of help-seeking behaviour was used as it helped the study to explore alternative methods of treatment seeking used by Congolese migrants and the motivation or beliefs guiding the choice of treatment.

3.7 Limitations of the study

During the fieldwork, the study was faced with some challenges that need to be mentioned here. As social sciences deal with human beings who express feelings and emotions, it was not easy to raise sensitive health matters (Babbie, 2004). Some people were reluctant to disclose themselves. Others, especially women, did not contain their feelings and emotions after recalling painful events in cases such as rape, divorce and persecution. This often stopped the interviews and

obliged the researcher to again seek verbal consent in order to continue. However, this was not really a major problem. Some participants were relatively reluctant or too emotionally affected to narrate the different episodes of the dramatic events of their lives. Furthermore, struggling on a daily basis and facing socio-economic challenges in their dire living conditions in South Africa, some participants saw the study as focusing sharply on their various overwhelming economic problems. Nevertheless, all participants were interested in contributing to the study and no one raised the issue of being paid as a condition for taking part in the study.

3.8 Reflexivity: The voice of the researcher

Being part of the community, and sharing the same life conditions with participants, the researcher can, to some extent, be tempted to adopt an attitude that affects the collection of data. It is not easy to be self-critical as pointed out by Gray (2009) that many researchers usually overlook auto evaluation. In interaction with his fellow creatures, the researcher's position, language and attitude may also influence the way of collecting data. Both these problems call for reflexivity on the part of the researcher. According to (Gray, 2009:498), "reflexivity involves the realization that the researcher is not a neutral observer, and is implicated in the construction of knowledge." (Lenzo, 1995:18) adds that "this is not to say that there is an escape, a suspension of the uneven power relations inherent to any research enterprise; merely that such relations may be interrogated through a more modest self-reflexivity and have the potential to be interpreted and explored in fruitful ways that open spaces for new research practices." The commitment to self-reflexivity compels the researcher to examine his conduct in terms of "what is and is not done at a practical level, as confused as that may be and recognizing that these are serious limits to our abilities to self-critique" (Lather, 1993:674).

I examined myself as a Congolese, a refugee, a man, a teacher of English at International Community Centre (ICC), a student, and researcher. As a Congolese, it is important to mention that working in Congolese community was an advantage as I am member of the same community and speak the same languages the respondents speak and understand. However most of the time, Congolese are skeptical about responding to research questions even when the purpose of the study is clearly explained to them. In the event know the researcher as a member

of their community, some of them may exaggerate in answering or may refrain from a deep engagement in interviews. Being a refugee, I am in the same situation as the participants and face the same challenges in the host country. Sometimes I was affected by the participants' experiences and life conditions, and could not contain my emotions and feelings after listening to some challenging situations of the participants. This could have influenced participants' answers one way or the other. Furthermore, some matters, such as divorce, torture, persecution or witchcraft are culturally sensitive and people are not comfortable to raise them. Moreover, my presence, as a man among women, may have hindered the interaction process and freer response to questions, given the fact that Congolese women are often not keen to discuss some of their sensitive matters with a man. Some of them may be shy, others merely feel ashamed. My presence as an English facilitator could also have driven participants to speak even when they were not willing to do so. Language issues are also important to underline. Given the fact that all the interviews were done either in French or Lingala, participants' narratives might have been distorted or made deficient due to translation bias. All these issues can be considered as a drawback and might have affected the data collected in the present research. However, these drawbacks are minimal and cannot undermine the validity of the findings of the present study whose aim is to bring new insights to the cultural understanding of illness and methods of treatment-seeking among Congolese migrants who faced political violence in their country of origin and are coping with challenging living conditions in the host country. It is important to stress that my level of education did not have much impact on the way participants responded to the interview, although many of them were highly educated with a tertiary education. Knowledge shared with me had a cultural dimension and as a member of the same community sharing almost the same beliefs, they were comfortable to discuss with me these cultural issues. Furthermore, the fact that I taught them English made my interaction with them uncomplicated.

To summarize, this chapter has described in detail different steps used in the data collection process. Various points, such as research design, choice of participants, interview running, data analysis, encountered challenges (limitations of the study) and ethical issues were discussed. The following chapter will present the findings of the research.

CHAPTER FOUR: RESEARCH FINDINGS

Introduction

The present chapter is the core of this research. It presents and analyses the findings that help to answer the research question posed. Based on illness narratives, the aim of this study is to explore and understand through the perceptions of Congolese migrants, how the previous experiences in the Democratic Republic of the Congo shape their understanding of their current health problems. The aim is also to bring new insights to the cultural dimension of Congolese perceptions' of their illness and alternative methods of care-seeking. A number of academics (King, 2002, Rijken and Groenewegen, 2008, Eastmond, 2007, CNA, 2005) agree on the importance of beliefs surrounding individual's illness experience. They think that the patients can be able to tell their stories and get involved in the management of their illness. The data presented under each case comprises the following sections: illnesses experienced, causal attributions, symptoms and feelings, migrate on influence on the experience of illness, help-seeking behaviour and support received from others in coping with illness. The chapter attempts to answer the empirical research questions within the theoretical framework adopted in this research.

4.1 Presentation of case one: Anne

Anne is 35 years old. She has been in South Africa for three years and she has the status of asylum seeker. She has a degree in Law (criminal Law) which she obtained in DRC. From March 2005 she started to work for the Programme of National Demobilization, Disarmament and Reinsertion (CONADER)[3] in DRC. This programme was initiated by the government of the Democratic Republic of Congo with the support of the United Nations after the signing of various peace accords in order to end the war in the country. She and others worked in a conflict environment witnessing several cases of killing and other forms of abuse, and their lives were in constant danger. However, Anne had a good salary and a steady income and lived a good life with her family.

[3] The aim of the programme was to release from military service children soldiers under the age of eighteen, recruited by different armed groups and those who were not in good physical conditions, and to form an integrated national army with all the parts involved in the war.

In May 2007, Anne and her colleagues were arrested by the rebels and they spent four months in jail. From May to September 2007, the government in turn treated them as betrayers, having handed over the secret of the country to the enemies and they became wanted people. When they escaped from the rebels' jail, Anne and her colleagues had a warrant of arrest issued against them, resulting in a very unsafe situation. Anne left DRC with her two children, a six-year-old boy and a four-year-old girl, leaving her husband and other family members behind. Anne arrived in South Africa with her two children in November 2007. She did not have accommodation and was offered a place to stay with her children at the "Bienvenue Shelter", a shelter for newly arrived refugee women and children in Johannesburg. Bienvenue shelter offers newly arrived refugee women three months to stay. In view of Anne's situation however, she was allowed to stay there for more than three months, and left the shelter in April 2008, after 6 months.

When she left the Shelter, life became very difficult. The shelter had been giving them food, clothes and her children had been put in crèche. Without that, it was not easy for Anne to cope with the new reality of life. Unemployed, she had difficulty finding means of living for her children and herself. This affected her health. Furthermore, the fact that she came to South Africa only with her children and without her husband in an unprepared manner exacerbated her situation. Her husband joined them in February 2009 and found them renting a small room in Kensington. Anne fairly speaks, writes and understands English. She has been employed as a secretary in a private company in Johannesburg since February 2009 and earns a modest monthly income that allows the family to survive. Her husband is currently unemployed. Since May 2009, they have been renting a one-bed room cottage in the same area. The following sections present Anne's in-depth narrative focused on illnesses she has been going through and different events that she described as significantly contributed to the deterioration of her health.

4.1.1 Illnesses experienced

Anne went through many problems and experienced several illnesses such as high blood pressure and potential breast cancer. To the question aimed at finding out what health problems Anne experiences, she said:

> *Here, before I had a problem with hypertension (high blood pressure)… not long ago, I have been operated from a masse in my right breast and the doctor said if he didn't remove it, it would develop a breast cancer … and I was also traumatized. (Interview, Anne)*

Anne faced many problems. She worked in a war environment witnessing killing and being exposed the deafening sounds of heavy weapons. She was arrested, persecuted and tortured, and this forced her into exile. She lost her job, as well as other resources and found herself empty-handed. She found herself alone with her two children, in a country where she did not know where to get help, with no job, no accommodation and no social support. She was concerned with the education of her children and did not have financial resources to school them. Furthermore, she left her husband and was not sure whether he would come one day and was carrying the burden of the new environment alone. All these difficult situations made her develop high blood pressure.

In the next section, I present Anne's beliefs regarding the causes of the illnesses she mentioned.

4.1.2 Causal attributions

From Anne's perspective, the onset of her illnesses could be explained. Anne attributes her illnesses to many causes. Some are linked to her adaptation to the new environment of South Africa after being uprooted from the DRC. She describes how the difficulty to cope with the new reality in a new environment exposed her to many health problems. Others are related to the fact of working under the strain caused by the war and several cases of abuse.

> *You know, when you're forced to exile from your country abruptly, without planning it, and you find yourself in a situation where you don't know from where to start, it is very tough. In my case, I came here with my two children. I came before my husband because I was the target, and my husband hided himself somewhere. I also brought my children to protect them. I had a problem of hypertension because I was on the verge of drift, due to the fact that I came to a country where there is no social protection or support. It is not like in countries where everything is organized, refugees or asylum seekers are put in shelter by the government, they are given food, they are provided with some pocket money, nothing (Interview, Anne).*

Anne thinks that her illness (high blood pressure for example) is due to her abrupt exile with two children in an unexpected manner and to the though life in the new country. Therefore, she had to work hard to secure shelter, food, clothes and money for both herself and children.

Beliefs regarding food seem to have influenced Anne's understanding of the causes of some of her illnesses, as she explains:

> *… Breast cancer was due to South African food which is full of chemicals, because it is not natural. Before, I never had this problem. We never had this problem in my family. I could suffer from malaria caused by mosquitoes, but developing breast has never happened in my family… In the DRC, there is a diversity of vegetables, a variety of food. But here, everything is really with a lot of chemicals: chicken, beef, pork, etc. so there is no diversity of food as in Goma. That is why problems like this can happen to me. (Interview, Anne)*

It is important to stress that Anne speaks as a lay person and this is her perception of illness that I am attending to explore in this study. Anne's beliefs may be supported by some facts observed in the country. Usually in the DRC, people prefer eating food which is natural. It comes from farmer and they do not keep it in a cold room. In many rural areas, there is no electricity and people use other methods to conserve food, especially meats, such as drying and smoke-drying.

Furthermore, Anne is aware that other women living in South Africa and eating the same food may not be exposed to breast cancer as she explains it.

> *…it depends on people's bodies, we do not have the same bodies and our bodies do not react in the same way. (Interview, Anne)*

It was also said previously that Anne was arrested, persecuted and tortured. The previous experiences of violence shaped her understanding of the origin and causes of other illnesses affecting her. What health problem did this violence expose her to?

> *Trauma started in the DRC. You know, I was working in an environment of strain. I lived the loud banging of powerful guns. Many times, there were stampedes. I witnessed slaughters and we were many times attacked. And when I was arrested, it became serious. And once in South Africa, this trauma was increased by difficult life conditions: no job, no accommodation and difficulties due to the new environment. The fact of being uprooted changed everything in my life: my projects, my priorities, my view of things, everything utterly changed (Interview, Anne).*

Anne acknowledges that trauma finds its origin in the DRC, but South Africa contributes to aggravate her illness because of the hardship of the new socioeconomic environment. She therefore uses this as evidence to emphasize it:

> *When I left shelter, my life conditions became worse. I was put under the support of Jesuit Refugee Service (JRS). JRS should give me a monthly stipend of R500 and this should end after three months. In my case, thanks to the intervention of my counselor, they added again three months. Where could I find an accommodation for R500? When you add other expenses like food, clothes, crèche for my boy, it became very tough since I did not have other means of living, except the support from JRS (Interview, Anne).*

Anne acknowledges that trauma started in the DRC because she was under pressure, and breast cancer was covered in South Africa and was caused the food eaten here which is full of chemicals. It may also be possible that her breast cancer started in the DRC as well. If violence exposed her to trauma, the same situation could also expose her to other illnesses as breast cancer. But the aim of this study is to bring what the individual possesses as knowledge regarding illness, which underpins her beliefs and cultural understanding of the health problems s/he experiences.

Lack of shelter, food, employment and abrupt exile were the main causes of this illness, according to Anne. Anne uses the expression *"I was in a cul de sac"* to stress the situation in which she was.

In addition to the causes, Anne was also emotionally affected and this was caused by the absence of her husband, the challenge of caring for children alone, and the separation with her family members from whom she did not have any news. Anne's trauma was diagnosed by JRS[4] and by staff at the shelter where she was staying. In *Bienvenue Shelter*, she expressed symptoms that made the shelter staff and JRS refer her to the Centre for Study of Violence and Reconciliation (CVSR)[5].

Anne reported that the CVSR identified different causes of her trauma, according to different events that she experienced in DRC and the reasons for her particular behaviour were explained to her. I did not try to access Anne's counseling report at the CVSR. I only focused on individuals who explained to me the counseling process as it was done to them and the relief they received from it.

> *The trauma I had was due to the fact of having been arrested and all these mental torture and physical cruelty I endured. For example, they could explain (a therapist at CSVR) to me that my fear of people around was due to the fact that I was wanted and I thought all they became my enemies and they could arrest me anytime. Beating my children too much was due to violence I*

[4] Jesuit Refugee Services (JRS) provides limited accommodation and assistance, referrals to hospitals and clinics, counseling to refugees infected and affected with HIV/AIDS, limited funeral assistance, educational assistance for primary and secondary schools and small business assistance.

[5] The CVSR provides individual and group counseling to survivors of violence and torture, facilitates support groups and conduct programmes to raise awareness on trauma.

> *witnessed and lived myself in. It became as a way of revenging torture and persecution that I endured every time I was arrested. (Interview, Anne)*

Instead of taking her suffering as a curse or punishment from God because of considering herself a sinner, Anne gives a spiritual meaning to her suffering.

> *At the spiritual level, I am not discouraged. I tell myself that the Lord has done a lot for me.... He has allowed this in my life so that I can live a new experience. But I see it as a new experience, as gold is forged in the oven. You see, before the gold shines, it must be put in the fire. That's how I see my situation (Interview, Anne).*

Suffering is seen as a way of purification, salvation and attaining eventual happiness. Some people believe that whoever succeeds without suffering dies early. Anne uses this image to identify her pain as a cross that she has to carry before accessing victory. Anne is Roman Catholic. What she is presenting here is her religious belief which might be different from her cultural viewpoint. In fact, Roman Catholics imitate Christ as a model of suffering and consider the cross as a metaphor for suffering that leads to victory and salvation. Religious beliefs may contribute to some of Anne's cultural perceptions of illnesses and suffering.

The next section presents Anne's symptoms of illnesses, and her feelings when facing the above mentioned illnesses.

4.1.3 Description of symptoms and feelings

Anne experienced different symptoms and feelings of various illnesses which depended on each specific illness. In the following lines, Anne tells how she experiences hypertension.

> *Hypertension, well, when I walk, I feel the sight is no longer good. I feel like I see the same things double, and then I have terrible headache and I have the presentiment as if something would befall me, you know. In fact, there's nothing but I have this presentiment. Sometimes, I feel my heart beating, I feel like I can fall down and then, it is that. In the beginning I thought I didn't have enough sleep, I would have to sleep, and even when I slept enough, but when I woke up, I could feel those violent headaches, I felt stressed, I was not really nervous, but I always felt I was not in a good mood and I felt not in peace. I was really stressed and I did not feel well. I felt like I could not see (Interview, Anne).*

These symptoms and feelings are individually experienced and culturally viewed or understood. They may be different from the medical perception, but they are useful to understand individual knowledge regarding her health problems. Anne generally experienced these symptoms when she thought too much about her whole situation as she says in the following quote.

> *You know, I was forced to leave my country, where I had good life, a good wage, I could do things according to my will, and I came to a country where I didn't have any resources because when we left, everything was blocked, we didn't have any other choice than to leave the country after my imprisonment. My husband could not stay home because everything was burned, we ended up empty-handed. In that situation, I should start everything from the bush. Also, the fact of living alone without my husband affected me too much because I was now obliged to do everything alone without any support like it was before when my husband was next to me. I felt lonely. I live with my husband, we eat together, plan together and take care of our children together. Now, I am alone and I don't know where my husband is and whether he is still alive or killed. This is painful, you know. How could I stop thinking? (Interview, Anne).*

The understanding from Anne's answer is that there is no better place in the world than home. Migration per se is not bad. However, it is good when it is planned. If people are forced to migrate against their will like in the case of Anne, migration becomes a challenging experience.

In the next paragraph, she describes the symptoms and belief concerning her potential breast cancer.

> *The lump was noticed by my husband and myself when I was palpating my breast and felt a solid swelling. For me, it was normal as I did not feel any pains. But my husband didn't find it normal and insisted that I should see a doctor. That's what I did. (Interview, Anne)*

> *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, Anne)*

In the understanding of Congolese culture and knowledge and practice of illness, cancer is hereditary. An individual may contract cancer only if there was somebody among his/her relatives who had the disease.

The following paragraphs examine the symptoms of trauma seen as another painful experience as faced by Anne. It is therefore important to highlight that trauma is not an illness, but a symptom that predisposes to illness. Mueser and colleagues support the view that trauma predicts a later development of psychiatric illness due to psychological vulnerability (Mueser et al., 2002).

For the symptoms of trauma, Anne expressed particular behaviours as described below.

> *You know, trauma is very complicated. You can't by yourself notice that you're traumatized. I became aggressive with my children, beating them every time. For a moment I wonder if I still loved my children, because I was very harsh with them. I was afraid of all the people around me, you watch over and express all your feelings, your whole mind on your environment; it makes you sicker in the long run. I became dirty and did not want to look after myself. I am telling you because you did not see me that time. The way I was looking like, you could not even approach me. I preferred to live in loneliness, and all these behaviours were related to trauma. Sometimes, I was even thinking of ending my life because I thought there was no reason of living again. (Interview, Anne)*

While Anne previously used her religious beliefs to explain suffering, the above quote presents Anne as somebody who was once stuck, hopeless and did not look forward to the future because she felt overwhelmed by problems as symbolised by her thoughts of suicide.

These symptoms were visible and led JRS and *Bienvenue* shelter to refer her to CSVR. The word trauma was used for the first time by the social worker at JRS. Anne herself did not think she was affected by trauma. Comparing her living conditions in her home country and the conditions in which she is in South Africa, Anne says:

> *Personally, I would say I was better in Congo than here in South Africa, because I was working and I had good salary. In fact I would say it is relative because there are people who work in the Congo and who fail to cover their basic needs with their salaries. But in DRC, life is more or less affordable, because you have the benefit of eating fresh food full of vitamins; with the salary we had my husband and I could cover our basic needs and make savings. In South Africa, with my salary, I am not able to satisfy my basic needs and to save. So I would personally say that I was better in Goma (DRC), than here. The only difference is that here I feel more or less secure compared to Congo. (Interview, Anne)*

She believes that the previous violence experienced in the DRC and current challenging living conditions have contributed to the weakening of her health. She sees each country as presenting strengths and weaknesses. One thing she prefers in South Africa is the relative security that the DRC could not offer her. Anne loves her country and thinks that it is the only place where she can have a good life. Unfortunately, she cannot live there as the country is torn by war and living there is risky. For this reason many people flee the DRC against their will, to seek a safer place. Once in a foreign country they often become homesick. In the view of Anne, her home

which should be a good place to be, becomes a 'landmined' insecure, and unstable environment (Dyck and Dossa, 2007). In contrast to the literature stressing pre-migration as the most common contributor to the current health decline of migrants (Groleau and Kirmayer, 2004), or ascribing migrants' symptoms to post-migratory factors (Whitley et al., 2006), the above statement infers that both pre-migration and post-migration factors shape migrants' understanding of their current health problems (Bhugra and Becker, 2005).

Anne has used different ways to seek healing for her different illnesses. In the following section, I present the help-seeking behaviour of Anne.

4.1.4 Help-seeking behaviour

In dealing with her illnesses, Anne had on several occasions changed her treatment regimen. Sometimes she stopped taking drugs because of anxiety and felt that the chemicals in tem could produce a toxic reaction. On another occasion, she followed the advice of her friends and family members to use traditional treatment and food as medicine. The type of help depends on her perceptions of each illness and its causes. After the breast surgery that she had in June 2010, Anne was off all western medication and turned to traditional ones.

> *Now I say the drugs also are chemical products, so I can't get my body used to those chemicals. I would have to give my body, my immune system another signal, another message and that is the conclusion we had here with my husband and my family (Interview, Anne).*

Anne therefore resorted to other treatments for her cancer that she defines below.

> *I use a plant called Artemisia*6 *as tea. This was recommended and sent to me by two of my uncles, one in Canada and another one in Germany, and the mother of my friend who also lives in Germany. Artemisia is a tropical plant which has the reputation of treating many diseases such as breast cancer, high blood pressure and so on. And then there is another product, it is the bark of a tree. In my mother tongue it's called Pandanga7. Pandanga is able to cure cancer and other diseases. It comes straight from the DRC and it is regularly sent to me by my mother. The two plants are bitter. (Interview, Anne)*

[6] Promoted by Anamed International (Anamed: Action for Natural Medicine in the Tropics based in Germany, but active in Angola, Benin, Cameroon, D.R. Congo, Eritrea, Ethiopia, Ghana, Kenya, Malawi, Mozambique, Nigeria, South Africa, Sudan, Switzerland, Tanzania, Togo, Uganda, Ukraine, Zimbabwe) and used as tea to treat cancer.
[7] *Pandanga (in Tshiluba)* is a root found in the forest of DRC. It is used to treat many illnesses, particularly cancer.

