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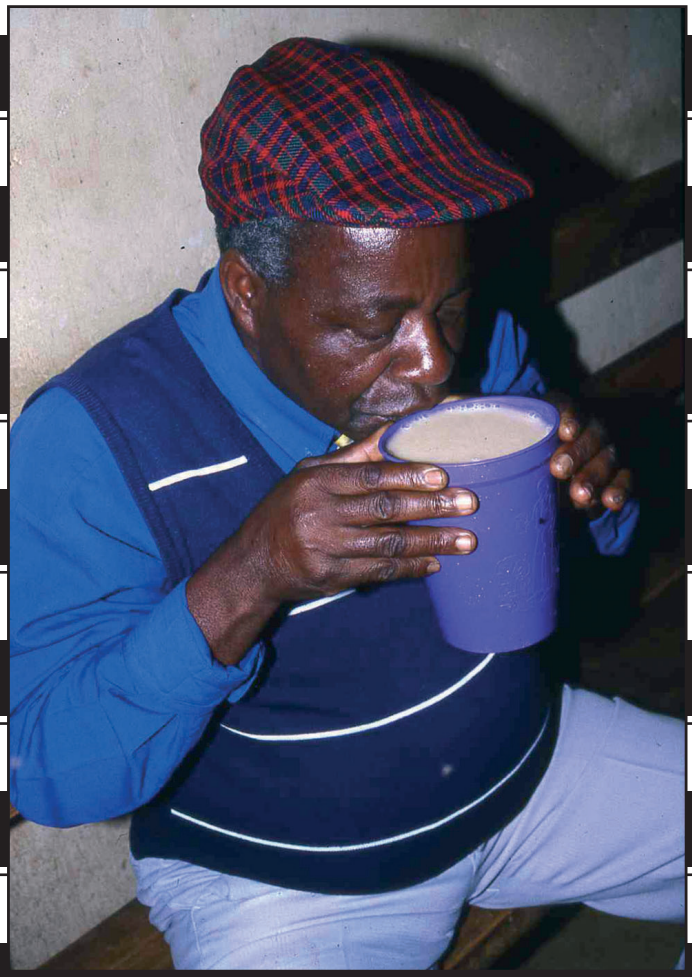

Consumption of local beer in Tanzania

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Frontispiece

In many rural African societies beer is one of the main food items consumed. People in the southwest of Tanzania say that local beer (*pombe)* is "eaten" not drunk. Most of the solid matter is still left in even after being filtered once during production and once before consumption. *Pombe*, in comparison to industrially produced beer, is considered a healthy brew.

(Mr. Stanley E. Kyando; photograph: Ruth Kutalek, see also article below)

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Cereal Beer (*Sheikhar*) in Jewish Sources

Zohar Amar, Efraim Lev, Zohara Yaniv

Introduction

Alcoholic beverages have always occupied a central place in all fields of Jewish life, as a common beverage on a daily basis, in festivals within the family, and in national cultural and ritual activity. This feature can be traced in Jewish literature, but most sources concern wine, the staple and common alcoholic drink, which was frequently used in the ancient world.

The centrality of wine in the Bible is well known, for it is frequently mentioned in various books and in other Jewish sources. The first recorded evidence of viniculture is attributed to Noah, who planted a vineyard after leaving the Ark (Genesis 9:20). In later sources wine was used for religious purposes. One was personal or within the family, namely the *Kiddush* (a ceremonial blessing over wine, recited on Sabbaths and holy days) and another was a communal ritual called the *Nesekh* (libation, a drink offering performed in the Temple). The biblical texts accepted the human need for drinking wine, although it was conditional on abstaining from drunkenness, which led to negative deeds. The restrictions imposed were mainly directed to those engaged in the holy service, such as the Nazirites (Numbers 6:13). Two of the best examples are Samson (Judges 13:7) and the High Priest (*kohen*) (Leviticus 10:9).

This chapter focuses on the s*heikhar se'orim*, known today as beer. The use of cereal s*heikhar* is an important feature, which as far as we know has not been treated in detail so far. Jewish sources throughout history, especially the most recent, deal with several kinds of s*heikhar* made from different species of fruits such as dates and figs. Our goal is to shed light on the uses of beer in Jewish tradition in the Land of Israel and in the Diaspora.

Ancient and Biblical Aspects

The Hebrew word s*heikhar* is mentioned frequently in the Bible, mostly parallel to wine (made from grapes). No information exists on the raw materials from which s*heikhar* was made. It is reasonable to assume that 'barley beer' was known in the Land of Israel at the biblical period since it was an acceptable drink in Egypt and Mesopotamia, but this is a circumstantial assumption and not clear evidence (Stern 1981).

Information about 'cereal s*heikhar*' begins to appear frequently in Jewish sources from the Roman period (63 BC-324 CE in the Land of Israel) to the present day. Among the most important sources in Rabbinical literature we note the *Mishnah* (the six orders of the *Mishnah* are an assembled legal code arranged by topics most relevant to Jewish life such as agriculture, festivals, civil law, etc.) written by the *tannaim*, namely third-century CE Jewish Sages. Then come the two sets of Talmud, the *Yerushalmi* (i.e., Palestinian) and the Babylonian. The Talmud is a commentary on the *Mishnah* and the *Tosefta* (laws added to the Mishnaic corpus). The final dates for the editing of the two sets of Talmud are disputed among scholars. The *Yerushalmi* reflects very little reality after the early to mid-5th century CE, while the Babylonian Talmud contains later materials. The Talmud was written by the *Amoraim*, namely later Jewish Sages of the late Roman and the Byzantine periods (the latter in the Land of Israel dates from 324 CE to 638 CE, the year of the Muslim conquest).

Additional sources are the commentaries to the *Mishnah* and the Talmud, and the Responsa (*she'elot uteshuvot*). This is a corpus of books containing questions relevant to Jewish life sent as letters to the foremost Jewish scholars in every age, and their answers, namely the Responsa. This corpus of Rabbinical literature proliferated across the Diaspora in the Middle Ages. Most of the sources that mention cereal beer (s*heikhar*) are of a religious nature and deal with aspects of *halakha* (the part of Jewish traditional literature concerned with religious law). These aspects are connected to all fields of the Jewish life, and cereal s*heikhar* is mentioned incidentally.

The *Mishnah* and Talmud Periods

Many kinds of s*heikhar* were known in the Land of Israel during the Roman period. They were mentioned by the Jewish Sages in connection with the blessing that had to be recited before drinking them. In the Babylonian Talmud, for example, a law appears in the name of the *tanaim*: "One date beer (*sheikhar*) and one cereal beer and one wine yeast – blessed upon them 'by whose word all things exist'" (B. Baba Batra 96b). A different source states that it is permitted to put barley and dates in water during holiday in order to brew beer (s*heikhar*). (B. Shabbat 139b; B. Moed Katan 12b).

The process of soaking and fermenting cereals produced *hamez* (i.e., leaven food or vessels; according to the Jewish law such food and vessels may not be eaten or used during the Passover festival). Biblical law (Exodus12:15) forbids the drinking of *hamez*. The *Mishnah* employs this word in reference to several kinds of cereal beers known in countries where a Jewish population dwelt during the Roman period. Instances are s*heikhar ha-mdy* (Median, i.e., Persian, beer), *humez adomy* and *zeytom myzry* (Egyptian zisom) (M. Pesahim 3:1). *Sheikhar ha-mdy* was a Persian beer consisting of barley water, and *humez adomy* (Idumean vinegar) was an Edomite beer made of vinegar in which the barley was soaked (B. Pesahim 42b). *Zeytom ha-myzry* was an Egyptian beer. The name comes from a Greek word, which penetrated Latin (*zythum*), meaning beer made out of barley and other ingredients (Krauss 1911: 244).

This kind of beer was used for medical purposes as well (B. Shabbat 156a; B. Berachot 38a). According to the sources it had two opposite uses: as a cathartic drug for the treatment of constipation and as a drug for the treatment of diarrhea. The recommended time to drink was between the festivals of Passover and Pentecost (B. Shabbat 110b). A controversy among two a*moraim* on the composition of *zeytom ha-myzry*, which is mentioned in the ancient sources, is presented in the Talmud. Rav Joseph asserted that it consisted of one-third barley, one-third safflower (*Carthamus tinctorius*), and one-third salt. By contrast, Rav Papa argued that it was made out of one-third wheat, one-third safflower, one-third salt and cumin (B. Shabbat 110b).

It seems that this controversy reflects the reality of third- and fourth-century Babylonia. Many kinds of beer were manufactured in this period in that country, and the great majority of the Babylonian Jews, who could not afford wine, regularly drank the cheaper drink, beer (B. Shabbat 140b). The circumstances of Palestinian Jewry were otherwise, and the Talmud makes this comparison, "the beer warehouses of Babylonia [are] like wine warehouses of the land of Israel" (B. Pesahim 8a).

The demand for beer among Babylonian Jewry resulted in the creation of an independent beer industry, since the idolaters' (i.e., the Gentiles') beer was forbidden to Jews, as was their wine (B. Ketubbot 31b). Rav Papa, for example, was a beer specialist who made his fortune out of this industry (B. Pesahim 113a). He attests to the quality of his s*heikhar temarim* (date beer), saying that it does not spoil with time (B. Baba Metzi'a 65a). Accordingly we learn that beer kept for a long time, although fresh beer was deemed to be of better quality (B. Baba Bathra 91a). Even though s*heikhar temarim* (date beer) was widespread in Babylonia, barley beer was common as well (Hrozny 1910: 7).

According to the sources (B. Ketubbot 8a), one of the symbols of the beginning of a marriage festival was soaking barley in a basin to brew the beer for the festive wedding meal (Beer 1982: 173). Another kind of beer, mentioned in the Talmud, was made from the plant *keshuta* with the addition of a sour aroma to the drink (B. Ketubbot 31b). *Keshuta* (Dodder) is a parasite plant of the Cuscuta genus (Convolvulaceae) living on *Izma* (T. Kil'ayim 1:11) (Felix 1967: 145 ff.). This thorny plant was identified as camel thorn (*Alhagi graecorum= A. maurorum*) (Amar 1995: 284 ff.).

On a festival day a Jew would cut the dodder to make a beer (B. Moed Katan 12b). This plant was mentioned by Pliny (indirectly), who asserted that in Babylon "it is used in making spiced wine, and is cultivated for that purposes" (Pliny XIII: 46:129). The drink, which was made of dodder, was named after the host plant 's*heikhar* of Izmi'. This drink had some medici-

nal qualities and therefore the Babylonian Jews who drank it never suffered from leprosy or boils (B. Ketubbot 31b).

The Talmudic sources mention other diverse medicinal uses of beer. Since it is hard definitively to detect and identify the beers that the sources refer to, whether barley beer or other kinds, we decided not to list them here (Rosner 2000: 47 f.).

Middle Ages

The greater majority of medieval Jewish sources that mention s*heikhar* are part of the exegetic literature written to elucidate the ancient sources. The medieval commentators frequently explained the Talmudic sources according to the historical and geographic world they inhabited. Several examples representing different geographic regions are presented below.

Rashi (1105-1040), the most important Jewish commentator, who spent his life in France, interpreted the Talmudic *keshuta* (B. Shabbat 107b) as "homlon" (hop). This identification is mistaken, for as noted the Talmudic sources meant dodder (Cuscuta spp.) while hop plants (Humulus spp.) are not parasites. The hop was and still is widely used in Europe as a raw material for beer brewing. The medieval world is clearly reflected in Rashi's writings about beer in France at his time: "*Sheikhar* is made out of barley water, such as ours" (commentary to B. Pesahim 42b). For s*heikhar se'orim* Rashi rendered the French word *bracier*, meaning fermented beer (commentary to B. Shabbat 139b).

