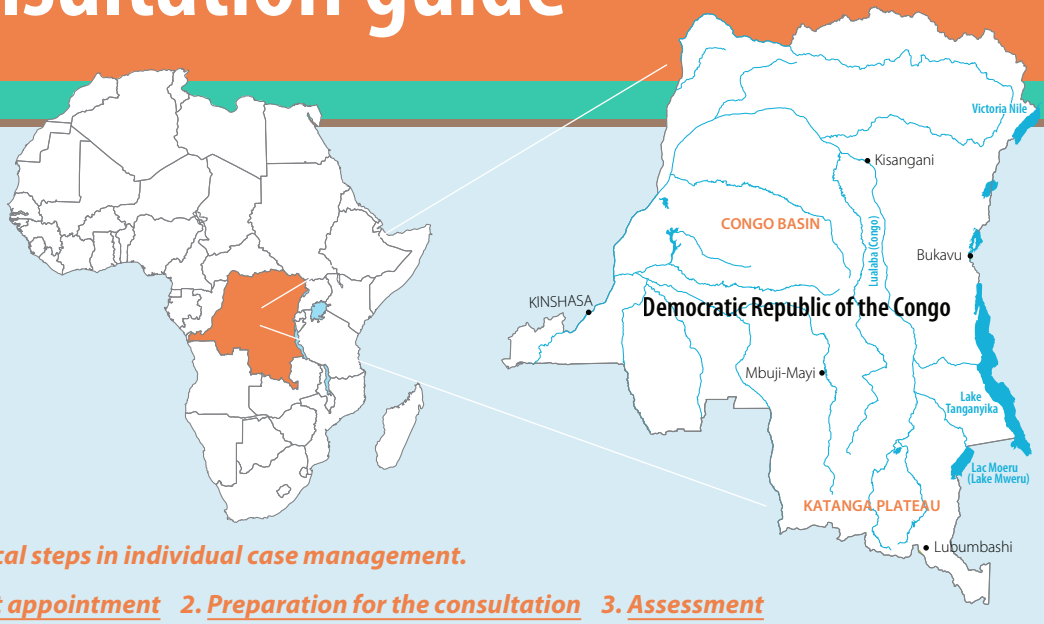
Congolese food and cultural profile: dietetic consultation guide



This resource is a guide for dietitian/nutritionists to provide culturally appropriate and effective services to people from the Democratic Republic of the Congo (DRC). It follows the ADIME format and provides information about the food and food practices of people from the DRC who have settled in Brisbane (Australia).

The profile follows the chronological steps in individual case management.

These include: 1. Booking a client appointment 2. Preparation for the consultation 3. Assessment 4. Diagnosis 5. Intervention 6. Monitoring and evaluation

1. Booking a client appointment

Key considerations

- Confirm with the client the preferred language for communication. Although French is the official language of the DRC, with Congo-born people in Australia, most speak Swahili as their main language at home (49.6%), followed by French (26.9%) and English (10.1%). The remaining 13.4% speak a range of other languages.[1]
- Emphasise the importance of being on time for scheduled appointments, because Congolese community members may have a different perception of time. Being late is no indication of the appointment's importance to the client.
- Encourage women to attend their husbands' appointments, because women are generally responsible for the preparation of food.

2. Preparation for the consultation

Working with an interpreter

It is important that a trained and registered interpreter be used when required. The use of children, other family members or friends is not advisable. Health services must consider the potential legal consequences of adverse outcomes when using unaccredited people to 'interpret' if an accredited interpreter is available.

If you have limited experience working with an interpreter, it is recommended that you improve these skills prior to the appointment. There are many online orientation courses available, and Queensland Health has produced guidelines for working with interpreters, which can be accessed here.

Traditional greetings and etiquette[2]

French is the official language.

English	French	Pronunciation
Hello/Good day	*Bonjour*	Bon-zhour
Thank you	*Merci*	Mair-see
Goodbye	*Au revoir*	Oh-reu-vwar

Shaking hands when greeting clients is often appropriate.