Healing goes with patients' minds (Good and Good, 1980, Kleinman, 1988, Garro, 2000, Darghouth et al., 2006, Risør, 2009). Patient's beliefs are central to healing and strongly contribute to recovery. Here Anne is strongly attached to traditional medicine. Plants, foods from DRC and from family members psychologically attach Anne to her country and her family. Healing is not about medication only. Food plays an important role in building the immune system and protecting the individual against many illnesses. Receiving food that comes from her country creates a certain confidence. Medication and food link Anne to her country, her family and her culture. In addition, the fact that these foods and plants are provided by her friends and family members from DRC, Europe and America, reinforces Anne's belief that they love her and cannot do something harmful to her. This strengthens Anne's belief that she will be healed to the extent that she discards western medicine. Essentially, she forgot the hospital and believed that she was already healed from her breast cancer. The hospital only helped in detecting and operating the breast cancer, but the strong medication to treat breast cancer was found in traditional medicine and in food from the home country. Pictures of Artemisia and *Pandanga*, see picture below:

For Anne, healing from her cancer is not only a matter of medication. Food plays an important role in building the immune system and protecting the body against many illnesses. Anne would like to give another healing regimen to her body by eating specific and natural foods. This is also part of the recommendations made by her doctor and family members.

> *The doctor gave me a list of things he told me to eat. He forbade me to eat meat and to drink coffee, and green tea. On the contrary, he recommended me to take more fish, fruit and other many things. Now my mother sends regularly food from home. She sends me more than 20 or 30 kilos of food from DRC. She sends me the smoked fish; she sent me fries and then soybeans. So, healthy diet is the method I have adopted to fight this problem (Interview, Anne).*

There might be a correlation between cause/effect, or between food and illness. It would be interesting to demonstrate whether food contributes towards healing. This is an issue difficult to explain in this study. However, form Anne's view, food is seen as a cultural element that ties her to her country, family members and her culture in which she grew up and she used these aspects as means of healing.

Anne had individual trauma counseling at CSVR from 2008. The counselor identified several causes of her trauma. This was due to different events she had experienced. The counselor tried to explain to her why she had behaved in particular ways and not others. In the beginning she was going there twice a week. Even now, she keeps going to CSVR, but not as often as when she started. She now goes once a month. Anne explained the counseling process in these terms:

> *You are in the office with the counselor. She asks you many questions about your life. You talk about your feelings, your perception of life and all the problems that overwhelm you. You talk about everything concerning you. As long as you talk, the counselor clarifies to you the causes of your feelings. For example she tells to you that your attitudes and feelings don't mean that you are mad, you are not mad. But this is common for somebody who lived in the environment of war, somebody who witnessed murders, it is normal for somebody who was arrested, persecuted or tortured. It is normal for being exposed to violence, but it is not the end. Look at how you can now rebuild your life in trusting yourself and others. It is really a relief process. I was nearly dead, in this interaction with the counselor, sometimes I was shedding tears. The counselor was there to encourage and explain to me each of my particular attitudes and behaviours. For example, I was so nervous, irritable, distrustful and ready to end my life, and the counselor was there to elucidate that my attitude was due to what I experienced, and she was showing me how to overcome and to build a new life. This was and continues to be a great relief for me (Interview, Anne).*

Anne acknowledges that the individual counseling she had at CSVR helped her to trust and build relationships with people and to love and be really a mother for her children. As a case in point, she explains the therapy she had to help her to love her children again and stop being abusive to them.

> *And I even remember my counselor gave me a paper where she asked me to write: "my mother's spirit is not dead." I still have that paper. So everything I was related to that. With that word, I repeated it every time and it helped me a lot. (Interview, Anne)*

While Anne believes in the types of treatment she had which contributed to stress reduction and healing from her different illnesses, she also assumes that some other psychological change occurred as well.

> *I got a job since 2009. It does not pay me much, but it does really help my family to face socio-economic challenges and to survive. Also, my husband joined us since February 2009. This was a great relief. You know, since my husband had arrived, at least I did not often go to the hospital for hypertension attack. This is significant for my healing. (Interview, Anne)*

The last method of help-seeking used by Anne is prayer. Based on her explanatory model, Anne accepted her illnesses as a way of purification before accessing happiness. She is convinced that

any outcome is an act of God. For this reason, she prays consistently in the hope that one day her prayer will be answered.

> *I see my case as a test, as purification, so it has connected me to God. I even say to God, Lord, I will never leave you until you bless me. I remember that I often pray around midnight. And I always say to God, Lord, at this hour, I know that your beloved ones have already been saved. I am currently asking you to think of us who have not had anything. Give me even the scraps that remained from where you served your beloved ones. I know that your beloved have been saved, save me as well. And it really motivated and strengthened me. (Interview, Anne)*

Anne's ordeal strengthened her faith and put her close to God whom she believed would help her to overcome her illnesses. With this point in mind, it is also important to understanding the role that others played to assist on her journey towards healing.

4.1.5 Role of others in Anne's healing process

Besides what she considers a great moment of relief brought about by her husband's presence in South Africa in February 2009, all her family members and friends - currently in DRC or somewhere else - rallied round to help her.

> *My family ... they really supported me, they were all united because I never stopped to have phone calls from my parents, my sisters and my whole family was there. They moved heaven and earth for me. Before, I did not even know that there was Artemisia; I did not know that there was Pandanga. My mom sends pandanga and food from the DRC every month. (Interview, Anne)*

Love, affection and sympathy shown to a sick person bring him/her great relief and contribute to healing. A sick person who does not get visits from people or support feels lonely and becomes sicker than before. But Anne lived and continues to experience the opposite as she clearly expresses it: "So I can say that they [her relatives] were sicker than me". We do not suffer alone, but we always suffer with others. Literature shows that emotional help is the most important kind of support people bring to an ill person (Bossart, 2003, WHO, 2003). A sick person who does not get sympathy, compassion and assistance from relatives may become more affected than before.

4.2 Presentation of case two: Christian

Christian is 64 years old. He was a member of the army since 1966 and became a colonel in the Congolese national army. He did his military training in many countries and ended in Rwanda in 2001. Christian left the DRC in fear of persecution in 2002. According to him, the current ruling party wanted to exterminate all former FAZ[8] (*Forces Armées Zairoises*) soldiers who worked for the former regime of Mobutu. Christian and others refused to be sent to *Kitona*[9] to a refresher training as was ordered by Kabila Senior. Their refusal saw Christian and other soldiers treated as rebels, arrested and tortured. He then decided to flee the country. Some of his friends and colleagues died in *Kitona*, where they were given food poisoned with caustic soda. Those who ate such food died from dysentery. With Kabila Junior as president in 2001, the situation became worse. Many soldiers of the past regime left the country because they became the target of the new ruling party.

In spite of not getting paid or any support from the Congolese army, Christian does not accept that he is no longer part of the army. He considers himself as still part of the national defense force of DRC. He arrived in South Africa eight years ago, on the 25 February 2002. He has been granted formal refugee status in South Africa. He is married and has twenty-one children. He has been away from his wife and other children for ten years now, two years spent in Rwanda and eight years in South Africa. Five of his children (two boys and three girls) are with him in South Africa but they do not stay together, and his wife is in DRC (Kinshasa) with fifteen of his children. His eldest son currently resides in Angola. Christian faces many challenges. He does not have good accommodation. He lives in a very small room given to him by a church in Yeoville. He does not work and receives a monthly stipend of R1000 from the United Nations High Commission for Refugees (UNHCR). The next section presents the illnesses Christian suffers from.

[8] Zairian Armed Forces are soldiers of Mobutu's army
[9] Kitona is a city located in the province of Bas-Congo (West of DRC).

4.2.1 Illnesses experienced

Christian experiences many health problems. He particularly suffers from gout, rheumatism, hypertension and diabetes. Gout and hypertension started in 2004. He takes the medication for gout, hypertension, rheumatism and diabetes. His life now depends totally on medication as he comments:

> *I have many diseases. Do you see all these syringes, they are given to me because I now have diabetes and I am on insulin. Do you see other medications in the fridge; they are insulin. (Interview, Christian)*

Christian experiences different illnesses and he relies on medication for relief. The way he explains his health situation shows that his life is mainly dependant on medication.

In the following lines, I present what Christian believes to be the causes of these illnesses.

4.2.2 Causal attributions

For a specific illness, Christian attributes a specific cause. For Christian, his current illnesses are mostly linked to his career in the military and his diet. Firstly, Christian attributes gout and rheumatism to the fact of eating too much meat as he eloquently expresses it:

> *If it is gout, it is the fact of eating too much meat. From my early age, since I was born I am a son of a mining company. We were having vouchers, we did not pay for food, you know; even when I started my family, most of the time I only used to eat meat. During my 2 year training in Rwanda, I was only eating fresh meat, you see. This affects my health today. (Interview, Christian)*

The perception that Christian has about his illness is culturally constructed as well as part of what he knows and remembers about the causes of his ailment (Mattingly and Garro, 2000).

Christian also attributes his illness to the fact that he stopped doing physical exercising once he came to South Africa. Before, when in the DRC, he exercised regularly in the army.

> *After 2 year training in Rwanda, I went back to DRC in 2001; and I arrived in SA in 2002. With the 2 years of military gymnastics or exercises, when I came to SA for the second time, I stopped doing gymnastics, I don't play football, and I don't jog, nothing. Maybe it is the repercussion of this lack of exercise causing gout and infinite rheumatism. (Interview, Christian)*

Christian's statement shows uncertainty as he uses the word '*maybe*'.

Today, Christian is weak. He does not have enough strength and energy to continue doing physical exercises, as he highlights:

> *The situation worsened, I am going to give an example. If I am attacked today by criminals, thanks to God because I have not been attacked yet, I cannot run now while before I could run 30 kilometers without rest. Now I can't run for even 2 meters. It is really impossible. (Interview, Christian)*

Furthermore, along his career as a soldier, Christian was several times arrested, beaten and he spent a lot of days in prison under painful conditions which can have a link to his current health problems as he sheds light:

> *As a soldier, I was many times arrested and seriously punished. During Mobutu's regime in 1995, I was arrested for 24 days in underground prison. I was seriously tortured. I was sleeping naked on a wet pavement. At that time, I was in Rosicrucian; they took off my necklace and ring, because they suspected that I would miraculously disappear in prison. I was beaten up on my bums; I received 100 batons on my buttocks from my fellow soldiers. Some blocked my arms, others my legs, I cried until I got tired. I spent 24 days in prison, 4 days naked in cold water. This can also result in some of my diseases such as rheumatism. (Interview, Christian)*

The army is an institution of strict discipline. The one who fails to observe the rules is often jailed and torture. The effects of violence may appear after a long period of time. Past violence endured can resume after many years and become a cause of illnesses.

Moreover, as it is common belief in DRC, some illness can be understood to be the result of misconduct in the community. The way people behave vis-à-vis others and the relationships they maintain with the community can expose or protect them from some illnesses.

> *If this can be understood as the result of my conduct, I recognize this as sin. As a soldier, I sinned a lot. For example I was involved in smoking drugs, and in prostitution; and this can be linked to my current health problems. (Interview, Christian)*

A human being is connected to his society. The society has a set of rules that seem to orient people's conduct and to be observed by all the members. If one transgresses, he may be exposed to some consequences. For example, drugs and prostitution are not tolerated as they are considered

antisocial. In the event that an individual believes his illnesses are related to his conduct or behaviour vis-à-vis others, the solution to his illness may be sought outside biomedicine.

When he thinks about his role as a husband and his responsibilities as a father, which he is unable to fulfill currently, and when he looks at his current status as a refugee with all the challenges he encounters in the host country, Christian becomes sicker than before. The result is that he is faced with many health problems now such hypertension. He comments:

> *Yes, I really feel my wife's absence and it is painful because the bible says a man will leave his parents, the woman will leave her parents and they become one person and make their family. Now for me, my wife is far from me for ten years… My children, ten years ago, I don't see them. They will be affected by a kind of education which is not mine. It always troubles me. I don't have resources to pay their school fees and support my wife. Today I am no longer like I was before. I lost all my advantages and I become refugee with all the challenges I face here, you know, it is not easy. The evidence is there, I am having terrible headaches. I don't have money now, where I am going to find money to pay deposit for a flat? All this results in many problems, it brings worries, hypertension and many other problems. (Interview, Christian)*

Christian is faced with socioeconomic challenges and emotional problems. He represents himself as a husband and father who should be next to his wife and fulfilling his responsibilities to his children. Being a refugee has reduced him and made him unable to accomplish his role as a husband and father. Separation from his wife and children brings fear of losing the opportunity of staying close to his family and educating his children in a way that is good according to him. When he thinks too much about his current situation, Christian becomes sick and the symptom for that is a headache. His headache is the result of his inability to respond to his basic needs in terms of food, accommodation and employment and the absence of his wife and children.

As for diabetes, diet seems to be taken as causal attribution. He expresses it as follows:

> *I was a champion in sugar consumption. I liked sweetened foods and drinks. In addition, alcohol also contains sugar and maize. I liked everything that had too much sugar like bread, cake and sweets. (Interview, Christian)*

Christian is talking as a layperson. The understanding that diabetes can develop from eating too much sugar is widely shared and can be considered part of "what is known and remembered" (Mattingly and Garro, 2000:72). In fact diabetes can be linked to sugar, but it is also known that diabetes may be hereditary. Furthermore, obesity can also expose an individual to this illness.
Besides diet as causal attribution of diabetes, Christian believes that his diabetes is the result of witchcraft. He vividly points out:

> *I link my diabetes to my diet; I liked too much sugar and alcohol. I also link it to sorcery. I cannot deny it. I am convinced that witchcraft also is one of the causes. You know, I am married and have children. My wife's family members can be witches and pass it down to my children. They want to attack you through your child, thanks to prayer they can't reach you. That is the reason why they just disturb your life with many illnesses. (Interview, Christian)*

In searching for the causes of illnesses, an individual may refer to religious, cultural, spiritual, and social beliefs. In understanding the causes of illnesses, not only tangible forces are identified but also intangible threats that lead to the beliefs that illnesses are the result of witchcraft. However, this is the opposite of the causes that Christian identified before. While he admits that he was a champion in consuming sweet foods which may have exposed him to diabetes, he also attributes his diabetes to witchcraft. Referring his diabetes to witchcraft may be seen as shifting responsibility away from his behaviour which might have led to this illness.

In locating the causes of his illnesses, Christian uses moral idioms (Risør, 2009) to elicit his conduct as a soldier. The use of drugs and other substances leads to immoral behaviour which can be considered as sin and which can affect health. Christian employs the word "trauma" in reference to death of colleagues and friends in battle. Christian outlines:

> *If this can be understood as the result of my conduct, I recognize it as a sin. At this point I have no doubt. You know, a soldier in front can drug just to avoid fear, because a soldier also is afraid sometimes. All those practices can produce some health effects. You also have the case of trauma caused by the death of your colleague while you are together. You see him falling after being shot, you can't carry him. You leave him there and this remains in your mind. Every time, you'll be thinking about your friend with whom you spent many times. Sometimes you came from the same area or you met under the flag and he is left in the bush. All this can affect you, you see. (Interview, Christian)*

For Christian, good conduct and living in harmony with his relationships is also a way of keeping healthy. Individual conduct may expose one to or protect from illness. Some illnesses that affect people are considered as the result of their bad conduct in society. On the contrary, there is a strong belief that those who keep good relationships are exempted from any attacks because they do not cause any problems to anyone. Christian brings out several medical, environmental and supernatural idioms to explain his illnesses. It is important to examine in the following section, the symptoms of different illnesses experiences by Christian.

4.2.3 Description of symptoms and feelings

Can you please describe the symptoms of your illnesses and tell me how your body feels?

To this question, Christian replied:

> *As symptoms of gout and rheumatism, my legs are sore. Every time, I used to ask children and my visitors to rub (massage) me, you know. When I walk, sometimes I am tired. I cannot do three or four kilometers of walking, I need to rest. I can't walk without support. I also always walk on crutches, so there is tiredness, pain and so on. (Interview, Christian)*

During his career in the military, Christian was accustomed to regularly exercise, running long distances and he was also a very good soccer player. He was considered as a good 'commando' and a tireless man. He has been transformed by his illnesses, especially gout and rheumatism and has turned out to be unfit.

Regarding hypertension and diabetes, Christian reports that he has terrible and repetitive headaches; he feels dizzy and always sweats.

However, bewitchment presents some symptoms as well. This often happens to Christian in dreams at night.

> *…but some dreams can show it. Sometimes you dream having sex with a lady at night, it is not good. This is witchcraft. Sometimes, you dream about a naked lady, it is not good. It is bad signs, you know. That is what is called husband or wife of night. Many times, if it happens to me like that even when I am deeply asleep, I have to wake up and break it up. (Interview, Christian)*

This phenomenon is more and more common in the beliefs of people from the DRC. It is known as the phenomenon of wife/husband of night (Nunez, 2010). However, it is also true that all the dreams are not related to this phenomenon. Some dreams can be the result of what the individual has seen and could realize during the day. The fact of staying alone and thinking about his wife who is not with him may also expose Christian to this phenomenon.

Bewitchment is believed to have many purposes, either to weaken the victim's health or to stop him from succeeding in any of his projects (Bever, 2000).

> *You know, witches, if they are not able to kill you or your wife, they will then make your child become a witch. Once your child becomes a witch, they will be fighting through him, by threatening your life with many illnesses… If a witch cannot kill you, he will be troubling you until your death. A child who becomes a witch will be asked to sacrifice his father or mother; but he will not be able to succeed because your God is protecting you. He can't reach you, but will just make you suffer like this. (Interview, Christian)*

This phenomenon of accusing children of witchcraft is popular in the DRC. It is also argued that the inability of parents to fulfill the needs of their families pushes them to chase their children away after using them as witches. Witchcraft seems to form part of people's beliefs today and cannot be separated from their way of perceiving and interpreting symptoms of many of their illnesses. Christian is just presenting his beliefs about witchcraft, and as expected, there is no proof for his claims.

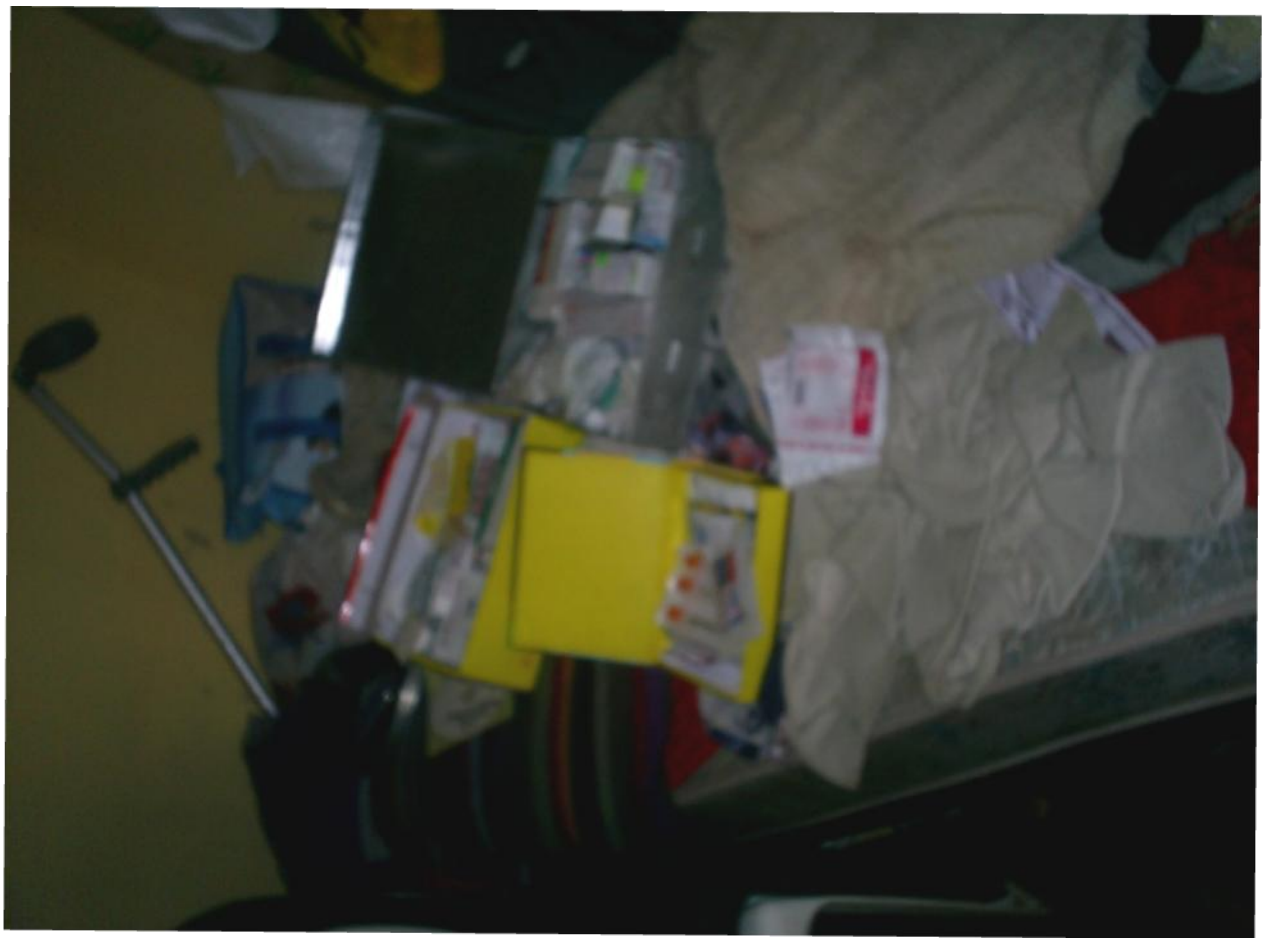
I now move on to the next step to discuss different ways used by Christian to seek help.

4.2.4 Help-seeking behaviour

The most used source of help for Christian is western medicine. Christian's physical condition and well-being depends on medication. He stresses:

> *Everyday, I go to the hospital. That is why I have shown you the medication I am taking and I have many others. If I show you those ones you'll be surprised. How can somebody's life depend on medication like this? Look at all these medicines I have to take. (Interview, Christian)*

Medication has become part of Christian's life. His question expresses at the same time his pain and fear. Christian knows that without medication, he will die. The following picture shows the assortment of Christian's medication on his bed. Notice also, the crutch leaning against the wall.



