Pregnant in a foreign city: A qualitative analysis of diet and nutrition for cross-border migrant women in Cape Town, South Africa

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ABSTRACT

How do migrant women navigate their food environment during pregnancy? Foods are imbued with new meanings in a new place, and in low-and-middle-income countries including South Africa, a changing food environment leaves the poor, including many migrants, vulnerable to malnutrition. Thus, one of the ways economic and social vulnerability may be experienced and reproduced is via the foods one consumes. Examining food perceptions in the context of pregnancy offers a potentially powerful lens on wellbeing.

Methods: Nine focus group discussions (N = 48) with Somali, Congolese, and Zimbabwean men and women, and 23 in-depth interviews with Congolese, Somali and Zimbabwean women living in Cape Town were conducted, exploring maternal and infant nutrition. We used thematic analysis to guide analysis.

Results: (1) Participants described longing for self-categorised “traditional” foods, yet had limited access and little time and space to prepare these foods in the manner they had back home. (2) Sought-after foods available—and even celebratory—for migrants in Cape Town during pregnancy tended to be calorie-dense, nutrient poor fast foods and junk foods. (3) The fulfilment of cravings was presented as the embodiment of health during pregnancy. (4) Iron-folic acid supplementation was perceived as curative rather than preventive. (5) While participants did not describe hunger during pregnancy, food scarcity seemed possible.

Discussion: Food perceptions during pregnancy reflected migrants’ orientation towards home. Fast foods were widely acceptable and available during pregnancy. These foods were not perceived to have negative health consequences. Nutrition interventions targeting migrants should consider the symbolic nature of food, the increasingly globalised food environment in urban LMIC settings, as well as the contexts in which health perceptions evolve.

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1. Introduction

For mothers and children, the consequences of maternal undernutrition and overweight globally are far-reaching, impacting acute and chronic disease, healthy development and economic productivity (Black et al., 2013). For migrant women, navigating pregnancy in a new country, nutrition represents one important mechanism through which health and illness is experienced and conveyed. Making sense of diet during pregnancy involves exploring the overall food environment—foods available, affordable, and accessible—as well as the ways these food environments are navigated by women and their families during the unique period of pregnancy.

While there are some studies that consider maternal diet amongst migrants in high-income settings (HIC) (Desouza, 2013), overall, very little is known about the relationships between migration and maternal nutrition in low-and-middle-income countries (LMIC). This is despite migrants forming a very important, and often vulnerable, global population. Globally, there are at least 213 million cross-border migrants globally (Urquia & Gagnon, 2011), of which 73 million are in LMIC and between 1.6 million and two million cross-border migrants in South Africa (CoRMSA, 2009).
In South Africa, the cross-border migrant population predominantly originates from other African countries (CoRMSA, 2009). Migrants from these countries are much more evenly split between male and female than previously; and young and healthy, and thus of childbearing age (CoRMSA, 2009).

In South Africa, as in many other countries, access to quality health care for migrants is circumscribed by the stretched South African public health care system, as well as due to active exclusion by authorities, marginality, and xenophobia (Crush & Tawodzera, 2014). Over the past ten years, xenophobic violence in South Africa has greatly increased the vulnerability of cross-border migrants, which is further complicated by tenuous legal status for many. Economic and social vulnerability intersects with changes inherent in moving from one physical location to another. Against this backdrop of economic and social vulnerability (Solar & Irwin, 2010) one of the most tangible physical consequences of migration is embodied through in the food a migrant eats in a new place.

Changes in diet are particularly important during pregnancy because of the long-term implications of maternal diet on the health of a mother and baby. Undernutrition in utero leaves children more susceptible to disease and developmental delays (Engle et al., 2007). The long-term health implications of excess weight gain during pregnancy include the health risks associated with long-term obesity (Galtier-Dereure, Boegner, & Bringer, 2000) as well as increased risk of developing metabolic syndrome and diabetes (Catalano & Ehrenberg, 2006). Moreover, while migrants may access to basic antenatal services in South Africa, nutrition only represents a peripheral part of overall care. Iron and folic acid supplementation represents one of the only specific aspects of nutrition that is addressed in routine antenatal care. In accordance with the World Health Organization recommendation (Stoltzfus & Dreyfuss, 1998), the South African Department of Health has a policy of providing iron-folic acid supplementations during antenatal care. However, it is not known how migrant populations perceive this recommendation. Exploring of maternal diets amongst migrant populations therefore offers both concrete (do women actually take iron-folic acid supplements?) and abstract (how does diet reflect the spaces and experiences of cross-border migrant women?) insights into the lives and health of those who travel between LMIC.