Evidence of beer drinking by the most important Deciders (*Poskim*) is found in the European halakhic literature. Rabbi Eliezer Ben Rabbi Yoel ha-Levey (Rabia: 1140-1225), in a discussion about the times of barely harvesting, testified that "we drink beer (s*heikhar se'orim)* before Pesah" (ha-Levey 1964). Rabbi Yaakov ha-Levey of Mulin (Maharil: 1365-1427) wrote that barrels used for beer brewing could serve as containers for keeping wine for Pesah, after proper cleaning and rinsing (Mulin 1989). His disciples testified that the Rabbi himself used to drink beer (s*heikhar se'orim shekoryn byr*) (Mulin 1989).

A different example of medieval exegesis, from another geographical region, is afforded by Maimonides (1138-1204). In his commentary to the Mishnah, he wrote that the s*heikhar ha-mdy* is made from "bread juice, similar to *al-mizr* that is made in Egypt daily". In another manuscript (M. Pesahim 3:1) it was written: "that we make" (Ben Maimon 1963: 107). *Mizr* is white beer, which was brewed in Egypt from fermenting bread, wheat, or barley. This drink was highly popular among Egyptian Jewry, as is clearly evident from the Genizah fragment of 1010. This is a letter sent from Acre (Akko) at the time of the Crusaders: Jewish gatherers of purple shellfish (murex) from Alexandria were reproved there for "drinking *mizr* (beer) in a tavern of bad repute" (Goitein 1967-1988: I: 119, IV: 261)). Note that the admonition concerned the revelry in the tavern, not the beer drinking, which was lawful.

Posterior Literature

In *saferoth aharonim* (Posterior Literature), namely Jewish literature written in the last four centuries, beer (s*heikhar*) is mentioned by several names: s*heikhar se'orim* (Karo 1993: 204), *biyra* (Pontrymoly 1947: 41a), s*heikhar shekorain*, *malts* (ha-Kohen 1987), etc. The last author mentions *kwas*, a drink brewed from bran water and flour (ha-Kohen 1987).

Beer is mentioned frequently in the *Shulhan Arukh*, one of the most important codices of Jewish law (*halakha*), which was written by Rabbi Josef Karo (1488-1575). Karo mentions "barrels of clay in which barley beer was poured" (Karo 1961). He also dealt with the blessing of: "barley water and barley water cooked for the sick" (Karo 1961). Rabbi Ya'akov Khuly (1689-1732), a citizen of the Ottoman Empire, mentioned another drink: "Faro (beer) fermented out of boiled barley, made for the sick to ease (cool) his heat (fever)" (Khuly 1969: 562).

These sources show primarily that beer was widespread and common in the Jewish diet and as a medicinal drink. The medicinal aspects of beer are conspicuous in a book on medicine written by Rabbi David de Silva (1684-1740), a Jewish physician from Jerusalem. De Silva visited several European countries, where he acquired his medical education. When he

returned to the Land of Israel he committed his impressions to writing. Almost all of it was devoted to the food and drink common in Europe when he was there. Special attention was paid to the differences between western and eastern beverages. While water was the most important drink in the east, Europeans mostly drank beer or wine. Since de Silva's descriptions are accurate and exceptional, and of prime importance to the history of beer, we decided to present them in full:

"In the cities of Holland and England, where the climate is cold and dry, water is not drunk at all, but water that comes from barley and wheat, named beer. Of this, there are many kinds: white and sweet, and red and sour, whose strength similar to wine. It gets the flesh red, strengthens the person and make him happy. But this kind induces kidney disease, since the wine there is expensive. Most of the citizens of the cities of Ashkenaz [Germany] drink 'wine of water', little water, since the wine is cheap. They also have beer of several kinds, mostly a strong red one." (de Silva I: 42a)

David de Silva referred to the fact that the Europeans did not customarily drink water in the knowledge that this was due to some medicinal factors. According to the medical theory of the time, for diverse kinds of fever the patient had to drink cold water. This was fairly simple and possible in the east. In Europe, by contrast, where water drinking was not a habit, but wine or beer was, the negative medicinal effects of those drinks had to be neutralized by the addition of several medicinal substances:

"In the cities of Ashkenaz [Germany], Holland, and England, s*heikhar,* called beer, is consumed. This fine beer is good, or a beer named *fikynyyah* (strong beer – pizzicante) after being filtered twice in order to cancel its 'winds'. Some drops of *ethrog* (citron) or any other sour fruit were squeezed in, and some *akymyos* (an alchemical compound) made out of inorganic materials is good to add to the beer and cause the fevers to be urinated out of the patients." (de Silva 76a:11; 53b).

Rabbi Yitzhak Lampronty (1679-1757) referred to the frequency of use of beer in Europe as well. He lays down several religious restrictions in his writings, saying that it is forbidden to bless over beer instead of over wine on the Sabbath: "Do not bless over the beer found in the cities of Ashkenaz and Holland since it is used for drinking instead of water" (Lampronty 1868: I: 19).

Conclusion

Beer drinking is mentioned in Jewish sources of all periods. According to the historical sources it was common in almost all geographical regions where Jews lived. The sources describe different kinds of beer, varied in their composition, all according to the customs in each region. The ancient sources in which beer is mentioned are found in the great alluvial valleys of Egypt and Mesopotamia. However, in the land of Israel and in other Mediterranean countries where viniculture was extensive, wine production and drinking was usual.

The Muslim conquest reduced the use of beer in areas they controlled as beer drinking was forbidden by Islamic religious precepts. In Europe, by contrast, beer became the staple drink, almost a substitute for water.

The Jewish sources reflected these considerations accurately. Beer is mentioned in the Jewish sources, which are mainly religious literature, only sporadically. However, the numerous quotations indicate that this drink was an important component of the Jewish diet and reflected faithfully the centrality of beer in the history of mankind.

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Coping with Stress, Mental Health and Psychotherapy in Long-Term Refugees. Exemplified in the Karen at the Thai Burmese Border

Peter Kaiser

Abstract

To stay mentally healthy in conditions like a refugee camp protective factors including functioning family- or community structures, a strong religious belief system and work are important. Data from the ethnic Karen in refugee camps along the Thai Burmese border reveal that the affected population seems to have better coping mechanisms as expected. Mental health experts should be careful in importing so called help and adapt the western individualistic approach in psychotherapy to the needs of community-centered societies.

Introduction

At the beginning of 2001 the number of people of concern (PoC) to UNHCR (United Nations High Commissioner for Refugees) was 19,8 million (UNHCR 2002). Even when they are able to leave their home country, an increasing number find no country willing to accept them as refugees. Due to the raising numbers of civil wars (in comparison to international conflicts), there has been a large increase in the number of internally displaced persons who in the late 1990's outnumbered refugees by as much as two to one. The UN lists more than 25 million internally displaced persons, but it warns that the total number may be much higher. (United Nations 2001).

Refugees are a particularly vulnerable population that is at risk from mental health problems for a variety of reasons: traumatic experiences in and escapes from their countries of origin, difficult camp or transit experiences, culture conflict, and adjustment problems in the country of resettlement, and multiple losses – family members, country, and way of life (Lipson 1993).

It is useful to consider the major psychosocial systems that are affected by the refugee experience, both within the individual and across the community as a whole. Suggested was the following simplified framework in which five fundamental systems are threatened or disrupted (Ekblad and Silove 1998):

- ✦ The attachment system: many refugees are affected by traumatic losses and separations from close attachment figures.
- ✦ The security system: it is common for refugees to have witnessed or encountered successive threats to the physical safety and security of themselves and those close to them.
- ✦ The identity/role system: the refugee experience poses a major threat to the sense of identity of the individual and the group as a whole. Loss of land, possessions, and professions separate individuals from a sense of purpose and status in society.
- ✦ The human rights system: almost all refugees have been confronted with major challenges to their human rights. These include arbitrary and unjust treatment, persecution, brutality, and, in some instances, torture.
- ✦ The existential-meaning system: the refugee experience poses a major threat to the sense of coherence and meaning that stable civilian life usually provides for most communities.

According to Jablensky the most common symptoms and signs that appear in refugees across different cultures include (Jablensky et al. 1994: 336):

- ✦ Anxiety disorders (i. e., high levels of fear, tension, irritability, and panic)
- ✦ Depressive disorders (i. e., sadness, anergia, anhedonia, withdrawal, apathy, guilt, and irritability), as well as
- ✦ Suicidal idealization and attempts, anger, aggression and violent behavior (which often finds expression in acts of spouse- and child abuse), drug and alcohol abuse, paranoia, suspicion and distrust, somatization and hysteria, and sleeplessness

Since 1975, with the escape of Southeast Asian refugees to the United States from Vietnam at the end of the Vietnam War and from the killing fields of Pol Pot in Cambodia (1975–1979), the effects of severe trauma were studied in these populations. The most frequent psychiatric diagnoses have been identified as posttraumatic stress disorder (PTSD) and major depression (Kinzie et al. 1989, 1990; Kinzie and Jaranson 1998; Krupinski et al. 1973, Davis 2000).
In a study of Vietnamese refugees a correlation was found between the severity of symptoms in adolescent and adult PTSD patients and the number of experienced traumata (Smith-Fawzi et al. 1997, Mollica et al. 1997). There is epidemiological evidence, that PTSD can be identified across cultures. Previous studies in refugee clinic populations (Kinzie et al. 1989, 1990) and in refugee camps found a relatively high prevalence of PTSD (greater than 50 percent) (Mollica et al. 1993), while more recent research indicates, that it occurs in only a minority of persons exposed to mass conflict; prevalence rates vary between 4 and 20 percent, with higher rates among women (Silove 1999).

To the authors the problem consists in the evidence that refugee - and other forced movements tend to be defined as emergencies requiring emergency responses and that these responses tend, in turn, to be defined in logistical terms: how many tents and how many tons of food, clothing, and medicines can be delivered in the shortest time possible. Failure to respond quickly and efficiently to these immediate needs may result in thousands of deaths. The emergency paradigm makes sense in some cases – for example, the rapid exodus and then repatriation of Kosovars – but many refugee situations would be described more properly as protracted crises, with displacement continuing for years (Jaranson et al. 2000).

The Situation at the Thai Burmese Border

Since the mid-seventies thousands of people fled Myanmar due to political unrest and civil war within the country. The so-called "displaced persons" are seeking shelter in 10 border camps along the Thai-Myanmar border. The number was relatively small until the eighties, increased drastically after massive fighting occurred between the Myanmar army and the opposition groups and climaxed during the student uprising in 1988 in Yangoon. Until 1992 the number increased from app. 13.000 up to 70.000 refugees. The current number of registered persons is app. 133.000 people (Burmese Border Consortium Statistics 01/2003) with several thousand new arrivals annually. Myanmar and Thailand haven't signed the Geneva Convention and therefore don't recognize this population as refugees, Thailand[1] because of its experience in decades after the Second World War, when being target for illegal migrants from all over Indochina. It hosted more than 370.000 refugees for about 13 years[2]. The Royal Thai Government declares the right of asylum seeking shelter as temporary and therefore to grant asylum as a goodwill action. The refugees are not found in UNHCR's statistics. Also the "internally displaced people" (IDP's) within Myanmar don't fall under UNHCR mandate. This number is estimated more than 1 million. Most of the so-called "IDP's" are settled along the border inside Myanmar. The majority is hiding in the forest, trying to survive, since their houses and paddy fields are destroyed. This makes their way of living desperate, almost impossible.