Be careful not to intimidate your client by making constant eye contact. Let the client guide you in the amount of eye contact required.

It is important to establish a respectful and trusting relationship between the dietitian and the client to improve compliance with advice.

Background

Religion	The population of the DRC is largely Christian but also includes Muslims, followers of traditional African beliefs, and Kambuangists – members of a native Congolese Christian sect.[3]
Language	French is the official language, while Swahili, Lingala, Tshiluba and Kikongo are languages used regionally.[3] In Australia, most speak Swahili as their main language at home (49.6%), followed by French (26.9%) and English (10.1%). The remaining 13.4% speak a range of other languages.[1]
History of conflict	Political conflict has occurred since the country's independence from Belgium in the 1960s. The 1990s brought increased civil tension and conflict due to attempts to overthrow the military dictatorship that had reigned for several decades. The country was also heavily affected by genocide in neighbouring Rwanda in 1994, which led to the influx of around one million refugees to the DRC. Conflict continues in parts of the country, and it is estimated that over 1.4 million people have been displaced.[4]
Migration history	As many as 470,000 refugees from the DRC have taken refuge in neighbouring countries. The largest numbers are in Uganda, Rwanda, Tanzania and Burundi. Conditions for the refugees vary both between and within countries, but in most camps conditions are harsh, unhealthy and unsafe.[3]
Gender roles	Family roles are well defined, with men generally protecting and providing for the family, while women perform domestic roles such as household chores and take care of children. In the DRC, women's legal rights are limited, with married women unable to open a bank account, obtain a passport, or rent or sell property without their husbands' permission.[1] Since the mid-1990s, there has been an increase in the number of women becoming wage earners in the DRC to help bring in extra income for the family.[3]
Household size	The average household size is 5.4 people per household in the DRC; however, this may range in size from 1 to 14 individuals.[5]
Population in Australia	The 2011 Census recorded 2,576 Congolese-born people residing in Australia.[1]

Health profile in Australia

Life expectancy	In 2007, life expectancy in the DRC was around 54 years.[5] No figures are available for Congolese life expectancy in Australia.
New arrivals	The health of newly arrived refugees who have resided in refugee camps is dependent on the camp from which they came. Some camps have health clinics, and residents may be able to engage in small-scale farming. Other camps lack services, and residents may be entirely dependent on food rations for survival. Health issues are exacerbated by the length of stay in camps, with many refugees living there for over a decade.[1] Common illnesses of new arrivals to Australia include HIV, malaria, gastroenteritis, tuberculosis, African trypanosomiasis (sleeping sickness), typhoid, and some parasitic conditions.[1] About 71% of children less than 5 years of age and 53% of adult women suffer from iron-deficiency anaemia. Diarrhoea affects about 15% of children, leading to iron and other nutrient deficiencies. Women also are likely to have low plasma zinc levels.[6,7,8] Like other refugee groups, the prevalence of overweight, obesity and nutrition-related chronic diseases increases with length of stay in Australia, so early interventions introducing healthy eating practices are useful measures to prevent disease.
Oral health	Oral health is deemed as a very low priority in the DRC due to extreme poverty. Congolese people in Australia may not place oral health as a priority.

Health profile in Australia – *continued*

Social determinants of health and other influences	Due to prolonged conflict in the DRC, many Congolese refugees have experienced great physical and psychological health impacts, especially women (due to sexual and gender-based violence).[3] Lack of English, work skills and disruption to education have led to high unemployment rates in Australia (25% vs 5.6% for the rest of the population).[1]

Traditional food and food practices

Religious and cultural influences

Cultural events include National Day (June 30). Social events include weddings, baptisms, funerals and religious holidays. Wedding feasts can last for days. These celebrations often include large meals that feature foods such as pork and chicken for those who can afford them.

Traditional meals and snacks

The traditional Congolese diet is very healthy. When conflict is absent, many people farm their own food and eat freshly grown and unprocessed foods.