Christian is taking medication to keep alive but he does not really like to be prisoner of medication. He often goes to the hospital for medical appointments and he also has many tablets and other types of medicines that he uses to treat himself following the instructions given to him by his doctor. All the treatments he undertakes only make his pain less intense, though nothing makes it disappear completely. Christian says:

> *I have a problem because there is no improvement, except for the operation of umbilical hernia where I feel better. Regarding gout and rheumatism, there is no change. I go there because the treatment relieves a little bit. But the change means I must be healed. (Interview, Christian)*

Getting treatment does not help him as long as it does not meet Christian's expectations. He needs a treatment that makes his illnesses disappear.

Christian also resorts to alcohol despite the medication he takes. The Bible, prayer, music and movies are other means of seeking help that Christian considers in coping with his suffering:

> *Sometimes I forget that I suffer from diabetes and hypertension. If I have a beer, I take it. However alcohol does not relieve. After drinking I sleep, but when I wake up I start worrying again. Sometimes, I read the Bible, or I have some movies to watch or I start singing old songs. Sometimes these songs pain me a lot because they remind me of my late friends with whom I used to go to bars or taverns to drink. This again troubles me. That's why sometimes I watch movies to help me to forget. (Interview, Christian)*

Christian resorts to alcohol as a way of dulling his pain. Literature shows that people turn to alcohol to numb the pain of harsh economic and social conditions (WHO, 2003:24) However, he recognizes that alcohol does not bring great relief. The person can sleep and when he wakes up, the same problems start again. This is how a person tries all possible means of relief when he is faced with problems. He thinks that by trying alcohol, he will get better. But in practice, alcohol does not help. On the contrary, it worsens situations.

What do you do to deal with the supernatural dimension of your illness? What kind of help do you seek and how does it work? Christian responded:

> *I pray to God. I use incense, but not every day. If I see that I am tired I burn incense because tiredness brings me a lot of nightmares. If you refuse to resort to magic or ancestral means, the great fetish is only Jesus. The best solution is only Jesus, because a witch is afraid of Jesus' name. If a witch hears Jesus' name, he is paralyzed. Jesus is the shield. Nothing is more powerful than prayer, because prayer is the final solution. (Interview, Christian)*

Regarding the supernatural dimension of his illnesses, Christian believes that prayer is the efficient means to fight the devil as witches are afraid of Jesus' name. Christian believes in Jesus. He is here sharing his beliefs as a Christian and as a member of a Pentecostal church. Pentecostal churches seem to have taken over the place of traditional churches. Many people see these sects as a place of miracles where God is manifest and where they find appropriate responses to their problems in terms of deliverance healing from illnesses caused naturally or supernaturally and from all cultural and spiritual bondages (Belcher and Hall, 2001, Jeannerat, 2009). The reason some people decide to leave formal churches is the view that in traditional churches, the presence of God is dormant. As such, they believe that only Jesus Christ is the most powerful weapon to fight evil. In contrast to Pentecostal churches' beliefs, Christian resorts to some practices from the Roman Catholic Church like burning incense. Before changing to a Pentecostal Church, Christian was a Roman Catholic and he is convinced that incense is powerful as its smell chases away devils.

What is the influence of the local environment on Christian's health?

4.2.5 The effects of migration on Christian's health

Christian believes that the South African environment contributes positively to his health.

> *No, to be honest, I would say if I was still in DRC, today I would no longer be alive. Look at my navel, when I came from Rwanda, I did not know that I had hernia. This was discovered at the hospital where I go to fetch medicines. I had a navel surgery at Edenvale hospital. After there were some complications and I was again operated on last year (2009). If I was in DRC, I would have died already because my stomach was bloated and three litres of water were drained from it. (Interview, Christian)*

South Africa offered Christian good healthcare and he had surgery for an illness that was discovered in the same country. He was sick, but had never noticed it in his home country. This shows that the host country is not only exposing migrants to the challenges of integration, but in this case, contributes to provide migrants with access to social services such as healthcare. However, there are other issues in the host community that negatively impact on Christian's health and wellbeing.

> *There is a great difference between my situation in the DRC and the one I have here, I mean a discrepancy. You know, in my country, if you are a senior in the army with a post, you are untouchable, you are respected and no one can play with you, you see. The only one who can arrest you is your superior. Here I see myself like a child in primary school. I am in a foreign country and people don't know me. In my mother tongue they say to be in a foreign country is like to be on a tree. Who knows you in a foreign country? Only those who saw or knew you in your country can say who you are. It is painful, you know. It worries me too much, sometimes on my way somebody can bump on you, you just look at him and you say if it was in my country, a person like this could not even approach me or could be whipped. It is painful. Look at the bed where I sleep; a bed too small and full of things. Before I sleep I have to remove everything. Sometimes I just sleep like this. I am not living here. (Interview, Christian)*

Here, Christian indicates that a foreign country makes people lose their identity and prestige. It is important to note that some issues are cultural and the change of location brings a new reality which is different from the country of origin. Other challenges are related to the difficult living conditions of the host country and the perception of foreigners by the local community. Much literature infers that harsh living conditions in the host country pose a significant challenge to the integration of migrants and may affect their health (WHO, 2003, Bhugra and Becker, 2005, Whitley et al., 2006, Rijken and Groenewegen, 2008). In this regard, comparing his current situation to the one he had in the DRC before migrating, Christian responded:

> *I told you, for example socioeconomic challenges, unemployment, difficult living conditions (for example this small room and small bed), can affect my health. The local community's attitudes vis-à-vis foreigners are frustrating. In the taxi, you give money for ticket, but to get your difference back is a problem. They only speak Zulu, a language you don't understand. Sometimes, you get upset and leave your money. One day I told the driver: "you want to take my money mahala (mahala in IsiZulu meaning for free)? May God bless you". He was afraid, I gave my money for ticket and he refused to give my change back arguing that I did not pay. When I asked him that question, he was afraid and gave my R50 back. One day, I was going to Helen Joseph Hospital, the driver refused to drop me off at the hospital. He turned the car before the hospital, but he was good because he gave me R5 back. Another one refused and dropped me far from the hospital. Seeing that, I identify myself as being on the tree, "kwabenda nkulu kwa mutshi" meaning to be in a foreign country is like somebody who is on a tree. (Interview, Christian)*

This metaphor is used to show that migrants in a foreign country are insecure, vulnerable. In the foreign country, they do not feel grounded or rooted. Their future seems bleak. Christian presents the host country as a place where no one knows and respects him. As long as a foreigner does not share the same language as the citizens of the host country, he feels unwanted and not respected. Local community members working in public services even ignore the rights migrants are entitled to (Pursell, 2004, Landau, 2006a, Vearey, 2008, Moyo, 2010). They can abuse them. In this situation, migrants prefer not to insist on or claim their rights for fear of being exposed to violence. This is the meaning that Christian refers to through the image of living in a tree to emphasize the difficulty of living in the host country because when somebody is on the tree, he must hang on and be careful, otherwise they will fall down. Christian's view may be extreme, nevertheless. Not all migrants would describe their situations in a similar manner. Migration may also contribute to the improvement of the migrants' well-being. Furthermore, there may also be some countries where migrants are accepted and integrated within the local community.

In dealing with his suffering Christian also meets some people who show him love, sympathy and compassion. The following section focuses on this aspect.

4.2.6 Role of others in Christian's suffering

To the question about the kind of help Christian receives from others, he answered as follows:

> *If I receive a gift from somebody, I just say God has touched that person's heart and led him to help me. I also take it as a reward for good things I did to others, because I also helped many people in my life and I can't mention it. Only God knows and I put everything in his hands…Give and it will be given to you. In my mother tongue, they say: "kupa kutekeshi*[10] *[meaning to give is to save]. (Interview, Christian)*

Although Christian thinks the Congolese community is not united in Johannesburg, he has benefited a lot from people. They have shown him love, sympathy and affection. Several times, he has benefited from different kinds of assistance from different people. He received from them different presents such as food, money, airtime, shelter and visits. However, Christian sees this kind of assistance as the result of his good deeds to people and summarizes it in this popular *Tshiluba* saying, "One will be rewarded according to the way he helped those in need. This reward will not necessarily come from those he helped, but even from anybody else. Good deeds will never be forgotten". This is embedded in the cultural beliefs of the Congolese.

4.3 Presentation of case three: John

This case concerns a forty-nine-year-old man, originally from Uvira. John is married and has five children – 3 boys and 2 girls and they are all in the DRC. John got involved in politics at an early age after completing his secondary school in 1983 and was a member of a political party named PLC (Parti de Liberation Congolais) allied to the Mai-Mai movement since 1995. He stood to defend his country and his people, the voiceless, against Rwandese occupation in 1998 during the war of liberation which resulted in the death of many civilians. According to him, some authorities he was working with were Congolese but traitors serving Rwandan interests. Many members of John's political party were abducted, some were imprisoned and others killed. John was arrested twice, first in 1998. He spent some weeks in jail. In April 2007, he was arrested for the second time. He was tortured, tied and jailed for two months. This happened in one locality named '*Mal Acquis*' (French name meaning badly acquired or ill-gotten gains), in Uvira. John was released in July 2007, thanks to the support received from some people whose identity was kept confidential. John was running his own business in Congo, and was also working for human rights since 1995.

[10] This is a proverb is Tshiluba mostly spoken in the province of Kasai (DRC).

As a human rights activist, John stood up against war, murder and all kinds of abuses in the eastern part of DRC and this made him risk his life several times. He therefore decided to leave the country for his sake. He came from *Uvira,* province of North Kivu, to South Africa at the beginning of 2009. Fear of persecution was the main reason of leaving the country.

In South Africa, he holds an asylum seeker permit and is unemployed. He stays at his younger brother's place and is dependent on him. But his younger brother is currently sick. In spite of being sick, John's brother has accommodated him and provides him with food. John's story is presented in-depth below, starting with the illness he is currently experiencing.

4. 3.1 Illness experienced

John suffers from cramps as he relates:

> *I often suffer from cramps in some parts of my body; especially my hands don't work properly. (Interview, John)*

Cramp is usually characterized by a temporary loss of function in a muscle or muscle group.

But what can be the causes of this illness? In the following section John tells how his cramps started and what caused them.

4.3.2 Causal attribution: "They made me suffer like a slave"

In the DRC, John faced a painful event and this was the reason for leaving the country. John believes that he was affected by torture and humiliation:

> *As causes, you know, I was arrested and tortured, the way I was beaten up was cruel, it was not normal. Because I was seriously tied up during the time I spent in jail. They made me suffer like a slave, it greatly affected me. And when I came out from prison, I spent 6 months, my body was not correctly functioning and all the problems started from there. (Interview, John)*

Torture or persecution affects the body and can cause this problem. Christian considers his torturers as devils because they did not treat him as a human being, but an animal, the same view as expressed by John above.

In South Africa, there are some situations that John sees as aggravating his illness, such as his brother's health as he explains:

> *I want to tell you that when I came here I found my younger brother in a tricky situation with a serious disease and this also worsens my situation. His situation always worries me. I am not fine to see my brother suffering like this. We are only three, I am the first born and he is the last born… His leg is swollen, he can't move, he feels his hips loosely, no I can't accept it. Before he could work easily, move around and do his business and now he can't do it, it is no longer like it was before. I am terribly affected by my younger brother's situation. I understand his disease deeper than himself. I live his pains more than him and I become sicker than him. (Interview, John)*

Here John shows that illness is not an individual concern. His brother's suffering is also his suffering. When he looks at his brother's problem, it is as if he is suffering from two illnesses, his and his brother's and becomes sicker.

John's younger brother suffers from '*Mbasu'* in Kikongo or '*Mulonge'* in Swahili (Elephantiasis[11]in English). After he was hospitalised, doctors were not able to define this illness and to explain it exactly, John assumes.

> *Doctors did not even give the name and I think they themselves did not understand exactly what it was. They only looked after the examinations and prescribed medications they asked him to take. That's all. (Interview, John)*

When doctors fail to exactly explain an illness to patients, the Congolese think it is dangerous and this creates fear and doubt that the patient might not get healed and could probably die. But it is also true that sometimes individuals would like the doctor to see their illness they way they understand it. An explanation which is different from their beliefs may be seen as failure on the part of the doctor to meet their expectations. In addition, doctors' communication in the interaction with patients is necessary to build trust and confidence. Health professionals need to adapt their language to patients' understanding. In the case of migration, language may cause a problem and make the communication difficult where health professionals and patients do not speak the same

[11] Elephantiasis is a chronic disease in which parasitic worms obstruct the lymphatic system, causing enlargement of parts of the body

language. Sometimes even English is not well understood. However, in practice, health workers select the information to give to the patients, an amount of information that they thinks, is sufficient for a patient to better understand his health condition.
In his explanation, John believes that those left behind in the DRC may contribute to the aggravation of his symptom.

I asked John, "Can you please tell me how your family contributes to your pain?" Here is the explanation he provided:

> *Those I left at home know that I am in South Africa and there is money here. If they phone they only ask for money and some want to come here. If I explain to them the situation in which I am they don't believe. They are taking me for a liar and this is painful. (Interview, John)*

In the view of the Congolese, migration is perceived as a way to financial enrichment. Kankonde talks about the perceptions of remittances amongst Congolese migrants. The author shows that migrants remit to avoid social death by fostering familial belonging and sustaining social status (Kankonde, 2009, Kankonde, 2010). If a person migrates, his family members expect some financial support from him. Failure to send money back home may contributive to health decay. Sometimes family members left back home do not believe that their relative living in the host country encounters some financial problems. John sees it as adding pressure and stress to him.

As shown previously, John is concerned not only about his illness, but also his brother's. But what does he think is the cause of his brother's illness? To this question, John answers:

> *I think they are indigenous illnesses as we say. These are illnesses that come from witchcraft, you see. Witchcraft is not accepted by people because there is no evidence. (Interview, John)*

Some illnesses may not find solutions in the biomedical field. There are several other ways that we can use, depending on the type of illnesses and their causes. This mainly happens to people when the first attempt of seeking healing is not successful. A human being always looks for meaning to all his health problems. This meaning may be found in religion, culture or philosophy. John attributes his brother's illness to witchcraft and labels it an "indigenous illness."

How does John know that his brother's illness is related to witchcraft and who said that? John replied in the following lines:

> *We discovered in prayer sessions. The pastor prayed, but before the pastor prayed somebody prayed and it was revealed. Then, the pastor also came up with the same revelation and he even cited the names of people who were involved. (Interview, John)*

He believes that it is the result of bewitchment and adds that the pastor even named the people involved. This is one of the reasons people like Pentecostal churches. They try to bring real answers to real problems people face. In fact, people want the church to preach in the way they believe. While traditional churches (Roman Catholic and Protestant) do not emphasize more on the issue of witchcraft whereas Pentecostal churches give a lot of attention to it.

I asked John why his brother had been bewitched and why do people want him to die? John said, "People are jealous of my brother's business and want him to fall down or to be physically eliminated". Jealousy comes from the fact that John's younger brother has got a shop where he sells fruits and vegetables. John said:

> *my brother's friends are not happy that the shop grows and they want it to end. But they cannot succeed as long as the owner is alive because he is courageous and may find other means to lift it up. (Interview, John)*

According to John, his brother was trapped in somebody's car he had hired and his illness started when he drove that car. John's support to his brother is not only material, but also spiritual:

> my presence beside my young brother is to protect him from those who would like to harm him. (Interview, John)

For this reason, many times when he thinks of leaving his brother, somebody always comes as a messenger to stop him from thinking so.

> *You know, it's just when I think of leaving that I see someone coming to stop me from going. So I do not tell anyone in advance that I am about to leave, only when I am tempted to do that, this message comes through those who support us in prayer. (Interview, John)*

John considers his role next to his brother as a '*guard*' to defend him against evil spirits. That is why sometimes he also faces the same attack as his brother as he explains:

> *They also wanted me to end like my brother. A snake was biting me while I was asleep. When I woke up I did not see the snake or any wound on my leg, but I felt pain like something bit me. I prayed and slept. The following day, our pastor came with a revelation that they are not happy because the business is still running thanks to me. They wish to do to me the same as they did to my younger brother. (Interview, John)*

Dreams are considered as predictors of something good or bad that may happen to people and are taken seriously. John's relation towards his brother shows that as an elder brother, he has the responsibility of protecting his younger brother. In Congo, elder brothers are considered as the incarnation of the fathers. John believes that he may be attacked because he is stopping his brothers' enemies from succeeding in destroying his brother's business and killing him.

One may ask why John is affected by his brother's illness. What is the cultural meaning of this? The issue is treated in the following section.

Cultural meaning of family and relatives: "the tie of the family does not cut off but gets weak"

John empathizes with his brother and explains:

> *We are brothers; we come from the same womb and blood. So, if my brother is sick I also feel that because we are united by blood. This is something that cannot be separated. Blood ties remain forever. That's why often I can feel the pain of my brother and become sick like him. (Interview, John)*

In Africa, most societies often emphasize the concept of solidarity. Solidarity is not only material but spiritual as well. If a person is sick, he does not suffer alone but with others, especially with his family members. They show their fraternity and compassion with the sick person and are the primary financial contributors towards the treatment of the ill person (Bossart, 2003). That is why the most important thing that draws John to his brother's suffering is the blood tie they share. His brother's suffering cannot leave him indifferent.

Strong blood ties keep the family united. There is a popular proverb in Lingala which states "*Singa ya libota ekatanaka te, kasi elembaka*" [literally meaning A family tie cannot be cut off, it only gets weakens". This means that even in the event of conflict, family members cannot split irrevocably. Because of blood ties, they will always stay together to sort the problem out.

The symptoms of cramp are presented in the following section of this case.

John attributes many causes to his health condition. I asked him if migration had alleviated or exacerbated his pain.

The effects of migration on the health of John: "I am like a child"

The change of environment imposes the challenge of adaption in the new environment. As a secondary reason that has negatively affected his health, John refers to adaption to the South African weather.

> *I also have a problem with weather. To adapt myself in this country is not easy as I come from a hot country, DRC and I am now in a country where the weather is so different and it is too cold. (Interview, John)*

The adaptation to the local community can be short or long, easy or difficult. As long as the individual stays in the new environment, he may overcome the challenges related to the weather.
In addition to the climatic conditions, John evokes the living conditions and how migration has reduced him to dependency.

> *I want to say one thing, I live here as a refugee or asylum seeker. In my home country, I was free. I could move around, do my business. Here you see, the conditions under which Congolese migrants live are very difficult, really not easy. So I try to live in the same way as my countrymen and countrywomen. I'm in charge of my younger brother. In Congo, I was living by myself, but here I live as a dependent, I depend on someone, I'm like a child. It really reduces me as a man. (Interview, John)*

As an older sibling, John is uncomfortable to be supported by his brother. He is the elder brother and is expected to take care of his younger brother. He uses the image of the child to describe himself because he feels heavily dependent on his brother.

John raises other issues related to the fact of being accepted and recognized as a refugee in South Africa.

> *Furthermore, papers are not easy to get at Home Affairs, because I would like to have papers to move out of South Africa and it is taking time and sometimes when I go there, I spend long hours standing up and queuing. This also pains me a lot. (Interview, Interview)*

Being a refugee causes strains, and can affect people's health and wellbeing. Papers are important as they help refugees to be identified and to access jobs and other services. The issue of papers is challenging as migrants struggle to get good papers to help them in finding jobs and using their skills. Many also find themselves arrested or deported because of documentation issues. This is supported by several literatures (Pursell, 2004, Landau, 2006a, Vearey, 2008, Landau, 2010, Moyo, 2010, Amit, 2010a, Amit, 2010b).

4.3.3 Description of symptoms and feelings

The main symptom of cramp is pain in the limbs. Some degree of pain is present every day, but it greatly increases with time as John states:

> *You know, when it starts I can't move my fingers, especially if I sleep. When I wake up in the morning, all the thigh muscles are tense. It means I can't move them, so I am in a difficult situation. My muscles are sore. In my mother tongue, we call cramp kishani. (Interview, John)*

The words John mostly commonly uses to explain his pain are '*moto*' in Lingala meaning "fire," '*koswa*' in Lingala, meaning "stinging" and '*kunjama*' in Swahili meaning "sore." These words are used as adjectives to describe the degree of pain John feels. As he always links his pain to his brother's pain, John also explains his brother's symptoms and feelings:

> *...his right leg is swollen and he feels terrible pain. He feels like he was broken into two pieces, the upper and the lower, and wouldn't hold together anymore because of pain. So he feels his leg heavy. And he is psychologically affected as well (not in a good mood due to pain). (Interview, John)*

This explanation shows the degree of pain his brother is going through. He cannot stay in his shop to run his business by himself because of pain. He therefore needs his brother to help him.

How does John deal with his *kishani* and his brother's *mbasu* or *mulonge*? In the next section, I present John's narrative regarding the type of help he seeks.

4.3.4 Help-seeking behaviour

John only once visited a doctor, in DRC, when his cramps started and this was in October 2007. Since his stay in South Africa, John has not gone to hospitals and churches because of mistrust created by rumours.

> *You know, I am a Congolese, I come from Congo. According to some trustworthy sources, there is news circulating in this country that the president has paid a lot of money to doctors to treat those who are in my situation differently, it means to inject them with poison. Those stories are always said here and it is true. We are here and we see a lot of Congolese being poisoned every time here and in DRC. Some come here to be treated, but go back home in coffins. (Interview, John)*

John does not trust hospitals and churches. Rumours influence the way he perceives them how he seeks healing. News from the grape vine is taken for granted and John easily accepts it. Rumours seem to have caught John's attention than official information.

But what does John use to treat his cramp or *kishani*? To this question, John answers:

> *I often use hot water with salt to treat my cramps. If the pain is too much, I can also use some painkillers, that's all. (Interview, John)*

In seeking healing, people resort not only to western medicine. They know many other ways and resources they can use for their illnesses. But the problem is to what extent these different ways help them to find relief. These ways are linked to their cultural beliefs and they cannot be separated from them.

John refuses to go to hospital or other pastors for fear of disclosing himself. He said there were rumours that the government of Kinshasa bribed some pastors and doctors here in South Africa to disclose those who oppose the current ruling party in DRC.