Long-term Displacement at the Thai-Myanmar Border

The situation of the refugees from Myanmar can be regarded as long-term displacement. Refugees are living already since the mid-seventies in the camps. Many of the children are have been born and brought up in the camps. The long-term settlements and the continuous support as well as the strict policies observed by the Royal Thai Government led to a complete dependent lifestyle without freedom of movement or any chance of independent economical support. For sure are such complex political situations, with many actors involved, often are not isolated events but linked with globalization and foreign policies (Sondorp and Zwi 2002). Such complex political situations with many actors involved for sure are not isolated events but linked to globalization and foreign policies.

Health Service Providers are international medical NGOs placed in different parts along the border area, each with its own mandate and objective. Some are focusing more on clinical care while others focus on the primary health

care strategy with a strong participation approach.

Since 1993 MALTESER Foreign Service provides primary health care at present for 28000 refugees. Currently, the rendered health service covers a well balanced range of curative, preventive and promotional activities. The changing health pattern with diseases, which are observed in stable settings, requires a different approach. While there is evidence that the general health situation among the long-term residents improved over the last 2-3 years, Malaria as a major killer few years ago shifted to rank 3, after respiratory infections and diarrhoeal diseases. Diseases like diabetes mellitus, chronic kidney diseases and hypertension are on the rise. However it has to be taken into account that the camp still receives new arrivals on a monthly base. The number differs between 100-300 people. Many of them are infected with Malaria, Filariosis or Diarrhoea. Seasonal outbreaks of Measles and Diarrhoea are common, again, mainly due to the new arrival groups.
A consequence of the refugee situation is the increasing number of drug and alcohol addicted people and domestic violence against women and children. A survey carried out by the CDC Atlanta showed a prevalence of domestic violence against women of up to 56%, ranking from verbal abuse to sexual abuse (yet unpublished data).

One has to ask which impact long-term displacement can have on the community as a whole. The closed setting, the unemployment of the people, the lack of income, a growing young generation without proper education and no employment might be influential factors which contribute to the increase in violence and in mental disorders among the people.

Because most of the people in need will not consult a psychiatrist on their own, the prevalence of psychiatric disease is difficult to evaluate, exceptions are exacerbations of typical psychosis or sometimes obvious attempts in committing suicide. According to the interviewed medical professionals in the camp sites, the MALTESER Foreign Service is responsible for (Mae Khon Kha and Mae Ra Ma Luang camps, respectively), the prevalence of psychiatric patients admitted to the IPD (inpatient department) and the number of patients frequenting OPD (outpatient department) facilities due to specific psychiatric problems like suicidal crises, major depression, fear, panic or delusion, is less than 5%. It seems to be more common to consult a priest or monk, or talk with women groups or peers, the investigator was told. In future it has to be evaluated, if the prevalence of unspecific symptoms of depression as sleeplessness, tiredness, numbness, is higher after the health workers and medical assistants in charge have been trained on this subject and made more alert to related symptoms.

Coping and Resilience

Refugee mental health challenges may also be understood within the context of refugee resilience and coping capacity. The opportunity to practice traditions, beliefs, and customs freely and to recreate social institutions can serve as protection factors.
To question this kind of influence his kind of influence on mental health is a salutogenetical approach (Antonovsky 1979), which differs from the typical pathogenetical way of thinking health professionals are usually engaged in. The following protective factors have been identified (Jablensky et al. 1994: 329f):

- ✦ Availability of extended family;
- ✦ Access to employment;
- ✦ Participation in self-help groups; and
- ✦ Situational transcendence, or the ability of individuals and groups to frame their status and problems in terms that transcend the immediate situation and give it a meaning (e. g., ethnic identity, cultural history).

Preexisting demographic and personality factors also affect eventual functioning and maintaining mental health (McKelvey et al. 1993).
In a large-scale epidemiological study done as a part of the Harvard Program in Refugee Trauma, the original data from studies of Cambodian refugees confined to the Thailand-Cambodian border in the 1980s and 1990s have been reanalyzed to evaluate the mental health impact of psychosocial factors in addition to traumata like social interactions and intrapersonal behaviors in the refugee camp, what to some extend is influenced by the attitude of camp authorities (Mollica et al. 2002). The

results suggested the extraordinary capacity of refugees to protect themselves against mental illness despite horrific life experiences. Recommendations emerged for refugee policy makers to create programs that support the following items:

- ✦ Work
- ✦ Indigenous religious practices,
- ✦ Culture-based altruistic behavior among refugees

As refugee mental health policy receives increasing attention from the international community, it must consist of recommendations and practices based on scientific analysis and empirical evidence.

Case studies of refugees making up part of a sample of 1348 persons relocated from Southeast Asia to Vancouver, British Columbia, suggest that altering one's perception of time may be an adaptive strategy (Beiser 1987). During periods of acute stress, refugees seem to focus on the present to the relative exclusion of past and future. The reemergence of past and future into consciousness brings about a risk for developing depression. Epidemiological data confirm inferences from case material, demonstrating that refugees are more present-oriented than the indigenous population. It was shown that a „nostalgic" time orientation, i.e. preoccupation with the past, is associated with elevated depression scores. It has to be differentiated between nostalgia, a maladaptive pattern (because of selective glorifying the past), and memory, which is an inevitable part of the process of personality integration. Social support derived from the ethnic community and from an intact marriage moderated the risk of developing depressive symptoms, apparently by enhancing a sense of identity and belonging (Beiser et al. 1989).

No single theory can adequately encompass the phenomenon of refugee trauma. (Morris and Silove 1992). For the distinction of ubiquitous psychopathological symptoms from local culture-bound behavioral responses it seems crucial to understand the socio-cultural milieu in which the patient is embedded. However, in assessment and treatment, excessive reliance on models of cultural determinism would be as unproductive as totally disregarding cultural factors (Westermeyer 1987). Although survivors of traumatic life events have similar symptoms, there are culturally determined differences regarding the meaning ascribed to the key concepts of trauma and torture. In some cultures, there is reluctance to express emotions or to reveal traumatic experiences, including sexual torture, until trust has been established. Consequently, forcing refugees to tell their stories may be counterproductive. In such situations, indirect methods may be more useful (Mollica 1988).

Cultural attitudes towards suffering also play an important role in help-seeking and treatment response (Boehnlein and Kinzie 1995). For instance, beliefs that suffering is inevitable or that one's life is predetermined may deter, for example, some Muslims or Buddhists from seeking health care. On the other hand, the personal faith, which is often the faith shared by large parts of the community, can give the feeling of safety and meaningfulness in times when hope is missing.

In Burmese dissidents who fled to Thailand, after participating in a 1988 uprising against Burma's government, one third reported traumata (interrogation (89%), imprisonment (78%), threats of deportation (70%), and torture (38%)). The prevalence of elevated symptom scores was 38% for depressive symptoms and 23% for criterion symptoms of posttraumatic stress disorder (flashbacks, anhedonia, avoidance). Two adaptive strategies – camaraderie and a Buddhist concept of self-confidence and fate (weria) – were associated with somewhat reduced levels of both classes of symptoms (Allden et al. 1996).

In the camps where the MALTESER Foreign Service is in charge, most of the people are Karen, an ethnic group who successively became Christian after being converted by American Baptists since the 1830s. According to official data, 18% of the Karen living in Thailand and Burma are Christians (Harris et al. 1999). A survey done carried out in 2002 by us in the camps counted 71% Christians, 24% Buddhists and a minority of Moslems of less than 5% (Benner 2002). The percentage of Animists (2.5%) is difficult to evaluate, due to the fact, than that some Buddhists still perform animistic rituals and animism seems to be a

taboo somehow. Besides the fact that the elite of the camp and the people in charge nearly completely recruit themselves from the Christian community, Christians as well as Buddhists do believe, that the People of the Karen is a chosen one. The return of the Lord to the Christians and the Maitreya (Buddha of the future) to the Buddhists respectively, will occur soon (Harris et al. 1999). The Christian Karen compare themselves with the Jewish people, and dream of a Karen Israel (Stern 1968). This religious background is capable of mediating hope and mental power to accept the status quo as a not forever lasting phenomenon.

Consequences

Cultures traditionally may use medications or religious/traditional ceremonies for treatment and be less familiar with Western mental health interventions. Western approaches tend to emphasize the individual and minimize the importance of the socio-cultural context and social networks (Jaranson 1991).
In group-oriented cultures, intervention-based group activities may be more relevant than individual therapies. Symbolic interventions are particularly important, such as supporting the grieving process for lost family members when burial is impossible. Illnesses, tension, and conflicts are resolved in traditional societies through existing inbuilt cultural processes. Interventions that do not recognize these factors could be detrimental (Chakraborty 1991).

Mental health programs should stimulate these mechanisms of adaptation and foster self-help to minimize helplessness. Programs should help refugees to develop coping mechanisms to replace or restore the lost protective factors offered by social networks, religion, and culture. Although it is important to initiate mental health programs during the emergency phase of the refugee crisis, this rarely happens, the same seems to be the case with most of the long-term refugees.

In order for refugee mental health care to be effective, it is essential that primary health care serve as the main health service infrastructure. The challenge is to orient and train primary health care workers in mental health skills and services, including diagnosis and therapy.

Mental health services should be closely coordinated with general health services, psychosocial services, and other relevant rehabilitation, social, educational, occupational, cultural, and recreational activities. Mental health services should be community based, and, wherever possible, focus on early intervention at the primary and later at the secondary and tertiary levels of prevention. Mental health services should be sensitive to gender and cultural issues and the needs of particular demographic groups, as well as to high-risk groups such as the physically injured and disabled, the severely mentally disabled, and survivors of extreme traumata, torture, and sexual abuse. In addition, the doctor must be sensitive to the differing ethnic responses to psychotropic medications in metabolism, nutritional status, age, smoking, and drug interactions.
The main outcome goal for therapy is increased self esteem to achieve personal goals, rather than symptom reduction. However, symptom reduction may also be a goal, particularly for high levels of the positive symptoms of PTSD, major depression, or other disorders that respond to medication. These disorders require a combination of medical, psychological, social, and legal intervention.

However, the reality is that most refugees do not get formal help. It is important to train community members to recognize signs of psychological distress and trauma and to inform persons suffering with from these problems that they are not alone, that their reactions and symptoms are not unusual. The advantages of this approach, used by members of the community, include minimizing linguistic or cultural barriers and providing better capacity to supervise people needing services. Disadvantages include the need for supervision and limited capacity for diagnosis or provision of psychotherapy.

Valuing cultural competence only because of the differences between the cultures is not sufficient. The subtleties and importance of the cross-cultural interactions between refugees and mental health services have to take into account too. Instead, paradigms from the „new ethnography“ (Clifford 2000) that reflect how cultures engage and influence one another must be incorporated into the delivery of mental health services. Existing frameworks for understand-

ing refugee mental health services have emphasized the idea of the "war zone." This framework prioritizes the result of exposure to war traumata and emphasizes concepts such as post-traumatic stress disorder, damaged self, and psychotherapy, while neglecting issues concerning culture and relegating them to a different setting of health service (so called "contact zone"). These are culture-based assumptions that influence the choices that mental health professionals make about refugee services.