In LMIC such as South Africa, the food environment has undergone rapid changes over the last two decades. The nutrition transition to energy-dense, nutrient poor foods has translated into rapid changes over the last two decades. The nutrition transition is embodied through in the food a migrant eats in a new place. Changes in diet are particularly important during pregnancy because of the long-term implications of maternal diet on the health of a mother and baby. Undernutrition in utero leaves children more susceptible to disease and developmental delays (Engle et al., 2007). The long-term health implications of excess weight gain during pregnancy include the health risks associated with long-term obesity (Galtier-Dereure, Boegner, & Bringer, 2000) as well as increased risk of developing metabolic syndrome and diabetes (Catalano & Ehrenberg, 2006). Moreover, while migrants may access to basic antenatal services in South Africa, nutrition only represents a peripheral part of overall care. Iron and folic acid supplementation represents one of the only specific aspects of nutrition that is addressed in routine antenatal care. In accordance with the World Health Organization recommendation (Stoltzfus & Dreyfuss, 1998), the South African Department of Health has a policy of providing iron-folic acid supplementations during antenatal care. However, it is not known how migrant populations perceive this recommendation. Exploring of maternal diets amongst migrant populations therefore offers both concrete (do women actually take iron-folic acid supplements?) and abstract (how does diet reflect the spaces and experiences of cross-border migrant women?) insights into the lives and health of those who travel between LMIC.

In South Africa, the food environment has undergone rapid changes over the last two decades. The nutrition transition to energy-dense, nutrient poor foods has translated into increasing rates of obesity (Popkin, Adair, & Ng, 2012). Globally, the obesity epidemic disproportionately affects the poor, even in LMIC (Popkin & Gordon-Larsen, 2004). Migrants in South Africa are vulnerable to both overnutrition and undernutrition: On the one hand, food insecurity is prevalent in urban settings across Cape Town (Battersby, 2011). On the other hand, migrants are migrating from countries earlier in the nutrition transition to South Africa where the nutrition transition is well underway. At times, they are also migrating from rural to urban areas. While rates of undernutrition and overnutrition during pregnancy are unknown, we do know that underlying rates of obesity and associated non-communicable diseases (e.g., diabetes and hypertension) are prevalent among all population groups in South Africa (Kruger, Puaone, Senekal, & Van der Merwe 2005; Van Der Merwe & Pepper, 2006). In South Africa, over 50% of women and 30% of men are overweight or obese (Kimani-Murage, 2013; Puaone, Matwa, Bradley, & Hughes, 2006). Despite the far-reaching implications of the nutrition transition, nutrition policy in South Africa remains broadly focused on undernutrition (Bryce, Coitinho, Darnton-Hill, Pelletier, & Pinstup-Andersen, 2008; Department of Health, 2013; Western Cape Government, 2013). Set against the global nutrition transition, understanding migrant maternal nutrition in a LMIC involves considering both an excess and lack of calories and micronutrients.

Given the backdrop of increasing non-communicable disease and the nutrition transition, maternal nutrition may therefore be an important mechanism through which health inequalities are perpetuated. In light of the marginality of many cross-border migrant women in South Africa, we propose that exploring migrant perspectives on food during this crucial maternal period offers a modest contribution to the literature pertaining to migrant health experiences in urban LMIC settings.

2. Methods

2.1. Sampling and setting

In 2013, over the course of nine months, we conducted 23 in-depth interviews with a purposively selected group of Somali, Congolese (Democratic Republic of Congo), and Zimbabwean women. For in-depth interviews, study participants fitted the following inclusion criteria: women over the age of 18 who were currently pregnant or had given birth in the last two years, and self-identified as Somali, Congolese (from the Democratic Republic of Congo, DRC), or Zimbabwean. The interviews included questions related to maternal and infant nutrition, including over-arching questions involving pregnancy, labour, delivery, and postpartum. Questions then focused specifically on nutrition throughout this period. In addition, we conducted two focus groups for women and one focus group for men, for each of the three nationalities. Each of the nine focus group discussions consisted of between 4 and 9 participants each (FGD, n = 48). Questions in focus groups broadly related to the collective experiences of eating patterns of pregnant mothers and nutrition for new babies in South Africa and participants’ countries of origin.