Linking this to his brother's case, John expresses his disappointment:

> *the doctor did not ask about my brother's personal life or his own opinion of the symptoms, he just said the treatment was over. (Interview, John)*

As stated previously, when the health professionals do not meet patients' expectations regarding the causes of illnesses, patients consider it as health workers' failure. In addition, health workers use the universal explanation, while patients use the cultural perceptions which are related to their

beliefs. This issue is also explored in the study on *Medically Unexplained Symptoms* in Danish primary care (Risør, 2009:512).

Prayer is the best means to deal with his brother's *mbasu* as John assumes:

> *We usually organize sessions of prayers at home, with fasting and other forms of spiritual mortification for his leg. (John, Interview)*

Here, John is sharing his knowledge and religious beliefs as a member of a Pentecostal church. While he believes in witchcraft, he also believes in prayer as the best means of fighting the devil.

John prefers to pray at home because he assumes that there is nothing special in the church:

> *I don't see something different in pastors' behaviour. (Interview, John)*

John refers to pastors' behaviours which he thinks do not match the gospel they always preach. For him it is better to stay home and pray instead of going to church. If John does not believe in the church's support, one may ask where he gets assistance in some circumstances. The answer is presented in the next section.

John has learned to accept the challenging living conditions imposed by migration. But sometimes he feels overwhelmed by problems and starts to worry too much. What does he do to get out of such a situation?

> *I often sing a hymn; I read the Bible and pray. This is all that comforts me. (Interview, John)*

God is the only one who can protect against worries and bring relief. Christians often maintain that God is the solution to all their problems. Spirituality is used as a solution to socioeconomic or material problems.

4.3.5 Role of others in John's illness

Financial support may be difficult to offer when people have to cope with socioeconomic challenges (Bossart, 2003). However, there are other kinds of support that people expect from each other. John comments:

> *Being in tough situations, there is nothing they can do for you, you see. But support is not only material, it is also moral and spiritual. That's what we enjoy the most. You can meet someone who asks how you're doing, how he is doing. Some give you advice and try to urge you morally, spiritually, you know. That is just the kind of support we have sometimes from our community. (Interview, John)*

John regularly receives visits from different people. Those people are mostly Congolese and sometimes migrants from other African countries. Some come to comfort him and his brother and others come to join them in prayer. Among them, there are also some Christians who do not have churches and believe like John, that it is not important to go to church because pastors are not good examples. Although it is not financial assistance, it does help as it brings some relief to John and his brother.

4.4 Presentation of case four: Liliane

Liliane is a fifty-six-year-old woman, originally from Kinshasa. She is a mother of three children, all of them boys. Two of them are with her in South Africa and the first born is currently studying in Kinshasa. She divorced in December 2005 and her former husband left her with all the children under her care. Liliane was working in the public sector in DRC since 1986. She started working after obtaining her bachelor's degree and went back to the university to complete her honours after many years. In 2005 she obtained a degree in Geography. According to Liliane, she worked among people who did not like her. This led to her arrest, torture and persecution. She was jailed in February 2009 and spent one month of torture, persecution and suffering in prison. After being released, Liliane continued to face threats and violence.

She left the DRC for three reasons. First, medical reasons because she sustained slipped disk resumed after the torture. She was treated in 2008 when she first visited South Africa. Secondly, she was affected by her divorce and did not want to stay in the same environment as her former husband. Finally, due to political reasons, her life was in danger in the DRC. For Liliane, the latter was the most important reason for leaving the country. As a Roman Catholic, she believes that a Christian should follow Jesus Christ's example and go through suffering. For her, suffering is the way in which a believer participates in Christ's passion before accessing happiness. Liliane arrived in South Africa in April 2009. She has an asylum seeker permit. She is current unemployed and

lives thanks to the support of the church which provides her food vouchers, although not on a regular basis. She faces challenges to school her children and pay the monthly rent. She lives in a room which she sublets in a house in Norwood. I present Liliane's story in the next part of this case study.

4.4.1 Illness experienced

In response to what health problems Liliane has been experiencing, she explains in these words:

> *Yes, I have a health problem. Remember I told you I came, for the first time, to SA in 2008 for my health, and even now I am here also for my health. It means in 2007, after several medical tests done in DRC, it was discovered that I have a slipped disc. That is my health problem I have. (Interview, Liliane)*

Liliane started suffering from her illness from 2007. She went through the painful experience of taking care of a disabled mother. She also faced challenges in her career and in marriage. Trying to understand what a slipped disk is, Liliane presents the following description that she learned from her doctor:

> *According to what the doctor told me, slipped disc is first of all a disease like any other disease. It can come from carrying too much loads in the early ages or when an individual grows up. An individual carries loads that exceed his weight and he may develop slipped disc as this disease basically is the destruction of the disks in the vertebrae. When the disks slim, the vertebrae get in contact with each other and the person starts feeling pain. (Interview, Liliane)*

From the doctor's general explanation, Liliane learned that a slipped disk could be due to carrying loads that exceed somebody's weight. In the next section, I present what she believes to be the causal attributions of her slipped disk.

4.4.2. Causal attributions: "I was taking care of my mother by myself"

Liliane explains the cause of her slipped disk this way:

> *Yes, because after, I remembered my mother, before her death, had a paralysis for 4 years. Then, I was taking care of my mother, lifting her onto the toilet seat. Let's say I was doing everything for my mother and I think it is, let's say my slipped disk comes from that load because she was an old person. So for 4 years, I was taking care of my mother by myself because I did not have sisters. I am her only daughter of my family and I only have brothers and I did not get any help for taking care of my mother. (Interview, Liliane)*

According to Liliane, the slipped disc she is experiencing may have been caused by the fact that she was taking care of her sick mother who became paralyzed for four years when Liliane was 28 years, from 1982 to 1986, until her mother died in 1986. This coincides with the doctor's explanation to her. Here, the patient appears to have been well-informed and from there she refers to a chain complex. Chain complex is a method that helps to explore - through migrants' stories , the sequence of events, either political or economic they experienced in their lives, that can have a potential link to their current health problems (Groleau et al., 2006). In this case Liliane ascribes her slipped disk to the fact of carrying her mother for a long period of time in the DRC.

Furthermore, Liliane considers other circumstances, in the DRC, as having contributed to her condition:

> *When I went back home, you know in DRC, life is so difficult. To get transport is not easy. Sometimes I would spend 45 minutes or an hour in the morning at the bus stop, standing up and waiting for the transport. When the taxi arrived, as many were waiting, I would run to find a place in. Sometimes, there was not transport and this forced me to walk a long distance to go to work. (Interview, Liliane)*

General conditions such as the lack of a good transport system, walking long distances in the DRC may have aggravated Liliane's condition. However, this is the belief that Liliane brings and it was not medically proven although it has a reasonable link with her condition.

Liliane was also subjected to other traumatic events. She explained it in the following quote:

> *I was arrested for one month and they beat me on my back using the butt of a rifle. (Interview, Liliane)*

Liliane was tortured and persecuted. In addition to that, she lost her job. The conditions in which she was kept in jail might have aggravated her illness as well.

In addition to that, Liliane faces emotional distress and socioeconomic challenges and she links this to her physical health problem of a slipped disk.

> *They are all problems because you know, when a lady is threatened or rejected by her husband, and when the husband abandons you with children, it is a problem which affects the psyche. So, any problems can always disturb anyone's psyche of somebody. (Interview, Liliane)*

Liliane is divorced and feels disappointed and lonely. She also has to look after her children alone, but does not hold a job. All these problems overwhelm her and affect her psychologically and physically. The symptoms associated with a slipped disk are described as Liliane highlights them in the coming section.

4.4.3 Description of Symptoms and feelings of slipped disk: "*it is essentially pain*"

Liliane describes symptoms and feelings of a slipped disc in the following vein:

> *So, as symptoms of slipped disk, it is essentially pain at the spinal column and in the legs and knees. Before I started getting health care, it was difficult to walk for a long distance and it was also difficult to stand up longer in the same place. I couldn't carry a load and even when I was seated, I had pain and to stand up straight was difficult. It was required of me to do such kind of exercise before standing up normally. That's how I was feeling. (Interview, Liliane)*

The symptoms and feelings of a slipped disk are mainly pain. Pain comes with movement. When Liliane is reaching for something in the kitchen, bending over to sweep or pick up something, lifting a bag of groceries, when walking for too long, or when she is standing longer in the same place – all of this can trigger a flash of pain that radiates downward and upward from the spine. Liliane is always in movement despite her pain. Left alone to care for her children, Liliane sacrifices herself to move here and there in order to look for any support to get food and find any assistance to get her children to school. The divorce and the socioeconomic hardships push Liliane not to rest. These reasons lead to thinking and worrying too much. When she moves, walks, or does any movements in an effort to find something with which to support her children, she feels a lot of pain. Thinking too much about the husband she had lost, about her divorce, about her children and the difficult living conditions she encounters in South Africa, induces headache and insomnia.

> *You know, somebody who is not working is already affected psychologically because he is not able to satisfy his basic needs and the needs of his children or his family. For my case, I have to respond to my children's needs. But without a job and the support of my husband, it is hard and I don't feel well. Pain is not only physical or corporeal, but also affective or emotional. If my living conditions are not well, I will always be affected in my health, you know. (Interview, Liliane)*

To Liliane's understanding, psychological and physical pains cause and complement each other, and cannot be separated. Liliane's comment about the pain she feels is, "The pain I feel is like somebody carrying something". She describes her emotional feelings as largely related to the feeling "of carrying responsibilities of children or playing the role of my husband". Liliane also gives a cultural understanding regarding the correlation between emotional and physical pain as indicated below.

a. Linking psychological and physical pains: "pain affects the psyche"

"Are there any links you can make between your emotional and physical pain?" Liliane is clear in her answer to this question:

> *You know, the spine is connected to the brain. Then when you think too much, you feel like your brain is overloaded with problems and from the brain the spine can also be affected and when you feel too much pain, it also affects your psyche; you can't sleep because of pain. The two levels complement each other. (Interview, Liliane)*

Liliane's explanatory model establishes a link between the psychological pain caused by unemployment, poverty and divorce, and the physical pain originating from her slipped disk. She uses her own metaphor to stress this relationship. Liliane thinks that shecarries, on one hand, the divorce which affects her emotions and on the other hand, the spine which affects her physical body. She likens her acute pain to somebody carrying a load.

Asked painful event affected her the most, she answered:

> *The event that affected me the most is the divorce. You know, if the divorce happens, not only you lose your husband but the care of children is now hundred percent in my hands. Their study, food, clothes, health, everything I am now doing it on my own. (Interview, Liliane)*

Looking at the degree of pain according to causes, it is important to mention that Liliane went through different difficult events: she lost her job, she was jailed and she got divorced. From all these painful events, she thinks the divorce affected her the most. Emotional pain is the most

challenging compared to physical pain, because emotional pain is difficult to control. One may ask the question why divorce is the most affective in Liliane's situation. The answer to this question is provided in the cultural perception of divorce in the DRC.

b. Perception of divorce in Congolese culture: "divorce affected me the most"

Cultural and religious beliefs in Congo do not accept divorce. Divorce is not common in the DRC because marriage is seen as a union between two families and divorce therefore divides communities (Council, 2004:8). A woman who divorces rarely gets support from her family members, even if the husband is the one who initiated the divorce and this happened because of his misconduct. The situation is more challenging if the woman is left with children and does not have any means to support her children. Her family will always tell her they cannot help her because they did not ask her to divorce in order to become a burden to them. Furthermore, it is difficult for a woman who gets divorced to contract another marriage with a man. She is not well- perceived and loses respect and consideration from the community. Some popular songs even advise men to marry a widow rather than a divorcee, considering that a woman divorcee is always perceived as the guilty party in a divorce. Literature shows that women are more affected when they are not initiators of the divorce (Sakraida, 2005).

> *I pay the price of the divorce. No one looks at me or my children, even my family members. A woman who is divorced in DRC is rejected even when doubly rejected; by the husband and her own family. It is painful and it is not fair, you know. In my case, the husband abandoned me with children and I am suffering to school and care for them. I don't receive any support either from his family or my family members, nothing. (Liliane, Interview)*

Worries bring illnesses and illnesses bring worries. Worries are caused by socioeconomic challenges. When somebody is not able to satisfy their basic needs, they start worrying and thinking. Liliane believes that thinking too much brings insomnia and this accentuates the physical pain. Illness reduces people's ability to perform their duties and to succeed in their lives. However, in Liliane's case, the absence of her husband is for her a threat to her own health as she has to play his role to satisfy the needs of her family. This comes as another example highlighting the relationship between emotional and physical problems:

> *Of course emotional and physical meet. For example now I am taking care of my children. You know refugees do not have a good life. If was still with my husband, there some other things he would do for the family, like looking for food, to pay children's school fees, rent and other expenses. Last time, my child was chased from school because of school fees, R4000. As I am not working it is difficult for me to pay R4000 for my child. I was not in peace, you know. I started thinking about where to find money to pay for my child and I went to UNHCR in Pretoria to ask for help for my child. This could be done by my husband if he was still with me. Now I play my husbands' role and I've become the breadwinner of the family. The absence of my husband forces me to play his role and this up and down deteriorates my physical state. (Interview, Liliane)*

Liliane is mostly affected because she has children to look after without any income. If she had a job, she would have suffered from the absence of her husband, but would be able to respond to the needs of her family. But she lost her job, abruptly left the country and also lost her husband and finds herself in a difficult situation with the care of her children.

What are the effects of a slipped disk on Liliane's life? The next subsection explores her response to this question.

c. The effects of a slipped disk on Liliane's life*: "This illness has trapped me"*

In responding to the effect of a slipped disc on her life, Liliane said:

> *The permanent pain worries me the most. Physically I am now restricted, yes, because I was a strong woman, full of initiatives, an entrepreneur. Now I am not able to do it because this illness does not allow movements. Now, to do business you need to move around, to carry heavy weights and I cannot do it again. I don't like the fact that pain persists in my body. I am now weak, limited because this illness has trapped me. (Interview, Liliane)*

Liliane was once a strong woman, full of energy. However, becoming sick with a slipped disk has changed her in terms of her energy as she cannot carry loads or walk long distances. Her condition has limited physical exertion because of chronic pain. She is also psychologically affected because she is not working and not able to provide for her children. Thus her pain is not only physical but also emotional.

Is there anything that Liliane can actually do? Liliane answers this question as follow:

> *However, I am still able to work in the office, to do intellectual work and I do not think this illness has changed my personality as a woman. (Interview, Liliane)*

This illness has not reduced other capacities and her identity. Liliane refuses to lie down and lose her identity as a strong woman. She would like to do something in order to take care of her children and herself. A sick person can become sicker than before if s/he does not feel integrated and participate in the community (WHO, 2003, Rijken and Groenewegen, 2008). The issue of being a foreigner in South Africa may aggravate or alleviate Liliane's suffering. I now turn to finding out how being in the host community of South Africa has influenced Liliane's health.

4.4.5 The effects of migration on Liliane's health

Liliane gives her experience of being a migrant in South Africa and shows how this is linked to her refugee status and how both affect her health.

> *Well, migrating to South Africa, for me, I find this experience difficult. Why? Because when I arrived here, I had serious problems. That made my life difficult, i.e. I was robbed by somebody, a Congolese, a brother. And difficulties here for me, as an immigrant in SA are too much. I can start with accommodation. Accommodation is too expensive; rent is really expensive, especially when you do not work. It is really challenging. And if you have children, as they must go to school, school fees are expensive. I think it is that, accommodation problem, school fees for children and there is a problem of language. Language is what gives life to a person in another country where they speak a language the person does not know. Then language adaptation is difficult because even to get a job, if you do not know the language, it is difficult. That is why even if you are qualified, as long as you have not mastered English yet, it is difficult. If you do not speak English, it is hard to find employment corresponding to your qualification. This is another difficulty. So there is language, accommodation, schooling of children. I am struggling on a daily basis with my children and as a mother. I can't be fine if my family is in the situation of lack. (Interview, Liliane)*

In the case of Liliane, the living conditions in South Africa expressed in terms of unemployment, accommodation, schooling children and the language barrier worsen her suffering. The language barrier limits qualified people in accessing jobs commensurate with their skills. However, the socioeconomic hardships of the host country are not directly linked to the origin of Liliane's illness, but they accentuate her pain because Liliane does not rest. She is in constant mobility doing what she can to raise money.

In addition to this, Liliane mentions some threats found in the local environment which she finds stressful.

> *… sometimes the behaviours of citizens of this country towards foreigners and criminality cause too much stress to me. For example they use to brand foreigners Makwerere. Why this discrimination? It worries me too much. (Interview, Liliane)*

Living in an environment where one feels accepted contributes to people's sense of wellbeing. Migrants seek to create a 'healthy place' which offers them security and promotes the quality of their lives (WHO, 2003, Dyck and Dossa, 2007). Exclusion is seen as a threat and affects people's quality of life. Nonetheless, it is important to mention that not all the South Africans hate or insult foreigners. Sometimes foreigners do not approach natives because of the language barrier or they just presume that all or most citizens of the host country may not accept them.

The next subsection examines the type of help Liliane resorts to for her slipped disk.

4.4.6 Help-seeking behaviour

Concerning help-seeking, Liliane commented:

> *I just go to the nearest clinic to get some painkillers. In any case, I do not know and even people whom I know suffer from this illness, none of them told me that he/she was getting treated with traditional medicine, because slipped disk does not affect bones only but it also affects nerves. (Interview, Liliane)*

Western medicine remains the main source of help in Liliane's case. She has never heard about any other means of treatment for a slipped disk besides a biomedical one. This confidence in western medicine might be created by the interaction between Liliane and her health worker and the way her condition was explained to her.

She resorts to some antibiotics and pain relievers when she feels too much pain. However, neither medication nor prayer brings any relief to Liliane because her illness is now chronic.

> *I don't know what to say; this is God's domain. This pain, as it is now chronic, it doesn't change even when you pray or take some painkillers, you always feel pain. (Interview, Liliane)*

Liliane's quote shows that she is not satisfied with the kind of treatment she is getting. She therefore looks for something greater than that. As she does not find it, she relies on the current

treatment in spite of the fact that it does not really help her. However, by keeping on using pain relievers, Liliane hopes that this treatment may help her get better. But at the same time, she is skeptical of ever getting better. As such, the treatment may not be successful because of the doubt that Liliane has planted in her mind.

When pain becomes chronic and terrible, she says that it is difficult for her to notice whether there is relief or not when she takes pain relievers. The sufferer's expectation is to get completely healed from the suffering. Nevertheless, healing - according to Liliane - is God's will and no one can force him. For her as a Christian, she takes her pain as a Cross following the example of Christ. She does not really expect physical healing from the church, but mainly spiritual. Liliane shares here her belief as a Roman Catholic that suffering is the way that leads to happiness. The support Liliane receives from the church is largely moral although sometimes the church provides her with some food for her children.
Asked how she was coping with the emotional pain of divorce, Liliane replied:

> *In that case, I commit myself to prayer. In case of insomnia, I sing gospel songs to obtain asleep. In addition, at home here, we share the word of God, and our life experiences or problems; and we pray together before we sleep. This is the way I get released from emotional pain. (Interview, Liliane)*

Sharing life experiences, building a community and praying together, help in dealing with emotional problems. Moral relief received from prayer becomes indispensable in strengthening the faith of the sick person and comforting her/him in suffering.

4.4.7 Role of others in Liliane's health Problem

I asked Liliane about the support he received from the community and she said:

> *Not really. JRS has agreed to pay fees for one of my children. But they just gave some books, a suit and a pair of shoes for him. They did not pay his school fees, nor did they buy him uniform. I was forced to look for money to pay his school fees and buy his uniform. Even the church does not give groceries to feed my family for the whole month. It is just a token, a once-off intervention. (Interview, Liliane)*

Liliane gets moral support from the Roman Catholic Church which she attends and sporadically the church also provides her with some food for her children. The church is a place where people interact to build communities and forge social relationships. Liliane seldom receives formal support from NGOs, especially JRS and this support is not sufficient.

At the place Liliane stays, the support that she gets is mainly emotional and is the continuity of the church's support.

> *We share the word of God and our life experiences with my neighbours. We also encourage each other because we all have problems. This helps us to keep on hoping, to persevere and to continue to believe that only God is able to change our particular situations. (Interview, Liliane)*

This type of support brings people together. It frees them from loneliness and depression. Material or financial support is often difficult to get and so migrants continue to be exposed to socioeconomic challenges and struggle on a daily basis. Nevertheless, sometimes it may happen that people refuse to share with others and just hide themselves behind poverty and other socioeconomic problems.

4.5 Presentation of case five: Pauline

Pauline is 40 a year-old woman. She has been in South Africa for two years and at present she has the status of asylum seeker. She came from Goma in December 2008. She left the country because of the war. Pauline has been married since 1994 and has eight children. She lives in South Africa with three of them (twin-boys of nearly and one girl of 10). Pauline has never worked since her arrival in South Africa. She lives with her younger brother who works in the security industry and whom she depends on. However, her brother is not able to offer her financial support because of the scant resources he has and because he has a wife and two children to look after. Pauline's husband lives in Kinshasa with the other children and rarely sends money for her upkeep and that of the three children in South Africa. Pauline and her husband lived happily from 1994 until 2007. Life was good and they did not have any problem. In 2007, Pauline's husband offered her as a gift, a ticket to visit South Africa as a tourist. At that time, she didn't know that she was already pregnant.

Her husband offered her this opportunity to visit South Africa when he had not visited the country himself. This shows that he loved her so much.