Traditionally, as mentioned above, mental health services tend to focus on treatments for individuals who are willing to present themselves as "patients." Relatively few refugees, however, are willing to be patients, although many suffer. In a "contact zone" (Clifford 1997) a place of exchange, interpenetration, and negotiation between two or more worlds could be created. Health care services, from a contact zone perspective, are not universal receptors that any incoming refugee group can plug into, nor are they a plug that can fit in the socket of every post-war nation. Rather, each situation is a complicated interaction between refugees and professionals, shaped not only by the particulars of a given location, but also by persons, professionals, ideas, policies, or Non Governmental Organizations from far away.

It has to be acknowledged that there are some networks in refugee communities. Perhaps they're strained networks, but whether they're family- or kinship networks or regard common religious, ethnic, or political outlooks, they are likely to have some protective function. One should be careful not to undermine those by establishing other procedures. This is not done intentionally, but a classic example within many refugee communities is to undermine the role of women within households through distributing food principally to men, as they are regarded as the head of a household.

The new conceptualizations of culture can affect services for refugees in several ways (adapted from Weine 2001):

- ✦ First, talking about traumata through interpreters does not necessarily make for culturally relevant care, nor does placing a mental health clinic in a community necessarily make the clinic inviting to that community. The "contact zone" perspective insists that providers take a closer look at how professional ideology, service organizations, and refugees attitudes may result in a pattern of underutilization of refugee mental health services, and how this might be changed.
- ✦ Second, the contact zone perspective shows that a crucial missing element in refugee services is a focus on the family and its strengths, based on the principles that the family is of central importance and that families are strong and good.
- ✦ Third, the contact perspective can be useful in managing cultural issues concerning the relationship between international and local professionals. Too often, international professionals investment in promoting ideas from outside exceed their commitment to understand the way that local professionals live and work. The epitome of this approach is "trauma training," where local professionals are plucked from their jobs and put in classes taught by "international experts." Such activities are bound to fail because they are detached from the actual delivery of services. A contact perspective encourages professionals to give up the role of colonizer (in the appearance of international trauma mental health expert) and to encourage processes of dialogue and translation that increase the expertise and authority of local psychiatric and community leaders.
- ✦ The stress should therefore be put on a more community based counseling approach, than on an individualistic psychotherapy.

Nevertheless, the ethnographical approach of the "participatory observation" (Malinowki 1922) is not easy to implement and sometimes remains a dream as Malinowski himself confesses in his diary published after he passed away (Malinowki 1967). Therefore the idea: "that in a sense a '*cultural consultant*' serves as a bridge between the medical model and the refugee's world view. Ideally, the cultural consultant should have experience and training in health care and should be bicultural and bilingual. Awareness of one's own identity, behavior, and biases is also important" (Ater 1998) will be difficult to realize.

Ultimately the cultural consultant's chief task is to answer the question: „Is this behavior normal?" This question lies at the heart of cross-

cultural psychiatry, which must determine normality in its cultural context (Budman et. al. 1992; Bulle 1987).
But whoever in a western country tries to work in both the fields of medicine and anthropology on an academically level, often is not regarded as enrichment to one of the both sides by colleagues, but as an outsider. Concerning an academic career it is close to committing suicide.

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Notes

[1] Thailand means the land of the free people

[2] Instead, in Thailand a *displaced person act (1951)* was implemented (Liepe 1996).

Contributions to Visual Anthropology

Consumption of Beer in Southwest Tanzania

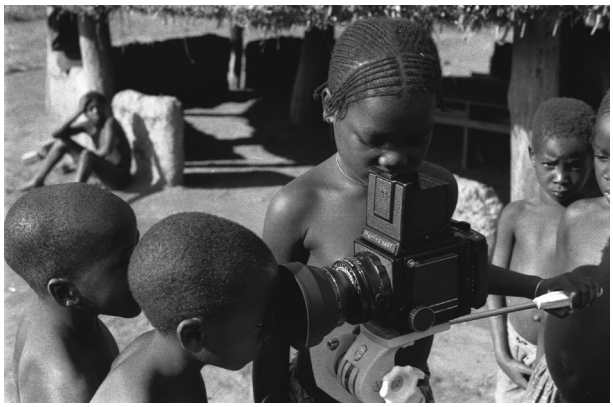
Ruth Kutalek

Introduction

In southwest Tanzania people know two types of traditionally fermented drink, a beer type and a wine type. The "wine" is produced from the sap of a bamboo species which grows in the cooler climates of the mountainous regions and is called *ulanzi*. Its harvest is highly seasonal; only during rainy season do the bamboo sprouts produce enough sweet sap to be collected and fermented. Production and marketing are usually done in small-scale enterprises. Taking care of the bamboo groves and the harvest of the sap is the task of women and men alike. The groves are usually owned by individuals who are able to earn, by Tanzanian standards, not inconsiderable amounts of money. Marketing of *ulanzi* is solely in the hands of women who rent small bars to sell this and other traditionally fermented drinks.

The general term for traditionally produced beer is *pombe*[1]. It is basically made of cereals or other starchy plants such as cooking bananas or cassava. Depending on its ingredients and stage of fermentation, *pombe* has various names. *Komoni*[2] (from English "common") is made from maize and finger millet (*ulezi – Eleusine coracana*), *kimbumu* contains more millet than maize, *ufuge* is made solely from millet, *kindi* from unpeeled cassava (*muhogo*), *myakaya* contains cassava, maize and millet and *kangala* (or *kangara*, both Swahili) is made from maize and sugar or honey. *Togwa* or *malenga* indicates beer in its early stages of production. Among the Bena in the southwestern highlands maize and finger millet[3] are preferably used to produce *pombe*.

Sometimes *mlangali* (a succulent *Euphorbia sp.*) is mixed into the brew, obviously using its irritating effect on the mucous membrane to make the customer drink more. According to Schultes and Hofmann (19979: 109) in Tanganyika *Datura ferox* was added to beer for its inebriating effects[4]. In northern areas it was reportedly used to facilitate robbery.



Our logo for this series: Azande children inspecting the camera of a visual anthropologist.
Photograph: Manfred Kremser

"In Bukoba it is a seasonal occupation of certain natives of that district to entice travellers to a meal and a convivial bowl of *pombe*. The victims become stupose or at time maniacal and while in this state they are deprived of any possessions which their hosts deem worthy of acquisition. The Medical Officer reported that he had examined victims some times after their illness and found their pupils dilated and markedly inactive to light." (Raymond 1938: 75).

People in the southwestern highlands, however, do not know about the intoxicating properties of Datura. To my knowledge it was never used as an additive to beer.

Production

The processing and marketing of *pombe* lies in the responsibility of women[5] It is produced at home and sold to a local *klabu* (slang from *kilabu*, Pl. *vilabu*, club). Sometimes also private homes are converted into bars (see Subbo 2001: 205). This gives the women the possibility to earn some money and make them to some extent independent from male income (Holtzmann 2001). The pombe shops are often owned collectively and rented by a woman who also sells the beer. Even small villages have at least one *kilabu*. Beer is sold in plastic containers of about 1/3 litre. A container is quite often shared by two close friends (see E. Garine 2001: 196). The main consumers of beer are men but also women increasingly drink *pombe*.

In a first step finger millet and maize are soaked, left to germinate for a few days and then dried in the sun. The sprouted and dried cereals can be bought at the market (Fig. 1) but they are often produced at home. It is then pounded, some water is added and the dough is allowed to stand for a while (Fig. 2).

The further preparations are time-consuming and arduous. The heavy sacks of sprouted and dried maize have to be brought to the milling machines where it is processed into fine flour. Nowadays in semi-urban areas it is very rare that the maize is pound by hand. Numerous buckets of water have to be carried from often far away pipes; firewood has to be cut and carried home. A large oil barrel that has today replaced the traditional earthen pots – which were certainly no less heavy – is filled with water and heated until the water boils. Then the maize flour is added, the whole mixture is heated again and finally the millet-mass is added (Fig. 3). The barrel is removed from the fireplace and the liquid is left overnight to rest and cool down. In the morning the warm brew is filtered through a sieve (Fig. 4) – formerly the sieve was made of plant fibres (Krauss 1994) – and finally through a woven plastic sack (Fig. 5). The brew is then ready to sell (Fig. 6). As far as I was told, no industrial yeast or yeast from previous brewing is added. Sprouted millet contains wild yeast (Raymond 1928) which might be enough as a source for fermentation. Also the pots and plastic containers used for the production of beer are contaminated with yeast, which seems to be enough to start new fermentation.

Consumption

As much as 380 litres of traditional beer per person is consumed annually in rural areas (Krauss 1994). There is quite a quantity needed to become intoxicated by beer. The alcoholic content of traditional beer lies around 2,5% (Shayo et al. 2000, Tusekwa et al. 2000). It is lower in alcohol content and higher in nutritiants than industrially produced beer (King and Burgess 1993). In many rural African societies beer is one of the main food items consumed. Beer is properly claimed as a food as it is a thick brew. People in the southwest of Tanzania say that *pombe* is "eaten" not drunk. Most of the solid matter is still left in even after being filtered once during production and once before consumption. *Pombe*, in comparison to industrially produced beer, is considered a healthy brew which in its early phases of fermentation is given to children, old or sick people and pregnant women. The high nutritional properties of early fermented beer are also supported by Western science (Mandishona et al. 1999). Generally, fermentation improves food digestibility and has several other health benefits (Etkin and Ross 2004).

The food aspect of beer is also stressed by one Ngoni-boy from former Rhodesia who in the early fifties wrote in an essay at school: "Beer and cattle are the food of the Ngoni. (…) If your friend comes and he doesn't get beer and meat, then although he gets porridge, he still says that there was hunger in the house." Another said: "Our life depends on drinking beer." And, comparing this habit of the Ngoni to another ethnic group, the Cewa, one boy commented: "The Cewa are just slaves, they merely eat. The Ngoni are like the Whites; they eat little and drink much." (Barnes 1959: 218f.)

Today, beer in the first place is consumed as a recreational drink. People come together in a small *klabu* to gossip, to talk about agricultural issues, about family matters and to get a little tipsy. In former times beer also played an important role in rituals concerning all major social events such as birth, marriage, adulthood and death but also in communal work to recruit labour (see McAllister 2004) and in warfare.