Food practices	**Common foods:** Some foods, such as rice, are staples across the country; however, food choices are usually dependent on regional location and the availability of food. *Northern*: Cassava (root and leaves) with meat, fish, vegetables and legumes. *Southern*: Maize, meat, vegetables, legumes and sweet potato. *Eastern*: Potato, beans (green and dried), cassava, meat and vegetables. *Western*: Cassava with fish, meat and vegetables (including legumes). *Central*: Cassava, maize, potato, meat or fish. The consumption of fish or meat will vary depending on wealth and availability in different regional areas. While this provides a general guide, there may be dietary influences from each individual's refugee experience and any countries they have travelled through, including refugee camps. **Meal patterns:** Most families have 1–2 meals per day, and large quantities are eaten at each meal. Traditionally, the main meal is consumed around 3.00 pm, and everyone in the household attends, however this pattern may vary due to school and work commitments**.** **Eating practices:** In village areas, meals are traditionally eaten from a large communal dish with one's fingers, using the starchy component to mix with and soak up the stew or sauce. In metropolitan areas, family members may be more likely to serve food on individual plates. The father of the family receives priority for food. Meals are usually eaten at the table.
Breakfast	Leftover cassava from the previous day; maize porridge made with water and sugar; egg omelette (without milk) and white bread.
Main and other meals	Meals consist of a high-complex-carbohydrate food (cassava, yams, potatoes or plantain) with a sauce or thick stew, often made with peanuts. This is based on fish or meat if they are available. This is often highly flavoured and spicy.[1]
Fruit and vegetables	These include tomatoes, root vegetables (taro, sweet potatoes, cassava and yams), pumpkins, peas, nuts, cassava leaves, okra, onions and mushrooms.
Snacks	Snacks are not normally eaten; however, if there is leftover cassava from the afternoon meal, this may be eaten in the evening.
Beverages	Water is consumed with all meals. Many Congolese who are not Muslim drink a traditional alcoholic drink made from banana or sorghum, called *lotoko* or *pétrole*. This drink has important social value for the Congolese, who believe that it unites people and fosters friendship.[3]

Traditional meals and snacks – continued

Celebration foods and religious food practices	Muslims make up 10% of the Congolese population. Islamic religious dietary practices include eating only halal meats and not consuming pork, pork products, gelatine or alcohol. Ramadan is a 30-day period of fasting for Muslims.[9] Goat stomach, sliced and boiled with onion and tomato, is a celebration food. Chicken with onion, tomato and rice is always served at Christmas. Traditionally, chicken is more cost effective for feeding large groups, as chickens are often bred by families. Other birds and pork may also be used, depending on availability.

Common traditional foods

Sombe, made from cassava leaves (*saka-saka*), onion and chilli. Dried fish or meat is sometimes added.		Cassava leaves contain cyanide and must be soaked in boiling water and pounded before use. The leaves are then boiled and pounded again and other ingredients added. This food has a number of different names, depending on the region and additives. For example, *Pondu* is a traditional Congolese recipe for a classic stew of cassava leaves (*saka-saka*) flavoured with onion, red palm oil, chillies, garden eggs and tinned sardines or mackerel.
Dried fish dish with cassava leaves, made from cassava leaves, onions, eggplant, celery leaves, crushed peanuts, smoked fish and palm oil		Cassava is prepared as above and other ingredients added, with fish last (after it has been soaked in water for 10 minutes). Peanuts are crushed to a powder. The palm oil is added last to retain its flavour. To see this dish being prepared, click here.
Fufu/Ugali, made from cassava and/or corn/maize flour		A paste is made from the cassava and/or maize flour. It is rolled into egg-sized balls and dipped in stew.
Igikoma, made from maize (corn), sorghum and wheat flours in equal amounts, sugar and water. Soya can be substituted for wheat flour.		This is eaten for breakfast as a porridge.
Kwanga*		This is fermented bread made from cassava and commercially produced throughout the DRC. It is wrapped in dry banana leaves.
Red palm oil		Red palm oil is high in saturated fat (palmitic acid), monounsaturated fat (oleic acid), vitamin E and beta-carotene, which gives its distinctive dark red colour. It is used in cooking many wet dishes and adds both colour and flavour. Red palm oil is available in African food shops in Australia.