Their relationship began to deteriorate in 2008 after the birth of the twins. One of them did not cry when he was born, and became paralyzed. He cannot sit, walk or speak. In the beginning, the couple was eager to help the child with the hope that his situation would improve. Realizing that they spent a lot of money and the child's state was not improving; Pauline's husband got tired and decided to give up on his wife and the child. Since she came to South Africa to live, Pauline and her husband seldom talk and she sees the future of their relationship as getting bleaker. Pauline feels lonely with her child's problem and does not have financial resources to take the child to a specialist. As a mother, she also thinks about her other children left in Congo and does not know exactly under what conditions they live. Pauline also worries about her marriage whose future is now uncertain. The husband and his family members are not happy with her because of the child's health conditions. Pauline feels her husband would like to get a divorce but does not clearly express this. Pauline's life therefore is a sad one and she often falls ill. Her health has become fragile and she frequently suffers from loss of consciousness. Since 2008 with the birth of the disabled child, Pauline's life has become a tale of suffering. It is therefore important to mention that besides the war - which is the main reason why Pauline fled the DRC - there is also the lack of support from her husband and her fading hope of finding treatment for her son's condition in South Africa. The cultural understanding that the sickness of a child is the responsibility of the mother and the husband's in-law's may have led the husband's decision to stop supporting the child. Furthermore, in South Africa, Pauline is unemployed and cannot work because of her son's disability. Nobody is there to look after the child if she is absent. She therefore feels trapped.

The following is Pauline's narrative, her interpretation and experience of suffering.

4.5.1 Illness Experienced

Pauline's answer to what health problems she currently experienced is as follow:

> *I think too much. After thinking too much, I become ill. I have developed gastritis. Last week, I was admitted to Johannesburg hospital for 5 days, because of gastritis caused by this problem. It also happens that I have insomnia; headache or I just start weeping. (Interview, Pauline)*

Pauline describes her situation as painful. When she looks at her child, she starts to think as she says, "too much". She always asks God questions about her child's condition such as *"why this?" "What have I done?" Is it a curse?"* When she speaks her eyes often fill up with tears. Because of her child's disability, Pauline often spends sleepless nights thinking about her child's problem resulting in gastritis and regular headaches.

Pauline started suffering from gastritis in 2008. She attributes this gastritis to various events. The next section explores what Pauline believes to be the cause of her current illness.

4.5.2 Causal attributions: *"my son was born with a disability"*

What do you think is the cause of this illness? Pauline provides the following answer:

> *Our love life was rosy as it usually is for most couples after the wedding. Life became utterly difficult when this (her son) was born with disability. Well, the child was not born normally as other children. He was born with malformation, he is sick and I feel anxious. I start asking why this. All the problems started there. (Interview, Pauline)*

Pauline and her husband had a happy marriage for many years. They maintained a very good relationship and communication. However, the situation changed in 2008 when she gave birth to the twins and one of them was disabled. Pauline's child could not sit, stand or speak. According to her, that was the beginning of her suffering.

The cultural insight of this case is that in the DRC a wife is expected to give birth to children who are in good health. If a married woman gives birth to unhealthy or disabled children, she is held responsible for that misfortune and can even lose her marriage. This situation is also mirrored by childlessness after some years of marriage. The wife is seen as responsible for that situation as well and is subjected to criticisms and all kinds of threats. This is what Pauline explains in the following quote:

> *Ah! I do not really know and I cannot criticize them [relatives from her husband side]. But it looks like I am responsible for what happened to my child. You know, in Congolese culture, a child who succeeds is associated with the father and the one who fails with the mother. A healthy child belongs to the father and a sick one is the mother's, always like that. (Interview, Pauline)*

Usually, in Congolese culture, the child's success is attributed to the father and a child's problematic behaviour or failure to the mother. That also explains why Pauline, as a mother, has to take the responsibility for her child's abnormality.

Asked about the first time she suffered from gastritis, Pauline gives the following answer:

> *Well, the first time I suffered from gastritis was in 2000 after the birth of my third daughter. I had a problem with my stomach, the placenta was not out and my life was at risk. You know, in our hospitals in DRC, each doctor comes with his instructions. I was not allowed to drink water for many days and from there I started experiencing gastritis. But after receiving treatment, this gastritis was over. But the gastritis I have now started in 2008 after the birth of the disabled child. This gastritis is caused by my present situation with this child. It has become almost permanent and chronic, even when you try to forget, it is really impossible. (Interview, Pauline)*

Pauline recalls having suffered from gastritis for the first time in 2000, after giving birth to her third child. The second experience of gastritis that Pauline has is due to the birth of her disabled child. This child is a source of many problems because of his physical condition, leading to a psychological problem Pauline calls "overloading." This overloading is due to her inability to solve all the problems she is having. She is currently faced with the problem of her child who is a cripple, the marriage she is losing because of giving birth to an abnormal child and the harsh living conditions in South Africa characterized by the lack of employment, good housing and food to provide to her children. These are problems that, according to Pauline, overload her mind and affect her health. Pauline suffers a lot when she looks at her child. She thinks too much and always cries. It becomes impossible for her to stop thinking.

Furthermore, Pauline regularly experiences headaches and is adamant that the headaches come from thinking too much. That is why she repeatedly uses the word "overloading" to summarize this situation:

> *Headache, well … I can call it overloading. Many problems, and this manifests through a headache. Sometimes, you don't know how to feed the children, how to treat the sick one. This sick child is in himself a problem. So, I have many problems. As I said, sometimes you carry the child the whole night because he is always sick; you as a mother, you can't sleep. Sometimes, he can sleep during the day and at that time; you can't sleep while you spent the whole night looking after the child. You have now to do some other house work or look after other children. All this disturbs me and causes headaches. (Interview, Pauline)*

Pauline is overwhelmed by problems. When she thinks about the condition of her child, other children she left in Congo whom she does not see and the marriage she is losing because of one disabled child, she feels overloaded through "*thinking too much*." Looking also at the living conditions of the host country and the difficulty to feed and school children who are with her, she feels overwhelmed and does not seem to find a way of sorting these problems out.

What is the cultural meaning assigned to this case of a *tshilema?*[12] In the following section, Pauline offers a cultural explanation of a *tshilema*.

4.5.3 Cultural meaning of a child born with a disability and her own way of describing it

What do you think about your child when you see him in this condition? What is the cultural understanding to this case? Pauline explains:

> *You know, this is the perception we always have. Many things are said. Sometimes, in our popular beliefs, we think about human sacrifice to gain wealth, especially when you have a lot of money and at the same time you have an abnormal child. Sometimes, we think about witchcraft and we mostly accuse aunts and uncles of bewitching the child or we may say witches always collaborate by paying back what they receive from each other in terms of human sacrifices. Sometimes we also think that the wife or husband has committed adultery with other men or women. There are also beliefs that a close family member stole people's belongings or killed people, reason why the child is born with such disability. But if I look at myself, personally, I've nothing to reproach myself for, I didn't go to a fetish priest, I was never a prostitute, I didn't go with another out of my marriage, never practiced magic, nothing. I only see a problem that happened to me, that's all. (Interview, Pauline)*

The birth of a disabled child usually raises much speculation and interpretation. Some link it to consumption of some food forbidden to women. The mother may have consumed a forbidden food when she was pregnant; others evoke mysticism, especially occultism (supernatural and magic practices performed by those who are initiated) in terms of human sacrifice. Some think about sins committed by a close family member and others can talk about adultery committed by the father when the wife was pregnant or refer to witchcraft. Pauline stresses that it is what people commonly believe. While she recognizes these beliefs as deeply rooted in people's thoughts, she does not take

[12] Tshilema (in Tshiluba, one of the local languages of the DRC mostly spoken in Kasai province) is a label used to describe or to call a child born with disability.

this as the cause of her child's disability. When she asks herself many questions about her conduct, she does not see where she could be guilty to deserve this as punishment.

Paulina's wellbeing is her child's wellbeing and she views the two as inseparable. She refers first to her status as wife. She feels disrupted because of giving birth to a disabled child and her marriage cannot be saved as long as the child does not get healed. Therefore, Pauline says:

> *…. we can be together, but the major problem is the child. If the child remains in this condition, it is difficult… (Interview, Pauline)*

Pauline's wellbeing is also related to her living conditions as a refugee. She also thinks about other children left in the DRC:

> *… you know that the care of children is the mother's duty. The father can go out and when he comes back, he does not have time to control children. He can give them money for food, but he does not pay enough attention to them like the mother does. (Interview, Pauline)*

She is trapped and cannot move as the disabled child needs constant attention. When she also thinks about other children, she gets worried because of the love and affection that she, as a mother, has for her children. The education of the children is mother's duty. The reason behind this is that it is always culturally argued that a mother can successfully raise a child without a father, but the opposite is not easy. Pauline is aware of her responsibility as a mother towards her children.

Affected by gastritis, Pauline experiences many feelings. What Pauline feels in her body and the way she describes her gastritis is presented in the next section.

4.5.4 Description of symptoms and feelings: *"I feel like in prison, I can't move"*

Pauline feels like her heart could stop at any moment and presents many symptoms as she describes them below.

> *I feel breathless and a terrible pain and it is burning inside. Lack of appetite, fatigue and you throw yourself here and there because of pain. I have a terrible headache. You feel like you have wounds inside and when you drink water, you feel it touches wounds. I don't know if you've already suffered or you know somebody who suffers from it, but it is a dangerous illness. Mostly it happens that I feel pain and start throwing up (vomiting), I am no longer in a good mood and I start weeping and I experience loss of consciousness. (Interview, Pauline)*

The painful situation Pauline has been going through is explained in her feelings. Shedding tears is another way of expressing pain. Looking at her child's situation and impending divorce owing to having given birth to a disabled child are both distressing her. Psychological pain may take a greater toll than physical pain. When she compares the two episodes of gastritis, she insists that the 2000 gastritis episode was less painful and easier to treat that the current one. The latter is more severe and difficult to cure because the problem that has led to it is not over yet and it has become a permanent situation.

> *Eh! The gastritis I have been experiencing since 2008 is more painful and stronger than the 2000 one. For now, doctors are asking me to live like a five-year child who doesn't have any problems to think about and who doesn't know that problems exist …. But it is practically impossible for me. As a mother, I am always forced to think, even when I refuse to do so. There are circumstances, for example my child's health and my marriage that will always push me to think over and over again. (Interview, Pauline)*

When asked about her husband's position regarding their relationship, Pauline replied in these words:

> *Ah! About my marriage, what can my husband say? I think you already understand that it is a big problem in my marriage. Because of this situation, there is no more love; the husband is no longer interested in you. It is almost over, the marriage, if I can say that. (Interview, Pauline)*

Pauline expresses her worries. Firstly she worries about her child's state which is not improving. Secondly, she worries about her other children left back home that she does not see and those who are with her that she has to care for. Thirdly, Pauline worries about her marriage which is in danger of failing because she has given birth to an abnormal child and lastly, she worries about life conditions in South Africa where she has a problem trying to speak English to help her find a job to take care of her family. All these problems affect her health.

> *There are some circumstances that aggravate my suffering. Mostly, it is the inability to speak English. This worries me too much, because I have a child to take or present at many places to seek help. You need to talk and explain the child's state, but I am unable because I don't know English. Sometimes I look for somebody to accompany me, but as you know, in this country, people are always busy eking a living. You will never find anybody totally free to help you every day. So, this language problem affects me too much. I am like a dumb person where I have to talk. (Interview, Pauline)*

Language barrier is a big challenge as Pauline needs to meet people, talk and explain to them the child's situation, expecting to get help from them. Even when she takes the child to the hospital, she

is not able to speak to doctors or ask for any assistance for the child. Sometimes she looks for some neighbours to accompany her, but they are not always available.

Asked how her child's condition affects her, Pauline answers in Lingala as follow:

> *My situation is so painful. You know, a child, after one year and some months, he must move, it also frees the mother. But in my case, I am condemned. I feel like I'm in prison, I can't move, I can't do anything else, even to look for a small job, because I must always be there to take care of him. (Interview, Pauline)*

To look for a small job as means of survival becomes problematic for Pauline, not only because of scarce jobs in South Africa, but also because of the child's condition. Pauline's child cannot sit, speak or move. He has becomes a burden, a load that Pauline has to always carry on her back. Pauline feels imprisoned, unable to move away from the child in order to look for a job. The child's health has trapped her and there is nothing she can do as no one is able to take care of such a child, besides Pauline herself. She explains it in this way:

> *The truth is that my problem didn't start in South Africa. I brought it from Congo. Thinking too much about my child's state, even if I was still in DRC, I would do so. The problem with South Africa is that I don't have any support and I don't know the language. There are specialists, who can try to save this child, but they are too expensive and I don't have financial resources to approach them. I try to do something, but as a woman I am limited and I don't know what doors to knock on. Nobody here is ready to come to my assistance. All this makes me think too much. I am alone to fight for this child in a country where I don't know the language and I don't have necessary financial resources to take him for treatment. (Interview, Pauline)*

While recognizing that the origin of her problem is not South Africa but DRC, Pauline also thinks that South Africa affects her condition. This is because she does not have any supports and the language barrier is emphasized as it hinders her efforts in seeking solutions to her child's condition.

Furthermore, living and depending on others is a strain. Pauline considers her presence and dependence on her younger brother as disturbing her brother's family as they have scarce resources and face the same challenges.

> *You know, I can say that it always happens. People already have their family to look after, their planning and their way of living. You come to add yourself and you become like a disturber or an intruder. You can now imagine how the attitudes will be, especially for us, ladies. I don't condemn my sister-in-law because I am also a wife and if I was her, I would also show the same attitudes. (Interview, Pauline)*

Staying at her brother's place is not something that Pauline likes. But she is forced to be there because she is not able to pay her own rent. Once a woman is already married, she rarely gets

support from her family members and the situation becomes more complicated in the case of divorce. The family members may always criticize their sister saying they did not instruct her to lose her husband. In addition, a married woman prefers to spend her life with her husband and does not feel comfortable to return to her family.

The next step examines the types of help Pauline relies on for her and her child and how effective these are.

4.5.5 Help-seeking behaviour

Pauline has frequently used western medicine as treatment for her gastritis and repeated headaches, as well as for the physical disability of her child, especially physiotherapy. As she says:

> *Well, I only go to the hospital, often at Johannesburg Hospital. I was there when I experienced loss of consciousness. (Interview, Pauline)*

Gastritis comes from worries created by life conditions. As long as life problems are not sorted out, medication taken may not be successful. The best way of getting rid of gastritis is to stop thinking too much. Is Pauline ready to stop thinking, what makes her think too much? She explains:

> *It is difficult, because if I look at this child, I am not in peace. It often happens to me to lose consciousness…. So, it is difficult for me to transcend if I see the situation in which this child is, and I think about my other children in Congo and my problematic marriage; I don't know if I'm still married or the marriage is finished. (Interview, Pauline)*

To stop worrying too much seems impossible to Pauline. The child's disability, possible divorce and separation from her children are problems that Pauline faces and is constantly preoccupied with, making it difficult to stop thinking.

The status of refugee and access to medical care: "without a South African ID, they can't treat my child"

The South African constitution guarantees the rights to medical care to all those staying in the country – citizens and foreigners, nationals and non-nationals, documented or undocumented migrants. In practice, it has been noticed migrants are often denied the right to health care or are not

well-treated (Amit, 2010a, Polzer, 2010, Vearey, 2008, Pursell, 2004, Moyo, 2010). Migrants' access to healthcare is seen as an act of generosity and the provision of care is done without diagnosis and it is inappropriate (Moyo, 2010, Amit, 2010a). This applies to Pauline's case as she explains the situation of her child:

> *The doctor who treats him clearly told me that without a South African identity document, they can't go further with this case. He just told me in English: "I can't help you…I can't" because I am not a South African citizen and I do not have valid papers, it means South African ID. I only have "Ngunda" [asylum seeker permit] and with that document there is nothing they can do for my child. He said they would help with this case, but because of my permit, "I can't." (Interview, Pauline)*

Pauline also takes the child to Johannesburg Hospital for physiotherapy. She thinks it is not done regularly and properly. The service is really limited as Pauline is an asylum seeker. For her, the physiotherapy and massage her child needs should be done regularly. The barrier to accessing proper medical treatment is that Paulina and her child are not South Africans. To be a South African and to possess a South African identity document appear to be conditions for proper treatment. Although this is Paulina's perception of the treatment provided to her child, the fact is that the issue of documentation is always raised as a condition to access appropriate medical care for migrants.

Besides medical treatment, Pauline resorts to other means of help as she explains:

> *Yes, I've already lost hope because nothing has changed, but the word of God gave me strength and I am still hoping. I only rely on God's will and grace. (Interview, Pauline)*

In addition to medical treatment for her and her child, Paulina prays to God for her child's problem. But sometimes she gets tired and loses hope because the child's situation is not improving. Losing hope is the sign of discouragement when something expected is not forthcoming. Pauline's prayer is that God heals her child. She is a member of a Pentecostal church and she believes in God's ability to perform miracles.

Thus, Pauline finds support in her religion, as she says the word of the Lord gives her strength to continue praying, even in those moments when she doubts the efficacy of prayer.Pauline explains what she prays for:

> *I hope that God will respond to me and I always ask him to perform miracles for my son's healing and my marriage's restoration so that my husband and I live together and take care of our children. That is my wish and my prayer. (Interview, Pauline)*

Pauline's prayer is based on her problems – her child's disability, the unity of her family and a possible reconciliation with her husband. Other perceptions have a bearing on Pauline's child's disability:

> *It looks like I've sinned. They don't regard me with favour. For them, I am responsible of this misfortune. Besides, they push their son to break up with me. They call me many insults, sometimes they call me witch. (Interview, Pauline)*

Giving birth to a child labeled *tshilema* is perceived as a shame. When people talk or refer to this family, they always use this derogatory name to identify them. Sometimes a family concerned by the situation believes that people always talk about them even when they do not. They become frustrated in the community. Pauline feels rejected by her husband and her in-laws.

The expectation of in-laws is to marry a wife for their son. The wife should be able to procreate and to give birth to healthy children. When a wife gives birth to an abnormal child, it is often understood as a curse brought by the wife to her husband and in-laws. Consequently, the wife must pay for that and mostly she is rejected and becomes subject to criticism. Under these circumstances, the family members can look for another wife for their son. It is possible that the change of attitude in Paulina's husband was due to pressure comes from his family members. They can even stop him from staying with his wife who is considered as root of evil and the marriage can be terminated because of that. The same situation is observed for a couple without children. Often the wife is accused of barrenness and subjected to harsh and consistent criticism. The in-laws not only attack the wife, but even her family. Sometimes they can terminate the marriage and ask the wife's family to return the dowry that was paid for her. The family members usually push their son to marry another wife who can give birth.

The kind of support that Pauline receives is mostly moral, expressed in words of compassion, hope and encouragement.

> *Congolese will always tell you: "just pray my sister, don't stop praying, God will help", that's all. To offer you some money or something to eat is difficult because they also suffer. (Interview, Pauline)*

Pauline accepts prayer efforts with gratitude. However, she wishes for more than prayer and emotional support. She wishes for financial support. In a country where people struggle to find a better job in spite of their skills (Vearey, 2008) and to satisfy their basic needs, it is rare to expect such support. Nevertheless, she believes that her countrymen and countrywomen could have helped if they were not in need as well.

CHAPTER FIVE: ANALYSIS AND DISCUSSION

Introduction

The study sought to explore how Congolese migrants perceive or understand illness and what resources they use as alternative methods of help-seeking behaviour to illness. The study aimed at exploring the cultural dimension of illness and the care-seeking behaviour among Congolese migrants, an aspect that is not given much attention in South Africa. Data presented in the preceding chapter provided insights into the perception of illnesses among some Congolese migrants living in Johannesburg. The analysis and discussion that follows establishes the relationship between the findings and the objectives of the study. Different themes such as the impact of previous experiences on migrants' health, the influence of the host country on migrants' health, supernatural forces as causes of illness, single motherhood and health, help-seeking behaviour, and the place of social support are discussed in this chapter. These themes were generated from the analysis of the data and they are discussed in this chapter in the light of the literature reviewed.

5.1 Socio-demographic characteristics of participants

Regarding the study population, the findings indicate that three participants are women and two are men. Participants are all Congolese (DRC); two of them are originally from Kinshasa and three are from Goma. Political violence is indicated as the main reason for leaving the country. Participants were all married at some point. For now, two are divorced, one is separated from his family for ten years and only one is still married and stays with her husband and children. Three of them live in South Africa with some of their children and other children were left in the DRC. Most of the participants in the study are unemployed and have socioeconomic difficulties as well as failure to integrate successfully in the South African community. They have been in South Africa for more than one year (two, three and eight years) and live in different suburbs of Johannesburg (Kensington, Orange Grove, and Yeoville). They have different university backgrounds (geographer, lawyer, and historian), one is a former soldier (colonel) and one has

no education level. All of them report to be asylum seekers, only one has a formal recognition of refugee status in South Africa. Most of them struggle to speak English. All of them present some health problems, one of the criteria used to select them in the present study. In the next section, I briefly present participants and the health problems they have been experiencing in South Africa.

5.2 Participants and health problems identified

Participants	Age	Arrival in SA	Health Problems	Year of diagnosis
Anne	35	2007	hypertension	2008
			Trauma	2007
Christian	64	2002	Gout and Rheumatism	2004
			Hypertension	2006
			Diabetes	2008
John	49	2009	Cramp	2007
Liliane	56	2009	Slipped disk	2007
Pauline	40	2008	Gastritis/headache	2008

Source: Fieldwork data

This table shows that all the participants in this study face different health problems. Most of these illnesses were diagnosed in South Africa. Two participants' illnesses were diagnosed in the DRC previous to their arrival in South Africa. Two of them deal with the illness of their close family members, in addition to their own health problems. Some of them came to South Africa with pre-existing health problems from the DRC (John, Liliane, and Pauline), others came without knowing that they were ill and their problems were discovered in South Africa (Anne and Christian). Most of them stated that the origin of their health problems for all of them is not South Africa, but the DRC.

In the next sections, I examine the extent to which the previous experiences before migrating and the living conditions in the host country affect migrants' health.

5.3 The impact of previous experiences on migrants' health

It is important to highlight the extent to which pre-migration stresses in the country of origin may shape the understanding of the current health problems in the receiving country. In the migrants' understanding of their own health problems, the society from where they come may help to identify the causes of their illnesses.