Beer's Role in History

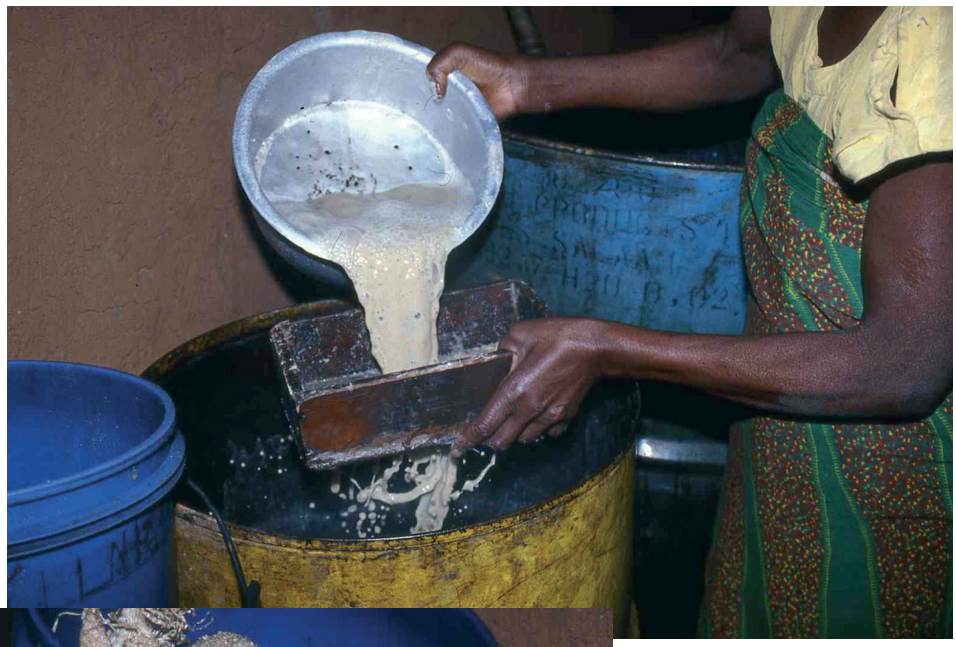
Beer was important to obtain assistance from neighbours for work (Culwick 1935, Dempwolff 1914). This was a way to reward the workers. No communal work was thinkable without the provision of beer. When a house was to be built, a roof to be thatched, a harvest to be brought in, beer had to be provided. Especially during the months of greatest agricultural activity was beer highly prized. By then people could no longer afford to brew beer because they had to ration their food. Barnes comments on the Ngoni: "Most of the outside assistance that may be required in a garden is raised by means of a beer-party. The man's wife brews beer, and it is made known in the village and around about that on such-and-such a day there will be a party to hoe in their garden.

Fig. 1: Sprouted finger millet – *ulezi* (*Eleusine coracana*) is sold at the market in Njombe.

Fig. 2: The sprouted and dried millet is pounded, some water is added and the mass is left to rest at a warm place.

Fig. 3: In a large barrel water and maize flour (of sprouted corn) are heated, then the millet-mass is added.

Fig. 4: Early next morning the warm brew is filtered through a sieve.



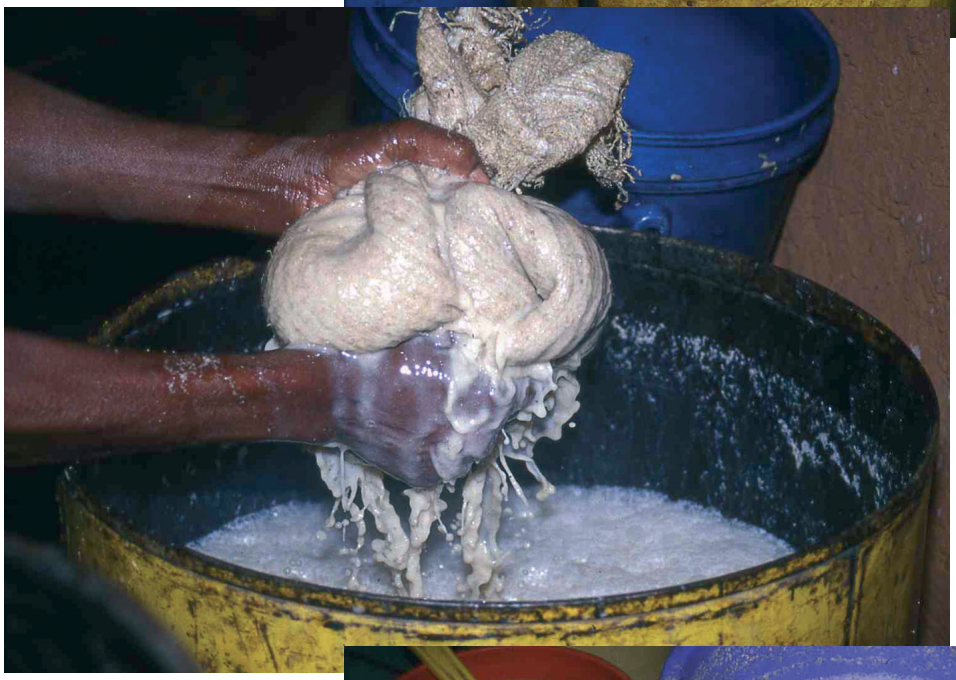


Fig. 5: Then the brew is filtered again through woven plastic sacks.

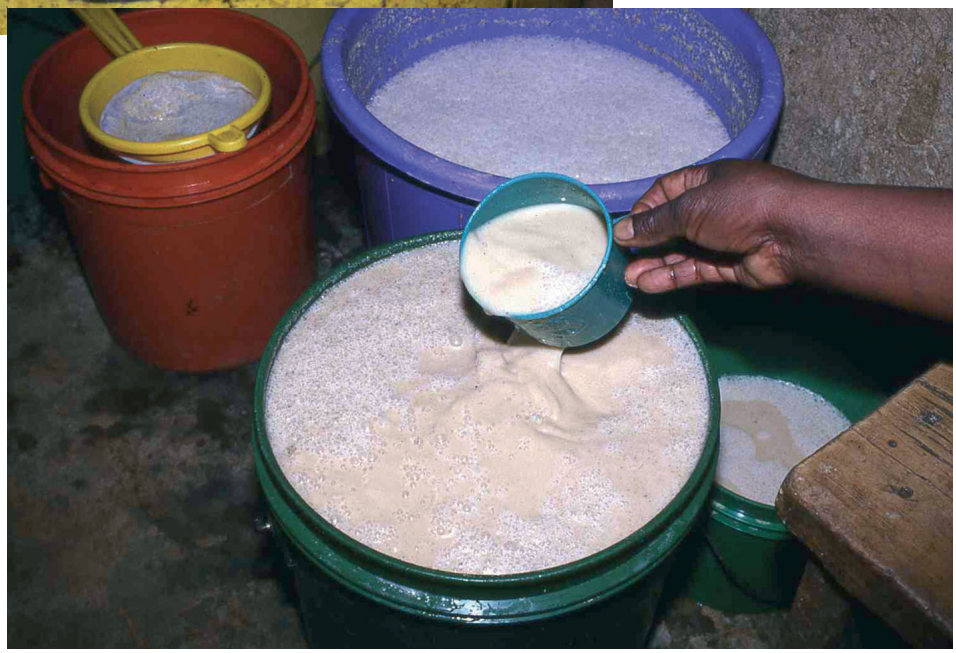


Fig. 6: The beer is ready to be consumed.

A dozen or so people go to the garden in the morning, and work until the task set by the owner of the garden is completed. They then move to the village, and are refreshed with beer." (Barnes 1959: 219)

In the ritual of blood brotherhood beer also played a significant role. Among the Sango two men from different ethnic groups could become blood brothers. Some blood from the arm of each of the men was poured in a cup of beer and drunk alternately (Heese 1913). Also the Hehe used beer similarly: "They (blood-brothers) help each other on all occasions and when beer is drunk they sit by each other." (Dempwolff 1914: 105). In war times beer was brewed to encourage the warriors. The chief "gives them beer and puts some magical substances into it, which they drink together." (ibid. 111) When returning from the battlefields "they send a messenger with the news that the troops are on their way home and they should start with brewing beer. When they are at home, now drinking beer, then they talk with enthusiasm." (ibid. 112) In the southwest beer was important when taking away the bride to meet her groom. When a woman was well advanced in pregnancy she returned to her mother. Beer was brewed and drunk while instructing the mother-to-be. When the child was born and capable of living, beer was brewed and the infant was shown to the community. Nigman (1908) reports that in addition to the living, also the ancestors celebrated a new-born baby with beer. A small pot of unfermented beer was put on the roof of the house for the ancestors, in some regions near the door. If the pot was not emptied until the next day – a sign that the offering was not accepted – the ritual had to be done again. In the past among the Bena the girls had to undergo certain initiation rituals, involving also circumcision, in which unfermented beer or *togwa* was served (Culwick 1935).

Great amounts of unfermented beer were prepared also for funeral rites. A small amount was poured over the grave as an offering and a pot of it placed at the head of the grave. If the grave was some distance from the house the pot was placed outside the hut and a little beer poured on the grave next morning. It was vital that the spirits approved the offering. If the beer was unspoiled and good, the people could proceed to drink it but if anything had gone wrong with the brew, the spirit expressed his dissatisfaction and the ritual had to be repeated. The funeral rites were also known as *ugimbi ya matapatapa* - the "beer of causing-to-arrive". If a man died, the rites were followed by *ugimbi ya mapwere* - the "beer of inheritance", when the heirs assembled to divide up the property. During the period between the two feasts the closest female relatives wore old and worn clothes, but on the day of *ugimbi ya mapwere* they appeared washed and dressed in new clothes (Culwick 1935: 126f.).

Offerings to the Ancestors

Beer is the sacrifical food. It has a very high symbolic value (I. Garine 2001: 58f.). The offering to the ancestors or *tambiko* is one of the few rituals practiced today in which beer is still significant. This ritual traditionally takes place once a year or once every two years but in urgent cases like severe disease, draught or loss of cattle, the *tambiko* may be held any time. The *tambiko* today is a very private affair. As late Mr. Mtenzi once told me: "There are many clans which are still doing it (the *tambiko*) but they wouldn't like other people to know about. Like, for instance, now, we go to Lupembe (in Njombe district) every second year, we wouldn't like other people to know, but we do it, every second year."

When the meat, beer and flour are offered to the ancestors they show with very clear signs if the offering is accepted or not. Mr. Mtenzi:

"If I go to these ancestors and speak to them, they don't speak, the ancestors themselves, but the actions which are happening outside are the ones that show that they have accepted me or they are angry. For instance we go there with our cows, kill the cows and if this meat is eaten without (us) fighting (with each other), then they have accepted, because sometimes, the animal who you would like to kill runs away and is gone completely. With this they would show that they don't like it."

For a *tambiko*, fermented beer is nowadays used but in the past, *togwa* – sweet beer at the beginning of fermentation – was offered. In the evening pots with beer were placed on the graves and if the beer was still sweet the next morning and did not turn sour, the offering was

accepted. If something went wrong, the offering had to be repeated until it was accepted (Culwick 1935).

The first *tambiko* I witnessed took place in Ilembula, a small town south of the main road Makambako - Mbeya on November 22, 1997. A traditional healer, Mariam, invited me to participate in this ritual which, as it turned out later, was held because one of her relatives had severe economic problems. Mariam gave last instructions to her family[6]:

"We cut pieces of meat to share in the family. Now we begin the process, our guest here will make some photographs. Don't close your eyes; look at the European snapping you. She will record, be careful, speak good words. You, the elder, please start to do it. The European here will snap even the dirty things here. She will be surprised when we do this, because they don't have that there. This meat goes with the liquor, you tell the audience, so that we start drinking. This flour is from maize, as well as the *pombe*. Now start talking to your ancestors, to your late father and your grandparents."

The first one to begin the offering was the father of the person for whom the *tambiko* was held:

"I have now come with this son that he is coming to pray for you and give you something you need. Now take the pieces of meat. Now please, this is the meat I want to give you where you are. These pieces of meat you all should eat, please don't be mean, share it. I told you that all family members must be together where they are. Tell them all that we are doing this. (…) Check that the cows and goats are in good order. When I earn money it is lost unknowingly. We need to prove if you received our things here, that everything is going good. If we find that the results are not good, we suspect you to be witches. Always come in our house and talk to us. Now we pour *pombe*, now you have got to do this, after you eat this meat you have to drink the *pombe*. Have these bites of meat with it."