** Photo supplied by Kwanga Market, Raleigh, North Carolina, USA.*

Food habits in Australia

Adaptations to diet in Australia	**Substitute foods:** If cassava leaves are not available, sweet potato leaves, silver beet or spinach leaves can be used. If cassava root is not available, yam can be used. Semolina may be eaten if maize is not available. **Changes to diet:** Congolese families may opt for taking sandwiches and other 'Western' meal items rather than traditional Congolese foods for lunch at work or school. Children are likely to start eating snacks following school and before bed. **Other influences:** Takeaways are likely to be limited to those items that can feed a large family without large expense, e.g. pizza.
Cooking methods	Cassava can be eaten by grinding the leaves or slicing the root. In Australia, frozen cassava leaves are ground using a rolling pin or a blender. Cassava leaves can be frozen for several months. Because cassava contains toxic cyanogenic glucosides, the roots and leaves need to be processed by soaking, cooking and/or fermentation before they are eaten. In the DRC, fish is often dried and smoked, and then mixed with other staple ingredients; this practice continues in Australia. Chicken is also eaten. Palm oil and peanut butter are used frequently in cooking.
Shopping/meal preparation	Traditionally, women are responsible for shopping and cooking. For refugees who have spent long periods in camps on basic rations, knowledge of traditional Congolese food and skills in its preparation may be absent. This is especially so for many younger refugees. Of Australia's Congolese-born population, 49.2% were under 25 years old in 2011.[1]
Food in pregnancy	Pregnant women may take two tablespoons of palm oil per day for 'good blood'.
Breastfeeding and first foods	**Breastfeeding:** In the DRC, 36% of children aged 0–6 months are exclusively breastfed and 64% of children aged 20–23 months are still breastfed.[5] **Introduction of solids:** Solids may be introduced prior to six months. Mothers may introduce thick maize/rice porridge, with possible additions of peanut butter, lemon, fruits or vegetables. Mothers may respond well to suggestions to introduce high-iron cereals to replace porridge but are unlikely to be already using fortified baby rice cereal and commercial baby foods as first foods. There may also be inadequate progression to solid textures.[10]

During the consultation

3. Assessment

Key considerations

- **Anthropometry:** Physical contact between members of the opposite sex may be viewed as inappropriate. For this reason, always ask permission before taking measurements that involve touching a client.
- **Meal patterns:** How meals are defined varies between cultures. It is important to ask more generally about when food and beverages are consumed throughout the day rather than set meal patterns (breakfast, lunch and dinner). Check the consumption of snacks and takeaways.

When taking a diet history, be sure to check the following:

Prompt	Why?
☐ Length of stay in Australia	Newly arrived refugees may have experienced severe malnutrition. Nutrient deficiencies (iron, zinc, vitamin C and iodine) are common. Newly arrived refugees may also have a poor understanding of the Australian food supply, especially how to choose and prepare local vegetables and fruit.

Prompt	Why?
☐ Migration history	Some refugees may have stayed in refugee camps in neighbouring countries on basic rations for over a decade.
☐ Religion	Some food traditions may impact on dietary intake, e.g. fasting for Muslims (approximately 10% of the population).
☐ Foods eaten during cultural or religious events, their frequency and duration	Celebrations may be frequent and prolonged, and this may influence overall dietary intake.
☐ Food shopping and preparation skills	These skills may be limited, especially for young people who have lived on basic rations in refugee camps for many years. Poor English literacy may make food label reading difficult.
☐ Access to and use of traditional foods	The Congolese traditional diet is generally healthy, so eating traditional foods may reduce the intake of poorer meal choices, e.g. cheap takeaways.
☐ Modifications to traditional diet focusing on vegetable consumption	The ability to appropriately substitute traditional ingredients for similar foods available in Australia will support healthy eating. A reduction in the amount and variety of vegetables eaten is common in migrant communities.
☐ Snacks consumed	These foods are likely to be energy dense, micro-nutrient poor choices such as sweet biscuits.
☐ Region of origin, i.e. coastal or inland, proximity to rivers	May impact dietary habits, especially fish and seafood intake.
☐ Amount and types of fruits consumed	Both the Congolese traditional diet and the diet in Australia may be low in fruit.
☐ Amount of added oil and fats to foods, especially red palm oil	Large amounts of cooking oil, especially red palm oil, may be used in cooking.
☐ Amount of added salt to foods	Salt is commonly used in cooking, and salted fish and meats are traditional foods.
☐ Takeaways/soft drink consumption	Inexpensive takeaways that can feed large families, such as pizza, are commonly eaten. Soft drink is linked to social acceptability by young people.
☐ Intake of food sources of vitamin D	This may be important for those with limited sun exposure.
☐ Infant feeding practices • breastfeeding • introduction to solids (iron-containing first foods) • progression to solid textures	Although breastfeeding rates are traditionally high, women may think that breastfeeding is not practiced in Australia because breastfeeding in public is rare and because of the large number of artificial formulas available in supermarkets and chemists. Mothers may have poor knowledge of available iron-rich first foods and the need to progress through textures.

4. Diagnosis

The following examples may be used as a guide for common PESS* statements. 'Problems' are taken from the *Nutritional Diagnosis Terminology eNCPT 2014*, which is available free in the members' section of the Dietitians Association of Australia website.

	Examples of common Problems (P) for PESS* statements	Common (A)Etiologies (E) for PESS* statements
On arrival	• Food and nutrition-related knowledge deficit (NB-1.1) • Inadequate vitamin intake (vitamins C, D and B12)) (NI-5.9.1) • Inadequate mineral intake (iron, zinc and iodine) (NI-5.10.1) • Inadequate fibre intake (NI-5.8.5) • Malnutrition (NI-5.2)	• Poor literacy and English skills (NB-1.1) • (On arrival) Reliance on basic food rations for long periods, due to extended stays in refugee camps (NI-5.9.1, NI-5.10.1, NI-5.2) • Short duration of stay in Australia and unfamiliarity with local foods, especially vegetables (NI-5.8.5, NI-5.2) • Parasitic conditions (NI-5.10.1 (iron)) • Consumption of high fat foods and large portion sizes with increased length of stay, especially for young people (NI-1.3, NI-2.2, NI-5.6.2, NC-3.3, NI-5.6.2) • Preference for highly seasoned foods and large amounts of salt added during cooking (NI-5.10.2) • Excessive consumption of high sugar foods (NI-1.3, NC-3.4, NI-5.8.4, NI-5.8.2, NC-3.3) • For men: spouse and/or daughter/s being sole preparers of meals (NB-1.1) • High consumption of takeaway foods (NI-1.3, NI-5.6.2, NC-3.3, NI-5.6.2) • High consumption of saturated fat sources (red palm oil and meats) accompanied by low intake of foods high in omega-3 fatty acids due to low fish intake for Congolese people from non-coastal areas (NI-5.6.2, NI-5.6.3) • Excessive consumption of energy-dense, micronutrient-poor foods at religious celebrations (NI-1.3, NI-2.2, NI-5.6.2, NC-3.4, NI-5.8.4, NI-5.8.2, NC-3.3, NI-5.10.2 (sodium)) **Note:** it is important to identify the underlying cause/s of eating behaviours.
Overweight and obesity	• Excessive energy intake (NI-1.3) • Excessive oral intake (NI-2.2) • Excessive fat intake (NI-5.6.2) • Unintended weight gain (NC-3.4) • Overweight/obesity (NC-3.3)	
Type 2 diabetes	• Inconsistent carbohydrate intake (NI-5.8.4) • Excessive carbohydrate intake (NI-5.8.2) • Intake of types of carbohydrate inconsistent with needs (specify e.g. high consumption of high-GI rices) (NI-5.8.3) • Overweight/obesity (NC-3.3)	
Cardiovascular disease	• Intake of types of fat inconsistent with needs (specify e.g. low intake of omega-3 fatty acids) (NI-5.6.3) • Excessive mineral intake (sodium) (NI-5.10.2)	

* PESS: Problem, (A)Etiology, Signs and Symptoms

For the Signs and Symptoms (SS) for PESS statements, use standard clinical measurements. Make sure the Signs and Symptoms relate to the identified Problems and not their (A)Etiologies.

5. Intervention

Nutrition education

Motivating factors for a healthy lifestyle	For men, protecting and providing for their family is often a key role, while caring for children is an important role for women. It may prove useful to emphasise that healthy eating can contribute to building and maintaining a strong, healthy body and can assist in performing these gender roles.
Preferred education methods	**Interpretation:** It is important to check with the client on the preferred language of communication and offer interpreter services when necessary. **Types of resources:** Music can be useful in communicating with those of low literacy or with children. **Counselling style:** Congolese people are often quite expressive, and you can often read what people are feeling in their faces. They generally will not smile just to please you and will talk frankly. Touching is a sign of friendship, so don't be surprised if some physical contact is made, especially in a community setting.
Literacy levels	Due to the disruption to education caused by conflict, literacy rates are low, with 67% of the population in the DRC being literate in any language (77% men and 57% women) in 2010.[11]
Health beliefs	Western medicine is generally well-accepted and considered effective in the Congolese culture. Christians may believe in the power of prayer to cure illness. Traditional healers and natural remedies may be used as a complement to Western medicine or by those who cannot afford modern healthcare.[3] Congolese people may not understand that health authorities promote breastfeeding in Australia and that all women have the right to breastfeed in public

6. Monitoring and evaluation

Methods for monitoring

- It may be inappropriate for male practitioners to take waist circumference or other such measurements of female patients. To avoid causing offence, practitioners should ask beforehand whether the patient is comfortable with the measurement being taken, or consider alternative methods of taking measurements if approval is not provided.
- Health is assessed in practical terms, so this may be a useful way of measuring change and reinforcing the benefits of continued dietary compliance. Examples include being able to work and to appropriately care for one's family.
- Check if the patient has access to transport (especially if referring to an outpatient clinic); otherwise phone follow-up may be more appropriate.
- Confirm the client's preference for having an interpreter present at their next appointment. For short follow-up consultations, telephone interpreting services may be more appropriate.
- Encourage wives to attend their husbands' follow-up appointments, because women often do the shopping and food preparation for the family.

Additional resources

- Queensland Health *Working with Interpreters: Guidelines* (http://www.health.qld.gov.au/multicultural/interpreters/guidelines_int.pdf).
- To find out more about multicultural health, Queensland Health's Multicultural Health page has information for the public and for health workers, including the *Multicultural health framework*. Go to http://www.health.qld.gov.au/multicultural/default.asp
- Good Food for New Arrivals: List of common African foods (http://pubs.asetts.org.au/African%20food%20list.pdf).
- Good Food for New Arrivals: Infant feeding (http://pubs.asetts.org.au/nutrition/Documents/AssistingRefugeeMothers.pdf).
- Community Information Summary: Democratic Republic of the Congo-born (https://www.dss.gov.au/sites/default/files/documents/02_2014/democratic_republic_congo.pdf).
- Refugees from the Democratic Republic of the Congo 2014 (http://www.culturalorientation.net/learning/populations/congolese-refugees).

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Please note: The web links in this document were current as at March 2015. Use of search engines is recommended if the page is not found.

This information is to be used as a guide and is not intended to describe all members of the community. There will be cultural differences between people belonging to different regions, religions and social groups, as well as between individuals within any culture.