In this regard, the study identified that migrants who participated in this research attributed some of their health problems to political violence in the DRC. It is known that since 1998, the country has been torn by violence, armed conflicts, and war. The war in the DRC has resulted in many orphans, murder, torture and persecution. The brutal experiences of war have left all kinds of physical and emotional illnesses in the survivors. The study found that participants were affected by the effects of the war; sometimes they were witnesses or victims of violence and were several times arrested, as explained by one of the migrants interviewed when asked when her illness started:

> *some of my illnesses, like trauma, started in the DRC. I was working in an environment of conflict. We were, every time, witnessing murders and were many times attacked and when we were arrested again, it became serious because of the torture and persecution inflicted on us. (Anne, Interview)*

Violence, arrest, persecution and torture were reasons most of the participants attribute to their illnesses. Almost all the participants experienced violence before migrating to South Africa and this badly affected their health prior to migrating. War, torture and persecution were the reasons for leaving the country for these participants. This shows they left their country of origin against their will after losing their belongings. This may also be linked to their current health problems. Being uprooted may explain homesickness because people leave their home country against their will and find themselves in an environment where they have to face many challenges pertaining to the integration process.

While a lot of studies focus on migrants' health and their access to healthcare in the host country (MSF, 2010, Pursell, 2004, Junghanss, 1998, Pophiwa, 2009, CoRMSA, 2009, Vearey, 2008, HRW, 2009), this study stresses the influence of previous traumatic events in shaping the current health problems affecting migrants in the host country. These findings conflict with the study

done in Canada amongst West Indian Immigrants which highlights only post migration as largely affecting migrants' health (Whitley et al., 2006). Participants in this study show that they were already exposed to violence in the DRC, before migrating to South Africa, and link this to the causal attributions of their current health problems, as expressed in the following quote:

> *…I was arrested and tortured. The way I was beaten up was cruel, it was not normal. Because I was seriously tied during the time I spent in jail… (Interview, John)*

Violence, persecution and torture are not only seen as the reason for leaving but also as the causes of the current ailments some Congolese migrants present in South Africa. In addition, some traumatic events may stay longer in the memory and continue to gnaw at the individual's health. This was raised in one interview where the respondent who is a former soldier remembered his friends killed on the battlefield and whose bodies he did not bury:

> *you know when I think about my best friend who was shot while we were still talking; and I couldn't even burry him because I would also be killed. I left his body in the bush and ran away and I don't know, maybe his body was eaten by animals, I feel too much pain. (Christian, Interview)*

Persecution and torture is not only physical, but also emotional or moral and can be created by many situations, such as the case of divorce affecting women's wellbeing, or the health of children or relatives. This issue will be discussed later on when I discuss the issue of single motherhood.

Migrants coming from the countries torn by war, or those who were exposed to torture, persecution or political violence can develop some health problems in the country of refuge as found in various studies conducted among refugees in various locations (Groleau and Kirmayer, 2004, Bhugra and Becker, 2005).

The religious beliefs influenced the understanding of causes of illness among participants in this study. People believed that what they did in their professional lives, their conduct vis-à-vis others might have led to their current situation.

> *I sinned a lot in my profession as a soldier; I was involved in prostitution and magic. I think I am now paying for that. (Interview, Christian)*

Individuals can be victims or perpetrators in a war situation and both can account for causes of illnesses. Remorse and self-blame is the main cause of distress in the case of perpetrators. This

is what (Nunez, 2010:10) calls 'sinful behaviours' including debauchery, idolatry, murder and sexual immorality when referring to what Pentecostal Churches perceive as possible underlying causes of illness . In this case the perpetrator believes in natural retribution being applied to him because of his past deeds or misconducts or wicked behaviour in society. Accordingly, restoration process of the individual to normal life is initiated on a different basis from biomedical treatment. In the case of the victim, self esteem is more likely to lead people to regret the loss of their dignity and think about the torture or persecution endured.

After focusing on the various factors that may influence migrants' health in the home country, I move on to the country of migration to see whether it can be used to explain migrants' causes of illnesses.

5.4 The influence of host country on migrants' health

Exile can be illustrated by the following old *Tshiluba*, saying: *"kwabenda nkulu kwa mutshi"*, meaning *being in a host country is like being on a tree,* as expressed by Christian, one of the migrants interviewed.

> *The South African environment stresses, because you're afraid. First, as a foreigner, you are not accepted. They say you're Makwerekwere, and then you do not know the vernacular language, so you have a difficult to approach South Africans. You do not know if they will accept you or not. (Interview, Anne)*

Another respondent said:

> *…difficulties here for me, as an immigrant in SA are too much. I can start by accommodation. Accommodation is too expensive; rent is really expensive, especially when you do not work. It is really challenging. And if you have children, as they must go to school, school fees are expensive. I think it is that, accommodation problem, school fees for children and there is a problem of language. (Interview, Liliane)*

Data from the fieldwork brought insight regarding problems that may affect migrants' health in South Africa.

Migrants participating in this study state that they encounter discrimination especially in accessing jobs, or other advantages in the country of migration. Anne said:

> *my suffering was aggravated by the fact of finding myself in a country where there is no social assistance: no job, no accommodation and difficulties of integration. (Interview, Anne)*

In addition, in South Africa, access to jobs or some facilities such as healthcare is not possible without South African identity documentation. This is highlighted in the following quote:

> *the doctor who treats him [my child] clearly told me that without a South African identity document, they can't go further with this case. He just told me in English: 'I can't help you…I can't' because I am not a South African citizen and I don't have right papers, it means South African ID. (Interview, Pauline)*

Some studies found that migrants were only involved in the informal sector in spite of their skills (Steinberg, 2005, Vearey, 2008). The lack of a green South African identity document limits migrants from accessing appropriate services. Despite what is stipulated on the asylum seeker permit and formal refugee status that the holder of these certificates has access to socio-economic rights including working and studying in South Africa, the reality on the ground is different. Access to employment in some institutions, housing and healthcare continue to be challenging for migrants who do not present a South African ID book (Greenburg and Polzer, 2008).

Access to legal documents is challenging in South Africa. Migrants spend weeks, days or hours to get or extend their permits. Despite what is written on the permits that they are entitled to socioeconomic rights as provided for in chapter 2 of the constitution including work and study, migrants are often denied access to certain services such as employment and healthcare. Lack of jobs and proper housing may affect migrants' health. The research identified that migrants selected in this study did not have proper housing; some lacked even a good bed. A case in point was of Christian who expressed it in these words:

> *…look at me, a great man [like me] and look at the bed in which I sleep, small and short. This bed does not fit me. It is smaller and shorter than my size. How can't I be sick in these conditions? (Interview, Christian)*

The lack of proper housing is due to the inability to afford rent. Migrants live in overcrowded places because the rent is too expensive (Greenburg and Polzer, 2008). Some cultural beliefs in Congo affirm that the bedroom is sacred and cannot be seen by anybody. It is a place of secrecy

and intimacy where only those who live there can have access. But in South Africa, the sacred aura of the bedroom has been taken away.

Migrants maintained that they face a lot of discrimination in South Africa. Discrimination creates frustration and fear, and can affect migrants' health. It is present in the daily interaction between migrants and the host community. Discrimination leads to social exclusion (Kamitanji, 2008). To refer back to the quoted *Tshiluba* saying above, such a condition may well denote a loss of worth by virtue of being away from home. Regard for outsiders in a host country remains subject to negligence and disrespect. One of the interviewees explains it very clearly:

> *you know, sometimes when I walk on the street, somebody just comes and bumps on me. I just look at him and I say: 'eh! Look at this one, he doesn't know me, that's why he can play with me'. If it was where I come from, he would never approach me or would have been beaten up. (Interview, Christian)*

The home country is a place where one is well known and where one may exercise his power and affirm his identity. The fact of moving to the host society makes an individual lose this prestige and become a nonentity.

Furthermore, language barrier is one of the problems that affect migrants' lives. (Moyo, 2010:129) writes that "the issue of language and cultural difference leaves room for miscommunication and dissatisfaction which in turn contribute to sub optimal care and unequal access by the migrant patients or the culturally different.".The issue of language was raised by all the participants in this study. Speaking English for example is considered an asset that gives advantage in the host country.

> *You know, I can say language is for communication what the heart is for the body. Whatever your skills, if you can't speak the language of the host country you can't do anything. (Interview, Liliane)*

In other studies, poor English was seen as a barrier to effective communication between migrants and health workers putting migrants at risk in terms of understanding instructions to avoid accidents at workplace (Anthony et al., 2009). Participants in this study were selected from an adult language centre where they came to learn English. The majority of them were skilled but expressed the need to master English in order to access employment commensurate with their skills. The inability to speak the language of the host country increases the marginalization of

migrants. What language do migrants have to speak in South Africa? This question was asked because migrants considered English to be inadequate in the facilitation of their interaction with the local community. Migrants participating in this study expressed it in the following words:

> *They only speak their mother tongue, mostly Zulu, everywhere: in hospital, in taxis and even in shops. If you say you don't know Zulu, they start insulting you in their language and you are marginalized*

Anne stressed the language problem by giving the example of her daughter:

> *…one day my daughter was terribly sick. The crèche phoned me to let me know. When I went there, my daughter was pale and was having a temperature. The principal said: 'If I let you go to the hospital alone with this child, she will die because no one will receive you as you don't speak Zulu. Let me go with you and introduce the child as mine." That is what she did and when she spoke to them in Zulu, the child was taken care of and was taken to the intensive care unit. (Interview, Anne)*

This example shows the ability to speak Zulu is an asset to accessing health care and to be close to the local community. Not knowing that language makes it difficult for migrants to benefit from many services. Furthermore, the example also shows that among the local community there are people who can accept and help migrants. All the citizens are not indifferent, unhelpful or xenophobic.

In addition, refugee status diminishes people's wellbeing. All the participants in the study were asylum seekers and they reported that their immigration status reduced them to dependents. Dependency is the result of being unable to find a good job and access proper housing. Some had been independent in the DRC but are now reduced to dependency. This explains why John likens being a refugee in South Africa to being a child.

While the study identifies the previous experiences in the country of origin as crucial in the shaping of current illnesses affecting migrants, it acknowledges that the host country contributes to relieve or aggravate people's illnesses (Whitley et al., 2006). Unemployment, lack of or poor housing, discrimination and language barrier are the main problems Congolese migrants deal with in South Africa and they impact heavily on their health and well-being.

(Bhugra and Becker, 2005:21) say that "host societies' attitudes, including racism, compounded by stresses of unemployment, a discrepancy between achievement and expectations, financial hardships, legal concerns, poor housing and a general lack of opportunities for advancement

within the host society, can lead to mental health problems in vulnerable individuals." Data generated by this reflect this finding. Participants in this study live in vulnerable socio-economic conditions in South Africa and perceive their illnesses as related to these difficulties of integration in the host country.

The socioeconomic factors impact on health and this relationship is clearly demonstrated in the 2003 *World Health Organization (WHO)* report. The socioeconomic burdens faced by migrants in the host country expose them to stress. (Bever, 2000:579) observes that "stress causes muscles to tense, for example, which is thought to cause most backaches and tension headaches." Bever (2000) highlights that stress does not have to be chronic to compromise the immune system; vulnerability lasts many hours even when the stress response is brief. The vulnerability can even be read on the faces of my respondents. All of them complain about headaches and they look sad, melancholic and desperate, as one of them declared to me:

> *I am no longer a human being. I am already a dead person, destroyed by problems. What you see is only my skin. (Interview, Pauline)*

Another participant stated:

> *I live in sadness. HCR helps me with R1000….The evidence is there, I told you, I am having headaches. I don't have money now, where I am going to find money to pay deposit for a flat? All this results in many problems, it brings worries, hypertension and many other problems. (Interview, Christian)*

WHO (2003:10) sheds light that "the longer people live in stressful economic and social circumstances, the greater the physiological wear and tear they suffer and the less likely they have to enjoy a healthy old age" (WHO, 2003:10).

Documentation has also been found to be a barrier to accessing social services provided by the host country (Menjivar, 2002, Greenburg and Polzer, 2008, MacNaughton, 2008, Vearey, 2008, CoRMSA, 2009, Thomas, 2010) that restricts migrants' access to health and other social services in the country of migration. Migrants are denied the services they are entitled to and, in some places, providing migrants with social services is seen not as their right, but as the expression of generosity from the staff members (Moyo, 2010). In this regard, the provision of healthcare

depends on the mood of the front desk worker who decides on the quantity and the quality of service to offer. These challenges bring anger, frustration, and disappointment to the body.

Data generated by this study shows that migrants experience discrimination in terms of accessing documentation, healthcare and employment in the host society. Discrimination is seen as one of the problems encountered by migrants in the host society. The concept of discrimination may be contested theoretically, but in practice, migrants often face the challenge of discrimination. Kamitanji (2008) quoting Wrench (1997:47) stresses that discrimination can be used when migrant workers are paid less in the same job as an indigenous worker or when special jobs are assigned to them that indigenous workers do not occupy at all.

5.5 Supernatural threats in the understanding of the causes of illness

Illnesses were attributed to several causes considered as natural and supernatural. The natural causes are understood as the exposition to germs, environmental factors or a physiological dysfunction caused by shocks. The supernatural causes of illness involve witchcraft designed to harm other people's lives (Garro, 2000:314). Participants in this study referred to bewitchment as causal explanation of their illnesses or the illnesses of their family members. Many adjectives are used to describe witchcraft: '*indigenous*', '*darkness*' and '*ugliness*'. Commenting on his brother's illness, John says:

> *I think they are indigenous illnesses.... These are illnesses that come from witchcraft, you see. Witchcraft is not accepted by people because there is no evidence. (Interview, John)*

Witchcraft is not officially accepted because there is no evidence. However, people use euphemisms to refer to this phenomenon. They describe a witch as a devil operating at night while people are asleep, using peanut shells as an aeroplane that helps them to fly from one place to another. In the DRC, there is a social pressure that even tries to convince officials to believe in witchcraft despite the absence of proof. Why do witches want to kill others? To this question, John answers:

> *Sorcerers are those who can provide or give an exact answer to this question. But what I noticed since I'm here, there is a climate of enmity among Congolese themselves. I can even say there is a climate of animosity between them. If someone succeeds, others are not happy. They want all of us to suffer. (Interview, John)*

Jealousy is one of the reasons cited for witchcraft. In an environment of poverty, the one who succeeds is not well accepted and is subject to jealousy. People prefer to be all at the same level. But how can somebody discover witchcraft? John says: "*God revealed to us in prayer*". Christian claims to see witches in his dream: *"I see things in dreams. I also did dream's initiation. If I dream about something I use to observe my situation after one day or two days or one week, even a month." (Interview, John)*

Linking dreams to bewitchment, John also stated:

> *…while I was asleep, I was dreaming a snake was biting me. When I woke up, there was no snakebite but I felt pain at that place. (Interview, John)*

Dreams cannot be neglected. They always have a meaning. Some are good for they announce success and others are bad and are linked to bewitchment.

It is believed that witches are able to possess and manipulate an individual. They regularly haunt people's sleep; they immobilize and suffocate people while sleeping. Wife/husband of night is a partner in a dream or in wakefulness but the phenomenon is invisible. Awake or asleep, an individual who has sex with the spirit enjoys it so much that he feels its effects and satisfaction when he wakes up.

It is common knowledge in various non western settings that any illness is believed to originate from a supernatural cause. In many cases, if not always, practices such as necromancy and divination are used as consulting alternatives. Kleinman (1988:11) writes that "the body-self is not a secularized private domain of the individual person but an organic part of sacred, sociocentric world, a communication system involving exchanges with others" Kleinman (1988) adds that to understand the meaning of illness needs first to understand the normative conceptions of the body in relation to the self and the world.

The explanatory model of some illnesses is based on the supernatural causes (Garro, 2000, Nguyen, 2008). From the African perspective, a human being is generally looked at holistically that is, s/he is an indivisible unit including body, soul and spirit. When coping with illnesses, s/he may attribute them to many causes: physical, emotional, demonic, and ancestral. The way of understanding and expressing illnesses may influence verbal as well as nonverbal

communication (Englund, 1998, Kleinman, 1988). These particularities may not be clear to nor can they be easily accepted and believed by those who hold different world views from those who believe in the supernatural.

The understanding of pain includes the wider socio-cultural view as medicine is unable to explain experienced pain for which there is no demonstrable pathological cause. Emotional pain is worse than physical pain because it is difficult to control (Bendelow, 2006:66). Some illnesses may be attributed to witchcraft no matter the explanation that can be used in medicine. Witchcraft may result from jealousy or from one's behaviour or conduct considered unacceptable in the community. Interpersonal conflicts not only make people think they have been harmed; they actually harm them, sometimes spontaneously and sometimes deliberately (Bever, 2000:583).

Beliefs in bewitchment do not expose one to it, but fear of witchcraft heightens susceptibility to it. This is a commonly shared belief in different African cultures stating that witches only attack those who fear them and they are afraid of those who face them. One of the informants understood this and expressed it in this way:

> *I know witchcraft exists but I am not afraid of witches. Since my early age, I believe that a witch can't do anything to me. That's where my strength comes from. (Interview, Anne)*

Interpersonal hostility can induce stress, and stress can induce a variety of physical ailments, regardless of any belief in witchcraft and magic.

The next section discusses single motherhood in dealing with family responsibilities.

5.6 Single motherhood and health

Single motherhood can be caused widowhood, bearing children outside wedlock or getting divorced. The focus of this study is on single motherhood following divorce. The divorce that affects female participants in this study constitutes a great hardship to their well-being. Liliane is clear on this point:

> *…the event that affected me the most is the divorce. You know, if the divorce happens, not only do you lose your husband but the care of children is now hundred percent in my hands. Their study, food, clothes, health, everything I am now doing it on my own. (Interview, Liliane)*

The divorce affects not only emotionally or psychologically, but also physically and economically. The woman is left alone with the burden of caring for children. In this context, even family members' support is seldom expected. But what is the cause of divorce? To this question, Pauline brings insight:

> *...since the child was born with a disability, everything in my marriage turned to worse. My husband no longer looks at me, and there is also the influence of his family members that aggravates the situation. They don't like me and push my husband to abandon me because I gave them a child they were not expecting from me. (Interview, Pauline)*

In Congolese culture, a wife is expected to give birth to children and to healthy children. A wife who does not give birth is always victim of marginalisation and ready to be chased for she does not fulfil the husband and his family's desire to have children and found a big family. Furthermore, a wife does not belong to the husband, but to his large family members. They have the duty of paying dowry for their nephew (Kankonde, 2009). Consequently, in case the marriage does not properly work, the decision of ending it does not come from the husband, rather from his extended family. Usually the wife is accused of witchcraft in case of divorce and children are assigned to her as well and hence she is left with the care of all the children.

Scant attention is given to the influence of divorce on divorced mothers' health. Sakraida (2005:226) says that "Divorce is a transition process defined as an event that changes relationships, routines, assumptions, and roles". Married persons have better physical and mental health compared to never married, widowed, divorced, or separated persons (Aseltine and Kessler, 1993, Doherty et al., 1989). Sakraida's (2005) study in Northeastern Indiana classified divorced women into three groups: initiator (who first decided to end marriage), non-initiator (recipient of end of marriage decision), and mutual decider (shared decision to end marriage). My study deals with the second group of women as non initiators of divorce.

In this research the divorce is seen as disruptive as women were not prepared for it. In addition, these women are burdened with the care of children while facing socioeconomic hardships.

There is little likelihood of contracting another marriage for these women because of their tarnished reputation by divorce on the one hand and the burden of raising children alone. In this regard, women find themselves in left behind and vulnerable. They always express physical and emotional pain caused by the fact of losing their husbands unexpectedly.

Marriage disruption brings loneliness, anxiety and unsteadiness (Sweeney and Horwitz, 2001:305). Single motherhood can also be contemplated in cases where a woman has been uprooted and separated from her husband because of war and political violence. In this regard, women express psychological distress caused by the lack of financial and emotional support from their husbands. Nevertheless, the situation can improve if they come to unite and stay together. This is not easy for broken matrimonial relationships because of divorce. The profile of the women victims of divorce is characterized by less emotional wellbeing (Sakraida, 2005:244).

The view in support of marriage as conditional to the well-being of women is culturally constructive and not shared by the author. The view is however supported by the data of this study which shows how women who see themselves as victims of divorce present emotional and psychological illnesses. However, from my view, marriage should be a place where men and women should be equal. Otherwise, it would be tantamount to gross discrimination against women. Such a paternalistic conception denies human dignity to women and encourages gender inequality. Furthermore, the cultural overemphasizing of the consequences of divorce only on women and not on their male counterparts will remain problematic as long as such gender bias is upheld as part of beliefs and practices in society. Be this as it may, one should bear in mind that women seem to be strong despite the influence of divorce in their life as they can successfully cope with the burden of caring for their children alone as one of the participants comments:

> *...you know that the care of children is the mother's duty. The father can go out and when he comes back, he does not have time to control children. He can give them money for food, but he does not pay enough attention to them like the mother does. (Interview, Pauline)*

I believe that they chase the wife with children because they know that the husband is not able to care for children as the wife. This is well demonstrated in a Congolese popular saying, "Educating a woman is educating a nation." At this point even men agree that nature has endowed a woman with great talent to handle problems that a man may not be able to solve. If a

woman is well educated, she becomes a great asset for the success of the education of her children and the stability of the household. A woman has the power over children and even over her husband in the house. She is the one who plays a major role in organizing and managing the family. That is a strength that women possess to successfully raise children even in the absence of the husband and father. In some of the comments among the Congolese, they argue that when one compares children raised by a woman to those raised by a man, those raised by a woman are balanced, responsible and less emotive because of the love they benefited from their mother.

If divorce causes emotional pain due to the fact of separation as stated by the interviewees, it may be important to examine the social support when dealing with painful situations. Who supports and what kind of support is given or needed? I now move on to the next section to discuss this issue.