After the elders finished their prayers the son spoke:

"You, grandfather, what I am telling you now, listen to me. As you told me formerly, it's true that I had to prepare this ceremony. Today the ceremony is this one. Please, stand for my problems; I have got so many of them. I don't want to see other troubles arising. If I get more problems I have to think that you are still a witch. I brewed this *pombe*; the meat is here for you. I still ask you to stand for my problems. What I produce from my farm should be profitable. If you don't stand for me I don't know what you will get next time. I have something to eat so you can eat. Please, the herds should be productive. If you start killing the animals here, what do you think you will get next time? You have to protect them. All the earnings must be prospering, therefore I give you this animal which has blood. Take the blood. As the other member said, don't think we killed a rat, it's for you, drink and feel happy. You must dance accordingly as you were doing while alive. We shall be happy when you receive us. I say thank you."

After everybody in the group offered his share of meat, flour and *pombe* and when they saw that it was accepted by the ancestors, they themselves were then allowed to eat the rest of the meat, drink beer and celebrate.

Traditional concepts of disease not only include physical symptoms but also miserable living conditions, misfortune in business or problems related to the family. To treat a patient adequately it is vital that, besides bodily or mental symptoms, the cause of a disease is detected. In the following case the traditional healer Lutumo (Kutalek 2001), through divination and discussion, reveals that the patient's disease is caused by an evil-wanting ancestor. He consequently suggests to her to hold a *tambiko*. Usually these kinds of diseases or conditions are severe or long lasting and concern the whole family.

Lutumo: How many children do you have?
Patient: Three boys, two girls.
L: What do you find them suffering?
P: They are suffering from several things.
L: Is their father present?
P: He died two years ago. Even his brother died, the only who remained is the aunt.
L: Are you a Hehe?
P: Yes.
(…)
L: Didn't you go to the *waganga* (traditional healers) to ask why these people died?

P: We went a long time ago; we were told that the deceased people were bewitched.
L: When your husband was still alive, did you quarrel with him sometimes? Do you remember it?
P: Yes.
L: You should remember it well. Who started to quarrel?
P (does not answer)
L: You should remember. That's why these children are suffering.
(…)
L: Did they build the grave of their father?
P: No. But the grave of my brother in law was built by his own children, but the grave of my husband was not built by my children.
L: First you should go and bring the hens to *babu* (grandfather) and *bibi* (grandmother), second your children and their elder brother should go and build the grave of their own father. While building it, take some of the pombe, cook some *ugali* (maize-porridge) and meat and call your own family."

A *tambiko* is also held when the ancestors are severely upset because social or religious rules were not obeyed. Lutumo once told me the following story: Years ago he worked for the Tanzanian Wattle Company which has large plantations of wattle trees (*Acacia melanoxylon*) around Njombe. The bark of the trees contains tannin which is extracted and used in the tanning industry; the wood is needed to supply the wood-factory, the tea estate, the hospital and attached houses with electricity. When the factory was built he was still a young man.

Lutumo: "Before building the factory it wouldn't work because the natives didn't like a factory here. The (former) owner of the area said that that place was for their *tambiko* (offerings). The white people had to give a cow to remove the ghosts there. They did it. When they installed the electricity they had to do the same thing. This time I was one of them who ate the cow, to do the offerings. When they installed the electricity I was in Dar es Salaam, the machine wouldn't work. They went to a man called Asugile. The man asked them: 'Why do you install the new electricity while the machine was working at first time? You didn't tell us that you want to introduce a new technology.' They asked him: 'What are we going to do?' He said: 'A man who can make the machine run is in Dar es Salaam now.' They had to phone me to come back. When I came back I went there and I made the things (offerings) and the factory went on well.

I and other three, we ordered one black cow for them. Before slaughtering it we said 'We can't slaughter the cow before asking the ancestors – *msimwi*.'[7] Before slaughtering the cow we took some flour and put it there. We couldn't go and cook a pot there (this is a special ritual), we just took some flour. When I went there I asked the management to show me the palls. 'How many palls do you have?' 'We have four.' We had some beer. I had to put one bottle to each of the palls for the ancestors to drink. Beer, just local *pombe*.

The first to put a bottle was I. The other three did the same like me. Lastly the white people came to see what we have done. Those white people made pictures of that. Then we had to pour that *pombe* around the palls. The rest which remained we drank ourselves. The white people asked: 'Can we start now to light the electricity?' 'You should wait. You should stay for three minutes so that we see the ancestors.' After a few minutes I asked: 'Where is your machine?' We went there, it was not working well, doing the opposite, returning back. When we checked the machine we put some finger millet. 'Now start your machine.' It worked. I instructed Mr. Mkongwa: 'Take a trunk of firewood and put it into the machine.' It was working. Since then the machine worked without any damage. I have got big ancestors!"

Discussion

Traditional beer in Tanzania is consumed in large quantities and is important regarding its nutritional factors. Though half of the grain in Africa is consumed in the form of beer, in few manuals on nutrition in developing countries is beer given the necessary space as an important nutrition factor (Kracht and Schulz 1999, Marchione 1999, Foster 1992). Its method of production allows women to earn money independently from male income, an aspect that up to now has not been given much attention. If women are able to earn money, the nutritious standards of their families increase because women usually give food higher priority than men (King and Burgess 1993). Also women are

usually more willing than man to spend their income on the education of their children. On the other hand the production of beer can lead to considerable problems within families and communities (Carlson 1992). Women, especially if they become prosperous, often put their reputation at stake when brewing beer (Subbo 2001). They have to fight against the opposition of courts, churches and men (Howard and Millard 1997). Men who are frequent customers of *pombe* shops can spend considerable amounts of money there – money that is better spent on school fees or medicines. Although public drinking is accepted and drunkenness in many societies even has a prestigious image (I. Garine 2001: 63) it is also often seen as a sign of social decline. Problems in Tanzania are especially evident with the production of a spirit called *gongo* which is often made of beer. *Gongo* is also produced by women who, in need of money for their family, are driven to crime because the private distilling of alcohol in Tanzania is forbidden by law. Almost every day newspapers report on the illegal distillation of alcohol which is mentioned in the same breath as homicide and rape. In fact especially if alcohol is distilled in modern vessels that do not permit the methyl alcohol to evaporate as the traditional vessels do, many victims die of poisoning or go blind through the consumption of contaminated alcohol. In beer production, cereals or other starchy plants are consumed (almost) only by adults. In the production of distilled alcohol, important nutrition factors are taken out of the circle but the spirit itself is much less nutritious than traditional beer; almost no important nutrition elements are left.

Beer is nevertheless of high social importance. Men, and in some regions also women, come together in clubs to exchange ideas, to do business or discuss family matters. Beer is used in traditional ceremonies and is especially important when communicating with ancestors. In this sense beer is a divine beverage.

Notes

[1] The yeast *Schizosaccharomyces pombe* is named after the traditional Swahili term for beer.
[2] If not otherwise mentioned all the following terms are Kibena terms.
[3] The ability of finger millet to convert starch into sugars is only surpassed by barley (anonymous 1996).
[4] In Ethiopia *geisho*, *Rhamnus prinoides*, is added to flavour the local beer and probably also to enhance its intoxicating effect (Vetter 1997).
[5] Among the Duupa in Northern Cameroon, for example, beer brewing is done by men (E. Garine 2001: 194)
[6] It is fairly unusual that a woman leads a *tambiko*. However, this might be due to her status as a traditional healer.
[7] Slang of the Swahili word *mzimu* (Pl.: *misimu*); ancestors

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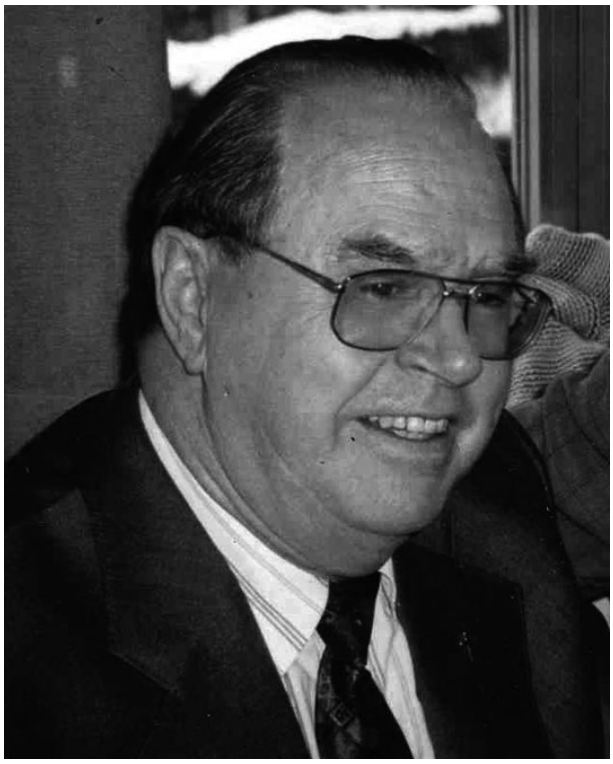
A Fascinating Life, Rich in Diverse and Exceptional Encounters
Father Hermann Hochegger, for fifty years a missionary to Africa



Father Hochegger

On September 8, 2005, I was happy to celebrate fifty years of research in African culture as a missionary of the Divine Word Fathers. My academic formation included the missionary academy of St. Gabriel, at Modling near Vienna (1955-1960). My first memorable experiences were the weekly meetings of the seminar in cultural anthropology led by Professor Paul Schebesta (Fig. 1), who introduced us to dialog with different cultures overseas. Schebesta had a charismatic personality. Long before the Second Vatican Council, he insisted that every missionary must acquire good insight into the cultural life of the peoples to whom he was sent. Today, the Catholic Church urges all missionaries be in dialog with cultures. Starting at that period of my formation, I achieved my first publications.

In the following years (1960-1963) I had the privilege of studying the French language at the University of Grenoble, and then to depart for Belgium, where I received the "licence" in African sociology and linguistics at the Université de Louvain. So I was qualified to teach at the Collège Saint Paul of Bandundu, Congo.

To intensify the dialog with African culture, I created CEEBA at Bandundu, the Centre d'Etudes Ethnologiques de Bandundu. The main activity of this institute was the organization of annual meetings (Colloques), prepared by detailed research on a given theme among the peoples of Central Africa. The results of these investigations were published periodically.

In 1969 I was sent to the Sorbonne in Paris for my doctoral studies. There I had the privilege of participating in the famous sessions of the Laboratoire d'anthropologie, Collège de France, directed by Claude Lévi-Strauss. Returning to the Congo, I continued directing the Institute of Bandundu, and teaching Introduction to African Cultural Anthropology at the diocesan academy of Kalonda in Western Congo.

Fig. 1: Father Hochegger and Prof. Paul Schebesta

The annual organization of symposiums (30 meetings in 33 years) was difficult in the hot and humid climate of central Africa, but we could enrich our insight into the cultural life of the people, mainly on the principal ideas of mythology (58 volumes published) and rituals (65 volumes published). Without a doubt, myths and rituals are the heart of every

Fig. 2: Recording oral tradition in Bandundu

culture, and give the observer the key to non-verbal communication, symbolic language ("Speech without words"), so as to know the focus of orally-oriented peoples (Fig. 2).

In the archives of the Institute of African Culture of Bandundu, 451 volumes of research papers can be consulted. Back from Africa, I produced 21 studies: 12 books published in French and 9 in English.

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Book Reviews

Jörg Kastner (2003) Propädeutik der Chinesischen Diätetik, second revised edition, Hippokrates Verlag, Stuttgart.

Jörg Kastner's book is very well structured, containing theoretical and practical sections. The theoretical section is subdivided into two parts, a brief introduction into the fundamental principles of Traditional Chinese Medicine and an explanation of the methodology of dietetic treatment. The practical section deals with basic nutritional recommendations as well as the specific application of Chinese dietetics. The body of the practical section includes the classification of about 90 foods, categorised by their energetic properties such as taste, temperature, effect on the organism, preparation and content. The book is rounded off by clinical examples of conditions such as diarrhoea and constipation, affections of the respiratory tract, hypertension, **neurodermatitis**, incontinence, impotence and many others. At the end of the book are detailed tables with nourishments and their energetic properties, on the one hand arranged in order of their appropriate element or transformation phase, on the other hand arranged in alphabetical order.

Lets take a closer look at the particular chapters:

Theory: A) Therapeutic Principles of Traditional Chinese Medicine
Kastner explains clearly and succinctly the interaction of Yin and Yang. He mentions the five elements or transformation phases and discusses the basic substances, *Qi*, *Jing*, *Xue*, *Shen* and *Jin-Ye*. Furthermore, he gives examples for dysfunctions of the five basic substances that are well chosen for the most part. One exception is the dietetic treatment for *Qi-stagnation*. Here he recommends the acrid or pungent taste which would be correct, but he does not differentiate between warm/hot and cool/cold

pungent foods. In this way he recommends hot and pungent nourishments like chilli, pepper, garlic and alcohol for the treatment of *Qi-stagnation*. Since *Qi-stagnation* often goes along with *liver-heat* or *fire* these foods could lead to inflammation of the eyes, headaches or even hypertension, so they are strictly contraindicated in this case. Also, later in the book when he discusses the particular tastes in more detail, he neglects cool or cold pungent foods like radish and talks only of hot pungent foods and their effects on the body.

Causes of disease
In this chapter Kastner enumerates causes of disease like the five emotions, the individual constitution, right or deficient nutrition as well as balanced or unbalanced life style. Furthermore he discusses five of the six pathogenic climate factors, that is to say *wind*, *cold*, *dampness*, *fire/heat* and *dryness*. While his discussion of these factors is sufficient, he doesn't mention *summer heat* that is responsible for flu like symptoms in the summertime. Kastner explains that *wind* is often the "carrier" of other pathogenic influences such as *heat* and *cold* and specifies *wind-cold* and *wind-heat*. His dietetic treatment recommendations for *wind-cold* – pungent spices especially ginger, spring onions, garlic and coriander – are excellent, however, his recommendations for the treatment of *wind-heat* – green tea, watermelon and celery, are more efficient in the treatment of *summer-heat* or *fire/heat*. To expel *wind-heat* a person would need cool or cold pungent foods with a dispersing effect like radish, white cabbage, mint leaves (Herba Menthae), mulberry leaves or Chinese chrysanthemum blossoms.
In the preface of the book Kastner says that he abstains from the discussion of Chinese medicinal plants used in dietetic recipes because such use takes a lot of experience and high qualification on the part of the TCM-therapist as well as excellent quality on the part of the medicinal herbs. Nevertheless, I sometimes missed the discussion of common western herbs because they can be very useful in getting the organism back to balance.

B) Methodology of dietetic treatment
In this section Kastner discusses the energetic properties of foods, including the thermal effect of foods on the organism, the taste of foods and its particular effect, the channels by which nourishments enter, as well as the effective direction of the foods. For each he gives examples for better understanding, although I can't wholly agree with his claim that cool foods nourish the blood since that is true only with a few edibles, to illustrate, take spinach. It has to be cooked with a warming method like baking in order to nourish the blood, whereas beef with its warming property exhibits its effect already when cooked as in soup. Contrary to Chinese herbal drugs most foods that restore the blood are of warming nature. In fact, later in the book when he discusses the Chinese syndrome of blood-deficiency (p. 63f.) he also recommends some warm foods to nourish the blood such as chicken, beef, carrots, cherries, longan fruit and apricots which are all great blood tonics.

How to influence the energetic properties
Here Kastner explains the effect of the various cooking methods, e.g. baking, broiling, steaming roasting, cooking with alcohol and seasoning in a comprehensible manner.

Essential recommendations in Chinese dietetics
This section contains descriptions of how inner attitudes influence the absorption of foods. Kastner explains that distractions during meals like discussions and strenuous conversations can cause emotional tension leading to anxiety, anger, or brooding, each having a negative impact on the stomach and spleen. The *Qi* of the digestion organs will be inhibited and weakened, and symptoms like loss of appetite and belching can occur. He emphasizes the special importance of the earth-element or transformation phase and describes how to strengthen the spleen and stomach by ingesting various foods, altering eating habits and utilizing various cooking methods.

Nutrition according to certain times
Kastner explains why it is important to eat according to the time of day as well as to the appropriate season. He emphasizes the importance of choosing foods that are grown locally and in-season. Among his recommendations for foods and drinks in spring, I missed purifying bitter herbal infusions like

dandelion or birch leaf in order to get rid of the accumulated *phlegm-heat* due to the rich, meaty, and hot foods consumed in winter. Also missed are blossom teas like calendula or orange blossoms in spring time (= the blooming time) to disburden *liver-Qi*. Nevertheless, the recommendations and foods to avoid for the other seasons are well chosen. Kastner also writes about nutrition according to several pathogenic factors and to the particular stages of life in this section. He notes that children have a natural desire for sweet tastes and that plain sugar should be replaced by honey, maple syrup, pear syrup, raisons or dates in order to not harm the spleen.

Practice: A) Common Application of Chinese Dietetics
Here, Kastner gives useful information for the TCM-practitioner on how to conduct a successful dietetic consultation. He lists common indications for a Chinese dietetic treatment and gives suggestions for the practice of dietetic counselling. Moreover he provides a useful list of general nutrition recommendations with pros and cons for each. The list contains essential Chinese wisdom like: Abrosia (fasting) can weaken the *middle burner*, the *Yin*, blood (*Xue*) and the essence (*Jing*), or: if clients eat a vegetarian diet, they should eat plenty of warming foods and use piquant herbs for cooking.

In the chapter *areas of application* Kastner discusses general deficiencies and excess syndromes quite thoroughly. He describes general *Qi-*, *Yang-*, blood-, *Wei Qi-* and *Yin-deficiency*, *dampness* and *phlegm* syndromes and *Yang-excess*. Looking at the elaborate lists of symptoms of particular syndromes one can assume that Kastner is a well-trained TCM-therapist with a wide range of experience. His recommendations of which foods and bad habits to avoid for particular syndromes are good, although I do find recommendations of foods a little meagre. For example, for the prevention or treatment of *Yin-deficiency* Kastner recommends pork and oysters – the former is not so healthy since it produces *phlegm-heat* and can lead to *stagnation*, the latter is quite expensive and hence unavailable for the average person. Yet, he does not mention duck or rabbit, two great foods to nourish the *Yin*. In the vegetable category he notes spinach, tomatoes, algae and does not mention zucchini, aubergines, broccoli or Chinese cabbage – all ideal foods to nourish the *Yin*. The recommendations of foods for the strengthening of the *lung-Qi* apply more to the expelling of *wind-cold*, cleansing the channels, or dispersing of the *lung-Qi* because lung-Qi cannot be strengthened with chilli, pepper, alcohol, radish or cress. Despite these few drawbacks and oversights, Kastner explains the origin and different types of *dampness* and *phlegm* very well. This is quite an accomplishment since these are complicated matters to understand in Chinese medicine.

B) Specific Application of Chinese Dietetics
This is a very interesting and useful section of the book. Kastner discusses the transformation phases *earth*, *metal*, *water*, *wood*, *fire* and their associated organs: *spleen/stomach*, *lung/large intestines*, *kidney/bladder*, *liver/gall bladder* as well as *heart/small intestines*. He thoroughly and comprehensibly explains the relevance, requirements, and functions of the particular organs (which are called "Funktionskreise" in German since they are not as understood as they are in western medicine) and discusses the most important and frequently seen syndromes like *spleen-Qi-deficiency*, *spleen-Yang-deficiency*, *stomach-Yin-deficiency*, *stomach-fire* etc. He explains pathogenesis, symptoms, dietetic and other causes of syndromes and also gives examples of parallel western diseases. For example, the Chinese syndrome of *stomach-fire* can go along with gastritis, stomach or duodenal ulcers, gingivitis or nose bleed. Such a conversion of Chinese syndromes into western clinical patterns is not always one-hundred percent correct but it can be useful for the western TCM-practitioner. One has only to keep in mind that a diagnosed Chinese syndrome does not have to be consistent with western diagnostic findings. The strength of Chinese medicine is that the TCM-practitioner is able to find a disorder by means of tongue- and pulse diagnosis earlier than any medical equipment can detect it.

Classification of Foods
In this chapter Kastner classifies nearly 100 foods by their energetic properties. He subdivides the nourishments into the following groups: vegetables, grains, spices and herbs, fruits, meats, fish and seafood, diary products, eggs and oils, nuts and seeds as well as drinks like coffee, tea and alcoholic beverages. The classification is clearly laid out and useful for practical application. Kastner notes in the

preface that in case of contradictory food classifications among authors he relies on his own practical experience. In addition to the classification Kastner lists particular indications for each nourishment, e.g. bamboo sprouts are indicated in case of *stomach-heat* which may cause symptoms like heart burn, gastritis, ulcerations in stomach and intestines, thirst and dry mouth as well as in case of *heat-phlegm* in the lungs which may lead to bronchitis, sinusitis with tenacious yellow sputum. When there is a contraindication Kastner notes it. He states, for example, that cucumber should be avoided by those suffering from *cold* and *deficiency syndromes* of the *middle burner* because symptoms like stomach pain and diarrhoea may become worse due to the cooling effect of cucumber. Still, there are some minor discrepancies. In the vegetable section broccoli, cauliflower, zucchini, fennel and carrot are not mentioned, although he lists them at the end of the book in the tables that, while not exhaustive are still informative. In the section spices and herbs, European and Mediterranean pot-herbs like oregano, basil, bay leave, lovage, parsley, summer savory and thyme that all dry *damp* or *cold phlegmatic* conditions like oedema, bronchitis with thin and white sputum, adiposity, or diabetes mellitus II are significantly absent. The only herb Kastner recommends to eliminate dampness or phlegm is ginger, although some drying herbs can be found in the tables at the end of the book. In the section "Diary products, eggs and oils" although Kastner lists soy oil, sesame oil and peanut oil, but neglects common European oils like sunflower oil, wheat germ oil and olive oil (again, he did list them in the tables at the end of the book). Chinese dietetics is such a broad field with an enormous amount of information, so even the best can miss things now and again. As a special treat, Kastner sometimes provides useful recipes. In case of bamboo sprouts, for example, he notes that they may be cooked, mixed with a little ginger, salt, and vinegar, allowed to cool and then eaten cold.

Clinical Cases

Kastner writes that with clinical examples he tries to build a bridge between Western clinical models and Chinese diagnosis of syndromes. He also notes that naturally this effort must remain inadequate – which I have to strongly agree with – but it should provide momentum for the Western therapist. He discusses about 60 clinical cases, from acute bronchitis to bacterial cystitis, explaining symptoms and pathogenesis and giving useful recommendations of foods and also foods/eating habits to avoid. All the cases he rounds off with the suggestion of acupuncture points (he does that already earlier in the book in the chapter specific application of Chinese dietetics), but does not note if they are to be sedated or toned. Finally, there is a bibliographical list quite at the end of the book (right before the tables with nourishments), but within the text Kastner abstains from most references. Only quotations from the "Huang di Nei Jing" or some other old Chinese sources are evident for the reader.

Overall, I believe Kastner has done an outstanding job detailing Chinese approaches to nutrition and dietetics. His style is interesting, his approach accessible and reasonable, and his examples understandable. While there are some discrepancies on the finer points, his book would be beneficial for TCM-therapists who have not studied Chinese dietetics formally or extensively.

Maria Michalitsch

Daverick Leggett (2004) Selbstheilung durch Ernaehrung. Rezepte für Harmonie von Yin und Yang. Goldmann Verlag, Muenchen

Daverick Legget's book is indeed a treatise on nutrition and Chinese dietetics. Since the author also reminds the reader of other pathogenic factors from such simple things as air pollution and shallow breathing, he shows quite a holistic approach to the pathogenesis of disease. In addition, unlike many books of this type, all quoted studies are marked with footnotes and are easily traceable for verification or additional information.

The foreword has been prepared by Misha Cohen, a well-known TCM-expert, practitioner, founder, and head of a leading clinic in San Francisco. In it, she expresses admiration and regard for Leggett because of his holistic approach and his expansive knowledge on the topic of Chinese dietetics. To

illustrate the latter Cohen picks out an example – the double effect of coffee on the human organism. Coffee and its effect triggers fierce discussions among TCM-experts since in Chinese literature it is described as having a warm, even hot effect on the body, while experienced TCM-practitioners find that it has a cooling effect in *qi-deficient* persons. In fact coffee can even induce *cold* associated with severe digestion and circulation problems. Leggett explains that coffee has both cooling and heating effects, depending on the dosage as well as the disposition and condition of the person drinking it.

The book is divided into five sections, including nutrition, fundamental principles of Traditional Chinese Medicine, beneficial recipes for the self-healing process, more important factors, and self-help assistance.

Part I – Nutrition
In this section Leggett examines pathogenesis of disease from an interesting point of view. He points out cosmic, cultural, family dependent, biographic and biological aspects of pathogenesis. He discusses air as a source of nutrition and the differences of breathing between babies and adults. Other sources of nutrition Leggett sees in water, trees and other plants, cosmic energy, sensuality, relationships and finally edibles. He examines the difference between inanimate and energetic water as well as how to recharge water with energy, and he explains the importance of the inner attitude while taking in a meal and emphasizes that this attitude will have an impact on the absorption of nutrients. He also talks about so-called "body wisdom" that empowers one to recover one's balance and with his book he wants to give an impetus to regain this body wisdom.

Part II – Fundamental Principles of Traditional Chinese Medicine
In Part II Leggett discusses the differences between western and Chinese views of disease, and why a certain person is susceptible to a particular illness. He explains the Chinese system of meridians and how it evolved from the first cell division on. He examines the *Yin-organs spleen*, *lungs*, *kidneys*, *liver* and *heart* and emphasizes the psychological aspect of the *spleen* as an organ that must receive both physical and emotional nourishment in order to be healthy. He also mentions that people suffering from an imbalance may concentrate on food although the answer to their healing process would lie in the fulfilment of a different desire such as the need for intimacy. Furthermore, the basic substances *Qi*, *blood* and *Jing* are discussed in this section as well as climatic factors and pathogens. Leggett explains the causes of *Qi-*, *blood-* and *Jing-deficiency* and other disease patterns such as *Qi-* and *blood-stagnation* and he does not list the symptoms of these disorders but discusses and explains them. The explanation of the symptoms contribute to a better understanding on the part of the reader, although Leggett's study is not as efficiently structured as other texts (see my review of Kastner's book as an example of successful organization). Recommendations of foods, spices and western herbs for the different syndromes are all well chosen and Leggett explains the connection of *blood* to the psyche and consciousness precisely and very well. Only one translation error occurred, sweet rice, a highly glutenous, strengthening type of rice, is mistakenly translated as "Milchreis" instead of "Süßreis". *Yin* and *Yang* are also discussed in this chapter, including their physical and psychological aspects, the cooking methods and companion foods that enhance and balance them.

Part III – Beneficial Recipes for the Self-Healing Process
At the beginning of this chapter Leggett explains nutrients from the eastern and western point of view, and gives examples for better understanding. Moreover, he provides a useful list of general nutritional recommendations in order for people to get better digestion and absorption of foods. He discusses the different food groups, such as grains – with particular attention to rice, oats, barley, rye, wheat, millet, amaranth, quinoa, buckwheat and sweet corn – vegetables, fruits, legumes, nuts and seeds, diary products, meat and fish, herbs and spices. Following this discussion, Leggett provides about 100 recipes that look delicious, healthy and easy-to-make in categories such as soups, salads, main dishes with grains, legumes, vegetables, fish and meats, sauces, dips, relishes, seasonings, breads, desserts and drinks. Each recipe is characterised by its main effect on the organism, by the organ that is mainly affected, by the thermal impact of the meal on the organism, and relevant contraindications. As an especially useful bonus, Leggett provides instructions on how to make one's own recipe and menu at the end of the recipe section.

Part IV – More Important Factors
The focus of this section is on the impact and effect of particular stimulants, foods and eating habits on the organism. Leggett examines food items such as coffee and tea, alcohol, sugar and diary products, as well as eating habits (e.g. vegetarian), certain stages of life (e.g. pregnancy, childhood etc.), body profile (slenderness and obesity), food abstinence, microwave cooking, genetic engineering and the energetic properties of vitamins, minerals and medicaments. This section contains a lot of useful and interesting information, such as the two countries with the highest consumption rate of milk – U.S.A. and Scandinavia – also have the highest rate of osteoporosis in the world.

Part V – Self-Help Assistance
As the title implies, this section contains information and advice for non-practitioners to use in order to foster or maintain their own health and well-being. Leggett provides excellent lists of foods that may be consumed to support the *Yin*, *Yang*, *Qi*, *blood*, dissolve *dampness* and *phlegm*, dispel *cold*, cool *heat*, and activate *Qi*- and *blood*-circulation. The section is rounded off by tables with foods and their energetic properties as well as the organs and basic substances they effect. The foods of each food group are arranged in alphabetical order and all are accompanied by their relevant indications. For example, watermelon is sweet and has a *cold* thermal effect, it affects the *bladder*, *heart* and *stomach meridian*, tones the *Yin* and drains *heat* by its diuretic effect.

Leggett's „Selbstheilung durch Ernährung, Rezepte für Harmonie von Yin und Yang" is a superb text, a real page-turner. It is written so absorbingly that the reader will not want to stop once he/she has begun. It is ideal for the complete layperson and handy for the highly trained professional TCM-practitioner – especially one who has strayed from a holistic approach due to the acquisition of advanced knowledge of Traditional Chinese Medicine. The book is not as clearly laid out as some, but the useful nutrition recommendations, the sumptuous recipes and the wonderful price-performance ratio compensate for that. Whether you are a veteran TCM practitioner or an average citizen looking to improve your understanding of Chinese dietetics and your health, Leggett's book is an ideal choice.

Maria Michalitsch

Forthcoming Conferences

Kassel, Germany October 21–23, 2005, 18th Conference Ethnomedicine, "Threatened lifes (*Lebenswelten*) – a challenge from the view of medical anthropology" www.agem-ethnomedizin.de

Bern, Switzerland, November 24 – 26, 2005, Conference of the Swiss Ethnological Society, there will be a panel from MAS (Medical Anthropology Switzerland) on November 26: "Home care and agency of the household. A micro-ecological approach to health (MEAH)"
info: http://www.agem-ethnomedizin.de/download/DOC-NL8-2-MAS_Panel_Program_final_Presse.pdf

Basel, Switzerland, January 13–15, 2006, 100th birthday of Albert Hofmann – international symposium. Info: Angela Consigli, Gaia Media Foundation, PO Box 350, CH-4003 Basel,
phone +41 (0) 61 261 40 82, angela@gaiamedia.org, http://www.gaiamedia.org, http://www.LSD.info.
More conferences on Ethnobotany and Ethnopharmacology see: ISE - Newsletter 5,2 – 2005, p. 14, http://www.ethnopharmacology.org

Beijing, China, September 23 – 26, 2006, 1st World Congress of Cultural Psychiatry of the World Association of Cultural Psychiatry
http://www.WACulturalPsychiary.org
http://www.WACP2006Congress.org

Call For Papers

Eating to live. Food under precarious living conditions in "rich" countries

Coordinated by Henri Courau; Anne Elène Delavigne and Karen Montagne

In the medias, contemporary food consumption is treated mainly through sensational subjects typical of western countries: sanitary security, certification, gastronomy, obesity, etc. Such subjects are also abundantly developed by researchers in human and social sciences, leaving aside the vital function of food. Scientific studies devoted to this latter theme are scarcely circulated. Only a few events linked to food aid associations (food banks) are from time to time promoted by the media, reminding inhabitants of rich countries that some of their fellow citizens cannot get sufficient food, in quality or quantity, according to current social norms.

Although one doesn't die of hunger today in our industrialised societies, eating to survive remains a daily fight for part of the population.

Food functions are well documented by social sciences: conviviality, table company, pleasure, identity construction, relation to body, etc. as well as different representations: good, healthy, hygiene, dietetics, etc. However what about such notions when eaters cannot follow food norms in their own society? Isn't food then more felt as marker of social status?

What types of relation do "precarious eaters" entertain with their food? (People with low or no income: from extreme poverty to "the new poor" officially recognized as such; those who because they are in a clandestine position cannot benefit from any official aid, or those refusing to be classified as poor; in rural or urban environment; etc.). Beneficiaries of institutionalised charities (associations, NGO) as well as those who use multiple channels to get food (barter, donation, mutual aid, vegetable gardens, etc.)

How do people feel about and use food which has not been earned by their own work?

And what about people who give out this food, their representations about it: How do people who volunteer or work in food aid organizations feel about the new poor and their relationship to food?

We invite you to contribute to this pluridisciplinary issue of *Anthropology of Food* with innovative papers (social and cultural anthropology, economics, human geography, history, sociology, political science, law …) concerning food under precarious living conditions in rich countries, through time and space.

Please send an abstract and a short CV to Karen Montagne: montagne.karen@wanadoo.fr. Answers will be given within 2 weeks after reception of texts. Full articles should be sent us before July 2006.
Please read the Recommendation section on website:
http://www.aofood.org/CallForPapers/FormatTextPourAOF.htm

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(photo in Ausgabe 3,3,2001)

Photograph last page

"Mganga wa kienyeji amitabia mgonjwa aliyeumwa kwa muda mlefu". (A traditional healer treats a patient who has been sick for a long time) Painting by George Lilanga (2005), Collection Ethnomedicine. Famous Tanzanian painter George Lilanga died on June 27, 2005. He became known for his "sheitani" style, depicting scenes with spirits, ancestors (Swahili *mizimu*) and other creatures of a magic world. It has been speculated that with his style Lilanga has influenced the young American artists of the Pop Art generation (e.g. Keith Haring).
In this painting he shows how a patient (the yellow creature) is treated by traditional healers. The patient kneels over a pot – one of the most important utensils and symbols in traditional medicine which is used for cooking medicine, fumigation and for oracles.

"Traditional healing" by George Lilanga 1934–2005

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