Sampling from three different migrant groups allowed for us to explore wide-ranging experiences of migration to Cape Town, rather than nationality-specific experiences. These three groups were selected because they constitute large, visible cross-border migrant communities in Cape Town, from three different regions of Africa (southern Africa, central Africa, and the Horn of Africa). While Cape Town has very high levels of socio-economic inequality, it is otherwise similar to other middle-income urban centres in the global South, making the findings of this study broadly relevant for settings where the food environment may be similar. Participants from all three populations typically lived in shared, inner city housing, some out of economic necessity and others out of the desire to save or send money home.

Most interviews took place in migrant homes, whereas focus groups took place primarily in more communal settings, including community centres, shops, and a women’s shelter. Recruitment was facilitated by non-profit organizations and community leaders from the three nationalities, and continued using snowball sampling. JHA worked with several organizations over the course of a year before and during recruitment. Before beginning the interview and guided by participants, the interviewer and interpreter/facilitator sought out a private room where no other adults were present. At times, young children came in and out of the interview, and the interview was paused and restarted to allow for participants to care for children. The content of the interview was uncontroversial and participants generally enjoyed discussing the topic. Given that the interviewer was a white woman, special care was taken to allow community facilitators to help in explain the research to onlookers.

2.2. Use of interpretation

During two focus group discussions, interpreters...
simultaneously interpreted between the moderator (JHA) and participants (one conducted in French and Lingala, one conducted in Somali). Four Somali in-depth interviews and one Congolese in-depth interview also included an interpreter. Remaining focus groups and in-depth interviews were conducted in English, with relatively fluent English speakers. All interviews and focus groups were recorded and the English portion of all interviews was transcribed verbatim. Transcripts were then checked by Somali and Congolese professional interpreters and discussed, to check and improve the quality of interpretation.

2.3. Data analysis

Data collection and the transformation of audio recordings into text marked the beginning of the analytic process. On-going analysis took place throughout the research process, in the form of a research diary, notes, and reflections. Both the in-depth interviews and the focus groups were analysed using thematic analysis, which, after immersion in the text, consisted firstly of inductive coding (Boyatzis, 1998). The themes were coded into categories, sorted into themes and assessed for dominant sentiments within and across the three migrant groups. More deductive, a priori coding formed the second layer of thematic analysis (Crabtree & Miller, 1999). All transcripts were uploaded to the computer software Hyperresearch (Researchware Inc., 2009, Massachusetts, U.S.A.), to assist with coding, sorting, and data management.

2.4. Ethics and informed consent

All participants received information about the study prior to enrollment, and signed informed consents that explicitly outlined their right to confidentiality and to withdraw participation at any time. Ethics approval was granted for this study from the University of Cape Town, Faculty of Health Sciences, Human Research Ethics Committee (Ref 009/2013).

3. Results

The results are presented in five sections, in which we describe the five key themes identified when coding the interviews and focus groups relevant for migrant diets while pregnant. Women participants ranged in age from 20 to 40, and had had given birth to between one and six children. Men, who were represented in focus groups only, ranged in age from 20 to over 60 years of age (not all participants ranged in age from 20 to 60 years of age (not all participants were willing or able to provide their age). Many Somali women participants had not attended formal school at all, while some Zimbabwean participants had completed some tertiary education. Most participants described themselves as having moved to South Africa in the previous five years.

3.1. Craving “traditional” foods during pregnancy

It was common for respondents from all three countries of origin to emphasize that despite the busyness of life in Cape Town, they had been raised with a strong domestic tradition:

They [South Africans] want to eat out, after work they buy some KFC [Kentucky Fried Chicken] or something … but for us, we know how to cook, when we get married and then we know how to run the house, we know how to cook … We watched our mothers.

29-year-old Congolese mother of 1

It was in this context that participants emphasized craving the “foods of home” (27-year-old Zimbabwean mother of 2) during pregnancy. In response to broad opening questions about eating during pregnancy, many in-depth participants began by describing their cravings for “traditional” foods. Congolese and Zimbabwean women generally emphasized their desire for leafy greens, often dried or otherwise preserved, ground nuts, and dried fish that were not generally consumed by populations in Cape Town and were understood as distinctively “Congolese” or “Zimbabwean”, but not “South African”. Many participants emphasized the feeling of satisfaction evoked by eating these foods:

When you eat the ngaingai [sour preserved vegetables] you feel fine!

27-year-old Congolese mother of 1

However, despite their cravings, eating these foods during pregnancy was expensive, unusual and required forethought, rather than being part of the quotidian and familiar acts of household food preparation, which typically took place with extended family back home. Participants from Congo and Zimbabwe occasionally bought dried vegetables that originated in Congo, Zimbabwe or Mozambique. The greens were pricey, and already dried and ready to use in cooking. Whereas at home, women spoke of their mothers preserving greens, fish and mopane worms for future consumption, this connection was severed by migration, and women usually relied on traders to bring the foods from their countries of origin. In the inner city, “traditional” food preparation—usually time-consuming—was difficult. Thus, participants faced barriers to accessing and affording ingredients, finding kitchen space to prepare food, and finding time to prepare meals. For Somalis, the importance of freshness meant that even when foods were imported from Somalia, they still fell far short of ideal, because the freshness of the food was as important as the food itself. Thus while camel liver is imported to South Africa, in oil, at great expense, it could never be comparable to the camel liver of a freshly slaughtered animal.

3.2. Consuming energy-dense, nutrient poor foods

In the context of globalization, both foods and people move freely and foods are imbued with new meanings in the context of the new place. Specifically, consumption of “fast” foods and “junk” foods during pregnancy reflected a complicated intersection between socioeconomic status, health perceptions, the celebratory nature of pregnancy, and the food environment. In particular, men’s willingness to “treat” their wives or partners during pregnancy frequently took the form of providing energy-dense, nutrient-poor fast foods and junk foods.

As with cravings for traditional food, migrant women in this study did not usually present their consumption of fast foods during pregnancy as either healthy or unhealthy. Rather, they represented their consumption in terms of desire, and in terms of being able to satiate their craving in the context of pregnancy. Many respondents described consuming more fast food during pregnancy. The terms “fast foods” and “junk foods” were not usually the terms the women used, they tended to name specific foods—potato chips, sweets, biscuits (cookies) and soft drinks, particularly coke—or restaurants they craved food from—such as Kentucky Fried Chicken (KFC) and Nandos (A South African chain restaurant serving chicken). Requesting and consuming fast foods and other foods from restaurants were presented as a way of celebrating pregnancy, as it represented a significant and exceptional expense:
Mine [my girlfriend] she used to like these cool drinks. You buy those 2L coke, like two in the fridge, when you get back from work around 5 one is finished, by tomorrow morning another one is finished!!

Zimbabwean men’s focus group

There’s sometimes that I feel like ribs. Sometimes I feel like Chicken Lickin’ [a South African fast food chain]. He would make an extra effort to bring them.

Zimbabwean mother of 2

One woman described the anticipation of having KFC during pregnancy, because during pregnancy such a craving would be satisfied:

… when I was young I said I will want to eat KFC because my husband will be working … and I would like to eat those stuff … expensive stuff …

Zimbabwean Focus Group participant, age 20, mother of one

In discussions with Somali women, participants’ framed morning sickness as an opportunity to make the most of the only stage of life when they would be pampered. When asked whether their husbands would get them special foods during pregnancy, focus group participants agreed emphatically:

R1: They get whatever you ask!
R2: Actually there’s only one time they’re gonna give you whatever you ask. ‘Cos the other times they gonna refuse. [Laughter and agreement]
R3: Pregnancy is a big chance for a woman!! [Laughter and agreement]

Somali women’s focus group

Somali participants tended to report severe nausea during the first trimester of pregnancy, whereas participants from Zimbabwe and Congo didn’t talk about morning sickness in such extreme terms. Women unanimously agreed that pregnancy was a period during which Somali women enjoyed unique leverage and attention.

Yet fast foods did not effectively substitute for traditional foods, and were often described as being refused by women after the fact:

Like you buy even nice food, you buy KFC, you say ‘ah let me spoil her’, you buy KFC, she don’t want! [you ask] ‘What you want?’ She’ll tell you that she wants something that you can’t even get in South Africa … she can tell you like in Zimbabwe they got small, small fishes … those one!

Zimbabwean men’s focus group

Indeed, for Congolese and Zimbabwean women, the desire for fast foods tended to be juxtaposed with the lack of availability of traditional foods:

There in Zimbabwe I used to eat our own traditional foods. […] Yes, but with this one it was totally different. [with this pregnancy] I wanted sweet stuff, fast foods. I almost ate fast food for this one I didn’t cook for myself I was lazy even here at home. I think it is because … it is difficult for me to have our own traditional food. So I had to force myself to have an alternative.

30-year-old Zimbabwean mother of two

While Congolese and Zimbabwean participants described the comfort they felt after eating traditional foods or clay soil, they did not describe this sense of comfort after eating KFC or Nandos. They largely described the ways that pregnancy made it possible to get food that would otherwise be considered too expensive. While they craved traditional foods, women and men consumed fast foods and junk foods, revealing a context in which energy-dense, nutrient poor calories were available, acceptable, and also considered affordable in the specific context of pregnancy.

3.3. Perceptions of nutrition: longings framed separately to health

Health was typically not raised as a focal point of one’s cravings. Rather, pregnancy—and particularly early pregnancy—was a significant event because of the way that spousal power dynamics shifted. Love and pampering was conveyed by foods procured at significant cost during the first part of pregnancy, and the actual food was less important or universal than the sentiments the food conveyed. Health was secondary to the experience of celebration. In this context, caloric excess during pregnancy may be a more pressing concern for this population. However, given the consumption of nutrient-poor calories, caloric excess may well coexist with micronutrient deficiency.

Women consistently described their eating habits as emerging from desire, rather than out of a preconceived notion of health, food was healthy because it was “the food I know from when I came into the world” (24-year-old pregnant Somali mother of 1, 12S), and trying to fulfill a craving was inevitable:

You don’t decide! [Laughter, agreement] It’s a craving! [Laughter and agreement] […]

Zimbabwean Women’s Focus Group

Most study respondents did not describe fast food as necessarily unhealthy; it was largely not considered in health terms at all. Many women described eating what they felt like eating, and it was generally assumed that this was what they should eat. For example, when asked whether she ate well during pregnancy, this participant felt she did:

Yes. Because if I feel [like] something, I eat it. If I feel [like] I want to eat KFC, I can do it, I’m going to tell someone, ’oh buy for me KFC’, I can eat it.

26-year-old Congolese mother of one

Participants’ cravings during pregnancy were considered synonymous with health both for women and their babies, because the health of a mother was not distinct from the health of their baby. When asked if she was consuming a particular food for her own health, or for the sake of her baby, one participant exclaimed, “for you and the baby! You are pregnant! If you take, the baby take also!” (31-year-old Congolese mother of 2).

When women reflected on the nutrition advice of their own, now absent, mothers they described this advice as empowering rather than prescriptive. They were encouraged to trust their bodies and eat what they felt like eating:

She [mother] just said, ‘you must eat what you are craving for’, because the pregnancy won’t have a programme that, this is the food you must eat, and she just said that if you like you want this feel free to eat, she wasn’t specific ‘eat this, eat this’.

30-year-old Zimbabwean mother of 2
She (mother) would just give you whatever you are craving for if you say you want that she will give it to you.

26-year-old Zimbabwean mother of 2

Rather than health and desire existing separately or even conflict with each other, the fulfilment of desire was the embodiment of health. Participants used the categorization of “healthy” as a familiar, oft-repeated, but not very meaningful category. For some women, fast food was perceived as a healthy food choice while pregnant, particularly in relation to combatting negative experiences such as nausea. When asked what makes KFC, and particularly KFC milkshakes healthy, this participant responded:

“… a familiar, oft-repeated, but not very meaningful category. For some women, fast food was perceived as a healthy choice while pregnant, particularly in relation to combatting nausea. When asked what makes KFC, and particularly KFC milkshakes healthy, this participant responded:

Because if I drink them I’m not going to vomit. If I drink tea, I’m going to vomit. That’s why I think it’s better to maybe drink milkshake … Because, there is vitamins in KFC.

26-year-old Congolese mother of one

Some women presented a different stance: while it was rare for a woman to describe eating or avoiding specific foods for the baby, or generally for good health, there were a few instances of Zimbabwean women describing their nutrition in terms of the health of their child. This 26-year-old Zimbabwean mother of two expressed this sentiment of altering her diet-or resisting her cravings—for the sake of her baby’s health. She framed this in terms of the advice of the clinic:

Sometimes yes, I was tempted [to eat fizzy drinks, fast food] so I had to eat but when I think about the baby that I’m carrying I have to say no and maybe opt for something else. Like instead of biscuits I had to buy crackers … Crackers … like TUK [a type of cracker] those biscuits so if I think of eating biscuits with cream I had I to opt for a TUK.

29-year-old Zimbabwean mother of two

Despite wanting to eat for the sake of her baby, the advice of the clinic was foreign and inaccessible to her experiences of pregnancy:

They recommend you to eat more … err … meals like salads those healthy stuff but, you know when you are pregnant you can’t have just a salad!

29-year-old Zimbabwean mother of two

In this instance, clinic advice felt inappropriate to the participant’s cultural and social contexts, which reaffirmed her sense of reliance on her own beliefs.

3.4. Iron-folic acid supplementation and a focus on acute health needs

It was very rare for participants to mention taking vitamins before or during pregnancy. Iron deficiency anaemia was well-known and described by many participants from all communities. It was usually referred to as “low blood”, or “not enough blood” or “the blood is too small” (Somali men’s focus group). However, if women felt healthy and were consuming the foods they liked, they did not see a need for iron-folic acid supplementation, which was generally perceived as curative and as “medicine”, rather than routine and preventive. At times, participants described being given iron-folic acid supplements and feeling obliged to take them without any real understanding of the benefit they provided. Rather, the supplements were perceived to have side effects without any clear benefit:

I don’t know they just say you must take the vitamin tablets. They are good for the baby and stuff like that; but they gave me the vitamin tablets and I took them once. And whenever I took them I felt dizzy. I felt like … so I stopped taking them.

31-year-old Zimbabwean mother of 3

For me that vitamin, if you take it you become sick! I never take it. If I take it I’m not going to eat until the next day. Dizzy, nausea! If you don’t take it you’re fine.

28-year-old Congolese mother of 3

Another perspective was that supplementation—and even prenatal visits in general—were necessary because food in South Africa was perceived as unhealthy:

I would, I would say yes because; in Zim women don’t do the Preggie Vite … At all … They don’t do the calcium; the folic and the … They just give birth. My two sisters gave birth in Zim. They don’t even go to the clinic until they’re six months […] So the food there it’s, it’s nourished enough to help mommy and baby. But when you’re here they say ‘you need to take some folic; you need iron tablets.’ Yes … I understand why they say that.

30-year-old Zimbabwean mother of 4

In this light, supplementation was a concession in an unhealthy context. Women’s reasons for not consuming iron and folic acid supplements were related to their perception that supplements produced the side effects of nausea and dizziness, and that iron-deficiency anaemia was an acute illness to be treated, not prevented. This perception was consistent with participants’ focus on acute, and short term, experiences of health.

3.5. Food scarcity

Lastly, there was little mention of food scarcity. Participants’ resisted questions that implied food choices were made on the basis of cost, and did not describe hunger.

It [fruit] is not expensive. Even one rand (US$0.06) you can buy fruit … 50 cents (US$0.03) you can buy fruit. It’s not expensive.

30-year-old Congolese mother of 3

The experience of overall food scarcity was only briefly expressed, in the abstract, in a Congolese women’s focus group. In this context, dietary diversity, rather than overall calories, was a concern for migrant families:

It’s kind of [depends] on your possibility, because you can see some people who are eating same food from first to first … Because maybe the income is low, you know our country is war, sometime the war come here in Cape Town, you move like to J’burg, so you leave everything in Cape Town, and there is no income for you, so you have to eat the food that you see every day, every day, so the child also is going to [be] used [to it]

Congolese women’s focus group
4. Discussion

In LMIC, studies and interventions related to pregnancy have tended to focus predominately on short-term health as a reaction to acute problems such as anaemia, teenage pregnancy, and malnutrition, despite increasing rates of obesity and associated chronic disease. This study highlighted the ways in which under- and over-nutrition are linked to migrants’ food environment, and in particular, to the backdrop of the nutrition transition. Whereas previously food scarcity was much more likely a concern than caloric excess, in the current food environment energy-dense, nutrient poor foods seem to be both available and accessible to migrants in inner-city Cape Town.

As an exploratory study of a new topic amongst cross-border migrants in Cape Town, the categories of migration may not have been sufficiently explicit. For example, participants were not excluded on the basis of when they arrived in South Africa—though all participants had been in South Africa less than ten years. It is vital to clarify and grapple with the categorisation of “migrant” and “migrant” in quantitative follow-up studies of nutrition in migrant populations. Nevertheless, participants’ self-description highlighted the ways that notions of home, pregnancy, and food intersected. Moreover, food was a key way that participants presented their sense that they were outsiders to their marginality in Cape Town—to us as South African researchers.

Participants’ descriptions of “traditional” foods served as a window into both diet in the host country as well as participants’ longing for home. Cravings were biocultural (Young & Pike, 2012), where desire for food was rooted in both what is socially constructed as “normal” as well as in the physical experience of pregnancy. Participants of all three nationalities frequently used the term “traditional” to refer to foods. However, concepts of “tradition” are not stagnant or true for all time (Friedmann, 1999). Diet was not only physical, but also symbolic; food was one of the ways that identity was retained, renewed and re-asserted, particularly for migrants (Ziegelman, 2011). Past studies have explored the importance of food for immigrants in a new place, and in the U.S. literature, long after someone identifies as “American”, they retain a preference for foods from their country of origin (Ziegelman, 2011). The symbolic meanings of food were apparent in this study: Participants from all three countries of origin spoke about craving “traditional” foods, and the foods of home, which were a nutritious and important part of a healthy diet in migrants’ country of origin (Flyman & Afellayan, 2006; Uusiku, Oelofse, Duodu, Bester, & Faber, 2010). Moreover, while in countries of origin, these foods were cheap or free as they were typically foraged rather than actively cultivated, in Cape Town they needed to be purchased. Thus, their role in enhancing food security was fundamentally changed.

While recognizing that food traditions are constantly in flux, it seems important to explore the ways that culturally relevant food preparation can be preserved in an urban context. Where strong food traditions exist, food is more likely to be prepared from culturally relevant food traditions, food is more likely to be prepared from food traditions exist, food is more likely to be prepared from food traditions exist, food is more likely to be prepared from food traditions exist, food is more likely to be prepared from public health agenda of improving health outcomes amongst women and children, while being imbued with deep symbolic meaning vital to wellbeing and health. Urban agriculture, and improving supply chains for wild green vegetables, which also grow in rural areas of South Africa, may be one key mechanism to provide cheap, nutritious food that is acceptable to both cross-border migrants and internal migrants from rural areas of South Africa.

While associated with pleasure and food traditions, food was also utilitarian. Eating for the sake of good health was seen as a foreign, and perhaps frivolous, concern. This contrasts with the conflict between health and pleasure that is present in healthy eating discourses in high-income countries (HIC) (Niva, 2007). While women’s description of their diets during pregnancy suggest that participants felt they obtained adequate calories, women did not necessarily consider food more or less nutritious based on composition of fats, sugars, protein or micronutrients. Nor did they describe their food intake in terms of calories or quantity. Rather, food was described as longing and lack of access to fresh foods. A focus on satiating cravings seems potentially problematic in the Cape Town context, where fast foods and junk foods were common cravings. Consuming fast foods during pregnancy seemed to be an evolving food tradition in Cape Town. Few women in this study described a sense of obligation to limit or consume particular foods during pregnancy, because of potential negative health effects or risks. Advice from participants’ mothers was general and non-prescriptive, and it is important to note that mothers were not physically present; any advice was based on past pregnancies in one’s country of origin, or communication by phone. It is not immediately clear from the literature whether, and in what context, eating for “health” results in healthier diets than eating in accordance with cravings.

Previous literature has tended to frame diet in terms of choice in relation to knowledge. For example, discussions of diet involve explanatory models of self-efficacy, health beliefs and a person’s locus of control (AbuSabha & Achterberg, 1997). However, the notion that knowledge and choice drive decision-making during pregnancy seems to be at odds with the two main ways that migrant participants framed their diet during pregnancy: in terms of the unavailability of traditional foods (i.e. a lack of choice) and in terms of cravings, or deeply felt urges that were internal, personal, and distinct from notions of health (i.e. somewhat independent of knowledge of a “healthy” diet). Partners, friends and family catered to participants’ cravings, reflecting the social dimensions of food and the celebratory nature of pregnancy, despite significant costs. For this segment of the urban population, “special”, craved food was primarily unhealthy. Thus, the broader socioeconomic forces that served as a backdrop to pregnancy nutrition in this population loom large. The contexts in which foods are consumed should therefore be a focus of policy intervention. Given the prominence of the food environment in shaping food decisions for migrants, we caution against nutrition interventions that focus narrowly on education and behaviour change. Rather, interventions that target food environments or the broader contexts of food preparation (fuels, time, and space for cooking) would be appropriate.

Many of the experiences described by cross-border migrants in relation to food and nutrition during pregnancy might also apply to internal migrants from rural areas of South Africa. Internal migrants in many countries may experience a similar juxtaposition of very busy, stressed lives with poor availability of kitchen facilities and relatively more access to industrialised foods. The experience of dietary changes as well as low socio-economic status, lack of kitchen space, and feelings of alienation in an urban environment—all affect, but are not limited to cross-border migrants. In low and middle-income countries, the low prioritisation of food
during pregnancy may be further compounded by overstretched and inadequate public health care facilities.

The perception of iron supplements as a curative medication for acute symptoms was juxtaposed with women’s inclination to crave traditional green leafy vegetables during pregnancy. In Cape Town, the unavailability of these greens, layered with the perception of supplementation as unnecessary may translate to increased risk of anaemia, relative to a participants’ diet at home. Since women did not go to the clinic until late in their first trimester, iron and folic acid supplementation did not occur pre-conception nor during the first trimester, when adequate folic acid stores are vital (Manuenn, de Jonge, Cornel, Spelten, & Hutton, 2014). In their review of maternal nutrition and birth outcomes, Abu-Saad and Fraser (2010) asserted that, given the complex interrelationships between micronutrients, rather than focusing on single micronutrients—such as iron or folic acid—women’s overall, long-term nutritional status should be the focus of interventions. This approach seems appropriate to the migrant case. Migrants’ understanding of anaemia was juxtaposed with their lack of awareness to iron-folic acid supplementation, thus illustrating the ways that maternal and infant health was framed in terms of acute and tangible, rather than in terms of long-term and more abstract, health problems. This phenomenon may be in common with non-migrants in LMIC who may be oriented towards reacting to acute health needs, rather than focusing on long-term health.

Rather than necessarily reflecting food security, silence around hunger seemed to reflect that it is hard to discuss hunger with a stranger. The National Food Consumption Survey Fortification Baseline I (NFCSB-1) found in 2005 that one in two households in South Africa experienced hunger, and only one in four households appeared to be food secure from a nutritional perspective (Grundlingh, Herselman, & Iversen, 2013). Previous studies have found migration to be a determinant of urban nutrition insecurity (Choudhary & Parthasarathy, 2009). For Somalis in particular, who represent a particularly close-knit community in Cape Town, it is likely to be a source of shame that a fellow Somali is without food. While women’s cravings and consumption of fast foods may seem to conflict with the possibility of food scarcity, these reports of consuming fast foods also seemed somewhat rooted in experiences of scarcity.

Lastly, in studies of overall nutrition, an individuals’ low socio-economic status is linked to the consumption of energy-dense, nutrient-poor diets, which in turn is associated with poorer health (Darmon & Drewnowski, 2008). Past research into experiences of cravings has highlighted the potential relationship between obesity and previous experiences of hunger (Stowers, 2012). In this article, we have suggested one dominant way migrants thought about pregnancy was through the lens of being “special”. “Special” meant foods that were ordinarily difficult to afford, including fast foods and junk foods. While women’s cravings for fast foods did not reflect caloric scarcity, they reflected something about the economic reality of migrant women, and the ways that migration, economic hardship, and the nutrition transition converged and the ways that women relished fast foods during pregnancy. If, indeed, food scarcity is a reality, it is likely that dietary diversity, rather than overall caloric needs, may be the more pressing concern. The issue of migrants’ perceptions of food scarcity is worthy of further investigation. The notion of pregnancy and birth as “special”, and the ways this celebratory time shifted power dynamics within newly nuclear families, may have implications for interventions and health. Women’s increased power was manifested in food consumption. Given that men play a role in navigating the Cape Town food environment on behalf of their wives, understanding men’s perspectives on health and wellness is a vital part of understanding and intervening to improve nutrition.

Children of parents who have experienced significant food insecurity seem more susceptible to obesity, as well as heightened risk of chronic disease (Veenendaal et al., 2013). For cross-border migrants, the dominant theme of craving and consuming obesogenic foods during pregnancy may represent a mechanism through which long-term health inequalities are reproduced. As such, nutrition interventions targeting both cross-border and internal migrants should consider the symbolic nature of food, the increasingly globalised food environment in urban LMIC settings, as well as the contexts in which health perceptions evolve.

Author contributions
Jo Hunter-Adams designed and implemented the study, and wrote the first draft of this paper.
Hanna-Andrea Rother had a supervisory role throughout the design and implementation phases of the study, and substantially contributed to several stages of the drafting of this paper.

Conflict of interest
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