5.7 Help-seeking behaviour

The study found that western medicine was not the only way used by participants in this research to seek healing. There is a combination of different methods of care. These methods are used depending not only on the issue of language that hinders migrants from seeking healing in public hospitals in South Africa, but also on the beliefs surrounding illness and its causes (Mattingly and Garro, 2000, Menjivar, 2002, Thomas, 2010). Western medicine is the main source of care, but it presents the weakness of being composed of chemicals only as one participant expressed it:

> *…now I say the drugs also are chemical products, so I can't get my body used to those chemicals. I would have to give my body, my immune system another signal, another message and that is the conclusion we had here with my husband and my family. (Interview, Anne)*

Food from the home country is also considered as medicine to deal with illness. Nature provides a lot of resources that can be used to deal with some illnesses:

> *I use a plant called Artemisia as tea. And then there is another product, it is the barks of a tree. In my mother tongue it's called Pandanga. Pandanga is able to cure cancer and other diseases. It comes straight from the DRC and it is regularly sent to me by my mother. The two plants are bitter. (Interview, Anne)*

For other illnesses, western medicine is the only method of healing as stated by an informant:

> *I do not know and even people whom I know who suffer from this illness, none of them told me that he was getting treated with traditional medicine, because slipped disk does not affect bones but it also affects nerves. (Interview, Liliane)*

Furthermore, prayer is considered as a powerful method of seeking healing. Prayer occupies an important place in Congolese beliefs. Congolese are essentially religious and believe that only God is able to heal any kinds of illness. Many of them believe in miracles and in some churches they preach that a church where miracles are not performed to respond to people's needs for healing, is not a church of God. Hence many people join Pentecostal churches seen as capable of performing miracles in order to respond to believers' needs. Prayer is believed to be a strong and powerful way of fighting against evil:

> *I think the solution is more spiritual than medical because the stories happen spiritually. They are stories which are not visible with a physical lens, as devils operate spiritually. To attack them, you must resort to spiritual means. Concretely, we organize the sessions of prayer, the serious sessions of prayer and fasting. (Interview, John)*

The same attitude is observed when faced with other mystical phenomena such as husband/wife of night:

> *Each time, before I sleep, I always ask God to surround my bed, my room and this plot with the blood of his son, Jesus Christ. (Interview, Christian)*

Prayer is accompanied by acts, rituals called in the Roman Catholic Church, sacramental. Thus, migrants use resources such as holy water, olive oil, and incense:

> *Many times, I experience the phenomenon of wife of night, even when I am deeply asleep, I have to wake up and break it up. You see, I have bibles almost everywhere, I burn incense and its smell chases away bad spirits. (Interview, Christian)*

> *My brother smelled like a dead person. This smell disappeared because I was applying anointing oil called in Swahili tajiri [meaning rich], on his leg. It is oil applied to sick people and it has a healing power. Thanks to prayer and that oil of anointing, the dead spirit is chased away. (Interview, John)*

Olive oil is used as anointment. It contains curative power. Other resources like boa grease are also used for the same purpose. It is important to underline that two of the informants were

Roman Catholics and three were involved in Pentecostal churches. The ones in the Pentecostal churches were first Roman Catholics and changed their religion later. But they still keep some beliefs of the Catholic Church. In the popular faith, everything used in religious practices is linked to healing. This shows that migration does not involve loss of cultural knowledge. On the contrary, migrants become more attached to their culture through local resources from their countries of origin (Englund, 1998, Menjivar, 2002, Thomas, 2010). Traditional medicine was of use for illnesses whose causes are believed to have a link with migration.

5.7 Place of social support in dealing with illnesses

The World Health Organization (WHO) (2003:12) states that 'long periods of anxiety and insecurity and the lack of supportive friendships are damaging in whatever area of life they arise.'

> *My family ... they really supported me, they were all united because I never stopped to have phone calls from my parents, my sisters and my whole family was there. They moved heaven and earth for me. Before, I did not even know that there was Artemisia; I did not know that there was Pandanga. My mom sends pandanga and food from the DRC every month. (Interview, Anne)*

This study brings new insights to the understanding of the body. The understanding of the body is holistic and complex (Bendelow, 2006). The body does not belong to one person, but to the whole community (Menjivar, 2002, Bossart, 2003, Thomas, 2010). Health is not an individual concern; the sick person's body is our bodies. As a matter of fact, the decision making process on alternative ways of healing seeking does not often depend on the patient alone in the first place. This illustrates the commonly shared African communitarian value and belief generally expressed in this way: "I am because we are". Participants in this study are aware of the support received and considered it as precious for it brings relief to their suffering:

> *…as Congolese, I am used to solidarity, to human touch. When there is all this, I feel myself morally in my country, close to my family and in this atmosphere, I feel comfort, confident, because my problem becomes my family's business, you know. So, I am mindset. (Interview, Anne)*

In her own words, Thomas (2010) supports this value when reporting on meaning, value and place in health-seeking amongst Southern African migrants in London. This is to show how

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 (WHO, 2003:22).

Nevertheless, one may ask who supports and what kind of support is needed and offered and where does it come from? The following responses answer this question:

> *Often support is moral, spiritual and in terms of advice. Support is not financial because people themselves struggle to survive in a country where life is difficult. (Interview, John)*

> *People don't have money to offer because they also in financial constraints as us. (Interview, John)*

> *They only ask you to pray and continue to hope but to give money or food is difficult. (Interview, Pauline)*

In examining the kinds of support and their sources, the study of Bossart (2003) done in Cote d'Ivoire concludes that the main source of assistance comes from close family members Bossart's study focuses more on financial support that the family members contribute to assist the sick person. Family members seem to be active in accelerating their relative's healing. This promptitude to bring financial support in the healing of one family member is justified by the blood ties existing between them. However, support is not only financial but moral as well.

It is seen in this study that the community also supports the sick person and this assistance is mainly emotional or psychological (Bossart, 2003, Nunez, 2009, Nunez, 2010). The support of the community may take several forms such as compassion (Bendelow, 2006). Bossart (2003:349) holds that "help includes all actions taken by all engaged actors with the aim of improving the well-being of the patient, or with the goal of relieving his or her suffering." However, (Bendelow, 2006:62) says that "compassion and pity may well be elicited, but only as an ephemeral reaction as the response lasts until it is eclipsed by a more pressing tragedy." Compassion is also a form of what people feel about somebody's suffering. Sometimes, it is an expression that they would like to do something to help if they were in a good situation. When

one feels economically uncomfortable to help financially, they express compassion. This is mostly the kind of support found in this study, because people themselves are in need and cannot help.

Sometimes people may also refuse to assist financially, not because they do not have enough to offer, but merely because they are not ready to share. This is seen even among the family members. Bossart (2003) supports that social network's help is sporadic and very often the sick person has to ask friends and family several times before the assistance comes. It is also noticed that often, the assistance does not come when the patient is suffering but only if s/he dies.

Churches bring spiritual and material support to their people. Lorena says that "Pentecostals take seriously [people's concerns] or African worldviews (Nunez, 2010). While Pentecostal churches emphasize spiritual level, traditional churches assist vulnerable people by providing them with food and other forms of assistance. This was stressed by Liliane in the following quote:

> *I belong to the Roman Catholic Church. I receive moral support and sometimes the church gives me food for children. (Interview, Liliane)*

This is significant to consider the two levels of assistance as they complement each other. Alleviating people's suffering by providing them with food is one of the objectives of evangelization. In the Roman Catholic Church, preferential option for the poor is a big concern. They always provide them with soup kitchen and food parcels. In contrast, Pentecostal churches focus more on the spiritual level and neglect this survivalist aspect of human beings.

Gender difference can also be observed through various ways of providing and receiving help during illness. Women receive less assistance when facing illness as they are themselves responsible for the nursing of the ill (Bossart, 2003:353). Generally, the community holds women responsible for the misfortune and failure of the children while men are not accused and this affects women's health.

Beliefs around the causes of illness (Garro, 2000) may also bar people from receiving any help from anybody. For example, when illness is attributed to bewitchment, the family members and the ill person will be reluctant to receive any form of assistance from the suspect. The type of illness (mental illness or HIV/AIDS) may also limit the social assistance because of discrimination and stigmatization (Bossart, 2003).

While acknowledging the assistance of human beings in rendering compassion, advice, prayer or visit to alleviate the pain of the ill, it may be argued that human beings may also be the authors of the individual's suffering. Some people can express compassion or sympathy and at the same be slanderous. In that context, compassion becomes helpless for the sick person and does not bring any relief. In this regard, one respondent declared:

> *I left the church because we discovered that the pastor himself was a witch. He was not praying for people but became jealous of them and was blocking their success. (Interview, John)*

John sees witchcraft in the pastor's behaviour, which is no longer a good example to attract congregants and build trust and confidence in him.

Conclusion

This study provides insights into an area that is not widely explored, the cultural dimension underpinning illness and care-seeking behaviour of Congolese migrants in Johannesburg. The qualitative interviews served the purpose of achieving this goal by illustrating specific areas where migrants provide pertinent information regarding their perception of illness and alternative ways of seeking healing. Themes generated from the findings include many areas such as previous experiences in home country, the influence of the host country, supernatural threats, single motherhood and the influence of other community members on the migrants' health. These themes were discussed and linked to the literature reviewed to give a holistic meaning of suffering of some Congolese migrants. Although small, the number of participants in this study gives us a deep understanding of illness causation and help-seeking behaviour.

CHAPTER SIX: CONCLUSION

This chapter is based on the summary of the key points drawn from the research and on how the study informs the broader discussion on understanding illness and treatment seeking behaviour among Congolese migrants in Johannesburg.

This study sought to explore how Congolese migrants in Johannesburg perceive their health problems and what resources they use as help-seeking behaviour to respond to their illnesses. This study aimed at understanding the extent to which the previous traumatic experiences Congolese migrants had in the DRC before coming to the difficult living conditions of South Africa shape the perception of health problems that currently affect Congolese migrants.

The report was structured in six chapters. Chapter one presented the background, rationale and posed the research question. Chapter two concentrated on the theoretical framework of this study. The study adopts a constructivist theory to help in identifying meaning attached to illness by Congolese migrants (Ponterotto, 2005).

The study focuses on the subjective meaning of illness constructed from the experiences and the perspectives of those who lived them (Burch, 1990). Meaning is constructed through narrative (Coker, 2004, Eastmond, 2007). Narrative is based on what is "known and what is remembered" (Mattingly and Garro, 2000:72). What is known and remembered are individuals' accounts. Individuals' accounts draw strength and verisimilitude as they are nested within accounts of a collective past (Mattingly and Garro, 2000:32). What is known and remembered here is knowledge about illness and different events that may be taken or described as causal attributions. The aim is to know how remembering of the past may be linked to what is lived in the present; how the understanding of the past helps individuals give meaning to their lives and the world (Mattingly and Garro, 2000). Knowledge about illness is linked to individuals' specific culture. The cultural knowledge about illness and its causation can guide the interpretation and reconstruction of the past (Mattingly and Garro, 2000).

Dealing with migrants who find themselves in a foreign land, this study also aimed at understanding the impact of migration in South Africa on their current health problems. In considering this aspect, this report brings a holistic understanding of suffering from the views of

Congolese migrants. This complex understanding includes psycho-physical, emotional, cultural, and spiritual meaning of pain or illness which goes beyond the biomedical approach of illness (Gilbert et al., 2002, Bendelow, 2006), to identify different situations which can be used to ascribe meaning to the current ailments they experience. The help-seeking behaviour is used in this study to highlight alternative methods of care seeking used by Congolese migrants and the motivation behind the choice. The research methodology underlines the process of developing the present research. It presents the research design and describes how participants are selected, their socio-demographic characteristics, the interviewing process, the ethical issues and problems encountered during the fieldwork.

Data collected have shown that both, pre-migration (DRC) and post-migration (South Africa) experiences are contributive to health decline of migrants who have participated in this study. It emerged that participants in this study faced political violence that forced them to escape from the DRC and shaped their understanding of the current health problems they are dealing with. Some were jailed, persecuted and tortured. Others witnessed killing and other forms of abuse in their home country. To some extent, the current health problems affecting this group of migrants are linked to the past traumatic experiences lived in the DRC (Eastmond, 2007, Mattingly and Garro, 2000). Illnesses are seen as stemming from natural and supernatural causes (Garro, 2000, Kleinman, 1988). Witchcraft is cited as cause of illness which is a mysterious harming power, due to jealousy of seeing somebody succeeding.

Furthermore, the study offers insights on the phenomenon of single motherhood and the influence of divorce on women's health and understanding of the role of a woman in marriage. In the case of divorce where women are non-initiators, they are emotionally affected and the custody of the children is given to the mother. Essentially, such children are abandoned with her. The mother has to carry the load of educating the children alone. A married woman is expected to give birth to children who are healthy. In the event that a woman gives birth to a child with disability, she is accused of witchcraft and other antisocial behaviours. The consequence is that she may be divorced. This misconception is frequent in the DRC, because the country is patriarchal. However, this study does not support such misconceptions which hinder gender equality.

Moreover, the foreign country (South Africa) is seen as aggravating their pain because of the dire living conditions (unemployment, difficulty to access housing and to satisfy their basic needs and those of their children and difficulty to be accepted by the local community as individuals with specific cultural patterns and participate in the host country). Migration leads to loss of identity as expressed by participants in this study, for example, "*here I am like a child*". The foreign land is a place of uncertainty; migrants are imbalanced, ungrounded, unsafe and insecure. As one of them says, "*to be in a foreign country is like somebody who is on the tree.*"

This study also highlights the social meaning of suffering. Somebody's illness involves other community members. We do not suffer alone, but with others. This is demonstrated in how family members are preoccupied with their relatives' illnesses (Bossart, 2003). This involvement is motivated by blood ties which bind family members together and make them suffer with each other.

Finally, this report examines alternative methods of care seeking used by Congolese migrants. This study shows that in addition to western medicine, different resources are taken into account in dealing with illness and thinking of seeking care. These resources are used according to the perceived causes of illness and the decision of using such routes does not come from the sick person himself but mainly from his family members from the home country and elsewhere (Thomas, 2010). Attachment to one's culture, religion, food, country, people, friends and family may create a certain confidence in the psychology of the ill person and contribute to the healing process. Congolese are essentially religious and prayer is considered as a powerful method used to deal with some illnesses, especially those considered as causally linked to witchcraft. Religion and prayer are also accompanied by some rituals. In this regard, the Congolese resort to some practices such the use of holy water, incense and olive oil, considered as vehicles of healing. Most of the participants in this study are members of the Pentecostal Churches, but they were Roman Catholics in the DRC. Even though they left their earlier church, they still keep on using some Catholic practices they learnt and that they believe to be powerful in fighting illnesses and the devil.

This study attempts to bring insights to the cultural knowledge of Congolese migrants and their perceptions of illnesses, an area that has not often focused on. However, the results of this study cannot be generalisable to a large number because it only focuses on a small number. But the

focus on a small number helps bring in-depth knowledge on Congolese perceptions of their illnesses. Furthermore, participants in this study are not health professionals. They speak as laypeople of their perceptions of illness through what is known and what is remembered (Mattingly and Garro, 2000). What is known and remembered is knowledge about their bodies and pains and the circumstances that may be linked to that. Congolese migrants talk about their experiences of pain by focusing on lived experiences in the DRC and in South Africa, including the narrative of suffering (Bendelow, 2006). These perceptions are grounded in a cultural lens and may or not be scientifically proved. However, they need to be considered as they lead to alternative methods of treatment seeking behaviour and contribute to the healing process. In addition, the study only deals with participants who were victims of political violence. Other studies focusing on a large number of Congolese who were not involved in political violence may bring more insights.

REFERENCES

ALDER, P. & ALDER, P. (2003) The Promises and Pitfalls of Going into the Field. *Contexts,* 2**,** 41-47.

AMISI, B. (2006) An Exploration of Livelihood Strategies of Durban Congolese Refugees. *New Issues in Refugee Research.* Durban, University of KwaZulu-Natal: School of Development Studies and Centre for Civil Society

AMISI, B. B., R (2005) In the absence of Citizenship: Congolese refugees struggle and organisation in South Africa. Durban, School of Development Studies and Centre for Civil Society, University of Kwazulu-Natal.

AMIT, R. (2010a) Lost in the Vortex: Irregularities in the Detention and Deportation of Non-Nationals in South Africa. Johannesburg, Forced Migration Studies Programme.

AMIT, R. (2010b) The Zimbabwean Documentation Process: Lessons Learned. Johannesburg, African Centre for Migration and Society, University of the Witwatersrand.

AMSTRONG, D. (2000) Social Theorizing about Health and Illness. *The Handbook of Social Studies in Health and Medicine.* London, Sage.

ANDERSEN, H. M. (2004) Villagers: Differential Treatment in a Ghanaian Hospital *Social Science & Medicine,* 59**,** 2003-2012.

ANTHONY, J., MARTIN, E., AVERY, A. & WILLIAMS, J. (2009) Self Care and Health-Seeking Behavior of Migrants Farmworkers. *J Immigrant Minority Health*.

APALATA, T., KIBIRIBIRI, E. T., KNIGHT, S. & LUTGE, E. (2007) Refugees' Perceptions of their Health Status & Quality of Health Care Services in Durban, South Africa: A Community-Based Survey. Durban, Health Systems Trust.

ASELTINE, R. H. & KESSLER, R. C. (1993) Marital disruption and depression in a community sample. *Journal of Health and Social Behavior,* 34**,** 237-251.

BABBIE, E. (2004) *The Practice of Social Research,* Belmont, CA, Thomson Wadsworth.

BAILEY, E. J. (1987) Sociocultural Factors and Health Care-Seeking Behavior among Black Americans. *Journal of the National Meidical Association,* 79**,** 389-392.

BELCHER, J. R. & HALL, S. M. (2001) "Healing and Psychotherapy: The Pentecostal Tradition". *Pastoral Psychology,* 50**,** 63-75.

BENDELOW, G. A. (2006) Pain, Suffering and Risk. *Health, Risk & Society,* 8**,** 59-70.

BEVER, E. (2000) Witchcraft Fears and Psychosocial Factors in Disease. *Journal of Interdisciplinary History,* 30**,** 573-590.

BHUGRA, D. & BECKER, M. A. (2005) Migration, Cultural Bereavement and Cultural Identity. *World Psychiatry,* 4**,** 18-24.

BIDDLE, L., DONOVAN, J., SHARP, D. & GUNNELL, D. (2007) Explaining Non-Help-Seeking amongst Young Adults with Mental Distress: a Dynamic Interpretive Model of Illness Behaviour. *Sociology of Health & Illness,* 29**,** 983-1002.

BLAAUW, P. F. (2005) The Dynamics of the Informal Sector in South Africa - A Case Study of Day Labourers in Pretoria. *Biennial Conference of the Economic Society of South Africa.* Durban.

BORUCHOVITCH, E. & MEDNICK, B. R. (2002) The Meaning of Health and Illness: Some Considerations for Health Psychology. *Psico-USF,* 7**,** 175-183.

BOSSART, R. (2003) "In the City, Everybody Only Cares for Himself": Social Relations and Illness in Abidjan, CÔte d'Ivoire. *Anthropology & medicine,* 10**,** 343-359.

BOYD, K. M. (2000) Disease, Illness, Sickness, Health, Healing and Wholeness: Exploring Some Elusive Concepts. *Med Humanities,* 26**,** 9-17.

BREAKWELL, G. M., HAMMOND, S. & FIFE-SCHAW, C. (2000) *Research Methods in Psychology* London, Sage

BURCH, R. (1990) Phenomenology, Lived Experience: Taking a Measure of the Topic *Phenomenology + Pedagogy* 8 130-160

C.S.P (1999) Barriers to Help-Seeking. *SIEC Alert.* Alberta, Canada, Centre for Suicide Prevention.

CAMPBELL, J. (2000) "Narrative and Method in the Anthropology of Medicine". IN SKULTANS, V. & & COX, J. (Eds.) *Anthropological Approaches to Psychological Medicine.* London, Kingsley.

CNA (2005) Social Determinants of Health and Nursing: A Summary of the Issues. *Canadian Nurses Association***,** 1-10.

COKER, E. M. (2004) "Traveling Pains": Embodied Metaphors of Suffering Among Southern Sudanese Refugees in Cairo. *Culture, Medicine and Psychiatry,* 28**,** 15-39.

CORMSA (2009) Protecting Refugees, Asylum Seekers and Immigrants in South Africa. Johannesburg, Consortium for Refugees and Migrants in South Africa.

COUNCIL, R. (2004) A Guide to Congolese Cultural and Social Norms. London, Resettlement Inter Agency Team.

CSDH (2008) Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health. *Final Report: Executive Summary.* Geneva, Switzerland, World Health Organization.

DARGHOUTH, S., PEDERSEN, D., BIBEAU, G. & ROUSSEAU, C. (2006) Painful Languages of the Body: Experiences of Headache among Women in Two Peruvian Communities. *Culture, Medicine and Psychiatry,* 30**,** 271-297.

DAVIES, A., BASTEN, A. & FRATTINI, C. (2006) Migration: A Social Determinant of the Health of Migrants. *In the Framework of the "Assisting Migrants and Communities (AMAC): Analysis of Social Determinants of Health and Health Inequalities" Project.* Geneva, Switzerland, International Organization for Migration (IOM).

DOHERTY, W. J., SU, S. & NEEDLE, R. (1989) Marital disruption and psychological wellbeing: A panel study. *Journal of Family Issues,* 10**,** 72-85.

DYCK, I. & DOSSA, P. (2007) Place, Health and Home: Gender and Migration in the Constitution of Healthy Space. *Health & Place,* 13**,** 691-701.

EASTMOND, M. (2007) Stories as Lived Experience: Narratives in Forced Migration Research. *Journal of Refugee Studies,* 20**,** 248-264.

ENGLUND, H. (1998) Death, Trauma and Ritual: Mozambican Refugees in Malawi. *Social Science & Medicine,* 46**,** 1165-1174.

FENNELLY, K. (2005) The Healthy Migrant' Effect. *Healthy Generations,* 5.

FIGUEIRAS, M. J. & ALVES, N. C. (2007) Lay perceptions of serious illnesses: An adapted version of the Revised Illness Perception Questionnaire (IPQ-R) for healthy people. *Psychology and Health,* 22**,** 143-158.

GARRO, L. C. (2000) Cultural Meaning, Explanations of Illness, and the Development of Comparative Frameworks. *Ethnography,* 39**,** 305-334.

GEORGE, M., BIRCK, K., HUFFORD, D. J., JEMMOTT, L. S., FAAN, R. N., WEAVER, T. E. & FAAN, R. N. C. S. (2006) Beliefs About Asthma and Complementary and Alternative Medicine in Low-Income Inner-City African-American Adults. *J Gen Intern Med,* 21**,** 1317-1324.

GHANE, S., KOLK, A. M. & EMMELKAMP, P. M. G. (2010) Assessment of Explanatory Models of Mental Illness: Effects of Patient and Interviewer Characteristics. *Soc Psychiat Epidemiol* 45.

GILBERT, L., SELIKOW, T.-A. & WALKER, L. (2002) *Society, Health and Disease: An Introductory Reader for Health Professionals*, Gauteng, Ravan Press.

GOOD, B. J. (1994) *Medicine, Rationality, and Experience,* Cambridge, Cambridge University Press.

GOOD, B. J. & GOOD, M. J. D. (1980) The Meaning of Symptoms: A Cultural Hermeneutic Model for Clinical Practice. *The Relevance of Social Science for Medicine*.

GOOD, M. J. D., BRODWIN, P. E., GOOD, B. J. & KLEINMAN, A. (1994) *Pain As Human Experience: An Anthropological Perspective,* San Francisco University of California Press.

GRAY, D. E. (2009) *Doing in a Real World,* London, SAGE.

GREENBURG, J. & POLZER, T. (2008) Migrant Access to Housing in South African Cities. *Special Report No. 2.* Johannesburg, Forced Migration Studies Programme - University of the Witwatersrand.

GROLEAU, D. & KIRMAYER, L. J. (2004) Sociosomatic Theaory in Vietnamese Immigrants' Distress. *Anthropology & medicine,* 11.

GROLEAU, D., YOUNG, A. & KIRMAYER, L. (2006) The McGill Illness Narrative Interview (MINI): An Interview Schedule to Elicit Meanings and Modes of Reasoning Related to Illness Experience. *Transcultural Psychiatry,* 43**,** 671-691.

GUPTA, V. B. (2010) Impact of Culture on Healthcare Seeking Behavior of Asian indians. *Journal of Cultural Diversity*, 17.

HADZIABDIC, E., HEIKKILA, K., ALBIN, B. & HJELM, K. (2009) Migrants' Perceptions of Using Interpreters in Health Care. *International Nursing Review***,** 461-469.

HEALTH, D. O. (2007) Revenue Directive: Refugee/Asylum Seekers with or without a Permit. *BI 4/29 Refug/Asyl 8 2007.* Pretoria, Departtment of Health/South Africa.

HRW (2002) The War within the War: Sexual Violence against Women and Children in Eastern Congo. IN WATCH, H. R. (Ed.). New York.

HRW (2009) South Africa: Improve Migrants' Access to Healthcare Xenophobic Violence, Discrimination Imperil Immigrant Health. Human Right Watch.

IOM (2009) Migration Health. *Eye, A Bulletin of News, Information and Analysis on Migration Health in Southern Africa*

JAIN, M., NANDAN, D. & MISRA, S. K. (2006) Qualitative Assessment of Health Seeking Behaviour and Perceptions Regarding Quality of Health Care Services among Rural Community of District Agra. *Indian Journal of Community Medicine,* 31**,** 140-144.

JEANNERAT, C. (2009) "Of Lizards, Misfortune and Deliverance Pentecostal Soteriology in the Life of a Migrants". *African Studies,* 68**,** 251-271.

JUNGHANSS, T. (1998) How Unhealthy is Migrating? *Tropical Medicine and International Health***,** 933-934.

KAMITANJI, K. (2008) Social Integration of Congolese Refugees in a Town in Southern Nrway. *Centre for Peace Studies.* TromsΘ

University of TromsΘ.

KANKONDE, B. P. (2009) The Ties that Bind and Bond: Socio-cultural Dynamics and Meanings of Remittances among Congolese Migrants in Johannesburg *Forced Migration Studies Programme.* Johannesburg, University of the Witwatersrand.

KANKONDE, B. P. (2010) Transnational Family Ties, Remittance Motives, and Social Death among Congolese Migrants: A Socio-Anthropological Analysis *Journal of Comparative Family Studies* 41**,** 225-244.

KENWORTHY, P. (2010) Post-World Cup xenophobia in South Africa.

KING, R. (2002) Illness Attributions and Myocardial Infarction: The Influence of Gender and Socio-Economic Circumstances on Illness Beliefs. *Journal of Advanced Nursing,* 37**,** 431-438.

KLEINMAN, A. (1988) *The Illness Narratives: Suffering, Healing & The Human Condition,* New York, Havard University Press.

KOSCHMANN, T. (1999) The Edge of Many Circles: Making Meaning of Meaning Making. *Discourse Processes,* 27**,** 103-117.

KOSS, M. P., HEISE, L. & RUSSO, N. F. (1993) The Global Health Burden of Rape. *Psychology of Women Quarterly,* 18.

KUPER, A. (2007) The Intersubjective and Intrasubjective in the Patient - Physician Dyad: Implications for Medical Humanities Education. *Med Humanities,* 33**,** 75-80.

LANDAU, L. (2006a) Protection and Dignity in Johannesburg: Shortcoming of South Africa's Urban Refugees Policy. *Journal of Refugee Studies,* 19**,** 308-327.

LANDAU, L. (2006b) Transplants and Transients: Idioms of Belonging and Dislocation in Inner-City Johannesburg. *African Studies Review,* 49**,** 125-145.

LANDAU, L. (2010) Government Wasting Money, Violating the Rights of Foreigners in Arrests, Detentions and Dangerous Deportations Johannesburg, Forced Migration Studies Programme, University of the Witwatersrand.

LANDAU, L. B. & WA KABWE-SEGATTI, A. K. (2009) Human Development Impacts of Migration: South Africa Case Study. Johannesburg, UNDP: Human Development Reports/Research Paper.

LATHER, P. (1993) Fertile Obsession: Validity After Poststructuralism. *The Sociological Quarterly,* 34**,** 673-693.

LENZO, K. (1995) Validity and Self-Reflexivity Meet Poststructuralism: Scientific Ethos and the Transgressive. *American Educational Research Association,* 24**,** 17-23+45.

LIE, B. (2002) A 3-Year Follow-Up Study of Psychosocial Fuctionning and General Symptoms in Settled Refugees *Acta Psychiatr Scand,* 106**,** 415-425.

LYONS, E. (2000) *Research Methods in Psychology* London, Sage.

MACNAUGHTON, N. (2008) Health Disparities and Health-Seeking Behavior Among Latino Men: A Review of the Literature *Journal Transcultural Nursing,* 19**,** 83-91.

MANDERSON, L. & ALLOTEY, P. (2003) Storytelling, Marginality, and Community in Australia: How Immigrants Position Their Difference in Health Care Settings. *Medical Anthropology,* 22**,** 1-22.

MATTINGLY, C. & GARRO, L. C. (2000) *Narrative and the Cultural Construction of Illness and Healing,* Berkeley - Los Angeles - London.

MCCARTHY, M., CHERSICH, M. F., VEARY, J., MEYER-RATH, G., JAFFER, A., SIMPWALO, S. & VENTER, W. D. F. (2009) Good Treatment Outcomes among Foreigners Receiving Antiretroviral Therapy in Johannesburg. *International Journal of STD & AIDS,* 20**,** 858-862.

MENJIVAR, C. (2002) The Ties That Heal: Guatemalan Immigrant Women's Networks and Medical Treatment. *International Migration Review,* 36**,** 437-466.

MOSSELSON, M. (2007) Are South Africa's New Health Policies Making a Difference? *Centre for Health Policy***,** 1-3.

MOYO, K. (2010) Street Level Interface: the Interaction Between Health Personnel and Migrants Patients at an Inner City Public Health Facility in Johannesburg. *Forced Migration Studies Programme.* Johannesburg, University of the Witwatersrand.

MSF (2010) No Time to Quit: HIV/AIDS Treatment Gap Widening in Africa. *Analysis of the Widening Funding Gap For HIV/AIDS Treatment in Sub-Saharan Africa.* Brussels, Médecins Sans Frontières.

MUESER, K. T., ROSENBERG, S. D., GOODMAN, L. A. & TRUMBETTA, S. L. (2002) Trauma, PTSD, and the Course of Severe Mental Illness: An Interactive Model *Schizophrenia Research,* 53**,** 123-143.

MULLER, C. (2003) Investigating South Africa's Informal Sector: Measurement, Participation, and Earnings. *Economics.* Durban, University of Natal.

NEALE, P., THAPA, S. & BOYCE, C. (2006) Preparing a Case Study: A Guide for Designing and Conducting a Case Study for Evaluation Input. *Monitoring and Evaluation.* Watertown, Pathfinder International.

NGUYEN, T. (2008) Yin Illness: Its Diagnosis and Healing Within Len Dong (Spirit Possession) Rituals of the Viet. *Asian Ethnography,* 67**,** 305-321.

NUNEZ, L. (2009) Is It Possible to Eradicate Poverty Without Attending to Mental Health? Listening to Migrant Workers in Chile Through Their Idioms of Distress. *Journal of Health Management,* 11**,** 1-12.

NUNEZ, L. (2010) Healing and Deliverance Ministry offered by Pentecostal/Charismatic Churches Johannesburg, University of the Witwatersrand.

OLAFSDOTTIR, S. & PESCOSOLIDO, B. (2009) Drawing the Line: The Cultural Cartography of Utilization Recommendations for Mental Health Problems. *Journal of Health and Social Behavior* 50**,** 228-244.

PATTON, M. Q. (1990) The Nature of Qualitative Inquiry. *Qualitative Evaluation Methods***,** 9-23.

PATTON, M. Q. (2002) *Qualitative Research and Evaluation Methods. Thousand Oaks,* London, Sage Publications.

POLZER, T. (2010) Population Movements in and to South Africa (Updated Verssion). Johannesburg, Forced Migration Studies Programme.

PONTEROTTO, J. G. (2005) Qualitative Research in Counseling and Psychology: A Primer on Research Paradigms and Philosophy of Science. *Journal of Counseling Psychology,* 52**,** 126-136.

POPHIWA, N. (2009) Healthy Migrants or Health Migrants? Accounting For the Health Care Utilisation Patterns of Zimbabwean Migrants Living in South Africa. *Forced Migration Studies Programme.* Johannesburg, University of the Witwatersrand.

PRATT, M. & WERCHICK, L. (2004) Sexual Terrorism: Rape as a Weapon of War in Eastern Democratic Republic of Congo. *An assessment of programmatic responses to sexual violence in North Kivu, South Kivu, Maniema, and Orientale Provinces.* Kinshasa, USAID/DCHA.

PURSELL, R. (2004) Accessing health services at Johannesburg's clinical and hospital: Towards a Local Government Response *Forced Migrants in the New Johannesburg: University of the Witwatersrand,* 16**,** 93-98.

RIJKEN, M. & GROENEWEGEN, P. P. (2008) Money Does Not Bring Well-Being, but It Does Help! The Relationship between Financial Resources and Life Satisfaction of Chronically Ill Mediated by Social Deprivation and Loneliness. *Journal of Community & Applied Social Psychology,* 18**,** 39-53.

RISØR, M. B. (2009) Illness Explanations Among Patients With Medically Unexplained Symptoms: Different Idioms For Different Contexts. *Health,* 13**,** 505-521.

RSA (1996) Constitution of the Republic of South Africa. Pretoria, South Africa: Government Printers.

SAKRAIDA, T. J. (2005) Divorce Transition Differences of Midlife Women

Issues in Mental Health Nursing, 26**,** 225-249.

SANPAD (2004) Guidelinesfor Netherlands Research Partners on SANPAD-Funded Projects. *NL Partnership Manual June 2004.* Durban, SANPAD.

SINGH, M. & DE LOOPER, M. (2002) Australian Health Inequalities: Birthplace.

SMITH, B. (1998) It Doesn't Count Because It's Subjective! (Re)conceptualising the Qualitative Researcher Role as 'Validity' Embraces Subjectivity *AARE Annual Conference.* Adelaide.

SOLAR, O. & IRWIN, A. (2007) A Conceptual Framework for Action on the Social Determinants of Health. World Health Organization.

STATSA (2008) Tourism and Migration, 1984-2007. Pretoria, Statistics South Africa.

STEINBERG, J. (2005) A Mixed Reception: Mozambican and Congolese Refugees in South Africa. *Iss Monograph Series.* Institute for Security Studies.

STERN, L. & KIRMAYER, L. J. (2004) Knowledge Structures in Illness Narratives: Development and Reliability of a Coding Scheme. *Transcultural Psychiatry,* 41**,** 130-142.

SWEENEY, M. M. & HORWITZ, A. V. (2001) Infidelity, Initiation, and the Emotional Climate of Divorce: Are There Implications for Mental Health? *Journal of Health and Social Behavior* 42**,** 295-309.

THANH, V. T. & ROOSEVELT, W. J. (1986) Social Support and Subjective Well-Being among Vietnamese Refugees. *The Social Service Review,* 60**,** 449-459.

THISTED, R. A. (2003) Are There Social Determinants of Health and Disease? *Perspectives in Biology and Medicine,* 46**,** 65-73.

THOMAS, F. (2010) Transnational health and treatment networks: Meaning, value and place in health seeking amongst Southern African migrants in London. *Health & Place*.

UEHARA, E. S. (2007) Disturbing Phenomenology in the Pain and Engagement Narratives of Cambodian American Survivors of the Killing Fields. *Med Psychiatry,* 31**,** 329-358.

UEHARA, E. S., FARRIS, M., MORRELI, P. T. & ISHISAKA, A. (2001) Eloquent Chaos in Oral Discourse of Killing Field Survivors: An exploration of atrocity and narrativisation *Culture Medicine and Psychiatry,* 25**,** 29-61.

VEAREY, J. (2008) Migration, Access to ART, and Survivalist Livelihood Strategies in Johannesburg. *African Journal of AIDS Research,* 7**,** 361-374.

WATHEN, C. N. & HARRIS, R. M. (2007) I try to take care of it myself: How rural women search for health information. *Qualitative Health Research,* 17**,** 639-651.

WEINMAN, J. & PETRIE, K. J. (1997) Illness Perceptions: A New Paradigm for Psychosomatics? *Journal of Psychosomatic Research,* 42**,** 113-116.

WHITLEY, R., KIRMAYER, L. J. & GROLEAU, D. (2006) Public Pressure, Private Protest: Illness Narratives of West Indian Immigrants in Montreal with Medically Unexplained Symptoms. *Anthropology & Medicine* 13**,** 193-205.

WHO (2003) Social Determinants of Health: The Solid Facts. IN WILKINSON, R. & MARMOT, M. (Eds.) Second Edition ed. Geneva, Switzerland, International Centre for Health and Society.

WHYTE, S. R. (1997) *Questioning Misfortune: The Pragmatics of Uncertainty in Eastern Uganda*, Cambridge, Cambridge University Press.

WINGATE, M. S. & ALEXANDER, G. R. (2006) The Healthy Migrant Theory: Variations in Pregnancy Outcomes among US-Born Migrants *Social Science & Medicine,* 62**,** 491-498.

YS WONG, S. & LEE, A. (2006) Communication Skills and Doctors Patient Relationship. *Medical Bulletin,* 11.

YURKOVICH, E. E. & LATTERGRASS, I. (2008) Defining Health and Unhealthiness: Perceptions Held by Native American Indians with Persistent Mental Illness. *Mental Health, Religion & Culture,* 11**,** 437-459.

WEBSITES

http://www.indexmundi.com/south_africa/unemployment_rate.html

APPENDICES

Appendix I: Guiding questions for fieldwork

Identity

1) How old are you?
2) Where were you born?
3) What is your marital status?
4) What level of education have you completed?
5) How many children do you have?
6) Are you here with your family (wife/husband and children)?
7) When did you arrive in South Africa? (When did you arrive in Johannesburg?)
8) What do you do in order to survive in SA?
9) How long have you been in South Africa?
10) Why did you leave DRC?
11) What city do you come from in DRC?

Health problem

1) What health problem do you have?
2) What do you think are the causes of your health problem(s)?
3) Can you tell me a little more about those events and how they are linked to your health problem?
4) What symptoms and feelings are you currently experiencing? Please describe them.
5) When do you experience these symptoms? Are certain situation in which you feel relieve from these symptoms? When?
6) How long have experienced these symptoms? Have they changed over the time? If so, how?
7) Did a person in your family or in your social environment experienced a similar health problem to yours? If yes, how do you consider your health problem to be different or similar to this other person's health problem?
8) When did you begin to suffer from your health problem?
9) When did you realize that you had your health problem?
10) What happened when you had your health problem?
11) How do you call your health problem in your language? Is there any name or label regarding your health problem?

Migration and health

1) Do you consider that having migrated to South Africa (SA) has influenced your health more generally?
2) Do you consider that your living or work conditions in SA have an influence on your health problem in anyway? How?

3) Does SA environment affect your health? How?
4) Can you describe a little bit the relationships between you and the local community?

Explanatory Model of Health

1) Why did your (HP) start when it did?
2) What happened inside your body that could explain your (HP)?
3) Is there something happening in your family, at work or in your social life that could explain your health problem?
4) Can you tell me how that explains your health problem?
5) What usually happens to people who have a health problem like you?
6) How do other people react to you?
7) Who do you know who has had the same health problem as you?

Health seeking behaviour

1) Have you sought help for this health problem?
2) Where did you go and who did you see for help?
3) Why did you choose to go to these places? Or ask these people?
4) Did the treatment sought bring change in you?
5) Did you get any treatment for your HP? What kind of treatment was it?
6) Are you satisfied with the medical care that you got? Why?
7) Is there any thing else you would like to add?

Appendix II: Information Sheet and Verbal Consent Form

Title of research project:

Understanding illness and treatment-seeking behaviour among Congolese migrants in Johannesburg.

Research Protocol: H**100913**

Names of principal researchers:

Dostin Lakika

Department/research group address:

Forced Migration Studies Programme, Wits University, 1 Jan Smuts Avenue, Braamfontein, Johannesburg

Telephone: (011) 717 4033

Email: dostinlakika@yahoo.fr

Hello! My name is *Dostin Lakika* and I am conducting a research project that is exploring the cultural understanding of illness and treatment seeking behaviour of Congolese migrants in Johannesburg.

I would like to invite you to take part in this study as it will help us to understand the influence of previous events and current challenges in the perception of illness and alternative methods of seeking care employed by Congolese migrants in South Africa.

What does this study entail?

Your participation in this study will include the following:

- 1-3 interview sessions (this will take a maximum of one hour).

Risks: There are very few risks in participating in this study. I will ask you some personal questions about your life and health problems you have. You may experience some discomfort in discussing some of the topics in the interview. But, you may find it helpful to talk about these issues with someone. If for any reason you are uncomfortable you can skip a question or chose to stop the interview at any time. If any of the topics discussed in the interview upset you, I can refer you to a counselor that you can talk with further.

Benefits: You may not receive any direct benefit from participating in this study. But, this research will help us to understand the cultural and religious beliefs of illness among Congolese migrants living in South Africa in order to identify their health problems and look for how to help them.

Costs: There are no direct costs associated with this research project.

Payment: No payment is provided to participant, only light refreshment.

The information that will be collected is purely for research purposes to learn more about Congolese migrants who live in Johannesburg and their health problems; and how they solve them.

The information that you share with me may be written up in research reports. We will NOT use any of your personal details and it will not be possible to identify you personally in any of the research reports.

Participation is completely voluntary; you are under no obligation to take part in this project.

You may withdraw from this project at any stage; this will not affect you in any way.

Researcher: please read through this carefully with the participant

- I agree to participate in this research project.

- I have read/been read this consent form and the information it contains and had the opportunity to ask questions about them.

- I agree to my responses being used for research on condition my privacy is respected, subject to the following:

    - I understand that my personal details will be used in aggregate form only, so that I will not be personally identifiable.

- I understand that I am under no obligation to take part in this project.

- I understand I have the right to withdraw from this project at any stage.

PARTICIPANT:

Printed Name of Participant Date

Person who sought consent (researcher)

- **I (*Name of Researcher*), herewith confirm that the above participant has been fully informed about the above study and has given verbal consent to participate in the study.**

Printed Name Signature/Mark or Thumbprint Date

Appendix III: Audio Taping: Verbal Informed Consent Form

I give my consent to be audio taped during the interviews. I have read the Participant Information Sheet and understand that my identity will be kept confidential. The researcher has explained to me that the tapes will be typed up and used only for the purposes of the study **"Understand Illness and Treatment-Seeking Behaviour among Congolese Migrants in Johannesburg".**

I understand that after the tapes will be kept for 2 years after publication, or for 6 years if no publication results.

I also understand that I am free to withdraw this consent at any time.

PARTICIPANT:

Printed Name of Participant Date

Person who sought consent (researcher)

- **I (*Name of Researcher*), herewith confirm that the above participant has been fully informed about the use of audio taping for the above study and has given verbal consent to the interviews being recorded.**

Printed Name Signature/Mark or Thumbprint Date

Appendix IV Ethics Committee Clearance

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (NON MEDICAL)
R14/49 Lakika

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER H100 913**
PROJECT	Understanding illness and treatment seeking behaviour among Congolese migrants in Johannesburg
INVESTIGATORS	Mr DM Lakika
DEPARTMENT	force migration studies
DATE CONSIDERED	17.09.2010
DECISION OF THE COMMITTEE*	Approved Unconditionally
NOTE:	

Unless otherwise specified this ethical clearance is valid for 2 years and may be renewed upon application

DATE 20.10.2010

CHAIRPERSON .....
(Professor R Thornton)

cc: Supervisor : Ms L Nunez

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10005, 10th Floor, Senate House, University.

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

Signature

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES