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P. Petit okt. '24

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[1] Author holds copyright to all photos. All photos were taken with permission of the interlocutors.

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Acknowledgements

One October afternoon in 2012, I sat in the cafeteria of the Faculty of Social and Behavioural Sciences at Leiden University, sharing a cup of tea with my friend Dr. Adalbertus Kamanzi, then a senior lecturer at IRDP in Dodoma, Tanzania. I told him about my idea of starting a PhD on objects used for healing purposes and my wish to conduct the research in Tanzania. He reacted with great enthusiasm. From there, my plan gradually took shape, and in 2013 I formally began my PhD trajectory by enrolling in the CERES PhD Course. It has been a long journey alongside my professional work, and I would like to express my gratitude to all those who have supported me throughout these years.

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1.

Introduction

1.1 Background

Sarah[2] is a 26-year-old Christian bachelor student with a young child. She lives in Tanzania, in one of the urban areas of Dodoma. We sit on the bed in her room, which is located in a building where other students (and their children) live. Her room is mostly taken up by a double bed with a mosquito net. On one side of the room there are clothes piled up. On the other side of the room there is food, like tomatoes and onions, to be cooked on a small cooker. We sit on the bed and talk about how Sarah keeps her child healthy and whether she has heard about *ilizi*,[3] the more frequently used word for *hirizi*. The word is translated in the Swahili dictionary as charms or amulets (TUKI 2001: 104), which are said to be used for protection and healing. She tells me that if her child is ill she gives him paracetamol, but if the illness persists beyond two days then she would go to the hospital. She protects her child from the cold by dressing him in a sweater, socks, and trousers. In addition, she lets the baby sleep under a good baby blanket, and she uses a heater. She has a small mosquito net for the child when he sleeps in the afternoon (photo 1.1), and at night they both sleep under the big mosquito net. Sarah has heard about *ilizi*, but because she believes in God, she does not use such objects for her child. God is everything to Sarah. In her experience, people do not talk about *ilizi* because such objects are frowned upon; they are associated with 'witch doctors'. When a child is sick you pray to God, like her mother has taught her. Sarah does use *miti shamba*,[4] which are herbs from a tree or plant. Her parents send them to her or she brings them back to Dodoma after having visited them in her native village. Sarah uses two kinds of *miti shamba* to warm the body, which come from the avocado

***Photo 1.1** Small mosquito net for baby*

[2] In order to protect the identity of my interlocutors, pseudonyms are used throughout this thesis.

[3] *Ilizi* is not mentioned in the TUKI (Taasisi ya Uchunguzi wa Kiswahili) dictionary, but *hirizi* is and is translated as charm, amulet, talisman (2001: 104). However, since most people interviewed used the word *ilizi*, I use that word instead of *hirizi*. All Swahili words in the text are italicised; see also the list of Swahili words in Annex A: Glossary.

[4] The literal translation is 'trees of the fields.' This research is in no way concerned with analysing or establishing the biological or chemical components of the substances that are mentioned, but exclusively with the narrative practices of how people talked about these. To give an indication of what the people were talking about, I tried to find translations of the words mentioned in the narratives of the interlocutors.

plant. Both kinds of herbs are mixed with cold water and, when necessary, one cup of each kind of herb is consumed over the course of a day (interview 7, 5 May 2017).

What all human beings have in common is that they desire to stay healthy. And if they have children, they especially want their children to stay healthy. As the introductory case shows, Sarah uses different ways to keep her young child healthy: medicines when the child is ill and protection and prevention of illness by clothing, sleeping under a mosquito net, herbs and prayers. Improving the health of young children is part of the Sustainable Development Goals. In Dodoma there are several programmes relating to the health of young children, like the vaccination programme. According to Turner (1996: 9), disease is the outcome of a disturbance in the interaction between body and mind. This disturbance can be caused by misfortune. By misfortune, I mean the four categories distinguished by Whyte (1997: 16-18): i) failure of health, for example a woman with pain in the stomach or a child who is sick; ii) failures of prosperity, like poor crop yields, the death of livestock, employment and financial problems; iii) failures of gender, including problems of sexuality, reproduction, and marriage; and iv) failure of personal safety, for example a person hit by a motor vehicle or struck by lightning. When a disturbance in the interaction between body and mind happens, and people from the middle classes – in comparison to lower-class people – become ill, at least in Dodoma, Tanzania, they have better access to healthcare options and resources because of health insurance and/or the ability to pay the bills. According to Feierman (1985: 74), death "comes sooner to poor people than to the rich," but also "sooner to people in the country than in the city." Walking through Dodoma and talking to its residents reveals that living in this urban environment provides access to private and government hospitals and mobile clinics, but also pharmacies, shops with herbal medicines, and several kinds of indigenous healers. Young adults belonging to the middle classes form the focus of this research. Although they have access to biomedical care, the research explores how these young adults negotiate the relationship between indigenous healing and modern medicine in the context of their own health and that of their young children (under five years old). The aim of my research is to find out if and how these young adults in the specific context of Dodoma, Tanzania, receive and use information about certain healing objects, like *ilizi*, in their daily lives. I want to understand what these young adults' perceptions are of the modernizing world of Dodoma, where all the various global influences converge: new forms of knowledge; forms of biomedicine; options for jobs; and their religious groupings.

The vignette involving Sarah, a young adult who is pursuing higher education, provides a case that reveals how a higher educated young adult responds when her child is ill. She makes use of biomedical care, protects her young child in various ways, and rejects

the use *ilizi* based on its negative connotations. Sarah is one of many students who moved to Dodoma for their studies. The Tanzanian capital, Dodoma, is growing due to students coming to study, but also because people working at government ministries are moving from the coastal city of Dar es Salaam to Dodoma, as well as people are looking for employment opportunities in the expanding city.

During this research project, it became clear that there are several options for when a child is ill: to get medication, mostly paracetamol, from a pharmacy; go to a hospital; or go to the indigenous healer to get a material object like *ilizi*. But what choices do higher educated young adults in this growing urban environment make in relation to health issues for themselves and their young children? To explore this matter, I will first address the issues that relate to this topic, namely, the middle classes to which the young adults interviewed belong, health – as a topic central to this research – and the use of material objects for health-related issues.

The research offers a different angle than the existing literature concerning the health-seeking behaviour of the middle classes, namely, the use of material objects. It explores a specific aspect, i.e., the middle-class view of material objects, like *ilizi*, which are used for healing and protective purposes. This exploration is based on the narratives reported by young adults, religious leaders, and indigenous healers, and examines the choices they make with respect to their health. The narratives aim to show how young adults are making sense of this highly complex domain and can be seen as observable actions (following Mattingly and Garro 1994: 771) with respect to why an object is used or not used for health or protective purposes.

1.2 The topic: The relational triangle between the middle classes, health, and the use of objects

This study looks into the issue of how young adults living in Dodoma who belong to the middle classes, and who have been through higher education, make use of the health, religious, and educational facilities present in the urban environment of the city, while at the same time being knowledgeable about the use of and having access to material objects for healing and protection. The young adult, Sarah, from the introductory vignette, says she does not use objects for healing purposes because of her religious convictions. This thesis explores whether her response is part of a wider, common narrative and, if so, what kind of (common) narrative the young adults share concerning knowledge of material objects for health-related purposes. Even when the young adults say they do not use objects for healing, it is apparent that they have knowledge about these objects through movies, narratives heard from

relatives or friends, or they have seen the objects themselves. Therefore, it becomes a question if and how the yound adults position themselves vis-à-vis these objects as fitting or unbefitting their lifestyles, context, or morality. It is important to look at the young adults in the urban environment in relation to health-related issues, since this urban environment presents them with a number of conflicting health options that they are required to make sense of and to make informed choices about. Despite living in an environment where access to education and religions like Islam and Christianity continue to play a big part in their lives, and where they have easy access to biomedical care, there are older and long-standing ideas about health present on which they are forced to take a position. By gaining insight into the choices young adults make concerning using or not using specific material objects, and how they formulate their views, we gain better insight into the daily lives of young adults and how their living in an urban environment with access to certain facilities influences their decision-making. Generally, young adults, and in particular those from the middle classes, do have access to multiple health options, and for this reason they are the focal group of the research. How do these young adults act when they encounter a range of facilities and ideas concerning health in the city? I took healing objects as a focal point around which these views on multiple options, are explored. As indicated, an object can be obtained from an indigenous healer, and the knowledge about these kinds of healing objects seems hidden. While this complicates the exploration of the narratives around young adults' options for healing, in order to be able to look at the topic of health-related issues from different sides, the narratives of religious leaders and indigenous healers are also presented. As will become clear in the thesis, young adults see indigenous healing and the use of material objects as belonging to the past and as something malign that is associated with witchcraft and Satan. Moreover, they see such material objects as a hindrance to full immersion into the urban, globalised world, where access to education, biomedical care, and the primary religions[5] of Christianity and Islam exist.

1.3 The middle classes and social narratives: Contradictions within modernity and healing

Before examining such indicators as access to facilities and progress in an urban environment, I first present the literature concerning the concepts around the formation of the middle classes (since young adults belonging to the middle classes

[5] I use the term primary religions to indicate that the named religions were mentioned by my interlocutors when I asked them about their religion. By using this term, I acknowledge that the interlocutors may also affiliate themselves with other religions like AIR (African Indigenous Religion).

form the focal group of this research), social narratives (forming the data for this research), and literature concerning ideas about modernity and healing, to make sense of young urbanites' relationship with objects for health and protective purposes. In addition, and based on these concepts, a framework is built in which the narratives of the three focal groups will be positioned.

1.3.1 Urban middle classes in Dodoma

To understand the rise of the middle classes in Dodoma, I will first introduce the artificial establishment of Dodoma. In 1961, Tanganyika became an independent country with Julius Nyerere as the first prime minister.[6] In the 1950s and 1960s, Nyerere implemented the idea of 'African socialism' (*ujamaa*), steering away from private sector development (Lem *et al*. 2013: 12). Nyerere wanted to build an African socialism in Tanzania by liberating and empowering the rural peasantry and their production. The main focus of *ujamaa*, as formulated in the *Arusha Declaration and TANU'S Policy on Socialism and Self-Reliance*, was: the need to "build a society where no person exploits another, everybody works and reaps a fair return for their labor"; "to de-emphasize the importance of money and industries as starting points of development"; and "to de-emphasize urban development and focus on rural development" (Otunnu 2015: 19, 24). The project did not succeed due to, among other reasons, the weak international economic conditions, including the crisis in global capitalism in the 1970s and 1980s (ibid.: 26). One of the aspects that has remained from Nyerere's legacy is his choice to designate Dodoma as the capital of Tanzania since 1973.

The city of Dodoma used to be a small market town, Idodomya, but in 1910 it became connected to Dar es Salaam via a German-built railway (Siebolds and Steinberg 1981: 682). The name Dodoma comes from the native Gogo language and means 'it has sunk'. The story behind this name is that, "supposedly, one day during the rainy season, an elephant drowned in the area; the villagers in that place were so struck by what had occurred, that ever since the locale has been referred to as the place where 'it (the elephant) sunk'."[7] The name Tanzania, a combination of Tanganyika and Zanzibar, came into use when the country became the United Republic of Tanzania in 1964 with Julius Nyerere as its first president (ibid.: 682). Dodoma became the capital

[6] Britannica, Britannica Editors. "Julius Nyerere: president of Tanzania". *Britannica,* 3 June 2023, https://www.britannica.com/biography/Julius-Nyerere (accessed 28 August 2023).
[7] "Explore all countries – Tanzania; Government, Capital", last updated 9 April 2025, CIA The World Factbook (accessed 13 July 2023). When I checked again in April 2025, the etymology has changed to Dodoma originating from the name of a nearby mountain. https://www.cia.gov/the-world-factbook/countries/tanzania/

in 1973 when an official start was made to move administrative and political functions from Dar es Salaam to Dodoma. This was done in order to help the economically underdeveloped central region and to relieve the burden on the former capital by moving administrative, commercial, and political activities away from it. Dodoma lies in the middle of Tanzania, far away from the bigger cities; it gained more attention as an important road junction – the place where the two national highways intersected – after the introduction of the motor car after the First World War. The site of the town had negative features like overgrazing and a lack of agricultural development, which contributed to the aridity of Dodoma region, where few people were living (ibid.). In 1974, a Master Plan for the development of Dodoma town was made – and accepted in 1976 – with the following goals: Dodoma had to become the symbol of Tanzania's social and cultural values and aspirations; a diversified industrial-commercial development programme was to supplement the aforementioned functions; the quality of life should be enhanced by the provision of housing and extensive municipal services; and, lastly, the "mistakes of colonial planning and features of modern big cities" were to be avoided (ibid.: 683-4). The authors (Siebolds and Steinberg 1981: 688-9) suggest that if the Master Plan was based on the conditions of Dodoma at the time of the publication (1981), and the town had been developed by building on those foundations, by controlling support for small industries and agriculture, the capital "would have been integrated in the overall social development strategy of rural development, and support for small scale industry" (ibid.: 688) instead of becoming a burden on the national budget.

According to Lem *et al.* (2013), the rates of economic growth in sub-Saharan African countries are a notable development and, because of the high and stable growth rates, investments and trade have boomed, and "many social indicators have improved" (ibid.: 8). Tanzania was one of the seven countries in the top ten with a projected fast-growing economy between 2011-2015, according to *The Economist* (ibid.) and Dar es Salaam was one of Africa's ten largest cities in 2010 (ibid.: 21). As of 1 July 2020, the World Bank has designated Tanzania a Lower Middle Income Country (moving upwards from a Low Income Country); poverty and mortality rates are declining, and GDP between 2013 and 2019 fluctuated between 5,445 and 6,867.[8]

[8] "*GDP growth (annual %)* – Tanzania" www.worldbank.org https://data.worldbank.org/indicator/NY.GDP.MKTP.KD.ZG?locations=TZ (accessed 10 July 2020). The World Bank bases the categorisation on the Gross National Income (GNI) per capita. *"What it means as Tanzania rises to middle income level"*, www.thecitizen.co.tz, 3 July 2020 – updated on 1 November 2020 https://www.thecitizen.co.tz/news/-What-it-means-as-Tanzania-rises-to-middle-income-level/1840340-5587126-wklp9rz/index.html; https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2020-2021 (accessed 8 July 2020).

Upcoming middle-income classes are clearly present in a globalised world (cf. Kroeker *et al.* 2018). African economic growth is caused by domestic consumption and urbanisation and, indeed, the rise of the middle class goes hand in hand with urbanisation (Lem *et al*. 2013: 19, 20). The African Development Bank writes that the "middle class may hold the key to a rebalancing of African economies" (African Development Bank 2011: 1). Not only economic development is important, but also human development, as indicated by the Human Development Index (HDI). In 2021, Tanzania ranked 160 out of 191 on the HDI and is categorised as having Low Human Development.[9] The HDI shows that the country has a life expectancy rate of 65 years. The expected number of years of schooling in Tanzania is eight, while the mean number is six years of schooling. With the rise of the middle classes and urbanisation, the level of children getting an education[10] is also expected to increase as the options for health services result in lower (child) mortality rates.[11]

There is no consensus about the definition of the middle classes, which is often linked to the level of income. In 2011, the African Development Bank published a market brief with a definition of the middle class: individuals or households that fall between the 20th and 80th percentile of consumption distribution (Afriacn Development Bank 2011: 2). This means that they fall between the working class and upper class, and this position is mainly based on the level of income, namely, a per capita consumption of $2–$20 per day (ibid.). Shule mentions that the definition by the African Development Bank concerning the $2–$20 consumption figure does not resonate with reality in Tanzania (Shule 2016: 191). Within her research, the people who identified themselves as middle class used both income and education to position themselves (Shule 2016: 195). Lentz (2016: 29) uses the level of education, as it can lead to upward mobility, which, as Coe and Pauli indicate, allows the concept of middle class to be used as a lens through which to study aspirations and cultural practices (2020: 7). Because of the migration of the middle class, mainly due to study in Dodoma or get a job, their position can shift, either positively or negatively. As Van Dijk puts it, the "middle classes often pursue upward social mobility via migration to other places and back again" (2020a: 181). I will use the term middle classes as a practice of distinction (following Spronk 2009, 2014, 2016; Lappeman *et al.* 2021; Lentz 2016; and Coe and Pauli 2020). Chapter 2 explores further the mobility aspect of the young adults interviewed in relation to, among other things, migration to Dodoma for study or job purposes.

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[9] *"Human Development Index (HDI)"* www.hdr.undp.org, https://hdr.undp.org/data-center/specific-country-data#/countries/TZA (accessed 30 October 2023). In 2018, Tanzania ranked 159 out of 189 on the Human Development Index.

[10] NBS 2019 Tanzania in figures: https://www.nbs.go.tz/nbs/takwimu/references/Tanzania_in_Figures_2019.pdf

11 For declining child mortality rates, see e.g., https://data.unicef.org/country/tza/ (accessed 8 July 2020).

Spronk (2014) is another researcher who argues that it is not only the level of consumption that indicates whether someone belongs to a middle class. She argues that two other factors can be considered to define belonging to the middle class: 1) access to education and salaried occupations; and 2) modern self-perceptions and lifestyle choices (ibid.: 99). In another article, she mentions that we cannot only rely on economic definitions and study the middle classes solely based on indicators like education, income level, and consumption patterns. According to her, "the middle class is not a coherent category, depending on the discipline or profession it is employed differently" (Spronk 2016: 12). She therefore studies middle classes as a "classification-in-the-making" (ibid.).

Lappeman *et al.* (2021) conducted research on consumer lifestyle indicators in ten cities and, based on their study, presented characteristics that indicate a middle-class lifestyle. Their research excluded housing and education as indicators, since there was a lack of data to provide "conclusive trends in the housing status" (ibid.: 76), and to support the assumption that the whole middle class was educated at a higher level. The other characteristics, namely, financial management, employment, mobile/internet penetration, and healthcare, were revised. In the case of healthcare, the new characteristics were: view medical insurance as a necessity; do not visit 'traditional' healers; and have regular medical visits (ibid.: 78).

As will become clearer later in this chapter, I agree with the above-mentioned authors (Spronk 2009, 2014, 2016; Lappeman *et al.* 2021; Shule 2016; Lentz 2016; and Coe and Pauli 2020) that only looking at the level of consumption does not resonate with reality, and, also following Southall (2016) and Spronk (2014), I have applied other parameters, such as education and occupation, to indicate whether a young adult belongs to the middle class or not. Because of the use of these other parameters, I have omitted the income indicator from my definition of the middle classes.

Another discussion where there is no consensus is the use of either the singular term middle class or a plurality of 'middle classes' (cf. Lentz 2016, Kroeker *et al.* 2018, Van Dijk 2020a). According to Lentz, "middle classes in the Global South are seen as being on the rise, and, heralded as bearers of new values and lifestyles" (2016: 25). She "would argue in favour of a fairly wide understanding of middle class(es) as social formations that can embrace a broad variety of socio-economic situations and lifestyles" (ibid.: 41).

Kroeker, O'Kane, and Scharrer (2018: 1) state that the middle class in Africa is an "overloaded" class, due to unexamined assumptions and inflated expectations. They question the assumptions in three dimensions, namely, economic, political, and lifestyle, where the latter focuses on demographic change, education, and urbanisation.

Positioned within the lifestyle dimension, I will use access to education as the focus of my thesis, but I add religious affiliation and biomedical care as indicators, since all three aspects are important indicators within Dodoma's urban environment and will help determine which young adults are part of the middle classes of Dodoma. Kroeker *et al.* rather write about a plurality of 'middle classes' instead of one single 'African middle class' (ibid.: 1). They point to something new happening concerning Africa's 'middle classes' in different dimensions, e.g., in the processes of urbanisation, migration, increasing school enrolment, and the social groups that are emerging and may qualify as middle classes (ibid.: 2). Kroeker *et al.* also question whether it is correct to connect the economic growth to class formation, because they argue that doing so ignores important aspects of middle-class life in Africa (ibid.: 4, 6). Kroeker *et al.* define the middle 'classes' "as sets of individuals who are neither rich nor poor, but without any imposition of statistical or other limits on the membership in those classes" (ibid.: 9). The development of Africa's middle classes is influenced by, among other things, urban–rural relations tied together via ethnicity, kinship, economic informality, and insecurity (ibid.: 23). In this regard, my thesis relates to the key question of how the middle classes live, think, love, and consume (Kroeker *et al.* 2018).

Following Rijk van Dijk (2020a) and Kroeker *et al.* (2018), I will discuss middle classes as a pluralistic phenomenon instead of "a singular and monolithic biography" (Van Dijk 2020a: 182), since, during my research, I encountered young adults belonging to different occupational categories (e.g., teacher, shopkeeper, nurse), but who shared the same access to and use of urban facilities such as religion and education, and who have access to different kinds of health providers. It became clear from the interviews I conducted, by visiting the places where interlocutors lived, and through the informal conversations I had with my friends, and from visiting their homes, that different kinds of lifestyles exist amongst Dodoma's urban middle classes. There is a pluralistic phenomenon of middle classes present in Dodoma urban who, as I argue – and as will become clear later in this thesis – share a common social narrative.

1.3.2 Social narratives on the use of material objects for healing

The starting point of the thesis are the narratives reported by three groups of interlocutors, namely, young adults, indigenous healers, and religious leaders. The narratives concern the health of the young adults and their young children (under five years old) with a focus on material objects used for protection and healing. These narratives focused on health-related issues, since my assumption was that objects would be used in these matters. The start of the research therefore aimed at gathering narratives to find out whether material objects were used for protection and healing

and what was known about said objects. Given the focus on health-related issues, I also explored the narratives of indigenous healers as providers of treatment for these kinds of issues, as well as the narratives of religious leaders who influence the choices of young adults within their daily lives. Through the narratives reported, I aim to acquire insight into the daily lives of the young adults and their children, as well as into the roles that indigenous healers and religious leaders play. In addition, I aim to understand what role material objects play in health-related issues within the daily lives of the young adults in order to gain insight into their perceptions and into how young adults are making sense of a complicated world where various global influences converge. This part of section 1.3 examines the concept of social narrative, with an overarching theme of sharing common knowledge. The second part looks into the use of material objects for healing.

A number of different themes can be found within the literature on narratives. My research focuses on narratives in relation to illness (cf Mattingly and Garro 1994; Mattingly 2000; Hill 2005; Bolaki 2016). Hill (2005) indicates that the study of narrative is an important method in cultural anthropology and that narratives "make public the covert underlying presuppositions that organize the worlds in which the speakers live" (2005: 157). I follow Mattingly and Garro (1994: 771), who state that narratives are used "when we want to understand concrete events that require relating an inner world of desire and motive to an outer world of observable actions and states of affairs." Within my research, the concrete event is the making and/or using of an object, and the observable actions within Mattingly and Garro's definition can be seen in my research as the narratives on why a certain object is used – or not used – for different purposes, in this case health or protection. The narratives are not actions that can literally be observed, but rather are discursive actions that reveal something about the perceived social reality of the young adults.

The perceived social reality that I explore is a middle-class social reality and the narratives on the objects indicate a kind of social border, a perimeter around the lives of these young adults. Furthermore, their narratives meet the narratives of others, especially religious leaders and indigenous healers, about the same matters. This can result in narratives that contest or limit each other, or that determine how these narratives are interpreted.

Hydén (1997) provides a review of ten years of research on narratives and writes about three kinds of illness narratives, namely, illness as narrative, narrative about illness, and narrative as illness. To this, I add a fourth one, namely, narrative about how to protect against illness. Social scientists started using narratives as a way to create and give meaning to what Hydén calls social reality (ibid.: 50). According to him, the

importance of a narrative "lies in its being one of the main forms through which we perceive, experience, and judge our actions and the course and value of our lives" (ibid.: 49). He adds that researchers became interested not only in *what* is said, but also in *how* people talk about and present certain events (ibid.: 50). The prevailing definition is that narrative as an entity is "distinguishable from the surrounding discourse and has a beginning, a middle and an end" (ibid.) and that there is "an emphasis on the temporal ordering of events that are associated with change of some kind" (ibid.). Hydén mentions several categories of people who can construct and present narratives, namely, the person who is ill, the family of that person, or the medical professional (ibid.: 53). In addition to these categories, I add the category of religious leaders, since they also present narratives and have an opinion on objects used for healing and/or protection. Moreover, religion is used as a means of healing in the sense that people pray in order to heal their child, as will become clear in Chapter 2. During my research, I did not meet people or children who were actually ill, but I asked people what they (would) do when their young child or they themselves are ill. Hydén articulates "five uses that can be made of the illness narrative" (ibid.: 55), three of which are applicable to my research. As will become clear, two of these are "to transform illness events and construct a world of illness" and "a form of strategic interaction in order to assert or project one's identity" (ibid.). However, the form that is most applicable in my research is the one where illness is transformed from an individual occurrence into a collective phenomenon (ibid.). Hydén states that the narrative "is also a medium for conveying shared cultural experiences" (ibid.: 64). This thesis explores the individual occurrences as mentioned in the narratives and also the collective phenomena and shared cultural experiences into which they are transformed.

By researching the narratives reported by young adults, religious leaders, and indigenous healers, I explore the contours of a common narrative or a narrative in which contesting issues are shared, and their social imaginary. I do so by focusing on the knowledge and use of material objects for health-related issues and by exploring what young adults say they do and need to do (according to religious leaders) in their daily lives.

Studying narrativity in a local context

Interestingly, a focus on Tanzania can be found within the literature on narratives. Kamat (2008a) describes everyday life in the context of poverty in Mbande, a Muslim village on the coastal outskirts of Dar es Salaam. He analyses narratives to find out how concerns about health and social support networks are affected by neoliberal market reforms. According to him, the narratives told give crucial insights into "the cultural understandings of the ways in which neo-liberal policies have affected people's everyday lives" (Kamat 2008a: 360, 361). The narratives of the people he interviewed

are characterised by nostalgia, memories, and melancholic views on the economic and societal changes that have taken place (ibid.: 360). Hill (2005: 159) points out that discourse "is the most important place where culture is both enacted and produced in the moment of interaction." The important aspects of everyday life and health, and the relationship between them, which are central in Kamat's work are also the focus of my research. Whereas Kamat mostly focuses on people confronted with poverty and uncertainty, I look at people belonging to the urban middle classes. Bryceson (2011) has also conducted research on narratives in an urban environment of a modest size (similar to that of Dodoma[12]) in Tanzania. She focuses on individual livelihood activities and macro-economic urban performance, based on surveys and interviews with village elders. Just like Bryceson states in her article, my research also adds to the literature on the dynamics of smaller urban settlements, which, according to her, are foundational to the future of urban Africa (2011: 274). The articles by Kamat (2008a) and Bryceson (2011) show that research has been done on narratives in Tanzanian environments, but my research goes a step further and examines how narratives can be used to gain insight into the health-related issues in everyday life in an urban context.

Another case where the narrative approach was used in Tanzania and with a focus on health-related issues is the research by Pembe *et al.* (2017) on maternal referral in rural Tanzania, where the "narrative analysis was used to describe and create meanings out of the decision-making process" (ibid.: 1). This study focused on exploring the "complex influences in the social environment that may prevent women in rural Tanzania adhering to the referral advice given by health workers" (ibid.). Both Pembe *et al.* and I focus on health-related issues, but Pembe *et al.* (ibid.: 2) use the narrative approach to gain insight into people's thoughts on daily issues while focusing on the maternal referral advice. By contrast, I focus on the daily issues of what young adults do in health-related situations with respect to themselves and their young child(ren) under five years old. And while Pembe *et al.* based their research on in-depth interviews with 19 people, I engage with a much broader range of people in order to gain a better understanding of the focal group of young adults belonging to Dodoma's urban middle classes.

In my research, illness narratives relate to the things young adults do when they themselves or their young children are ill, and to the narratives they know about the object of *ilizi* (and possibly other material objects) used for healing purposes or

[12] While the two administrative areas Katoro and Buseresere had a population of 30,472 inhabitants in 2002 (Bryceson 2011: 279), Dodoma already had a population of 70,000 inhabitants in 1980 (Siebolds and Steinberg 1981: 682).

protection. By focusing on these narratives, I aim to acquire more insight into the social reality of the daily lives of young, urban adults.

Knowledge, the knowing subject

The previous part set out the context of narratives concerning illnesses and narratives in Tanzania. But why is it interesting to look at narratives in relation to illness? The focus of my research concerns narratives about the existence of objects and narratives about the use of objects, both in relation to health-related issues. During the fieldwork, it became clear that the interlocutors have narratives on the use of objects, but this did not necessarily indicate that they use the objects themselves. The concepts of secrecy and ignorance come into play regarding the difference between knowing about an object and actually using it. Kirsch and Dilley write about ignorance, including various forms of not-knowing (both intentional and unintentional), unknowing and secrecy (Kirsch and Dilley 2015: 1). They define the notion of 'secret' as an "unequal distribution of knowledge in a social field" (ibid.: 3), where some people share the same kind of knowledge while others do not know about it (ibid.). This thesis explores what aspects of knowledge the secrecy around an object relates to: is it knowledge about the existence of the object and the specifics on how it looks, or is it perhaps knowledge about the use of the object? People may be secretive about whether they use objects like *ilizi* and whether they wear such an object and, if so, on which part of the body. The interlocutors did not seem to be secretive when talking about their existing knowledge about what they have heard or seen; indeed, they were willing to share narratives. The subject of health and healing will be looked at through the narratives on the material object of *ilizi*. Following Kirsch and Dilley on ignorance (ibid.: 5), I can also apply the concept of ignorance to myself. Indeed, I tried to turn this into a strategy of intentionally not-knowing to gain insights and to learn about this topic and how young adults narrate about health in relation to material objects. I will elaborate more on this in the methodology part of this chapter (1.5).

Linked to the objects used for health purposes are the indigenous healers, who are the ones making these objects. As Feierman states in his article entitled "The Social Roots of Health and Healing in Modern Africa" (1985), healers use secretiveness as a survival strategy. Chapter 3 focuses on the landscape of the various healers who are working in different places in the city of Dodoma. As can also be seen in Dodoma, Feierman mentions that there is a coexistence between many kinds of practitioners and offers the examples of Christian prophets, Muslim teachers, herbalists, dispensary aides, and many more (Feierman 1985: 74).

Last (2007) writes about the importance of knowing about not knowing and raises the question of how much people know, and want to know, about their own medical culture.

He suggests that "not-knowing or not-caring-to-know can become institutionalised as part of a medical culture" under certain conditions (2007: 1). He suggests that the break-up of traditional medicine as a system is the origin of 'not-knowing.' This resulted in two developments: first, the lack of knowledge and certainty is concealed by secrecy; and second, "a scepticism in which people suspect that no one really 'knows'" (ibid.: 11) that there is no system. According to Last, not wanting to know or not knowing about one's own medical culture can be characterised by a secrecy concerning medical matters, since practitioners do not describe their methods, and by scepticism about the motives and self-image of external authority (ibid.: 9). The notion of (not-)knowing or not wanting to know may lead to different narratives reported by the young adults, indigenous healers and religious leaders, as well as different narratives about the object itself. This thesis explores the different narratives reported.

The following part of the chapter discusses the use of objects for health purposes, i.e., protection of and curing the body. Objects can appear in different shapes and forms and can consist of different materials. The central object of my research is *ilizi*. During interviews, young adults most frequently mentioned *ilizi* when asked about objects associated with healing and protection. Based on these responses, I chose to make *ilizi* a focal point in my study of narratives relating to such objects, not only with young adults, but also when interviewing indigenous healers and religious leaders. Furthermore, analysis of these narratives revealed that *ilizi* plays a key role in understanding wider notions of enchantment and disenchantment. During the research, it became clear that a material object like *ilizi* is seen as a medicine, since it is used to cure a child from, for example, a disease like *degedege*[13] or the measles. Van der Geest and Whyte (1989: 345) write about the definition of medicines, which are "substances used in treating illness" or "substances with powers to transform bodies" (Whyte *et al.* 2002: 5) and that "medicines are *things*" (emphasis in original text) (Van der Geest and Whyte 1989: 345). Following Appadurai (1986: 5), I look at an object (in my case *ilizi*) and analyse its meaning by looking at its trajectory, its use, and its forms in order to be able to interpret what Appadurai calls the human transaction that relates to this material object. By doing this, it is possible to say something about the human and social context of the material object. Thus, *ilizi* is not seen as a normal thing like a "product," "object," or "good" – following Appadurai (1986: 6) – but rather as a commodity, even though I do use the word material object[14] to indicate *ilizi*. Appadurai defines commodities "as objects of economic value" (ibid.: 3), and states that

[13] *Degedege* is a locally defined illness of children characterised by fever and convulsions (Makemba *et al*. 1996: 305). Within this thesis, the term epilepsy or the description of trembling children are also used and indicate the same illness.

[14] In the next part of the chapter, I will explain the decision of using this term.

these commodities have social lives. This means that the commodities are "things-in-motion" (ibid.: 5), which can illuminate their social and human context; the meaning of the objects are inscribed in their uses, their trajectories, and their forms (ibid.). Most of the objects I encountered during my research are also economically valuable objects, namely, an object you have to purchase from a healer. I argue that because these objects have economic value, they therefore have social lives. The narratives about these objects, collected from the interlocutors, present data about the social lives of these objects: which objects are accepted, in which primary religion, in what places (urban-rural) and are there objects amongst them that are used secretively?

Religion and objects

The thesis looks into what role religion plays in the lives of the young adults of Dodoma, and explores whether, and in what way, it can be related to the use of material objects. According to Meyer and Houtman, there has not been much research on "more 'positive' categories for religious 'things'," (Meyer and Houtman 2012: 16) and therefore scholars are not good at understanding how things matter "in ways that recognize the valuation, animation, and the role of 'things' within a given religious setting" (ibid.). They use the word 'things,' which, according to them, cannot be "clearly circumscribed and that creates some degree of nervousness or anxiety (ibid.)." They offer an example from Shakespeare's *Hamlet* of the supernatural appearing in a materially concrete form (ibid.). Meyer and Houtman describe the difference between objects and things. Objects are used in the "framework of a subject-object relation, in which the former supposedly wields control over the latter," while thing "suggests an extra dimension that expands the realm of rationality and utility" (ibid.). They use things in a broad sense, including bodies, bodily fluids, images, and artifacts, but also technologies and spaces (ibid.: 17). Garcia Probert and Sijpesteijn (2022: 2) write about examining texts and amulets as objects where materiality, transformation, reinterpretation, and traces of use are taken into account in order to be able to trace how people used these objects and what kind of powers were attributed to them. Whereas the authors of this edited volume conducted research on amulets that were not in use at time of the publication, I have done research on objects that were in use at the time of the research. I opt for the use of the word 'material object' to indicate objects like *ilizi*, because I have also collected narratives on the materials the objects are made from; indeed, this forms an important part of my research. The objects within my research contain an extra dimension (the place where the object can be worn) and can be made of physical materials. I look at material objects in a broad sense, and therefore also include herbal medicine (*miti shamba*).[15]

[15] An overview of the material objects can be found in Annex B.

An important aspect of objects used for healing is the efficacy of the healers who make these objects. According to Young (1977: 183) efficacy is applied to practices that intend to treat or prevent illness and has three meanings of which the second is important in relation to the efficacy of healers: efficacy "can refer to practices which appear to have produced the desired effects" (ibid.). Young adds that proof is empirical in relation to this meaning, with which he means that "beliefs and assumptions are confirmed through everyday experience" (ibid.). The desired effects depend on the healer. As Young writes, the *debtera*-diviners (healers who can among other things prevent and cure sickness) add information to the texts until they are satisfied with its efficacy (ibid.: 186). In addition to the efficacy of the healers, there is also the efficacy of treatment (Feierman 1985: 79). This can be divided into two kinds of efficacy, of which the first is the efficacy of a therapy, which "might be judged on its effect on social relations" (ibid.). Feierman gives an example where the efficacy is judged by its effect on social relations: an American who goes to another kind of therapist for another kind of illness than the real illness, because that person does not want to be called mentally ill. The second kind is efficacy based on technical features of the therapy, whether there are short term effects, and whether dangerous side effects are controlled. The problem, according to Feierman, is not that there is no therapeutic efficacy in African medicine, but that diverse healing traditions "co-exist with little capacity to exclude one another from the range of practical options" (ibid.: 80). The choice of healthcare within Dodoma can mainly be seen as cultural and is part of the shared social imaginary of what the young adults say they do. This concept will be further explained in Chapter 4. Both efficacy of biomedical care and indigenous healing will be addressed.

Besides the impact of the person who makes the material object, the object itself is also important and, moreover, religion can play a large role in this regard. My contribution to the study of the relationship between material culture and religion lies not so much in exploring the use (i.e., functionality) and meaning of materiality within religion, but rather in examining how religion influences the use and meaning of material objects for health purposes, as well as the perspectives of religious leaders on these practices. Meyer and Houtman (2012) write that, after the year 2000, material culture and materiality became important terms in the study of religion. This resulted in "generating new empirical questions about how religions shape the world in a concrete manner" (ibid.: 6). The editors of the journal *Material Religion* state that "a materialized study of religion begins with the assumption that things, their use, their valuation, and their appeal are not something added to a religion, but rather inextricable from it" (ibid.: 7), thus materialising the study of religion. This is also applicable to the social narrative on the object of *ilizi* – as this thesis will demonstrate – where not only functionality but also, for example, the meaning, significance, and expression of the material object cannot be seen separately from religion.

The research focuses on narratives concerning the daily lives of young adults belonging to the middle classes in a modernising world, an upcoming city in Tanzania, in relation to health-related issues. To put this in the right perspective, the next part of the chapter looks at the concepts of modernity and healing and the relation between them.

1.3.3 Contradictions: Modernity and healing

Within the current urban environment of Dodoma, a parent – in my research, a young adult belonging to middle classes – can choose between several existing, parallel medical options when seeking treatment for their sick child. The modern conditions of health and healing force them to make choices and to take a moral stand, influenced by the primary religions of Christianity or Islam, their level of education, and the urban environment. The young adults narrate the choices they have and the choices they make. The following part of the chapter examines the existing literature on modernity in relation to religion and health.

My research relates to studies on Pentecostalism (cf. Meyer 1998; Van Dijk 2002) in which modernity and religion are related to rejecting the (ancestral) past. Globalisation contributed to the spread and influence of modern forms of religion, such as Pentecostalism. The influence of religion plays an important part in the lives of the young adults of Dodoma. The young adults want to make use of the modern facilities existing in Dodoma and, in having access to those facilities and living in an urban environment, and this informs certain narratives concerning the use of a material object for health-related purposes.

As previously indicated, the use of a material object for healing purposes may be historically related. Kamat (2008a) writes about remembering and suggests that it is a reconstructive process in which "the present is explained with reference to the reconstructed past" (Garro and Mattingly 2000: 72 as cited in Kamat 2008a: 363-4). During his research, Kamat encountered interlocutors who were 'longing for the past' and this can be related to the discourse on nostalgia (Kamat 2008a: 368). The young adults participating in my research were not longing for a time gone by, as Kamat mentions; indeed, they were more likely to break with the past, in the sense that Meyer (1998) writes about.

Meyer (1996) writes about the influence of Christianity on the use of an object. The article concerns religious conversion, a topic that is clearly present in my research. Meyer (1996) focuses on the conversion of the Ewe people to Christianity and describes how missionaries believed they had to lead the Ewe away from Satan to the Christian

God (ibid.: 210). According to Meyer, some Ewe Christians were insecure, because they found that missionary Pietism was not able to counter evil. “Christians not only also fell sick; they also lacked the practical means to search recovery” (ibid.: 217). An anecdote in her article makes clear what the influence of religion can be on the use of objects for health-related purposes: a female congregation member is no longer part of the congregation, because she used *dzo* strings (and she was hiding these objects) to protect her during pregnancy (ibid.: 217-218). Chapter 4 goes more deeply into the influence of religion on the use of objects within the context of Dodoma.

Max Weber’s notion of (dis)enchantment is a key concept for my research related to modernity. By living in an urban environment like Dodoma with its facilities and access to education, multiple options for religion, and access to biomedical care, and based on the narratives told by the young adults who form part of this study, it is clear we can talk of the presence of a process of disenchantment. Disenchantment can be defined as the decline of magic in the modern (western) world (Laermans and Houtman 2017: 93). The young adults follow a pathway of being or becoming more educated, and of having more wealth, in an environment where science plays a big part in resolving problems (ibid.). Based on their narratives, the thesis analyses whether the young adults present a disenchanted view of their health choices, and in this regard what the role of religion and indigenous healers is regarding health-related issues, and also with respect to objects made for health-related issues.

Within the landscape of healing, different forms of health providers can be distinguished, but in the urban environment of Dodoma, biomedicine is the most prevalent form of health provision. Feierman (1985) writes about the difference between literature on biomedicine and popular medicine, namely, that much of the literature assumes that biomedicine is “based on objective knowledge of real phenomena” (ibid.: 105) and that it works, while popular medicine is not based on such objective knowledge and does not work. He adds that knowledge on biomedicine is treated as autonomous and efficacious in most publications on biomedicine in Africa (ibid.: 105-6). According to Feierman, both biomedicine and popular medicine are forms of ethnomedicine. This means that “they are embedded within a system of social relations, and give concrete form to assumptions about reality drawn from the wider culture, which in turn influences the wider culture” (ibid.: 110). The existence of both types of medicine in Dodoma links to the different narratives presented in this thesis and to how they are formulated, contest each other, or become paradoxical, i.e., between what young adults say they do and what I have observed. The thesis explores the influence of, among other things, the primary religions of Christianity and Islam on young adults’ choices concerning healthcare options, including visiting an indigenous healer and/or visiting biomedical practitioners.

I encountered various kinds of medicine with different names in my research. The next section discusses the terminology concerning traditional, indigenous, and modern healing.

Traditional, indigenous, and modern healing: Definition of terms

There is ample literature on indigenous healers in Africa (cf. Feierman 1985; Gessler *et al.* 1995; Erdtsieck 1997, 2003; Hooghordel 2021). As Gessler *et al.* (1995: 145) put it, the indigenous healers vary in sex, level of education, and religion, and are a heterogenous group of persons. Research on health and healthcare providers reveals a difference between traditional and indigenous. I will elaborate on these concepts in order to clarify why I opt for the use of the word of 'indigenous' instead of the more commonly used (in the literature) word 'traditional.' The World Health Organization defines traditional medicine as "the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness" (WHO 2013: 15; see also Feierman 1985: 112 for an earlier definition from WHO). Or, as Hooghordel summarises, "traditional healing is generally agreed to be a mix of medicinal and religious elements, based on knowledge, skills, and experiences" (2021: 10), and the word tradition is used "to refer to matters that are old and valuable, worth preserving" (ibid.: 19). Thornton also calls the term 'traditional healer' a misnomer if by 'tradition' an unchanging conservation of past beliefs and practices is meant, "and by 'healer' someone who practices some version of physiological therapy aimed at organic disease" (Thornton 2009: 17). Hooghordel uses 'indigenous healing' (2021: 113) instead of 'traditional healing,' because, for her, the words 'tradition' and 'traditional' proved to be ambiguous in her research. According to her, both words have a connotation with customs that are regarded as historic, old, and valuable, and that the *sangoma* (the type of indigenous healers in South Africa that she studied) profession is performed 'the way it has always been done.' She also thinks "more justice is done to the flexibility and the transformation" (ibid.: 115) she witnessed in her research than the word 'traditional' offers (ibid.). I agree with Hooghordel's proposal and will use the term indigenous healing instead of traditional healing in the rest of the thesis, because, in my opinion, healers adapt to modern influences, for example by referring patients to biomedical health options, while also continuing to employ knowledge on herbal and other kinds of treatments retrieved from the 'past.' In my view, the word traditional does not reflect the influence of modernity.

Besides the debate on the use of traditional or indigenous healing, there is a similar debate on the use of modern and traditional healing. Biomedicine can sometimes be seen as 'modern.' In the Tanzanian context, Marsland (2007) refers to as modern

medicine (*dawa ya kisasa*) or hospital medicine (*dawa ya hospitalini*), and all different kinds of indigenous healing as 'traditional' – it is also known as local medicine (*dawa ya kienyeji*), natural medicine (*dawa ya asilia*), or *miti shamba* (literally trees from the fields) (ibid.: 754). Marsland's research made it clear that these 'traditional' healers "worked to reposition themselves within this 'modern'" (ibid.: 751) by looking at the similarities between biomedical medicine and their own. She adds that while these two categories of 'traditional medicine' and 'biomedicine' produce paradoxes and contradictions, according to her, they also provide a clue to the motivations for 'intentional hybridity' (ibid.).

Marsland perceives a division between 'modernity' and 'tradition' (ibid.: 764), but she does not address the point that, under the condition of modernity, biomedical practitioners develop ideas about what modern and traditional medicine is. Frequently, this is a narrative about modern medicine being better than traditional medicine. 'Traditional medicine' can also be seen as 'modern' as much depends on who defines the terms under which the 'modern' and the 'traditional' are conceptualised. Based on my research, I argue that there is no explicit division between 'traditional' and 'modern' medicine, at least from the point of view of the indigenous healers, since they incorporate aspects from contemporary urban facilities and add those to the ways of healing that were already known or taught by ancestral spirits or older family members. Marsland quotes a healer who is trained in Islamic and 'local' Tanzanian medicine and says that the traditional treatments are inside tablets given at the hospital, that it is the same *miti shamba* inside the hospital pills. According to that healer, the difference is that the healers dig up the roots and boil them, which takes a long time (ibid.: 758). In my research, I collected narratives about the use of *miti shamba* in health-related issues and its acceptance within religions like Christianity and Islam. In her research, Marsland discovered that although Christians are discouraged from using *miti shamba*, in reality they use it in secret. They are not expected to use these kinds of medicines because the missionaries who introduced so-called missionary medicine were against traditional treatments and visiting healers (*waganga*) (ibid.: 757). How young adults and religious leaders relate to the use of *miti shamba* and to visiting indigenous healers is addressed in my research and discussed in the next chapters.

As the previous paragraphs have shown, different kinds of medicines are described in the literature: 'modern' medicine (Marsland 2007) or 'Western' or hospital medicine (cf. Last 1992, 2007) on the one hand, and 'traditional' medicine (Marsland 2007; Last 1992, 2007) on the other hand. Last's conclusion is that 'traditional' healers do not follow one single, consistent theory of logic, and that their clients and kin do not expect them to follow a consistent theory (Last 2007: 5). In addition to the two mentioned categories, Last adds a category of Islamic medicine. He writes that Islamic medicine overlaps with 'Western' medicine because of its herbal specifics, and with traditional medicine

because of its involvement with spirits or *jinn*. I will follow this perspective and address both herbal medicine and the involvement with spirits or *jinn* in Chapter 3, with a view to judging whether my research also forms one separate category or not.

The young adults living in Dodoma have access to all kinds of facilities that come with an urban environment, e.g., education, religion, and healthcare facilities – both 'modern' and 'traditional' medicine –, which forces them to make choices about the influence of these factors on their health. For example, where do they go when they have a health-related problem? What factors influence their choices, and how? This thesis explores this relationship and describes these processes, with a focus on (narratives about) objects used for health-related purposes.

1.4 Research question

The previous part of the chapter discussed the context and the concepts of the research. My research describes how the current generation of young adults (25-39 years old) has a strong preference for biomedical care but, nevertheless, has narratives about objects used for health-related purposes. They navigate between the conditions available in the urban environment (among other things, biomedical care, Islamic and Christian religion, and access to education) and their narratives on certain aspects of the different systems of healing. In the midst of urbanisation, with people moving from other (rural) areas to Dodoma, there is a variety of options for dealing with health-related issues. By combining a focus on middle classes with the material objects used for health-related issues, the thesis demonstrates a new way of looking at the middle classes in an urban environment, and provides more insight into the daily lives of young adults from the middle classes in relation to their health-related choices and how they formulate their position. To the best of my knowledge, no study has been conducted on the connection between the middle classes and health issues related to ideas about healing objects. I therefore aim to bring these two issues together by answering the question:

> *How do young, educated, urban adults belonging to the middle classes express their own and their young children's health concerns in relation to healing objects?*

To answer this question, I look at the narratives of young adults from the middle classes living in the urban environment of Dodoma,[16] Tanzania, as well as narratives

[16] Dodoma is also the name of the province, but the research focuses on the urban area of Dodoma.

from different kinds of indigenous healers and religious leaders. All of these narratives are examined in the context of religion, education, and urbanisation. The research focuses on healing in the everyday life of young adults in Dodoma and is based on fieldwork conducted between 2014-2018. As this thesis will show, there are different narratives concerning various decisions made with respect to health-related issues and from the perspectives of the three focal groups indicated earlier.

The main question can be divided into sub-questions. Each chapter will answer a different sub-question in order to be able to answer the main question.

- Chapter 2 focuses on the part of the main question concerning understanding the health concerns and decision-making of young adults belonging to the middle classes and their young children by answering the question: "How do young adults belonging to the middle classes navigate the plethora of occupational, health, religious, and educational options in the growing city of Dodoma?"
- Chapter 3 focuses on the health aspects mentioned in the main research question and relates them to different kinds of health providers – following the division of Kleinman (1980) – and to healing objects by answering the question: "Which folk healers produce particular objects that are used in health-related issues and how is this situated in the medically plural urban environment of Dodoma?"
- Chapter 4 zooms in on the object of *ilizi*, the focal point through which the narratives are looked at and result in a social imaginary, and answers the question: "How is the social imaginary on *ilizi* constructed in an urban environment in relation to misfortune, shame and secrecy, and witchcraft?"
- Chapter 5 zooms out again and connects the aspects presented in the previous chapters by answering the question "How do young adults reconcile the relationship between education and biomedical care, the primary religions, and indigenous options for health-related issues?"

1.5 Methodological approach

In order to find out how young adults create narratives about their own and their young children's lives, a qualitative approach was deemed most suitable. This section explains how the research is rooted in conducting ethnographic fieldwork in a city. A qualitative methodology has been chosen in which ethnographic research techniques have been applied.

Selection of research area and setting the scene

The research focuses on young adults with young children whereby the aim was to mainly

interview those belonging to the middle classes. Before starting the fieldwork in Tanzania, I had to decide where to conduct the project. It became clear that Dodoma was an optimal setting to gain more insight into those young adults since it offers a relatively new and modern urban context in which the upcoming middle classes have access to multiple health options in new ways. Dodoma is a smaller city, but a city in development, and a place that, to the best of my knowledge, did not appear in the literature on the use of material objects. The relocation of the Tanzanian government from Dar es Salaam to Dodoma began in 2017. This is relevant to understanding the level of education that is part of the development of the newly forming middle classes in the city. In 2017, 16 of the 19 government ministries had already settled in Dodoma, as had the Prime Minister's Office (East African 2017). With the inauguration of the new president, Samia Suluhu Hassan, the move to Dodoma was complete.[17] The 2022 Demographic and Socioeconomic Profile of Tanzania showed that the literacy rates for persons aged 15 years and older increased to 76.3% for both sexes in comparison to 67.5% according to the 2012 Census (NBS 2022a: 113). In addition, the Profile shows a net enrolment rate in primary schools of 91.3% for Dodoma urban for both sexes (ibid.: 135). The Profile does not give percentages for Dodoma for Secondary School, but the percentage for Tanzania urban is 85.6% for both sexes (ibid.: 120). This indicates that the number of children attending school is increasing and that may lead to a higher number of people with a higher education and becoming part of middle classes. According to Kessy (2022), the move to Dodoma will likely improve three aspects, namely: it will shorten travel times to Dar es Salaam and facilitate access to government services; it will spur development in the southwest of Tanzania; and it will spur economic growth in Tanzania's periphery regions in the southeast and southwest of Tanzania. More specific, by relocating the capital to Dodoma, Tanzania aspires for Dodoma to become a city like Dar es Salaam with access to amenities, including certain housing standards, medical care, schools, and recreational facilities (ibid.: 15, 17).

In 1952, the estimated number of inhabitants in Dodoma was 12,000; in 1980 this had risen to 70,000 inhabitants (Siebolds and Steinberg 1981: 682). In 2017, the population of the Dodoma region was 2,312,141, of whom 456,035 people lived in Dodoma City Council (United Republic of Tanzania 2019: xi, 18). The estimated numbers of inhabitants of Tanzania in 2012 were approximately 43.6 million people in Tanzania mainland and another 1.3 million people on Tanzania Zanzibar (NBS 2012). According to the Demographic and Socioeconomic Profile of 2022, there were approximately 59.8 million people in Tanzania mainland and another 1.8 million people on Tanzania

[17] "Tanzania has moved its capital from Dar after a 50-year wait – but is Dodoma ready?", Ambrose T. Kessy, *The Conversation*, published 4 June 2023, https://theconversation.com/tanzania-has-moved-its-capital-from-dar-after-a-50-year-wait-but-is-dodoma-ready-206508 (accessed 13 July 2023).

Zanzibar (NBS 2022a:x). Data from the World Bank[18] indicates approximately 56 million inhabitants of Tanzania in 2018 and the CIA estimated there were 65 million inhabitants in 2023.[19]

The data presented in this thesis are based on almost eight months of qualitative research in the city of Dodoma, spread over five periods: June-August 2014; May 2015; May 2016; May 2017; July-August 2018. By stretching the fieldwork over a longer period of time it gives a good impression of the changing city of Dodoma and its inhabitants. During the first fieldwork period in the summer of 2014, I became familiar with the city and decided on the focus of my research. I wanted to understand how people were protected and cured from illnesses by using material objects. During the first fieldwork period, it became clear that these kinds of objects were mainly used with respect to children under five years old. Thus, young adults and their young children became the central focus of the research in the remaining fieldwork periods. By asking about the objects used and the narratives the interlocutors know about healing objects, I also gained a better understanding of the changing lifestyle and daily lives of the young adults with a higher education who are part of Dodoma's middle classes.

Fieldwork stages and methodology

During my first period of fieldwork in 2014, I found out that people were more willing to talk about young children (under five years old) in relation to the use of objects than to talk about adults. The reason for this is that adults wear these kinds of objects in hidden places, while young children often wear them on visible places, such as the wrist. I conducted the fieldwork slightly differently in each of the periods. In 2014-2016, my research assistants and I started interviewing young adults to get to know more about the narratives they create about objects used for healing and protective purposes and what the young adults do in their daily lives to stay healthy. In view of collecting their narratives and by way of comparison, we started interviewing religious leaders in 2017/2018 based on the narratives we collected while interviewing an indigenous healer. In 2018, the focus was on finding indigenous healers since we had not interviewed many before. Also, the role of herbs for health-related issues in the daily lives of young adults was taken up in the interviews as of 2017. During the research, I expanded the topics that the narratives were addressing. Consequently, my focus was not only on the material objects, but also on health-related issues in general, to find out how the young adults protect and cure themselves and their young children when they are ill. These topics were

[18] "Data for low & middle income, Tanzania", the World Bank, https://data.worldbank.org/?locations=XO-TZ
[19] "Explore all countries – Tanzania; People and society", last updated 11 July 2023, CIA The World Factbook, https://www.cia.gov/the-world-factbook/countries/tanzania/ (accessed 13 July 2023).

interrogated by interviewing not only young adults, but also indigenous healers and religious leaders.

The approach was ethnographic and a variety of methods were used, such as semi-structured interviews, participant observation, and some informal conversations with friends and my research assistants. I also used photos and film as a tool to document and visually communicate about the objects and herbal medicines, different kinds of healers and Dodoma as the world the young adults live in. The majority of the narratives reported were gathered through semi-structured interviews. Most interviews lasted approximately one hour, while interviews conducted at the mobile clinics and hospital were briefer since those interviews were spontaneous, and the interlocutors had full agendas.

In order to gain more insight into who visited the indigenous healers, and for what kinds of problems, I conducted participant observation. This also allowed me to see whether what the young adults said they did, matched what I saw and heard being done at the offices of the indigenous healers. In 2018, I conducted the longest participant observation with an indigenous healer; I visited his office six times. I was able to sit down and watch people come and go. Where possible, I made notes about how the people visiting the healer were dressed, what kind of transport they used to get there, and I asked the healer what the reasons for the visit were.[20] In addition, I looked for signs of healers when walking through my neighbourhood and the wider town or when travelling by *dala dala* (minibus) (see Chapter 3). By visiting the offices of the healers, both in the shops in town as well as on the outskirts, I gained an impression of what kind of customers seek help from healers, but also the different types of materials they use in their practices (see Chapter 3). As indicated before, I visited some of the healers several times during the total fieldwork period or in one fieldwork period.

Where possible, I took photos of the material objects I saw and about which I collected narratives, but also of the different kinds of healers and their offices in urban Dodoma and of some herbs/trees. Interestingly, when talking to the interlocutors, two of them informed me they had a home video concerning the subject of *ilizi* and witchcraft, respectively: the first home video concerned *ilizi* that had been found on the doorstep in 2016 by the son of one of my interlocutors who had filmed the unpacking of it. The second video, from 2014, showed a news item about two 'witches' who were supposedly caught during their flight and were interviewed about their actions. Both of these videos are discussed in Chapter 4.

[20] Chapters 3 and 4 go into the specifics of these visits and the cases I collected using participant observation.

During the interviews, I collected narratives from young adults, but also from the different kinds of indigenous healers and from religious leaders about various kinds of objects used for healing and protective purposes. The objects mentioned in these narratives related to health issues and can be found in Annex B. They are recorded based on the material they were made from, which resulted in the following categories: herbs; animals; other materials; and *ilizi*. This list provides an additional overview of the health-related issues for which objects can be used, as gleaned from the narratives of young adults and indigenous healers.

Based on the narratives collected, I started to focus my research and made lists with questions, which varied slightly for each group of interlocutors, and which I also slightly changed or added questions to the list during the different fieldwork trips. Together with my research assistants,[21] we decided on what kind of people we wanted to interview: we started by interviewing young adults (2014-2016) and religious leaders (2017-2018) or indigenous healers, which were the three main groups of people whom I interviewed about the research topic. By interpreting the answers of the interlocutors, we expanded our focus from young adults to religious leaders and indigenous healers. In order to build trust, I presented myself (as did my research assistants) as a kind of student who wanted to learn about these kinds of objects used for health and protective purposes, and to learn what the indigenous healers do and the religious leaders preach. I always started with introductory questions and with a question about whether the interlocutor knew any narratives about the use and features of objects used for protection and healing purposes. As each interview progressed, I also asked the interlocutor if they used the object themselves. As became clear during the research, it was a sensitive subject surrounded by secrecy, but I was able to talk to a wide range of young adults, religious leaders from both primary religions (Christianity and Islam), and different kinds of indigenous healers, which allowed me to collect meaningful data, even though it might be limited on some points (these limitations are addressed in sections 1.5.2 and 1.5.3).

1.5.1 Demographic characteristics of the respondents

During the fieldwork periods between 2014 and 2018, I interviewed people born in over 24 different cities, from over 34 different ethnic groups, and living in 27 different areas in Dodoma city. During those periods, I interviewed 59 young adults between the age of

[21] Following Pool (1989), I write in the plural when I had the help of a research assistant, since I asked the question in English, but during an interview in Swahili both question and answer (except sometimes the basic questions about their name, age, ethnic group, etc.) were translated into English by my research assistant(s).

25 and 39 years old, with and without (young) children. The reason I interviewed young adults is because that age group is more likely to have young children (under five years old), and, as indicated before, people are more willing to talk about healing objects in relation to young children than in relation to themselves. I also interviewed 13 people younger than 24 years old, the youngest of whom was 18 years old. To compare their narratives, I also interviewed people older than 40 years (24 people). Unfortunately, I was not able to ask all people all questions (for example their age or marital status), because of lack of time on the side of the interlocutors and so I had to choose which questions I wanted to ask. This primarily relates to those interviews conducted at the hospital or mobile clinic. In 2015, I was told by two interlocutors that it would be good to visit a certain hospital, since children wearing an object used for protection or healing had been seen there. I obtained permission to conduct interviews in that hospital and an introductory letter from the Institute of Rural Development Planning (IRDP), Dodoma, a signature from the Medical Officer from the Municipal Office, and a signature from the *Mkuu* (Senior) at the hospital (fieldwork notes May 2015). There were also four interviews with multiple people whose age I did not ask, but most of them fall into the category of young adults. From the total of people interviewed, 30 were Muslim, 68 were Christian (e.g., Roman Catholic, Lutheran, Anglican, Protestant, Seventh-Day Sabbath[22]), and one person was Hindu. Most people who indicated that they were Christian did not mention which denomination they adhered to, and, for this reason, I talk generally about the Christian denomination. In those cases in which I do know what denomination of Christianity the person adhered to, it will be explicitly mentioned. The majority of the people interviewed – two thirds – were women. To look at the research topic from different angles, religious leaders (three Christian and two Muslim) were also interviewed as well as 13 indigenous healers and midwives. Most indigenous healers interviewed were older than 40 years old, and were either Muslim or Christian.[23]

As mentioned earlier, I use Kirsch and Dilley's theory on ignorance (2015) with respect to my own role and as a strategy to gain narratives about the use of objects used for protection and/or healing. Before starting the first fieldwork, I had neither heard about cases involving the use of objects in health-related situations nor encountered such cases in the literature on Tanzania; I was completely ignorant. During the years of my fieldwork, I developed insights into these kinds of objects through narratives collected from interlocutors. I became less ignorant, but with most interviews I held back on

[22] Some interlocutors called it Seventh-Day Sabbath, but it most likely relates to the Seventh-Day denominations, e.g. Seventh Day Baptists.

[23] I do not think that all male healers are Muslim and all Christian healers are women but I haven't interviewed enough healers to draw a conclusion on this division.

revealing my gained knowledge in order to allow each interlocutor to give their perspective. Sometimes, I used the gained knowledge to check with an interlocutor what they knew about that issue. For example, I sometimes asked if the interlocutor knew any narratives about a certain object that I had previously heard about, or that I had heard that an object like *ilizi* might be worn by a young child and asked the interlocutors if they knew why.

1.5.2 Fieldwork experiences and challenges

The first period of fieldwork took place in 2014 and was designed to get to know the area and to narrow down the focus of the research. I was attached to the Institute of Rural Development Planning (IRDP – also called Mipango), a university in Dodoma, where my local advisor (Dr Adalbertus Kamanzi) was working. Initially, I went to the library to find literature on Dodoma. Through friends made via IRDP and the place where I was living, I started conducting interviews to find out if people knew any narratives about objects used for healing. Together with my local advisor, we thought that by asking about narratives rather than their own individual situation people would be more willing to talk. This proved to be a constructive method, since most people I interviewed knew of and were willing to tell me about narratives.

I brought both notebooks and a voice recorder during my first field visit. Spronk (2006) and Van der Steen (2011) experienced that people were sometimes hesitant and less open if an interview was recorded. I therefore decided not to use a recorder, but to make extensive notes in a notebook, to maintain an informal setting and in the hope that people would find it easier to talk with me. Consequently, the role of the research assistant became very important, because I was reliant on their translations. I sometimes wrote down Swahili words I heard, to check with the assistant what the interlocutor said if I had not heard it in the translation. I was also dependent on the research assistants to find interlocutors. They did their utmost best to find young adults, indigenous healers, and religious leaders to be interviewed. This might also be a positive point, since the research assistants were all local young adults who had better access to possible interlocutors than I had as an outsider.

While conducting fieldwork, I was living in a compound of expats (including Dutch, Japanese, American, and Swiss) in one of the wealthier neighbourhoods of Dodoma. By living on the compound, I was not included in the daily city life, but I had good contacts with the people working on the premises of the compound, my research assistants, and friends from IRDP, and went almost daily into town, for example to buy vegetables and fruit in and outside the central market called Majengo.

Over the course of the five fieldwork periods, I had four research assistants – recent graduates from local Dodoma universities – who were not just translators, but as indicated, also played a crucial role in identifying and inviting people for interviews. They asked people they knew, or got suggestions for interlocutors through people they knew, or through the snowball effect. Working with four different research assistants (sometimes two at the same time) enabled me to interview people from different areas within Dodoma and with different backgrounds and professions. In addition, a few Focus Group Discussions were held: one with a group of senior nurses/doctors, one with a group of young adults who visited a clinic, and three interviews with a group of 2–3 my friends. The research assistants also helped to translate during the interviews when the interlocutor could only speak Swahili. The research assistant introduced me and my research topic to the interlocutors and informed them that everything they said was confidential; that I would use the narratives told, but that I would never reveal who the interlocutor was. I usually started the interview in Swahili asking the shorter and more basic questions, like their profession, level of education, where they were born, and where they live, and then the research assistant translated my longer and more difficult questions into Swahili for the interlocutor. Any interviews that took place in English I conducted myself, but also during those interviews my research assistant introduced me and my research to the interlocutor. During the first fieldwork period, I did not have a research assistant or a translator, hence most interviews were held entirely in English and three were held in English and Swahili – I wrote down those parts in Swahili to be able to translate them later. The first interview I had took place after approximately one month (mid-June 2014) and was with an indigenous healer. My local supervisor introduced me to the healer and helped to translate the Swahili into English.

I interviewed nine people at the hospital in 2015. The first two interviews were held in the common waiting area, where the nurse measures the temperature of the child and gives a tablet. After the treatment, the mothers were asked to stay to talk to me. This made me uncomfortable since there was no privacy, so my research assistant arranged for us to sit in a separate room. But after a while a senior nurse came into the office and started seeing women with ill children, while we were sitting there having interviews. We therefore stopped after conducting nine interviews. My research assistant and I concluded that the women would never show us whether the child was wearing an object or not because it was so busy and the interviews were not taking place in a private space. At one point there were about eight adults and two children in the room where we were conducting the interviews.

One of the problems my research assistants encountered was finding indigenous healers, mainly in the city centre. As Stroeken (2017: 161-2) mentions, many people

in the area of the capital of Dodoma deny that they engage in healing practices and I certainly encountered this secrecy during my research. In the search to find indigenous healers to interview, some healers were unwilling to talk to me, and sometimes it was not clear why. Being a white woman doing research made it more difficult to come into contact with especially indigenous healers, because, as one healer informed, me "they see you as a criminal investigator, because it is a secret, they do things that are not allowed."[24] In a few cases, the healers just stopped picking up the phone when my research assistant called. My research assistants introduced me as someone who wanted to learn what the healers do. On another note, as a mother of two children myself, it felt easier to talk to young adults about their children in relation to illness and objects.

1.5.3 Ethics

It was important to gain the trust of people belonging to middle-classes living in Dodoma, to make them feel safe enough to have conversations on the subject of this research. I tried to do this by greeting the people and explaining my research in Swahili, with help of my research assistants, and asking the interlocutors about any narratives they know (in order for them not to feel uncomfortable to have to talk about themselves). In addition, all interlocutors were informed that the narratives they told would be anonymised, and that if I would use the information they told me, it would not be traceable to them. The interlocutors then had a possibility to opt-out or agree to the interview. In that regard, my link to the IRDP (Institute of Rural Development Planning) also helped in gaining trust with the interlocutors. In order to protect the identity of my interlocutors, pseudonyms are used throughout this thesis.

During my Master in African Studies, I learned to speak Swahili fairly well, which enabled me to have basic conversations with the people in Dodoma, although I was not able to have in-depth conversations about my research topic. To practice a form of

[24] For example, during a few interviews interlocutors mentioned that some healers in Tanzania kill people with albinism to use their body parts in objects for protection. In August 2018, I also visited the Hope Delivery Foundation, a local NGO which deals with helping disabled people, especially albinism. One of their achievements was to educate healers during a seminar, where the healers also explained their challenges. They say that according to research there are approximately 500-600 people in Dodoma with albinism. People come from other parts of Tanzania to Dodoma, because it is one of the safer places in Tanzania, according to the people I spoke to from Hope Delivery Foundation. They mentioned that the number of killing people with albinism increased during the election time, which confirms the narratives I heard that body parts from people with albinism were used to gain power. See for example Mulemi and Ndolo (2014), Bryceson *et al*. (2010) and Alum *et al*. (2009) for literature on killing people with albinism in East Africa.

reciprocity, I brought most healers a small token of gratitude for their time, or brought some gifts like *stroopwafels* from the Netherlands, biscuits, soap, or sugar, or I had some photos developed from one healer together with me which she wanted to have. I also gave some religious leaders and other interlocutors a small token of appreciation as compensation for their time. Unfortunately, in some cases, particularly in relation to finding indigenous healers, I was asked to pay an amount between €30 and €300. I did not pay these amounts in order to interview these healers, because I did not want to take the risk that they would give me answers they assumed I wanted to hear and also it may change the expectations within relationship between the interlocutor and myself.

When starting the research and the fieldwork, I followed the main principles of the Code of Ethics for research in the social and behavioural sciences involving human participants, namely, and among other things, respecting the dignity of the interlocutors and their environment; minimising harm; adopting an ethical attitude in which I was mindful of the meaning, implications, and consequences of the research for anyone affected by it; and reflecting on ethical issues that may arise during or as a consequence of the research.[25] All interviews were written down in notebooks, which were all in my possession, in my house, and were only read by me. In addition, I converted the interviews into Word-documents, saved them on my password protected laptop which has always been in my possession and in my house, and e-mailed them to myself for additional storage and protection.

In 2015 my fieldnotes were stolen. Fortunately, it was at the beginning of my fieldwork, and I did not make a lot of notes and no names were mentioned, since the notebook did not contain interviews. I filed a police report, and when walking through town I looked if I could find my bag or its content. Unfortunately, the bag and its content were not retrieved.

Following the method that Koot (2013: 284) used, I am not searching for truth or reality, but rather I wanted to know ideas and thoughts, which I collected in the form of narratives. In this thesis, I present the narratives I collected from the three angles of young adults, religious leaders, and indigenous healers. The cases presented in this thesis, its conclusions, and hypotheses concern my interpretation of the narratives I collected during a given time.

[25] For the full Code of Ethics for Social and Behavioural Sciences, see: https://nethics.nl/gedragscode-ethical-code.

1.6 Outline of the thesis

The remainder of this thesis is organised as follows: Chapter 2 focuses on the daily lives of young adults whom I assume to be part of the middle classes living in the urban environment of Dodoma. To answer how those young adults navigate the plethora of social, health, and educational options, the chapter first examines the concepts of the middle classes and mobility. The chapter continues with a discussion of three important factors in the lives of the young adults – health, religion, and education – and uses the narratives obtained to discuss what young adults do when they or their young child fall sick. I will relate the narratives to the four misfortunes, as presented by Whyte (1997).

Chapter 3 focuses on the medical plurality that exists in Dodoma, with a focus on folk healing, as categorised by Kleinman (1980). The chapter starts with health seeking and health systems. The central part of the chapter reveals the different kinds of healers present in Dodoma and answers the question about which healers make objects used for health-related or protective issues. It also shows how this research differs from or continues the work of some authors working on health in Tanzania.

Chapter 4 discusses cases reported concerning the object named *ilizi*. The cases are used to gain insight into health and healing. This is be done through the narratives about that object collected from young adults, religious leaders, and indigenous healers in relation to the conditions of Dodoma's urban environment. There seems to be a social imaginary about the object of *ilizi*, since the narratives collected overlap, despite people being either Muslim or Christian and originating from different areas and ethnic groups. These narratives are related to different kinds of misfortunes, shame and secrecy, and witchcraft. These themes will be related to the three focal groups of this research, namely, young adults, indigenous healers, and religious leaders.

Chapter 5 details the issues that emerge amongst the young adults with respect to what they can make visible and what they want to keep invisible. The young adults live in a world where, seemingly, there is less and less room for non-scientific interpretations and health-interventions (Weber's enchantment), like visiting an indigenous healer for certain health problems, and biomedical and scientific interpretations weigh heavier for them. The chapter aims to show that this results in a relational triangle between education and biomedical care, the primary religions, and indigenous healers, with a focus on young adults.

Chapter 6 is the concluding chapter of the thesis and provides a summative argument that combines what has been argued in each chapter and ends with some future

research challenges. This study contributes to the gap in the literature on the issues of the middle classes in relation to objects used for healing and protective purposes. Throughout the thesis, I show that there is a contestation visible: young adults in Dodoma are familiar with objects used for protection and/or healing, either through narratives or by seeing them when they were young, but they say they do not use these kinds of objects themselves. On the other hand, it became clear that those objects do exist and are made by certain indigenous healers who also indicate that they sell these objects to young adults. Almost all young adults interviewed say they use biomedicine, both for themselves and for their young children. Some young adults say they do use herbs to keep themselves healthy. All of this does not mean that the young adults interviewed did not tell the truth when saying they do not visit indigenous healers. My thesis tries to make a modest contribution to the literature on narratives about the lives of middle-classes young adults in an urban environment, but with a focus on the dimension of material objects. By collecting these narratives, it became clear that there are contradictions in the daily lives of the young adults and the narratives made their views clear, but also those of religious leaders and indigenous healers.

2.

Young adults in the urban environment of Dodoma

2.1 Introduction

In May 2017, I interviewed Zuri, a young woman who says she is Christian.[26] She is in her early thirties and has four children between the ages of ten months and ten years old. She is a primary school teacher in an area on the opposite side of urban Dodoma to where she lives, which means she has to take two different *dala dalas* to reach the school. She was born in northern Tanzania. We sit outside her house on the porch with some bushes close by and a large *muarubaini* tree, which can be used for more than forty diseases according to Zuri (photo 2.1). Among other things, we talk about keeping herself and her children healthy, what she does when her child is ill, and about objects used on the body to keep the child healthy. The interlocutor's mother is also present and sometimes answers the question or 'discusses' with the interlocutor. Zuri keeps her children healthy by preparing fresh food for the children, buying different things like fruit, maize, and millet. She also keeps the home environment clean and takes the children to the hospital for check-ups. When the children are under five years old, she takes them to the clinic every month for a check-up. When I ask her what she does when the child is ill she responds:

> *When the child was ill, we went to the hospital, and got medicine, but unfortunately the medicine was not healing. When we looked in the mouth, we saw sores on the tongue. My mother-in-law directed me to burn herbs and smear that on the tongue. The herbs are* maganga karanga *(roasted groundnuts) of which she used the shell of the groundnuts that were already used, and also an empty match box plus the sugar cane strings which are left after chewing and the core of the maize. She burned these things together to get the ashes* (interview 9, 5 May 2017).

Zuri also uses other herbs for health-related purposes, for example a mix of guava and mango leaves when the child has a stomach pain or diarrhoea. When I ask her if she uses things on the body to keep the child healthy, she answers:

> *That goes back to a belief, a belief in religion, the belief in Eden gardens. We use the leaves and pray over them. The medicine is made from the leaves, we believe in them. We do not believe in objects on the body* (interview 9, 5 May 2017).

[26] As indicated in the introductory chapter, most people who told me that they were Christian did not mention which denomination, and, therefore, I use the generic term 'Christian'. In cases where the branch of Christianity is known, it will be explicitly mentioned.

Photo 2.1 *Muarubaini tree*

She does not use objects herself, but she has seen objects like *ilizi* in the village where she grew up. The objects consisted of black cloth around the wrist or a coin tied on a string worn around the neck. She informs me that "*the people who use the object think that by using such objects, children will not fall sick frequent, will not get diarrhoea and protect themselves from witches*" (interview 9, 5 May 2017). As will become clear in Chapter 4, I heard these kinds of arguments about the use and appearance of the object frequently.

Zuri's narrative presents us with a typical case of a young adult living in urban Dodoma, who is religious, has a steady job, uses biomedical facilities but also herbs, and who says she does not use objects for health-related purposes. This chapter presents other, similar cases about the daily lives of young adults belonging to the middle classes and living in the urban environment of Dodoma. These young adults became the focal group of my research, since it became clear during the first fieldwork period that objects used for health and protective purposes were visible on young children under five years old, but were not visibly worn by adults. As a starting point, I spoke to these young adults, as the caretakers of small children, to be able to study the use and the appearance of the objects, and to learn about their narratives living in the city with a focus on health, religion, education, and occupation. Many of the young adults had

moved to Dodoma from another part of Tanzania, demonstrating spatial mobility, but also revealing different ways of dealing with health choices in the urban environment of Dodoma with its many facilities. As described in Chapter 1, various health facilities can be found in Dodoma, both biomedical care and indigenous healers, but there is also a wide range of providers of education, from primary school to university, religious institutions, and different job opportunities, in both the informal and formal sectors. In addition to the spatial mobility of the young adults moving to Dodoma, social and occupational mobility are also present in relation to the four conditions of health, primary religions, education, and occupation. The central question of this chapter is therefore:

> *How do young adults belonging to the middle classes navigate the plethora of occupational, health, religious, and educational options in the growing city of Dodoma?*

The chapter will first go deeper into the concept of the middle classes and the different forms of mobility present, and it will present the young adults' narratives concerning the options and behaviour they adopt in the context of the conditions of their lives in an urban environment. The chapter then details the living conditions of the city of Dodoma with an emphasis on the four, above-mentioned aspects, and ends with an overview of narratives in relation to health-related issues, such as getting pregnant, miscarriage, and keeping young children healthy. This chapter describes how indigenous medicine is not commonly used by young adults of the middle classes, even though they are aware of its existence and availability, but that hospital medicine is commonly used by young adults. Herbal medicine is accepted as something used by religious leaders (both Islamic and Christian[27]), and is used by some young adults as an addition to biomedicine, and, as Chapter 3 will show, it is openly available in the city of Dodoma.

2.2 The middle classes

Young adults who are part of the middle classes form the focal group of this research. As mentioned in the introductory chapter, I opt for the term middle classes (instead of middle class), since it makes clear it concerns a pluralistic phenomenon; that is, – as Van Dijk (2020a) puts it – young people who often pursue upward social mobility via migration to other places and back again. I also avoid the term middle-income classes, since income will not be used as an indicator to establish if a young adult belongs to

[27] As will become clear both in this chapter and in Chapter 4.

the middle classes. Instead, I consider other factors like education and/or having a (steady) job. As this chapter will make clear, there is a sense of upward mobility among the young adults of the middle classes in Dodoma, but other mobilities, such as spatial and social, are also present. The emergence of an up-and-coming group of young adults from the middle classes in urban Dodoma is mainly due to the expansion of the city. According to Hommann and Lall (2019: 5), urbanisation in sub-Saharan Africa has not been accompanied by critical infrastructure investments due to low GDP per capita. Fewer resources mean that there is underinvestment in physical and human capital, such as schools, health clinics, and other infrastructure services. While the education, religion, and health sectors within Dodoma are large and diverse, during my years of fieldwork it became clear by my own observation that the infrastructure could not keep up with the increasing numbers of people coming to the city, which was visible in, among other things, the growing informal sector.

The upcoming middle classes in a global world have been central to several studies in the past two decades (see e.g., Carvalho 2012; Melber 2016; and Kroeker *et al.* 2018). As mentioned in the introductory chapter, the middle classes can be defined as individuals or households that fall between the 20th and 80th percentile of consumption distribution (African Development Bank 2011: 2). In other words, the middle classes fall between the working class and the upper class. Or, as Keeley (as cited in Melber 2016: 1) puts it: "By definition, 'middle class' is a relative term – it's somewhere above poor but below rich, but where?" To Kroeker *et al.*, the middle classes are "sets of individuals who are neither rich nor poor, but without any imposition of statistical or other limits on the membership in those classes" (Kroeker *et al.* 2018: 9). Within the dimension of lifestyle, the middle classes are more present in urban areas where they are educated and usually show "signs of a demographic transition and the development of a global lifestyle contrasting 'traditional', rural life worlds" (ibid.: 17).

Spronk (2006) provides an interesting case of the middle classes in Kenyan society. Her research focuses on young professionals in the capital, Nairobi, who are financially independent, have a relatively stable job, delay marriage, have a trendy lifestyle, and the basis of their social life is inter-ethnic (ibid.: 23-24). "Their lives go beyond dualist perceptions of 'modern' and 'traditional'" (ibid.: 25), they break down old boundaries, and explore new ones at the same time (ibid.). These young professionals have found a new way of living adapted to all the different circumstances, which are not the same as from their parents: they were born in Nairobi unlike their parents; they have careers in private sector where parents had lower middle class positions; they do not speak a local language since they have been brought up speaking English or Kiswahili; they have relations with people from different ethnic groups; they delay marriage, and are financially independent from parents (ibid.: 23-24). I see some similarities with my

research, mainly in the sense that the young adults I have interviewed also have a relatively stable job (or are a student). They also break down old boundaries and explore new ones in the sense that they want to break with the past by (saying that they) do not visit indigenous healers for health-related purposes, but rather (say that they) only go to a pharmacy or hospital to get medical treatment. The aspect that can be seen as a continuation of the past is the use of herbs to stay healthy or to cure certain illnesses. Not all young adults say they use herbs. The use of herbs is accepted by religious leaders, while going to an indigenous healer is not, as will become clear in Chapter 4. Linked to breaking with the past are the concepts of rupture and repair. The term rupture originates from studies of Christianity, relating to conversion; 'repair' relates to how Christians view conversion and change, and concerns the ways that "people seek to restore a sense of wholeness" (Richman and Lemons 2022: 337). A 'break with the past' is evident among Pentecostalists who have become Christian, and who break with the pre-Christian past (ibid.: 384). While, generally, the concepts of rupture and repair are related to Christianity, I would like to relate them to both Christianity and Islam. As established in the introductory chapter, young adults in Dodoma state that their primary religion is either Christianity or Islam, and most young adults say they were raised as either Christian or Muslim. I suggest that a 'rupture' with the past – marked by the adoption of Christianity or Islam and adherence to their religious leaders - has resulted in young adults belonging to Dodoma's middle classes rejecting indigenous modes of healing, such as the use of an object for healing purposes. This rejection can be understood as part of the 'repair' aspect. I argue that the young adults feel a sense of wholeness by being either Christian or Muslim and living by the rules of these religions as advocated by their religious leaders. The past can be seen as a more abstract past, since it does not directly concern their past, but more the past of the parents as in most cases they were the ones who converted to either Christianity or Islam.

The middle classes have become of interest since the 2000s, and are seen as the driving force behind urbanisation, bureaucratisation, and industrialisation; moreover, they "are seen as being on the rise," according to Lentz (2016: 25). She also states that education is the most important tangible instrument for achieving upward mobility (ibid.: 29). Spronk (2018) acknowledges four categories that characterise the middle classes – socio-economic positioning, socio-cultural entity, cultural-economic consumers, political actors – but she adds a fifth category. This concerns the middle classes as an aspirational group (in which Spronk follows Heiman *et al.* (2012 as cited in: Spronk 2018: 316)), and can be studied as cultural practice. By this she means that by having the ambition to climb the social ladder the middle classes are a classification-in-the-making (Spronk 2018: 315-316). Standing (2015: 3) writes about the precariat, a new emerging class, characterised by great uncertainty and insecurity, mainly concerning their labour. According to Standing, the precariat almost entirely

relies "on money wages, usually experiencing fluctuations and never having income security" (ibid.: 6) and they also have "fewer rights than most others" (ibid.), but it is also related to one's education (ibid.). The literature mentioned all indicate that the middle classes are a dynamic category and in motion. As this chapter, and, indeed, this thesis, demonstrates, social mobility is present among higher-educated people, in the sense that young adults migrate from other parts of Tanzania to Dodoma in order to find opportunities, and they do so either by getting a higher education and/or by finding a (steady) job. To most scholars, a key factor in identifying middle classness is (access to) education (and this also relates to salaried occupations). Other factors are consumption patterns and modern self-perceptions and lifestyle choices (Spronk 2014: 99). I did not talk about consumption patterns during the interviews I conducted since the focus of the research was health-related issues. But within my study, access to education is the main indicator of belonging to the middle classes, and – following Spronk – in relation to people's occupations. To get a better view of the research area, I not only interviewed higher-educated young adults, but also those who have attained the Standard 7 level or completed Form 4 and have a secure job. Having a (secure) job was the second important factor in my research in deciding whether someone belongs to the middle classes or not. Furthermore, I also classified those young adults still in higher education and a student at one of Dodoma's universities as belonging to the middle classes. Most of the young adults interviewed had young children, since I was interested in narratives about young children.

When analysing these young adults belonging to the middle classes, I propose to take socio-cultural differentiation (following Neubert and Stoll 2015) into consideration. Neubert and Stoll use two approaches in their analysis, namely, "socio-cultural milieus"[28] and "small lifeworlds" (ibid.: 3). Socio-cultural "milieus" concern people from sub-groups of a certain socio-economic position who share the same lifestyles and values. "Small lifeworlds" are the "social settings where people meet in a particular sphere of their everyday life" (ibid.: 3). Within my research, I look at the socio-cultural "milieus" instead of "small lifeworlds", since the narratives collected make clear that certain groups of people do share the same values, and it does not concern a social setting where people meet. This concept was developed in Germany, but, according to Neubert and Stoll (ibid.: 5), who present a case from Kenya, it is applicable to African contexts south of the Sahara, because of "its flexible approach to the positioning of milieus and its simpler concept of class" (ibid.). The macro-milieu concept works with two dimensions, namely, the division into different classes (i.e.,

[28] The concept of milieus was developed in Germany by the Sinus Institute (Neubert and Stoll 2015: 4). More information can be found at https://www.sinus-institut.de/en/sinus-milieus/sinus-milieus-international.

lower, middle, and upper class) and another based on differing cultural orientations (ranging "from preservation of tradition to modernisation, individualisation and re-orientation") (ibid.: 5-6). Neubert and Stoll aimed to identify several social macro-milieus that capture all members of Kenyan society, while I aim to determine one social macro-milieu in relation to the young adults in this study and the choices they make in their daily lives. This milieu is based on the narratives collected from young adults, religious leaders, and indigenous healers. There are also religious leaders and indigenous healers who belong to the middle classes, but they operate in a different social milieu. Belonging to one social milieu therefore does not indicate that all aspects of that milieu are unique; rather, it is all aspects together that make the social milieu unique.

A milieu is defined by a combination of 'milieu building blocks' and, in my research, I use this approach in an attempt to describe socio-cultural differentiation within the middle classes of Dodoma. Based on the narratives collected, I propose to call the social milieu I studied 'young, urban adults from the middle classes', and this term represents the overarching narrative as presented in this thesis. Within the context of this social milieu, I look at three groups of people: young adults, religious leaders, and indigenous healers. The building blocks, or social strata, I have used to propose the social milieu of 'young, urban adults from the middle classes' include, among others, demographic/social position, aims in life, and religion (see the left column in the table below):[29]

Building Blocks	**Young, urban adults from the middle classes**
Demography/social position	Young adults (25-39 years old) belonging to the middle classes
Spaces and places	Living in Dodoma's urban environment
Life aims	Having economic options, building a house, raising a family
Work/performance	Studying or having a steady job (e.g., shopkeeper, teacher, nurse)
Image of society	Urban environment with many facilities for education, religion, and health
Main religion	Islam/Christianity
Family/partnership/gender roles	Family mostly living in other parts of Tanzania
Ideals and role models	Partially disenchanted worldview (not visiting indigenous healers; educated; biomedicine); religious

[29] See Neubert and Stoll (2015: 9) for an overview of the criteria of the building blocks and the different kinds of building blocks.

As became clear, the middle classes is a concept in motion and will be used in my research to indicate a specific group of young adults between 25–39 years old with a higher education (or in the process of getting one) and/or having a (steady) job. For example, Mary is a 30-year-old Christian female, has a diploma from university and works as a librarian. She is married and has one child younger than 5 years old (interview 49, 22 May 2015). Peter is a 33-year-old Christian male, has a master's degree and works at a university. He is not married and has no young children, but I interviewed him to get to know his view on an object like *ilizi* and on his experience when he was younger (interview 14, 11 May 2017). As mentioned before, the social milieu I propose is based on the narratives of the young adults, indigenous healers, and religious leaders in which common values are shared. The narratives of the indigenous healers and religious leaders will be discussed in the coming chapters, while the narratives of the young adults with a focus on health-related issues are the focus of this chapter. These narratives will provide insight into the choices that these young adults make, why, and how they narrate their life conditions in relation to their occupation (2.4.1), religion (2.4.2), education (2.4.3), and health (2.4.4).

2.3 Mobility and borders

In this section, I will consider how certain forms of mobility and crossing borders are relevant to understanding the position and the health-related choices of the young adults who are the focus of this study. As Ticktin (2022: 2) makes clear, we currently live in a world where goods, people, and all kinds of things are on the move, and, in turn, have an impact on social life. In terms of the social life of people living in Dodoma, multiple mobilities can be seen. Ticktin writes about intersecting mobilities, which means the coming together of multiple mobilities and crossing paths (ibid.). These dimensions of mobility and borders offer us insight into, among other things, the daily lives of young adults, based on the narratives of the three focal groups in Dodoma.

As indicated in the introductory chapter, and earlier in this chapter, many of my interlocutors moved from other parts of Tanzania to Dodoma in order to get a higher education and/or employment. This indicates a large degree of both spatial and occupational mobility. These form an important part of the narrative of the young adults. In addition to people's spatial mobility, this and subsequent chapters will show that there is also a spatial mobility of objects, medicines, herbs, ideas, and images. Another form of mobility that can be found within my research is the type of social mobility associated with climbing a social ladder, but also social boundaries, in the sense of what you can do as a young adult to become part of the middle

classes. By being mobile – in any sense – a person or an object (like medicines or herbs) can cross borders. The two aspects of mobility and borders or boundaries are therefore inextricably linked.

In the introduction to *Borders and Healers: Brokering Therapeutic Resources in Southeast Africa*, which discusses both healers and those they heal as well as their contribution to constructing the borders that they transgress, Luedke and West (2006) write that they do not want to take the existence of boundaries for granted, but that they also want to discover how entities that are bounded "are produced and reproduced in the practice of healing" (ibid.: 8). The authors mention all kinds of boundaries: between the rural and the urban, local and global, the official and unofficial, and traditional and modern; between religion and science, the material and immaterial worlds, and healing and harming; and between ethnic groups, languages, and religious communities. They add that healers seem to cross boundaries constantly (ibid.: 2, 6). In my research, in the field of health, it is clear that both healers and young adults cross different kinds of borders, both figurative and literal boundaries. The young adults, the religious leaders, and the indigenous healers that I talked to name their primary formal religion as either Muslim or Christian; they are from different ethnic groups and most of them were born in places other than Dodoma. As Chapter 3 will show, the healers have their practices in different parts of urban Dodoma and are not centralised in one place in the way that Luedke and West describe (ibid.: 1). I will now discuss the three mentioned kinds of mobility and borders or boundaries: spatial mobility and borders (2.3.1); social mobility and boundaries (2.3.2); and occupational mobility (2.3.3).

2.3.1 Spatial mobility and borders

As mentioned in the introduction to this thesis, Dodoma has been the capital of Tanzania since 1973, when steps were taken to move the country's administrative and political functions from Dar es Salaam to Dodoma. Former president Magufuli ordered the people working in the ministries located in Dar es Salaam to move to Dodoma, a move completed by the current president, Samia Suluhu Hassan. This led to an increase in the number of people in the city, displaying a large degree of spatial mobility. This relates to the first kind of spatial mobility mentioned above, namely, amongst people: the interlocutors and their mobility and movement to and from Dodoma, not only from Dar es Salaam, but from various places within Tanzania. People also display spatial mobility in terms of seeking a consultation with a healer, since some of them travel to Dodoma from other places like Dar es Salaam in order to do so. In their introduction, Kroeker *et al.* (2018: 23) mention that urban-rural relations tie cities and villages together via factors like kinship, health problems, economic informality,

and insecurity and ethnicity, all of which have influenced the development of Africa's middle classes. These factors have a central status in people's experiences, but have been treated as marginal, according to Kroeker *et al.*

As will become clear from my research, many interlocutors are tied to their home cities and villages through kinship. The interlocutors in my research moved to Dodoma from at least 25 different places throughout the whole of Tanzania. Some people came from big cities (like Mwanza or Morogoro); others came from smaller regions.[30] Related to this is the different ethnic affiliations of the interlocutors: people from at least 34 different ethnic groups were interviewed,[31] for example, Gogo[32], Chaga, Mrangi, Maasai, and Hehe. Candace is a 24-year-old Christian female who was born in Morogoro, is from the Mpare ethnic group, and has come to Dodoma for a bachelor study at one of its universities (interview 8, 5 May 2017), while Amina is a 32-year-old Muslim female who was born in Kondoa district, is from the Mrangi ethnic group, and works in a saloon (interview 40, 20 May 2015).

Geschiere (2003: 44) writes about kinship in relation to mobility/boundaries and states that modern developments mean that kinship must now bridge spatially, i.e., the growing distance between cities and villages, and socially, i.e., the growing inequalities between the poorer relatives and their elites. The spatial distance becomes clear when interlocutors are asked where they were born and also, in some cases, when talking about herbs that they received from their parents. The social distance becomes clear when looking at the narratives told by the young adults in relation to certain advice given by relatives, e.g., what can be done with an umbilical cord or when a young child is ill (see 2.4.4).

Different kinds of spatial mobility emerge within the focal groups of my research. The first I would like to share concerns not only young adults, but also healers. My research reveals that the healers I interviewed travel between different places within Tanzania: sometimes in order to treat people, but sometimes also to obtain herbs for treatment. Chapter 3 will go further into detail concerning the different kinds of healers and their treatments, also in relation to spatial mobility.

The second kind of spatial mobility concerns that of medicines and objects used for health-related issues. Dodoma is a semi-arid area and therefore has to import food,

[30] I will not offer examples of these regions for reasons of privacy.
[31] Twelve people were not asked due to the earlier-mentioned time constraints, and one person did not know from which ethnic group he/she originated.
[32] The original inhabitants of Dodoma.

medicines, etc., including Panadol[33] from Kenya, other medicines from other parts of Tanzania, like Dar es Salaam, and herbs from Arabia. But there are also health related items that are not imported, such as the herbs that healers find in the area of Dodoma. Since the origin of Dodoma as a capital, the city has been growing and even though biomedical health options have now entered the medical landscape, as Chapter 3 will show, other forms of indigenous healing have not been 'pushed out.' My research reveals that my interlocutors did not bring biomedical medicines with them when they moved to Dodoma, but – as this chapter will show – herbal medicines were sometimes brought due to the fact that certain herbs and/or roots do not grow in the Dodoma area.

The spatial mobility of biomedicine was already present during the colonial period, when biomedicine was exported from Western Europe to Africa, having been introduced by private companies, medical missionaries, and colonial administrations (Olsen and Sargent 2017). According to Prince (2014 as cited in Olsen and Sargent 2017: 3), biomedicine is linked to modernity and development "that over time have not been realized in most African states." In Dodoma, there is a clear presence of different kinds of biomedical treatments and young adults must navigate their way through these options. To this day biomedicines are imported, for example from Kenya as well as from within Tanzania, hence the continued mobility of biomedicine. In addition, in contemporary Dodoma, there is also mobility of herbs and objects, as will become clear later in this chapter.

There is not only mobility of food and medicine, but also of objects that are used for health and protective purposes. As will become clear in Chapter 3, indigenous healers who make and/or prescribe objects (not only *ilizi*, but also, for example, lion vomit) for health-related issues can obtain them from other areas within Tanzania. Sacred objects used in Pentecostalism by Cameroonian migrants in Cape Town, South Africa, as Nyamnjoh (2018: 38, 42) describes, consist of, for example, holy water, anointing oil, wrist bangles, and DVDs with prayers and manuals on how to use these healing objects, but also objects like 'the blood of Jesus.' These kinds of religious objects, mainly Christian, are apparently also used by young adults in Dodoma: holy water to spray the bed, the Bible next to the bed, or a rosary.

Food and medicines are not only being imported from other parts of the country or from abroad, but they can also be made mobile by people who migrate and bring

[33] Panadol was frequently mentioned during the interviews as a medicine used when a child is not feeling well. The Panadol I bought myself, was from Kenya.

medicines from their home country with them, as Carvalho shows in her research on Guinea-Bissau where people migrate for educational reasons (2012). Carvalho claims that new migration circuits act as movements to diffuse both pharmaceutical products and biomedicine and "should be understood in the context of the transnational flows that characterize the modern age" (ibid.: 317). Indeed, she believes that this is one of the best examples of cultural globalisation as described by Whyte, Van der Geest, and Hardon (2002).

The third kind of spatial mobility is that of health seeking, i.e., choosing between the different kinds of health options. Within my research, health seeking was mainly related to the type of healthcare available (biomedical care or indigenous healing) and not as Rekdal (1999) encountered, mobility related to ethnic groups, in which the perception is that the origin of the most powerful healing lies outside its own culture (ibid.: 459). My research does reveal, however, that the efficacy of a healer is important in healing practices, in the sense that the healer who makes the material object is also important, not just the object itself. Moreover, one healer can be more powerful than another and can outperform certain effects (see cases in Chapter 4.2.1).

One of the questions I asked the young adults was what they do when they or their young child is not feeling well, and which health facility they choose to go to. Most young adults informed me that they use biomedical care options, as Chapter 2.4.4 will show. But, according to some indigenous healers, people of different ages and both men and women do visit them when the hospital fails to cure them.[34] For example, as one healer told me, the effectiveness of modern medicine can be reduced, but that herbs are fully effective (interview 4, first visit, 11 July 2018), in the sense that modern medicine does not contain all the working ingredients that herbs contain. I also collected narratives from indigenous healers who told me that they send patients with specific problems to the hospital in situations where the issues are beyond the expertise of the healer. By doing so, the borders between the non-biomedical and the biomedical are blurred. Or, that they refer the patient to another indigenous healer who has different or specific expertise than the referring healer.

As mentioned in the introductory chapter of this thesis, Marsland writes about boundaries between 'modern' and 'traditional' medicine in Tanzania, and states that 'traditional' healers are open to innovation, while 'biomedicine' is not and might therefore be seen as a system whose borders are (more or less) closed to innovation

[34] Since my focus was on the different types of healers, I did not interview many biomedical doctors and therefore cannot say whether they ever refer patients to indigenous healers.

(Marsland 2007: 756). According to her, the crossing or drawing up of boundaries gives us information "about the identity of medical practitioners and their need either to contest or reinforce the identities attributed to them by others, such as their patients" (ibid.). In her research, she found that both biomedical practitioners and *waganga* (healers) believe that tradition is 'backward' and that modernity is 'progressive.' She continues that the biomedical practitioner has to "defend his or her cultural 'purity' as 'modern'" (ibid.), while the *mganga* (healer) proves his or her practice is progressive by combining 'tradition' and 'modernity' (ibid.). As pointed out in Chapter 1, by making this division she does not address the point that biomedical practitioners develop ideas about what is modern and what is traditional medicine in a modern context. These ideas often concern a narrative in which modern medicine is perceived as being better than traditional medicine. However, it depends on who defines the terms under which the 'modern' and the 'traditional' are conceptualised. At no time during my research did I hear people say that they find 'traditional' medicine backward, but, as I will discuss in this chapter, young adults claim that they do not consult indigenous healers, and only use biomedical health options, or occasionally herbal medicine.

2.3.2 Social mobility and boundaries

Social mobility and boundaries are present within the daily life of a young adult, and give direction to what decisions young adults from the middle classes take, or what does or does not belong in their lives.

According to Kroeker, the African middle classes are highly mobile, both socially and geographically (2020: 143). Whyte (2005: 156 as cited in Kroeker 2020: 143) argues that "spatial and social mobility often mark episodes of the life course," for example leaving the parental home for educational purposes. This is clearly visible in Dodoma: there are several universities and many students come from other parts of Dodoma. Kroeker mentions that both kinds of mobility can be mutually influential, in the sense that spatial mobility can become a marker of social upward mobility, e.g., when people travel between rural and urban areas to combine a job in the non-manual sector with a farming job (Kroeker 2020: 144).

The most common reason why young adults say they do not visit indigenous healers for health-related issues relates to their religious convictions (either Christian or Muslim). Hence, we can infer they also enact a social boundary in relation to religion which the young adults say they do not cross and that seems to be the same for both Christian and Muslim young adults. As evidenced by a number of my interviews, people sometimes change religion: for example, an Islamic woman can become Christian when marrying

a Christian man. This became clear when interviewing Mariam, a woman in her late twenties who originally was Islamic, but converted to Christianity when she married (interview 19, 14 May 2015). But in all cases, those who expressed adherence to either Christianity or Islam do not visit indigenous healers.

Another religious social boundary became clear when interviewing people about objects used for health-related purposes. Some of my Christian interlocutors said that Muslim people did use objects but that they (as Christians) do not. Equally, a number of Muslims that I interviewed told me that they never use objects for health-related issues but that some Christian people do. While these narratives contradict and contest each other, they are also alike in the sense that they assume people from the other primary religion use objects for healing. Nevertheless, both groups had the same narrative about their own group, which is that neither group uses objects for health-related purposes or visits indigenous healers to obtain such objects.

A third religious boundary emerged via the case of a young healer who changed religion after being guided by his clan spirits (*mashetani ya ukoo*). These spirits appeared to the young man in dreams and made him ill, until he decided to become a healer and convert to Islam.[35] These clan spirits are sometimes addressed as ancestral spirits, as I will show in Chapter 3.5.1 on becoming an indigenous healer.

Many young adults interviewed moved to Dodoma to increase their life chances, through education (university degree) or by finding a job and being able to provide for their family and possibly build a house. A clear example is provided by Glory, who is a 25-year-old woman, doing a Master Science and Natural Resource Management at Dodoma University, and holds a bachelor's degree from Arusha university in the north of Tanzania (interview 6, 4 May 2017). Honwana (2013: 2429) has introduced the concept of *waithood*, a "prolonged period of suspension between childhood and adulthood." According to her, the problem for young Africans is that many of them cannot afford to start a family and are unable to take part in social adulthood, which includes, amongst other things, being independent, earning a living, providing for their children and family members. Spronk (2009: 504) also writes about young professionals delaying their marriage until they are around thirty years old, because they first want to work on their careers to be able to save and have a middle-class married life, or to postpone the responsibilities of married life. Most young adults whom I interviewed were studying, and/or building a house while starting a family at the same time, and most of them were already married (many under thirty years

[35] This 'wounded healer' paradigm will be further discussed in Chapter 3.5.1 on becoming a healer.

old). But in some cases, young adults were studying or working, building a house, while the new family was living in the place where the interlocutor came from and were waiting to be able to move to Dodoma once, for example, the house was finished (habitable). Like Glory, whom I introduced earlier in this section, who is married and has a two months old young child and is studying in Dodoma (interview 6, 4 May 2017). Another case is Salima, a Muslim woman in her mid-twenties, doing a bachelor in Dodoma and has a young child of 9 months old (interview 10, 6 May 2017). A final case is from Alexandra, a woman in her late thirties who works as a nurse in the north of Tanzania, but is also pursuing a master's study in Dodoma. Her youngest child of 2 months old lives with her, while the other three children live with their father in the north of Tanzania (interview 12, 10 May 2017).

In conclusion, there seem to be social boundaries in the lives of a young adult belonging to the middle classes: they live in an urban environment, are highly educated and religious, but it is not acceptable to visit an indigenous healer. Specifically, accessing biomedical healthcare options and/or using herbs for health purposes is accepted by their religion, but visiting an indigenous healer is not.

2.3.3 Occupational mobility and borders

One of the main reasons for young adults to move to Dodoma concerns occupational mobility, namely, the search for better (employment) options. Bruce (2011: 32) writes about secularisation and that during the phase of individualism resulting from the Protestant reformation, economic development brought occupational mobility. A rise in economic development, which, in turn leads to occupational mobility, is definitely visible in Dodoma. Due to the move of the government from Dar es Salaam to Dodoma, people assume that more employment options are available and therefore they move to Dodoma. This involves them crossing geographical borders in order to become occupational mobile. In section 2.4.1 I will go into the specific occupations of the interlocutors.

According to Heath and Zhao (2021: 172), the study of occupational mobility provides an approach for studying social mobility. They see occupational position as an indicator of the 'life changes' of an individual or a family, in which occupations are associated with income and material prosperity, but also a wider range of demographic, psychological, and social outcomes, such as mortality and fertility. Within my research the occupational mobility can relate to climbing the social ladder, which also relates to the social mobility. The young adults belonging to middle classes have a higher education, come from different parts of Tanzania to Dodoma to pursue a higher education and most likely resulting from that, obtain a steady job. As indicated

earlier, some young adults come to Dodoma for educational purposes, while other young adults travel to Dodoma to find a job after having an education in another part of Tanzania or even in another country. Like Peter – whom I introduced in section 2.2 – who did his master in another country, and came to Dodoma in 2011 to find a job. He now works at one of the universities of Dodoma (interview 14, 11 May 2017).

2.4 Dodoma

Geographical and social mobility and boundaries are found within Dodoma, but what kind of city is it? As already mentioned in the introductory chapter, Dodoma lies in the semi-arid centre of Tanzania and became the capital in 1973. This part of this chapter provides more insight into specific aspects of the city in relation to young adults: what kind of facilities can be found in Dodoma, what options young adults have concerning living conditions and jobs, and, in relation to health-related issues, how do young adults protect and cure their young children?

Dodoma used to be a village where the Bantu-speaking people of the Gogo ethnic group lived. However, there are approximately 125–130 ethnic groups in Tanzania. Today, due to urbanisation and the breakdown of tribal boundaries, you can find many of these groups in Dodoma. Other Bantu groups living in Dodoma are Wakaguru, Wanguru, Warangi, Wasagara and Wazigua, while Nilo-Hamites are the next largest group. Other groups include the Haya, Sukuma, but also Indians, Arabs, and Somalis (who are mainly merchants) (NBS *et al*. 2003: 8, 9).

Dodoma is a fairly small city and its city centre consists of several small streets that accommodate many different kinds of shops. One of the main shopping lanes features shops on each side of the street that sell, among other things, fabric, clothing, cooking appliances, and electronic equipment. Informal market stalls in front of the shops sell merchandise like clothes, shoes, toys, electric appliances, toothpaste, and children's books. As cars are not permitted in (most of) these shopping lanes, they are crossed by a series of one-way streets for cars, motorbikes, and cyclists. In these streets, you can find small restaurants, more shops with fabric and clothes (photos 2.2 and 2.3), but also a hospital and healers' practices and shops selling (branded[36]) herbs. The city became busier over the course of my years of fieldwork between 2014–2018, as evidenced by the growing number of hotels and the increasing number of small restaurants, bars, and the informal market expanding onto the sidewalks next to the Majengo market.

[36] This means herbs that are processed by the healers themselves and sold in jars or bottles, or are bought from other countries.

Photo 2.2 *Shop selling clothes*

Photo 2.3 *Stalls selling electronics and educational books*


Photos 2.4 and 2.5 *Fruit stands at Majengo market*

Walking through Dodoma city you see all kinds of women: dressed in original *kanga*s and *kitenge* and dressed according to the latest fashion. The women working on the compound where I lived dressed in both styles: some wearing earrings with the Chanel logo, or a *Nylon* magazine T-shirt (although the wearer was unaware of the magazine), tight jeans, while others wore dresses made from Tanzanian fabrics (some of which are imported from China). The younger men in the city mostly wear jeans and a T-shirt, while you sometimes see older men wearing an oversized suit. But you also see Maasai warriors in Dodoma city, with their red-and-blue cloth wrapped around their body, holding a spear in one hand. There is a large market (called *SabaSaba*) where second-hand clothes and shoes are sold, and there are numerous shops in the city centre selling fabric and where (mainly male) tailors work.

The central indoor market called Majengo (photos 2.4 and 2.5) is located near these shopping streets. In the market you can find all sort of fruits and vegetables, and on one side of the market, along the street, you can buy poultry, and a bit further down fruits, peanuts, and phone cards. This is also a place where the *dala dala* leave for other parts of Dodoma. In the course of the fieldwork, the informal fruit and vegetable market (which also sells second-hand clothes, shoes, bags, etc.) expanded into the streets leading away from the central market. This can be explained by the people working at the ministries in Dar es Salaam moving to the capital, Dodoma, as instructed by the previous president Magufuli. Dodoma is increasingly becoming a city with opportunities: for students and for people looking for a job.

The central area of the city is divided into different wards with names like Majengo (where the market is), Madukani (Swahili word for in the shops) and Mji mpya (Swahili for new city) and is surrounded by many more wards, and new wards are being built. In 1988, Dodoma Urban district consisted of nine urban wards (Viwandani, Chamwino, Makole, Uhuru, Kiwanja cha Ndege, Hazina and Majengo) and two mixed wards (Kikuyu and Tambukaleli) (NBS *et al*. 2003; 29-30). In 2002, Dodoma Urban consisted of 30 wards, 42 villages, and had a population of 324,247 people (ibid.: 7, 10). According to the 2012 census, the population was 410,956 people (NBS 2012). According to the 2022 Demographic and Socioeconomic Profile this had increased to 1,087,745 people and was almost equally divided between men (529,805) and women (557,940) (NBS 2022a: 37). In June 2014, Dodoma consisted of four Divisions (Dodoma Mjini[37], Hombolo, Kikombo, and Zuzu) and 37 wards with 133 villages. Dodoma Mjini is comprised of 22 wards with 85 villages. In 2022, Dodoma City had 41 wards (NBS 2022b: 30). These figures indicate that Dodoma is clearly a growing city. The interviews with young adults reveal that they live in different areas of the city, both in newly built wards and longer-standing wards; the majority do not live in the city centre.

You can see the expansion of the city on the outskirts of Dodoma, where many houses are being built. My experience and anecdotal reports from my research assistants, suggest that this building can take a long time. My research assistants told me that once they have managed to acquire a certain sum of money, they can proceed with the next step of building a house. During the building process, they can also have bricks made and stored in a separate location until they have enough bricks to build the house. One of my friends needs 1,050 bricks; one brick costs 10,000 TSH (approximately €5 at the time of my fieldwork). Another friend informed me that the total cost of build his house will be approximately 6,000,000 TSH (€3,000) (fieldwork notes May 2016). This is three times the Gross National Income of 2018.[38] House prices in Dodoma have increased as well. During an informal conversation with one of my friends in June 2014, he informed me that renting a house used to cost 40,000 TSH (approximately €20) but in 2014 it can cost up to 500,000 TSH (approximately € 250). Another friend pays 50,000 TSH per month to rent a one-bedroom apartment including water (fieldwork notes May 2017). These amounts are high for a person belonging to the lower-middle income class who does not have a steady income.

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[37] Dodoma city.

[38] Battaile, W.G. (2020). *What Does Tanzania's Move to Lower-Middle Income Status Mean?* https://blogs.worldbank.org/en/africacan/what-does-tanzanias-move-lower-middle-income-status-mean#:~:text=Tanzania's%20GNI%20per%20capita%20increased,a%20lower%2Dmiddle%20income%20country.

Other changes were noticed during my fieldwork periods between 2014 and 2018: as a consequence of people working at government ministries moving from Dar es Salaam to Dodoma, the city became much busier with *bodabodas* (motor taxis) and *bajajs*. The stand where the *dala dalas* and big buses to other cities in Tanzania departed was closed down. The *dala dala* stand was moved to another place in the city and the general stand for the big buses moved to Nanenane, an area on the edge of Dodoma, on the road to Dar es Salaam. Now, only the private bus companies have a stand in town. A new site for *dala dalas* and big buses, located on the other side of the city, where you would depart for the western part of Tanzania, is expanding. It is likely that the main *dala dala* stand was moved because of the developing city and the growing number of people who are travelling within the city or to other cities. Another change that makes the expanding city visible is the continuous construction of houses and new tarmac roads.

The next part of this section examines access to four important aspects of life in Dodoma, namely, occupations, religion, education, and health. This will give shape to young people's narratives about the city of Dodoma and their daily lives, specifically in relation to health-related issues, since that is the focus of my research.

2.4.1 Occupations

Dodoma is a city with a variety of job opportunities, and from the interviews with my interlocutors, it became clear that people come to the city specifically because of the opportunities. However, there are also clear limitations, in the sense that there is no large industry or large companies in Dodoma to provide people with employment. As mentioned in the introductory chapter, I will use occupation as one of the parameters for determining the middle classes. Most people in the middle classes interviewed in Dodoma work in a shop, as a teacher at one of the educational facilities, or in a biomedical healthcare facility. During my research, I took note of the occupation of 65 of my interlocutors. These included: students (5); teachers (7); shopkeepers/retail (11); administrative jobs (4); and health workers/nurses (8). Six of my informants had unique occupations like cartographer, librarian, or hospital ward executive officer. Four interlocutors had a lower educational level and worked, for example, as a housekeeper or housewife. There were also religious leaders (5) and indigenous healers (13). Two of my interlocutors were unemployed. It is likely that those people working in a shop or in the informal sector, as well as the indigenous healers, were dependent on how many people bought something in their shop or made use of their services for their income. Unfortunately, time constraints meant that it was not always possible to ask people basic questions like where they were born, what their profession was (34 people were not asked), and how many children

they had (46 people were not asked). In particular, it was not possible to ask people for this information during the interviews conducted at medical clinics. Because these interviews were not planned, and people had other business to deal with, we kept the interviews as brief as possible and only asked our main questions on health-related issues. However, the people being interviewed at the mobile clinic attended with their young children under five years old and I therefore was able to ascertain that these interlocutors were young adults with children and were therefore important in gaining the narratives of young adults living in Dodoma urban concerning their health choices and possible use of objects.

2.4.2 Religion

As this thesis will show, the primary religions of Christianity and Islam play a big part in the lives of the young adults interviewed; indeed, religion is one of the main reasons young adults give for why they do not visit indigenous healers or why they say they do not use objects for protection against or curing illnesses.

According to Burchardt and Wolhlrab-Sahr (2013: 605), worldwide migration causes the movement of religious identities and practices. Moreover, religiously diverse societies can present challenges. The main religions present in Dodoma are Islam and Christianity, but there are also Hindus and Sikhs in the city. None of my interlocutors indicated adhering to another religion, like African Indigenous Religion (AIR).[39] That is not to say that these religions do not exist in Tanzania or amongst the interlocutors.

Christianity was introduced to East Africa, the present-day countries of Uganda, Tanzania and Kenya, from the 1500s to 1631, the Christian missionary period (Maseno 2016: 108). In the fifteenth and sixteenth centuries the Portuguese reached the East African coast and sent missionaries to work in the Kenyan coast (ibid.: 109). Due to the expansion of the railway line in Tanzania early twentieth century, the missions were able to expand their outreach (ibid.: 111). The missionaries were also the first European medical workers in Eastern Africa, a role taken over by the government in the 1920s (Iliffe 1995: 239). Iliffe (1995: 53, 54-5) also shows that Islam reached East Africa through the easily-navigated trade routes of the Indian Ocean. One of the first indicators of eleventh-century commercial expansion and Islamisation was the foundation of a Muslim dynasty at Kilwa, which was located on the southern coast of Tanzania.

[39] I follow Williams (2021) and use this term to indicate the indigenous religions of Africa.

There are many different places of worship in Dodoma, including: several mosques; Anglican churches; Pentecostal churches (such as the (Tanzania) Assemblies of God, Evangelist Assemblies of God Tanzania, Pentecostal); Catholic cathedrals; Lutheran churches; a Methodist church; a church of God (*Kanisa la Mungu*); a church of the bible (*Kanisa la Biblia*), and many more. Some of the largest churches – a Catholic church, Assemblies of God, and a Gospel Media Studio with a church – can be found on the road to Arusha, a city in Northern Tanzania. The largest churches and mosques (photo 2.6) in the city centre are an Anglican church, the Ismaili Mosque, and a Lutheran church, all of which are very close to each other (fieldwork notes June 2014).

Photo 2.6 *Sunni Mosque Nunge*

The majority of interlocutors who were asked about their religion were Christian (approximately 68%). Approximately 30% of the interlocutors were Muslim. Within the Christian religions, several different denominations were mentioned, including Roman Catholic, Lutheran, Anglican, Protestant, and the seventh-day Sabbath. This corresponds with the many different kinds of churches mentioned above. The religious identities of the interlocutors were visible in the sense that they presented themselves as either Christian or Muslim and insofar as they followed the religious convictions of their religious leaders with respect to health-related issues, which will be discussed in the following chapters.

2.4.3 Education

As became clear in the introduction to this thesis, education level is one of the focal points for young adults interviewed in relation to their status as belonging to the middle classes. The education system in Tanzania is based around a 2-7-4-2-3+ structure. In other words: two years of pre-primary school, seven years of primary school, four years of ordinary secondary school (ordinary level, form 1-4), two years of advanced secondary school (advanced level), and at least three years of higher education (Nuffic 2015: 6). As indicated earlier, the interlocutors had different levels of educations, but most of them had a steady job. Miriam is a 48-year-old woman, holds a master's degree

Photo 2.7 *Institute of Rural Development Planning*

Photo 2.8 *University of Dodoma*

and works as a municipal nutrition officer in Dodoma (interview 2, 6 May 2015). Grace is a 32-year-old woman, has form 4 as a highest education level and during the time of the interview works as a shop attendant in the city centre.

All different forms of education, from day care up to university, are present in Dodoma. There are many primary and secondary schools, including those for children with special care needs, like the Dodoma Deaf School. The regular primary and secondary schools have their own school buses that pick up and drop off children to and from school.

There are several universities in Dodoma, including St. John's University of Tanzania, the Institute of Rural Development Planning (IRDP – photo 2.7), and the University of Dodoma (UDOM). St. John's University of Tanzania is a private university established in 2007 and owned by the Anglican Church of Tanzania. UDOM was also founded in 2007, but by the former president Benjamin Mkapa and sits on top of an unnamed hill, which affords views across Dodoma (photo 2.8). Several of the young adults I interviewed were living in Dodoma because they were studying at one of the universities. A few young adult women were living with a young child but without their husband, who remained back in their home area.

Approximately 28% of the interlocutors (whose education level is known) had Standard 7 as highest level of education. Approximately 21% had Form 4 as highest level. Of those higher-educated people interviewed, five had a bachelor's degree, five people had a master's degree and thirteen had a different kind of level of education, e.g., Degree, Certificate and/or Diploma.

2.4.4 Health

The main part of the interviews conducted focused on the health of the young adults and their young children under five years old. The questions asked related to health seeking and the main questions included: what do they do when their young child is not feeling well, or how do they keep their young child healthy? In their chapter on financial constraints and health-seeking behaviour in rural households in Central Togo, Leliveld *et al.* show that a large number of their interlocutors resorted to a form of self-medication when dealing with an illness of the adults themselves or their children. If they did not subsequently recover, then the interlocutors went to providers with a broader range of services, like a hospital or an indigenous healer (2010: 266, 267). Leliveld *et al.* distinguish six factors mentioned by their interlocutors in relation to health-seeking patterns: financial considerations; vicinity; familiarity; gravity of the illness; quality of the provider; and 'other factors'. They found financial considerations and the distance to the nearest health service location (vicinity) to be the most important factors. Choosing for self-medication or visiting an indigenous healer is mainly determined by financial considerations, in the sense that self-medication is low cost, and an indigenous healer can be paid in terms or in kind (ibid.: 268). There are several hospitals in urban Dodoma: the government-run Aga Khan Hospital, and General Hospital and the private DCMC Hospital (also named Ntyuka Hospital) (photos 2.9 and 2.10), Upendo Health Centre, Makole Hospital, and Mkapa hospital (the latter

Photo 2.9 *DCMC Hospital*

Photo 2.10 *Signpost at DCMC*

Photo 2.11 *Duka la dawa*

Photo 2.12 *Mobile clinic*

is the Dodoma University hospital). There is also a Maternity Care Centre in the city centre. Other medical facilities include the Mirembe Psychiatric Hospital and the Rehabilitation Hospital. Accessing Dodoma's biomedical healthcare system is based on health insurance. Employers issue a health insurance card but it cannot be used in all hospitals. Thus, in some cases, this insurance card determines which biomedical healthcare option young adults chose. But mostly it was practical reasons, like the length of the queues (which seem much longer in government hospitals than in private hospitals) or which services were provided that determined the health-seeking behaviour of young adults.

In addition to hospitals, there are also many pharmacies (in Swahili they are called *duka la dawa*, which literally means "shop of medicine") (photo 2.11) and at least two *duka la dawa za asili* (which means "shop of traditional medicine") in the city, and a chemist. There are also some clinics, two of which I visited in 2015. One was a mobile clinic (photo 2.12) and was only open once a month (fieldwork notes May 2015). While at one of those clinics, I observed that all the parents have their own notebook in which everything about their young child is written down. Each child also has his/her own, home-made weighing outfit, which is never shared with anyone else. In addition to these biomedical facilities for health-related issues, you can find signs advertising an indigenous healer (*mganwa wa kienyeji*), or someone who can help with love issues, with a phone number and name, pinned onto the electricity poles alongside the roads (photo 2.13). Other indigenous healers do not have such advertisements but can be found throughout different places within the city, mostly hidden as they work from home. Chapter 3 will further explore the issue of medical plurality with a focus on folk healing (following Kleinman's (1980) healthcare system structure).

A community health worker told me that the hospital he worked in had different programmes aimed at prevention, for example safe motherhood, hygiene, and sanitation. The programmes were implemented in different villages within the Dodoma region. The programmes have two goals, namely, data collection and a campaign on how to do certain things, like washing hands (interview 2, 23 June 2014). Another interlocutor who was doing a master's study and worked at an NGO, informed me that, in 2012/2013, the government and a number of hospitals – Aga Khan, St. Gemma, Amani, and perhaps DCMC – collaborated to provide maternal services. She told me that, consequently, she now feels more comfortable going to any of these hospitals (interview 10, 17 July 2014).

Photo 2.13 *Advertisement on an electricity pole*

The ten most commonly reported causes of death in the Dodoma region in 2000 were malaria, anaemia, pneumonia, protein energy malnutrition, meningitis, tuberculosis, cholera, diarrhoea, ARI (Acute Respiratory Infection) and pregnancy complications (NBS *et al.* 2003: 123). During the interviews, some people informed me that malaria, typhoid and UTI (urine infections) are the most common diseases in Dodoma. As one person put it: "*if you do not use [a mosquito net], you will die in Dodoma*" (interview 5, 3 May 2017). Most young adults told me that they go to the hospital immediately when they or their child is not feeling well. Or, they first take a Panadol/paracetamol, then wait a night/day, and if there is no improvement they go to the hospital. Most people gave several options of hospitals they went to.

All the people interviewed (young adults, indigenous healers, and religious leaders) were living in the urban environment of Dodoma city. The majority of the people interviewed made use of modern services like hospitals (either private or governmental, clinics or pharmacies). Not many people interviewed visited the shops in the city centre where herbs are sold, by mainly Muslim shopkeepers (see Chapter 3 for a more extensive explanation about these shops). Interlocutors who do use herbs seem to get their herbs from their home town in another area of Tanzania, or from around Dodoma. Chapters 3 and 4 will look further into the topic of herbal

medicine and its position in relation to biomedicine and material objects used for healing.

The previous part of this section showed that multiple healthcare facilities can be found in Dodoma, and that many young adults make use of those facilities as their first option when they or their young child are unwell. During the existence of Dodoma, the kinds of health care facilities have changed and the scope of what they provide have broadened, as the narrative from an older man shows. *Mzee*[40] Michael (interview 7, 11 May 2016), a Christian man from the Gogo ethnic group, born in 1945, who told me that he went to the *mganga wa kienyeji* (indigenous healer) to get some medicine for protection (*kinga*) for his own children. He used it for protection against *degedege*, but it can be used against many things. He told me that:

> *When the child was born, the umbilical cord was removed. They mix it with medicine for protection and wrap it in black cloth and wear it around the wrist. The mama could go to the* mganga[41] *and get the medicine. The child wears the object for 3–4 years, depending on the strength of the black cloth. When the child is playing it might fall off. The mama could remove the object from the waist, after up to six years. They wrap something with medicine from the* mganga. *They put one small thing in the cloth, and the whole piece of the cloth was wrapped around the waist* (interview 7, 11 May 2016).

Unfortunately, he did not know the name of the medicine that was wrapped in the cloth.[42] When he used to go the *mganga* he refused to take his child to the hospital, because he believed that if the child was injected with something then he/she was sure to die. He continued that now the hospital has improved, in the sense of having better treatment, he feels it is ok to take a child to the hospital. He told me that "*a long time ago, people were not well educated and the awareness was low*". Nowadays, he would go to the hospital with young children and as an adult. Indeed, he goes to the hospital to get check-ups and medicine for his asthma. When you go to the *mganga*, there is no check-up. He also told me that, nowadays, he does not see younger people using objects to treat health issues, because there is access to better medical services and people are more aware of what options are on offer. The old man continued by saying that, today, parents are aware of keeping their children healthy, and take them to the hospital when he/she is sick.

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[40] *Mzee* is the Swahili word for older man.

[41] The Swahili word for healer.

[42] Chapter 4 will go into what can be put inside the object.

When *mzee* Michael was a child himself, his parents used objects to protect him:

> *The umbilical cord is only put in the cloth around the wrist, and not on the waist. The object on the wrist can disappear. The object on the waist you can keep for another child who is coming* (interview 7, 11 May 2016).

He also used these kinds of objects with his own children. After his last child was born, he dropped the object in the toilet. At that time, he started believing in God, in the sense that he and his family converted to Christianity. This was also the time he stopped visiting the indigenous healer.
When my research assistant and I asked him if he has heard of *ilizi*, he confirmed. He heard that it protects the body against any attack, but that he did not know the deeper meaning. While *mzee* Michael told me that he has never used this kind of object, I argue that the object he received from the indigenous healer is *ilizi*, since it consisted of black cloth with an umbilical cord inside, and it is used to protect a child against an illness, against a failure of health. As indicated, he stopped using the objects for protection, became a Christian and stopped going to the indigenous healer. This is a clear example of the rupture-repair theory: he stopped using the objects and seeing an indigenous healer and at the same time converted to Christianity and started making use of biomedical health facilities, which became better as *mzee* Michael grew older. As this narrative makes clear, the indigenous healer was not able to conduct an asthma check-up, forcing *mzee* Michael to visit the hospital. I argue that this narrative affirms my hypothesis that, today, healers are (mostly) visited for other kinds of misfortunes than biomedical care can provide for, which will be further explored in Chapter 3. Unfortunately, I do not know if *mzee* Michael visited the healer for other kinds of issues. My findings point to this not being the case, since we asked whether we could visit the indigenous healer he went to, but *mzee* Michael informed us that the healer has died (interview 7, 11 May 2016).
The narratives reported relate to different stages, starting from the time a woman wants to get pregnant until the child is older than five years. The next part of the chapter deals with these different stages and is illustrated by narratives.

2.5 Narratives on pregnancy and young children

Fertility is an important concern within both Christianity and Islam. Both religions can intervene in the field of reproduction and do so by helping humans to respect and recognise their duties and rights in this area. According to Serour (2008: 35), the prevention and treatment of infertility is a significant issue within Islam, in which authenticity of lineage is a central feature. Family commitment in the form of childbirth and -rearing

is an issue for both partners. Serour tells us that reproduction is a process that involves not only the person who becomes pregnant, but also "the other partner, the child to be born, the family, society and the world at large" (ibid.: 35). In contemporary society, it is acceptable for a married couple to seek help in trying to have a baby (ibid.). According to Schenker (2000: 77), while the Vatican does not permit assisted reproduction within Catholicism, it may be practised within other Christian denominations. During my research, I asked the interlocutors how they protect and cure themselves from illnesses, and through the interviews with indigenous healers I learned about herbal medicines to be used for example to become or stay pregnant or to prevent miscarriage. With staying pregnant I mean that the woman in general has a healthy pregnancy, but may lose the child because someone is 'playing' with the child - which will be further explained in 2.5.1. With miscarriage I mean that a woman has miscarried by natural causes and looks for medicine to make sure she does not miscarriage any more.

Lindquist (2012: 338) asks how "people choose certain treatments and adhere to them, or maybe combine or alternate between them." Likewise, my research asked how (and why) do people choose for the use of objects instead of modern medicine, medicinal plants, or other forms or treatment, or vice versa? And what are their choices when they have the flu or when they suspect a more serious disease (like malaria)? Lindquist answers her own question by saying that the treatments are chosen because they are considered efficacious, but, at the same time, asks how this efficacy is constructed. And she adds the question "why does one believe that a treatment is the right one?" (ibid.). The cases from the previous sections and the narratives presented in this paragraph 2.5 aim to give a clearer picture of the options young adults choose and why certain choices (for example not using material objects) are made.

Health problems for men and women relating to sexuality, reproduction, and marriage can be summarised as misfortunes of gender (Whyte 1997: 16), and there are various options for healing and protection in this regard in Dodoma. When you encounter a misfortune of gender you can go to a hospital or to a pharmacy to get medicine. But there are also objects and/or herbs that can be used for protection and/or cure, of which cases will be presented in the following sections. These misfortunes of gender are divided into the following categories: becoming or staying pregnant (2.5.1); miscarriage (2.5.2); and young children (2.5.3).

2.5.1 Becoming or staying pregnant

To obtain more insight into the aspects of reproduction, I interviewed both young adults and indigenous healers to hear their narratives concerning what they know

can be done or used (herbal medicines, biomedicines, material objects) to become or stay pregnant. The first cases presented address the narratives reported to me, and the case of a young adult visiting an indigenous healer. The final cases address the narratives reported by indigenous healers. The presented cases aim to show what kinds of treatments can be sought when becoming or staying pregnant, for both women and men, and, in some cases, the narrative is related to religion.

One of my interlocutors, a Christian woman in her early thirties, shared some general narratives with me about objects for good health (*afya nzuri*) for women who are pregnant, who want to get pregnant, but also when the child is born. She reported that when a woman gets pregnant, she goes to the clinic to have her pregnancy checked. She will be given an injection in the upper arm for polio, *surua*[43], *pepopunda*[44], and she will receive malaria medicines, worm medicine, and medicine for the blood. She told me that a woman is also checked for HIV and is given a mosquito net. In addition, she receives information about what she needs to eat: vegetables, nutritious food like porridge, and fruits. When a baby is born, he/she gets milk from the mother until the baby is three months old. After that, the baby is given cow's milk and porridge. The baby is vaccinated when it is born, after one month, and again after three months. The baby's weight is also checked and it is tested for malaria and polio (interview 3, 24 June 2014). This case clearly indicates the use of biomedical care in relation to becoming pregnant and after the baby is born.

As indicated in the introductory chapter, and earlier in this chapter, both Christianity and Islam play an important role in the lives of young adults in Dodoma. According to Schenker, in Christianity and Islam sexual intercourse is perceived as almost exclusively meant for procreation, and only a husband and wife are allowed to have sexual intercourse (Schenker 2000: 81). In cases of infertility within Christianity, "everyone must understand and properly evaluate" (ibid.: 82) if a spouse is not able to have a child or who is "afraid of bringing a handicapped child into the world" (ibid.: 82). Within Islam, high fertility is important, and is associated with the tolerance of polygamy (ibid.). Moreover, according to Schenker, within Islam, it is acceptable to look for treatment when procreation fails, but it must be within the marriage contract and without the mixing of genes (Schenker 2000: 85-6; Serour 2008).

The next case is a clear example of the role of religion in a pregnancy related case. Kharim, a young, Christian adult in his late thirties with a university education and a steady job, shared the narrative he heard from his mother:

[43] Measles (TUKI 2001: 303).
[44] Tetanus (TUKI 2001: 264).

The child can be taken out of the womb by witches.
My mum's last born is a son, he is now doing A-level at school. Before he was born, the umbilical cord was around his neck. Someone is playing with him. If an umbilical cord is around the neck, in most cases the child, or the mother, or both die. The nurse who was with the delivery was Christian. She was praying. Because of the praying – saying words in Jesus' name – the delivery went well. Both mother and last born are alive. I ask Kharim if his mother went to the *mganga* to find out who is playing with her. *She never went to the* mganga *to find out who is playing* (interview 9, 11 July 2014).

In addition to cases collected from young adults that concerned themselves or relatives, I also came across a case during my participant observation at the office of the indigenous healer Hakeem. In 2018, while at Hakeems office, a young woman from Dar es Salaam came with a female friend for a consultation with the healer. The woman was 20 years old, wore a *kanga*, a red shirt with a print, a purple hat, a scarf on her head, and red slippers. The healer asked my research assistant to ask about the problems the woman had; she was told it was stomach problems.[45] She had been married for three years without getting pregnant. The wife of the healer prepared some medicine called *dawa za uzazi* (literally medicine of birth). The patient received two medicines in the form of a yellowish/beige powder, which were put in paper. One medicine is called *tumbo la wazazi* (literally stomach of the parents) and is used when a woman has problems getting pregnant. Pieces of the *dawa za uzazi* need to be boiled and the water taken every day, three times a day. When the pieces have all been used, the patient needs to throw them into the rubbish. The second medicine is *unga wa sufa* (almond flour), which is boiled or the woman can take the powder and lick it. Another medicine that can be used is *mizizi ya tulatula* (literally roots of *tula tula* plant, most likely nightshade) (photo 2.14), which the patient can

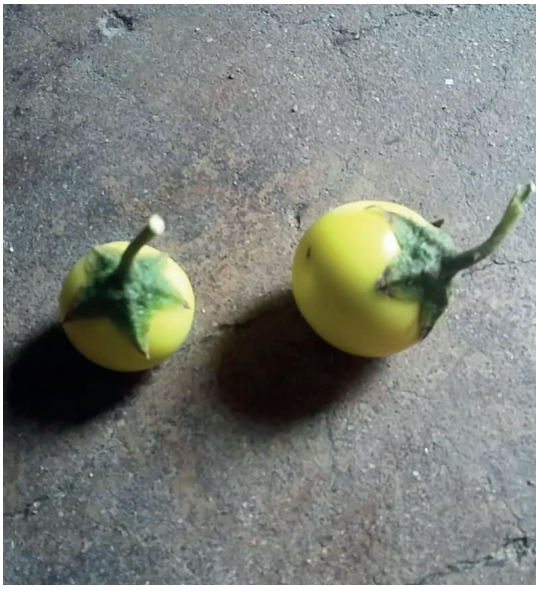

Photo 2.14 *Tula tula plant*

[45] We asked permission to be present before we entered the consultation room. No additional permission was sought for the research assistant or I to ask questions instead of the healer. The woman did not object to us asking questions.

take as a whole, or simply lick the powder form of it. The promise is that if she takes it every day for one month, she will get pregnant. The young woman had heard about this healer from people that she talked to in Dar es Salaam, where she will return the next day. The healer told me that the wife who is helping (he had several wives) used the same medicines as the ones he gave to the young woman from Dar es Salaam, and she has had six children. The healer, his wife, and the young woman then ask for some privacy, so my research assistant and I went outside to wait (interview 4, fourth visit, 31 July 2018). This case shows that the indigenous healer (*mganga wa kienyeji*) prescribes several herbal medicines to help the woman become pregnant, based on his own wife's successful use of the same herbs.

A final case concerns a more general narrative in relation to an indigenous healer. One of my interlocutors, a young, Christian woman working as a secretary, shared the narrative that if you live in the same compound as another woman, who does not want you to get pregnant, then you visit an indigenous healer (*mganga wa kienyeji*). The *mganga* will inform you that the other woman is bewitching[46] you. The healer will then ask you to get the woman's footprint from the sand or a piece of her hair, and he will use this to make medicine from it. He looks at the objects and tells you that someone is 'playing,' meaning that someone is malignly intervening. He can tell who is 'playing,' but keeps quiet if you don't want to know exactly who it is. He explains the conditions that will stop that person 'playing': you have to bring the healer a white or black chicken, and some *kaniki* (black cloth). The healer will make *ilizi*; he binds the medicines together, and encloses it inside the *ilizi*. Then you can go home. After one to three months, even a year, you will get pregnant. But what if a woman does not want to get pregnant yet? The same interlocutor also told me that there are a kind of sticks (*vijiti*), like trees. They are given as a form of injection (*sindano*) and are used to make sure you do not get pregnant. You can only get this injection in the hospital. If you do not want to get pregnant for three years, you will not get pregnant for three years (interview 7, 2 July 2014).

The above-mentioned narratives told by young adults reveal cases in which biomedical care and religion play a role in pregnancy-related issues. On the other hand, while visiting the office of indigenous healer Hakeem, it also became clear that young adults sometimes visit a healer for issues related to getting pregnant. The final case presents a more general narrative regarding what a young adult can do when someone is 'playing' with you to prevent you from becoming pregnant.

[46] Before she gave me this example, she told me that *kuroga* (to bewitch) is the same as *uchawi* (witchcraft).

The next cases relate to information I collected from the indigenous healers and sellers in the *duka la dawa za asili* about what they can prescribe when a woman wants to become or stay pregnant. One of the sellers from a *duka la dawa za asili* started laughing when I asked him about this subject, because, he said, it is top secret.[47] He did, however, show me the medicine: it was a plastic bottle containing a brownish fluid (photo 2.15). You dilute the fluid with water and drink it.

Photo 2.15 *Super Power medicine*

In an interview with an indigenous healer, Tish, I was told about the medicines used for getting pregnant:

> *I go in the forest in the mountains and prepare medicine from roots* mtulu *and* mweze *(Gogo names). I get the roots and pound them. You have to put it in water, the person who failed to get a job or who has bad luck, bathes one time in that water.*
> *Another medicine is* mtundi la mbewa *(Gogo name), of which the roots are boiled. When it is ready, you have to drink the boiled roots. After five days the patient has to come back with a hen. Then the hen is boiled together with the medicine, like soup. The hen doesn't have to have a specific colour. The woman takes the soup once and eats the meat. After that, the woman goes back home, and after one month she becomes pregnant* (interview 11, 9 May 2017).

The common denominator in the narratives collected from indigenous healers is that herbal medicines are used for getting pregnant. These herbal medicines can be prescribed and given by different kinds of indigenous healers, either in a shop in the city where herbal medicines are sold or by a healer who listens to your problems and prescribes a tailormade solution. The religious leaders acknowledge and accept the use of herbal medicines, but they do not accept the use of *ilizi*, which, in some cases, is made by the same healer who also provides herbal medicine. This seems to

[47] The indigenous healer did not explain why it was top secret. I assume it was in a bid to prevent the recipe from being stolen.

be a contradiction. But the explanation appears to lie in the different names given to healers, i.e., *mganga wa kienyeji* or *mganga wa tiba za asili*. As one Christian religious leader informed me: a *mganga wa kienyeji* is not accepted by the church, but a *mganga wa tiba za asili* is. The religious leader explained the difference:

> *A person who tries to oversee, to see beyond, that is a* mganga wa kienyeji, *someone who oversees your problems. The church is against that, because the church believes it is only God who can see beyond one's problems. And that human being has no such powers to oversee one's problems. By doing that they believe the* mganga wa kienyeji *is applying the satanic things to people. The* mganga wa tiba za asili *believes in God and prays over the medicines he gives. Therefore, that person is welcomed in church* (interview 16, 15 May 2017).

This may explain why the shops with the herbal medicines are visibly located in the city centre: religious leaders are not against herbal medicines, and therefore not against shops that sell herbal medicines as long as they are not involved in making material objects for health-related purposes. Religious leaders do not accept those indigenous healers whose practices offer both. By looking at the division between the different kinds of healers based on their Swahili names – see Chapter 3 for a more detailed overview – these differences become clearer than they do if you only look at the English terminology, i.e., indigenous healer.

I also encountered some narratives concerning infertility. When I asked the seller in the *duka la dawa za asili* what is prescribed when someone is infertile, he told me that, if it concerns a woman, then they have to boil certain medicines and drink one cup in the morning and one cup in the evening, for three days. If a man is infertile, then different substances can be used, such as *abdalasini* (basil) or *tangawizi ya unga* (powdered ginger). These ingredients need to be boiled together and, again, you drink one cup in the morning and evening for three days (interview 28 July 2014). *Mzee* Ibrahim, an indigenous healer whom I spoke to several times during my fieldwork, recommended that a man struggling with infertility should eat five to seven almonds every day for seven days (interview 1, 18 June 2014).

2.5.2 Miscarriage

While talking with young adults about young children and their health, they also reported some narratives concerning another aspect of reproduction, namely, miscarriage, which indicates a woman has miscarried due to natural causes. Consequently, I also asked some indigenous healers about treatments in cases of miscarriage.

One of my young, female adult friends – who has a college diploma and works as a secretary – told me that *ilizi* can be used when a woman has a miscarriage. She told me that if a woman suffers a series of miscarriages then she can go to an indigenous healer for help. She will then be given *ilizi* as a treatment, but only the healer will know what medicine is inside the object. The woman can wear it on a chain or a rope, but always under her clothes. A woman can also use a shilling attached to a rope and wear it around her wrist, upper arm, or neck, in order to stay pregnant after having had a miscarriage. The shilling hangs on the bottom of the rope, which must be black (interview 7, 2 July 2014). As became clear during the research, many young adult interlocutors maintained narratives such as this about objects in relation to health issues, but never admitted to using these objects themselves. This case made clear that an object like *ilizi* can be used for a positive cause, namely, to prevent miscarriages.

Another case concerns a female Christian, with Standard 7 as highest level of education, interlocutor who was 40 years old and had two older daughters. She had experienced a miscarriage during her second pregnancy and shared her narrative about this:

> *I did not feel well and went to the hospital to check if it was malaria or if I was pregnant. The doctor checked the blood and told me that there is a new visitor (*mgeni*) in her stomach. I got malaria for which I took strong medicine. After 6 months the baby died inside. I went to the hospital to get the baby out, I felt too much pain. My stomach felt heavy. After the baby got out, I received a medicine for the pain and different medicine for the appetite. When the pain was gone, the appetite came back. I prayed more and went to church more; I did not go to the* mganga. *A friend came to visit and prayed with us* (interview 11, 5 August 2014).

This young adult acknowledged having had a miscarriage, but she did not go to an indigenous healer for treatment, rather she made use of biomedical care and her Christian faith.

I spoke to a number of indigenous healers about miscarriage and the treatments for it. During our first interview, in 2014, *mzee* Ibrahim informed me that when you miscarry, you should chew on a certain tree[48] to clean the uterus and to become healthy again. This should be done for 21 days (interview 1, 18 June 2014).

[48] *The name of the tree did not surface in the interview, neither did which part of the tree you should chew on.*

The final case on the topic of miscarriage concerns an indigenous healer who owned a shop selling herbs (*duka la dawa za asili*). He informed me that it is top secret what is given when a woman has a miscarriage, but he did share some narratives. He told me that a woman might be given *tende na maziwa*, dates with milk, where the date is turned into juice. You can also use specific herbs (photo 2.16), which smell like chamomile, but it also looked as though it was mixed with other kinds of herbs. When a woman is pregnant, drinking the herb (half a cup twice a day) helps to keep the baby inside (interview 28 July 2014).

Photo 2.16 *Chamomile leaves*

This section aimed to make clear that there are different kinds of narratives amongst both young adults and indigenous healers concerning miscarriage that show particular similarities but also important differences. Most cases concerned the use of herbal medicines and biomedical care, but, as the first case showed, *ilizi* objects can also be used.

2.5.3 Young children

The focus of my research was on health issues relating to young children under five years old. As mentioned earlier, I focused on young children, because during the interviews, interlocutors said that with the young children it is accepted to visibly wear material objects used for healing and protection (like *ilizi*, which will be the focus of Chapter 4). My assumption was that people were more willing to talk about these objects in relation to (their) young children as there is less secrecy associated with them in this regard.

As Lefèber and Voorhoeve (1998: 1) mention, children are vulnerable. This is clear from the high levels of child mortality and child morbidity in local (African) situations. The World Bank provides information about the mortality rates of children under five years old for countries across the world. The mortality rates for Tanzania decreased to 47 per 1,000 live births in 2021. By comparison, in the Netherlands the mortality rate

in the same year was four per 1,000 live births.[49] One of the first questions I asked young adults was how they keep their young child healthy, which I also asked Zuri, the young adult mentioned in the introduction of this chapter (interview 9, 5 May 2017). Like her, many interlocutors answered that they make sure their child eats well, sleeps well, is clean (i.e., frequently washing/bathing the baby), and they take the child to the clinic in order to monitor their growth and get vaccinations. The young adults generally dressed their children in a shirt, a pair of trousers and a sweater, and always made sure there was a mosquito net for them or, if not, kept their environment clean. Some interlocutors also told me that they prayed for their child. These young parents tried to feed their children healthy food and drinks such as milk, bread, porridge, juice, *ugali*,[50] rice, and vegetables. In several interviews I heard that it is common in Tanzania for the baby to sleep in the same bed as the parents. According to one interlocutor who is doing a master's study:

> *Mostly the child sleeps with the mother when they still breast feed, until two years old* (interview 10, 17 July 2014).

When asked what they do when their child is not feeling well or is ill, most young adults informed me that they first gave them a Panadol/paracetamol, but if they did not get better, they would then take them to the hospital. The choice of hospital varied and, as indicated earlier in this chapter, is mostly based on practical reasons like the length of the queue or services provided.

As previously discussed, people can 'play with someone' when a woman is trying to get pregnant. But people can also 'play' when a baby is born, for example if another woman is jealous of you for getting pregnant. One of my young women friends told me that when a child does not feel well, or is crying a lot and trembling, the mother may ask herself why the child is sick every day. This interlocutor explained that she can go to the same healer that she visited in order to get pregnant to ask him/her why the baby is sick every day. The healer often tells the woman to bring certain items. The child is then made to wear things around the wrist or neck, or chalk is put on the baby's forehead before he/she goes to sleep. The interlocutor believes that this is to stop the child trembling (*ushituka*). Or, the chalk and medicine are put together in *kaniki* (black cloth), which can also be called *ilizi*. Often, the mother does not know what kind of medicine is used. How long the child has to wear the *ilizi* may differ; it might be a few years, until the child can speak, or until the child stops trembling or crying (interview 7, 2 July 2014).

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[49] Mortality rate, under-five (per 1,000 live births) – Tanzania, https://data.worldbank.org/indicator/SH.DYN.MORT?locations=TZ (accessed 20 December 2023).

[50] A thick porridge made from corn flour.

Kharim, a young Christian adult with a university education and a steady job[51] (whom I introduced in Chapter 2.5.1) told me another narrative concerning 'playing'. He told me that when young children are ill, it is a sign that someone is 'playing' with the child because of jealousy. A person whose child is sick goes to a 'witch doctor'[52] and the doctor makes cuts[53] with something on the chest or the arms. Another interlocutor mentioned that the cuts are made to protect the child against *wachawi* (witches), which gives protection for life (interview 4, 26 June 2014). Kharim explained that:

> K: *A child can also wear a charm around the wrist or ankle. Something round, clothing, black, with something in the middle. They might hide it, because they do not want to be local. People are changing.*
>
> GP: Do you know why it is the colour black?
>
> K: *Growing up Christian, darkness is not good. I think that is why it is black, because it is evil. Witches, when they are found they are black.*
>
> He shows a video of a friend of two witches who were found in Mwanza.
>
> K: *The woman was found with a sieve* (ungo)*, and the man was found with an arrow. They travel naked – it is their rule* (interview 9, 11 July 2014).

The above cases present general knowledge about the protection of a child, and how to protect a young child when someone is 'playing' with them. During the research, I encountered a few narratives concerning that the illness of a child being caused by someone who was 'playing' or, as mentioned in section 2.5.1, to cause a woman to miscarry. An indigenous healer can find out who is 'playing' with the child or with the pregnant woman and can protect the child or woman with an object like *ilizi*. But, as Kharim's narrative in 2.5.1 showed, it is also possible to pray for the child or the woman. Based on the narratives collected, I argue that the young adults of Dodoma who are higher educated and practice either Christianity or Islam claim they do not visit indigenous healers if they ever think that someone is 'playing' with them or their

[51] Due to privacy reasons, I cannot mention what his job is.
[52] The interlocutor used the English words 'witch doctor'. I assume the interlocutor means a *mganga*, a healer, since that is also the word he used during the interview when relating similar narratives.
[53] Cuts are generally known as 'incisions' and may be detectable. Incisions may involve different body parts for different reasons and can relate to different medicines for different reasons (cf Lefèber and Voorhoeve 1998 concerning scarring amongst young children as treatment for diseases).

young child, rather they resort to biomedical care and/or pray for their young child to get better. This claim is an essential part of their narrative.

The young adults' narratives revealed a variety of illnesses that young children may encounter and need to be protected against or cured of. As the following cases show, the narratives mainly concerned the use of herbs to cure diseases like diarrhoea and fever, when a child has pain in the stomach, rash on the body, or when a child is very thin. The first narrative was shared by a female interlocutor who works as a primary school teacher, and was about the use of biomedical care and herbs when her child had *chango* (stomach pain):

> *I tried to go to the hospital. But after waiting for transport to go to the hospital at midnight I called my mother, who brought me some medicine. The name is* omgilirima*, which is the name of the tree whose roots are used. The cover of the roots is pounded and put on a teaspoon with some water. When a child sneezes, you can also apply it in the nose, and you do this when there are signs of chango* (interview 4, 2 May 2017).

The second narrative was told by Brian (interview 5, 3 May 2017), a young adult in his early thirties who is a teacher at a secondary school, and it concerns a treatment for a child who has a rash. Brian comes from the Northern Tanzania where *omuyonga* (Haya name) can be used if a child has been sitting on the grass and gets a rash on the body. The *omuyonga* is smeared on the body, or the child needs to bathe in it. The medicine is made from the same grass that has given the child the rash. It is burned, which makes it black. Brian explains that he applied this medicine to his child when he was on holiday in his home region. He first visited a dispensary there, but the medicine did not work. He was told by some old people to use *omuyonga*. Brian informed me that, in the past, he would have used more indigenous medicines like these, but now he is living in Dodoma where these kinds of medicines are not available. He hoped that if he has a serious problem that he can obtain medicines from his home region.

The third narrative was told by one of my research assistants and is about a child who was very thin. It concerns an herb named *mapande*. If you wash the child in water with *mapande* then the child will put on weight. You can get the medicine from a *mganga*, but it is also available at the *duka la dawa za asili* (interview 1, 6 May 2015). In addition to *mapande*, another mix of herbs and fruit can be used. Jamila, a 30-year-old primary school teacher who has two children was asked by a friend why her child was not gaining weight. Her friend advised her to apply medicine while bathing the child, starting from the neck and moving down the body. The husk of the baobab (*ubuyu)*

fruit is pounded and mixed with roots of the *pigeon poa (mizizi ya mbazi)*. If the child is a boy, this needs to be mixed in water together with the root of a male pawpaw. She trusts the medicine, because it has worked for others, but Jamila decided not to apply it because she wants her child to grow normally (interview 4, 2 May 2017).

The herb *mapande* is also used to protect the child when the parents have sex.[54] According to one of my interlocutors, it is put in slightly warm water and the baby is washed with it just once. The parents wash with the herb before having sex. According to the interlocutor, the Wagogo practice this method for safe sex in order not to harm the young child (interview 4, 26 June 2014). One of my research assistants confirmed that *mapande* is used by the Wagogo people, but he did not know whether it is a Gogo or Swahili name (interview 1, 6 May 2015).

As the above-mentioned cases make clear, multiple young adults apparently know about a variety of narratives about the use of herbal medicines when a young child has health-related problems, like a rash. The following narrative combines the general aspects of keeping a young child healthy and a case of the interlocutor using herbs herself. Alexandra is a 38-year-old woman who works as a nurse, but she is also studying for a master's degree in nursing. She has four children, the youngest of whom lives with her; the other three live with her husband in Northern Tanzania. She keeps her child healthy by breastfeeding, going to the hospital for vaccinations and getting monthly growth check-ups, and checking the child for malaria and worms twice a year. She sleeps with the youngest child under a mosquito net. She chooses which hospital to go to depending on the child's problem. When deciding on a hospital for herself, she considers the length of the queue and waiting time. When she returns to her hometown in the north of the country, she uses herbs. But she informs me that in Dodoma the environment is different and it is difficult to prepare the *miti shamba* at the university. She does bring back herbs from her hometown, however, including *mushana*, *muarubaini* (neem tree) and *kashuaguara*. The latter is used for ailments such as stomach pain and is drunk like tea. *Mushana* is a mix of different herbs, and Alexandra drank it during her pregnancy to protect herself against malaria. Since the environment at the university in Dodoma is different, it is more difficult to prepare these herbs. Nowadays, she uses these herbs when she feels the herbs were not used in a long time (interview 12, 10 May 2017). It seems she uses the herbs more as prevention than to cure diseases.

[54] This is a safe-sex practice within religious-moral principles related to the notion of biomedical knowledge (cf Van Dijk 2020b: 110). It relates to ritual temperature, which can have a bad effect on the baby when the parents have sex (Jakobson-Widding 1989 as cited in Van Dijk 2020b: 111-2).

Herbs can also be used to keep the body strong, as one of my research assistants informed me. When he is ill, he goes to the hospital. Both research assistants get the herbs sent from his home area (informal conversation 28 April 2017).

Herbs can also be obtained from indigenous healers. These healers are acceptable to the church, according to a religious leader from a Catholic church, since the herbs are prayed about before being given to the client. A *mganga wa kienyeji* (indigenous healer), however, is not accepted in church, in the sense that the spiritual leaders will pray for them and – if known that a person is such a healer – they will often talk to that healer and try to convince them to stop their practice. As one spiritual leader informed me, the church will keep praying for that healer, but if the healer decides to keep coming to church and to keep healing, that healer will go to hell when he/she dies. If the healer decides to stop healing, that person will go to heaven after he/she dies (interview 16, 15 May 2017; interview 17, 16 May 2017; interview 19, 19 May 2017). Even though the religious leaders say that the *mganga wa kienyeji* is not accepted in church, it seems that is not quite true; they are actively prayed for and religious leaders try to get these kinds of healers to stop his/her practice.

Other protective objects: Beads

The previous cases make clear that both material objects like *ilizi* or herbs are used to protect a young child, but I also collected narratives about beads (*shanga*)[55] used for protection. One of my female friends – a young, Christian adult who worked as a secretary – shared a narrative about the use of beads with babies. Small girls – after they are three months old – are sometimes given a string of beads around their waist to help train the female shape. They have to wear it until they are five or six years old. They come in different colours, often red, yellow, white, or gold. The sister of one of my interlocutors put a string around the waist of her newborn girl. It was very small, my interlocutor said, and laughed making a sign with her thumbs and index finger against each other to indicate how small (interview 7, 5 May 2014).

In order to gain more insight into the use of beads, I went to the Majengo market with the female friend from the previous narrative. The market man shared that green beads

[55] Women not only wear a string of beads around the waist for health reasons, but also for reasons of attraction or beauty. The woman can also wear a chain of red beads to indicate to her husband that she is having her period. The beads are not only worn for decoration and sexual purposes. One of the vendors of these strings of beads at the Majengo market in the city centre told me that white and black beads can be used together with medicine. When a person goes to the *mganga* (healer), the healer tells the person to wear white or black beads. The person buys the beads herself and goes back to the healer, who then gives the medicine to wear together with the beads. The healer will tell you how and where to wear the beads, e.g., across the body, around the arm, etc. (interview 8 July 2014).

are used for children when they have *choo cha kijani* (green poo). When a girl is born, she gets green beads, when her poo is green, to help the child. According to the man at the market who sells these strings of beads, many Tanzanian children get green poo (interview 8 July 2014).
The beads are made of plastic and of *madini* (minerals), which is a form of glass, and they come from China, Indonesia, and India (photo 2.17). The salesperson buys them in a shop in Dar es Salaam (interview 8 July 2014).

Photo 2.17 *Strings of beads at Majengo market*

2.6 Conclusion

The aim of this chapter was to give insight into the daily lives of young adults in Dodoma belonging to the middle classes and how they narrate their lives in the city. The concepts of middle classes, mobility, and borders were used as analytical tools to analyse the narratives of young adults in relation to four urban factors: occupation; religion; education; and health. The central question of the chapter was "how do young adults belonging to the middle classes navigate the plethora of occupational, health, religious and educational options in the growing city of Dodoma?"

The chapter first elaborated on the concept of the middle classes, which, in my research, relates to the interlocutors' access to and use of education and salaried occupations as key indicators of whether someone can be seen as a person from the middle classes. In order to assess these young adults belonging to the middle classes, I considered socio-cultural differentiation and proposed the social milieu of 'young, urban adults from the middle classes', to indicate a shared social imaginary of what the young adults say they do.

Within the research, I encountered three different forms of mobility and borders or boundaries. Firstly, spatial mobility and borders, which can be divided into the mobility of the interlocutors between Dodoma and their home area; the mobility of the medicines and herbs into Dodoma; and the mobility of the interlocutors in terms

of choosing which health facility to go to when a person or young child is not feeling well. The herbs used may come from the young adults' home area, which, in itself, indicates that the young adults have migrated to Dodoma, and therefore, along with the herbs, are mobile. It also became clear that young adults say they visit the hospital or different hospitals and/or pharmacies when they or their child is not feeling well. Choosing which hospital to visit is decided by how good the childcare is and the length of queue and/or the distance to the hospital.

The second form concerns social mobility and boundaries: generally, the young adults say they do not use material objects for health-related purposes, since they have negative connotations and are not accepted by religious leaders (as will become clearer in Chapter 4). In their eyes, they have moved upwards socially, by being Christian or Muslim, being higher educated, and by living in an urban (instead of a rural) area with better access to certain facilities.

The third form concerns occupational mobility, which relates to the young adults moving to Dodoma in search of better options, namely, higher education and/or an occupation in the growing city.

As became clear, young adults have access to different kinds of facilities in the urban environment: there are many different kinds of churches and mosques, different kinds of education, from primary school up to and including universities, and access to different kinds of healthcare suppliers, ranging from pharmacies, private hospitals, shops that sell herbs, and indigenous healers. These factors influence the young adults' social mobility in the sense that the knowledge they gained from their primary religion and higher education informs their choice for biomedical care and/or herbal care when they or their young child is unwell. The young adults say they protect their child by attending vaccination programmes, sleeping under a mosquito net, dressing the child warmly, giving them certain foods and drinks, and some young adults mentioned that they keep their environment clean.

The relatives of young adults who advise them to use certain objects may come from rural areas or the home area. This advice may be generational and vary depending on who is giving it. For example, older relatives were brought up with all different kinds of healing options (albeit less biomedical care options), while young adults are brought up with an emphasis on biomedical healthcare. And the young adults are also brought up within the Christian or Islamic faiths and have access to different kinds of education. By following the convictions of Christianity or Islam, they are breaking with the past. Moreover, the way young, religious adults reject the use of material objects displays a 'repair'.

The main questions during the interviews were related to health concerns, health-related treatments and objects used in health-related issues. On the one hand, the narratives from the religious leaders, indigenous healers and young adults were about the young adults and their young children in relation to their health-related issues. On the other hand, the young adults themselves are also partly the ones who produce the narratives, namely in the way how they deal with the health facilities available in the city and the influence of religion and education to their actions in health-related situations. In other words, the young adults are both the producers and receivers of the narratives.

The next chapter explores the medical landscape of Dodoma in depth, to reveal the diversity of non-biomedical health, and specifically folk healing, in relation to the existing providers, i.e., shops where (branded) herbs are sold and different kinds of indigenous healers.

3.

Dodoma and its medical plurality: The role of folk healers

3.1 Introduction

Vähäkangas (2015: 4) writes about an indigenous healer who had his practice in a remote village in Tanzania and who was consulted by many people from different regions. This can also be seen in Dodoma, as Chapter 2 showed. According to Vähäkangas, the spatial mobility inherent in visiting a healer indicates the failure of biomedical services, but it also reflects "some deeper cultural longing that biomedicine is not able to address" (ibid.). Feierman defines biomedicine as is "permeated with the assumption that doctors can know the individual body, separate from the mind and from social relations, and can treat the individual through technical interventions" (Feierman 1985: 108). Nevertheless, as Chapter 2 showed, biomedical services are clearly visible and are widely used in Dodoma. Indeed, when talking to young adults in Dodoma, it was almost as if only one form of medical care, biomedical care, existed. But as the research progressed, it became evident that several types of medical care are available, and that Dodoma has a landscape of medical plurality. It became clear from my interviews that the young adults are aware of indigenous healers. Moreover, a broader medical plurality became evident when talking to indigenous healers, walking through town, talking to shopkeepers who sell herbs, and seeing Maasai healers by the side of the road. This revealed much more than the young adults discursively presented. As Chapter 2 showed, and as Chapter 4 will show, the young adults interviewed indicated their doubts about the efficacy of consulting an indigenous healer for health-related problems. These doubts are largely determined by their level of education and their primary religious affiliation (either Islamic or Christian), which has exposed them to ideological misgivings concerning all forms of indigenous healing.

This disjuncture between what young adults say and what I have seen and heard from others during my research forms a contestation this thesis aims to explore. This contestation becomes clear and tangible in the use of material objects by indigenous healers for different kinds of misfortunes, which will be the focus of Chapter 4. In order to be able to address the disjuncture between discursive and actual practice, I first need to make clear exactly what different healthcare options are available in Dodoma and which kind of healer can make a material object. Therefore, the main question of this chapter is:

> *Which folk healers produce particular objects that are used in health-related issues and how is this situated in the medically plural urban environment of Dodoma?*

To answer this question, this chapter presents a landscape of the folk healers present in Dodoma, and explores what they have to offer and for what kind of misfortune.

Within Dodoma, indigenous healing does not exist because biomedical services do not always work, as Vähäkangas (2015: 4) indicates, but it does provide something for certain issues that biomedicine is unable to address, perhaps a deeper cultural longing as Vähäkangas (ibid.) called it. This applies to the different kinds of misfortunes that healers address (i.e., not only health-related issues, but also jealousy, stolen property, or protection of the home), and also to the different kinds of medicines, which are not used by biomedicine (i.e., roots and plant leaves, animal parts, or material objects). To be able to answer the main question, the chapter starts by describing the different aspects of health seeking and health systems. To do this, I adopt Kleinman's (1980) three sectors model, which consists of popular, professional, and the folk sector, to structure the sampling of my informants (3.2). The chapter then explores the existing literature on one of these sectors in Tanzania, namely, folk healing, and I situate my research within the existing literature. It aims to address the question of whether healers can be found in Dodoma who provide something that biomedicine is unable to offer, in particular herbal medicine and/or material objects (3.3). The chapter continues by describing the different areas of healing I encountered in Dodoma and discusses the narratives I documented about the different health options in relation to what indigenous healers have to offer. This part of the chapter will also show which type of healer deals with objects used for health-related misfortunes (3.4) and, thus, it provides an answer to this chapter's leading question (see above). The last part of the chapter (3.5) focuses on two particular aspects of medical plurality, namely, how healers become a healer to give more insight into the profession of folk healing (hence, looking at the past of the healers) and whether and how clients are referred to a hospital or an indigenous healer to provide insight into how healers navigate and are influenced by urban modern facilities (hence, looking at the current situation of the healers working in Dodoma's urban environment).

It is evident that indigenous healers do exist in the urban environment of Dodoma, even though young adults say they do not visit healers for health-related issues. During my research, it became clear that the nature of a problem can determine whether someone consults an indigenous healer, or not. For example, healers may be approached in matters of stolen property or the desire to gain more power (as will be discussed in Chapters 4 and 5). These are issues of well-being rather than health-related problems. Well-being can be defined as "all the ways in which people experience and evaluate their lives positively" (Tov 2018: 1), in which life is experienced positively (ibid.). This can be understood in different ways, for example by evaluating your own life both cognitively and emotionally, or to take as a "starting point that there are certain needs or qualities that are essential for one's psychological growth and development" (ibid.: 2). Based on the narratives collected from the indigenous healers and the observations I made while visiting their practices, I argue that indigenous healers adapt to ideas of social

differentiation of healing expertise that can be related to notions of disenchantment,[56] in the sense that, in some cases, they do refer their patients to biomedical care (see 3.5.2). According to Bruce (2017), social differentiation is a necessary element of modernisation, and he gives the example that it would have been difficult for medical science to develop if religious institutions had maintained control over education (ibid.: 641). Within Dodoma, religious institutions play an important role in the daily lives of young adults but they do not appear to have control of the education and biomedicine domains. It seems that there is a division of authority in these different areas, which further complexifies society. The role of the primary religions in healthcare will become clear in Chapters 4 and 5. In this chapter – and in this thesis as a whole – I will show that there is a degree of disenchantment present, but at the same time also a degree of enchantment. Gessler *et al.* (1995: 146) ask why people go to a healer and not to a hospital, and relate it to differences in the concept of the cause of illness/disease, the approach to healing, and the healing methods used by indigenous and Western medicine. They mention that indigenous medicine offers explanations for the supernatural forces that are attributed to the cause of an illness or discomfort, while Western medicine does not have answers to these questions.

This chapter consists of two parts: the first part presents the framework of my research based on Kleinman's (1980) structure of a healthcare system (3.2), after which the chapter provides an overview of literature on folk healing within Tanzania, and situates my research within it (3.3). The second part of the chapter presents the landscape of folk healing in Dodoma based on the narratives collected from young adults and the different kinds of indigenous healers interviewed (3.4). The final section (3.5) presents cases on how to become a healer and on the influence of biomedical care on indigenous healing. First, though, I discuss the concepts of medical plurality, health seeking, and health systems using Kleinman's framework of three sectors (1980), with a focus on folk healing.

3.2 Health seeking and health systems in a medically pluralistic setting

Most of the young adults from the middle classes living in the city of Dodoma that I interviewed informed me that they go to the hospital or a pharmacy when their young child is not feeling well or when they are not feeling well themselves; they make use of the biomedical care options available in the city. During the research, I also talked

[56] Chapter 5 explores Weber's concept of a disenchanted world.

to different kinds of indigenous healers and shopkeepers selling herbal medicines who told me that they were consulted by men and women of all ages, including young, educated members of the middle classes, regarding a variety of problems. This indicates a medical plurality in Dodoma that is broader than only biomedical care. The choices people make for different healthcare options relates to health seeking behaviours and to understanding the different kinds of healthcare options and how they relate to a variety of health systems. This section will examine two concepts – health seeking and health systems – that exist within medical plurality.

The following section presents the framework that I use for my research, based on Kleinman's (1980) healthcare system structure and using concepts like medical plurality and health seeking. In the literature on health seeking and health systems, Kleinman's 1980 book is foundational in terms of providing a framework for studying the relationship between medicine, psychiatry, and culture. The book focuses on three interrelated subjects, namely, illness experiences, practitioner-patient transactions, and the healing process (ibid.: ix, 9). All interrelated healthcare activities can be seen as a healthcare system, which needs to "be studied in a holistic manner as socially organized responses to disease that constitute a special cultural system" (ibid.: 24). Kleinman argues that any study of illness and healing, patients and healers, must start with an analysis of healthcare systems. A healthcare system is a conceptual model that represents a particular understanding of how the actors in the social setting think about healthcare, but also of how people react to sickness and perceive, label, explain, and treat it (ibid.: 25-6). Kleinman defines healthcare as: "a local cultural system composed of three overlapping parts: the popular, professional, and folk sectors" (ibid.: 49-50), which together form an analytical framework that can be used to chart a local healthcare system. Within my research, I explored interrelated healthcare activities by focusing on small children under five years old and by paying attention to which objects are used for curing and protecting as a key element in health practices.

I used Kleinman's model of the three sectors to structure the sampling of my informants:

- The popular sector consists of several levels, like individual, family, and community beliefs and activities. According to Kleinman, it is the "arena in which illness is first defined and health care activities are initiated," and "it contains the points of entrance into, exit from, and interaction between the different sectors" (ibid.: 50-1). Within my research, I looked at how educated young adults perceive objects used for healing and protecting, with an emphasis on *ilizi* (which is the main focus of Chapter 4). I also interviewed young adults about what they do when they or their young child is not feeling well or is ill, which means looking at their choices and decisions (which is the focus of Chapter 2).

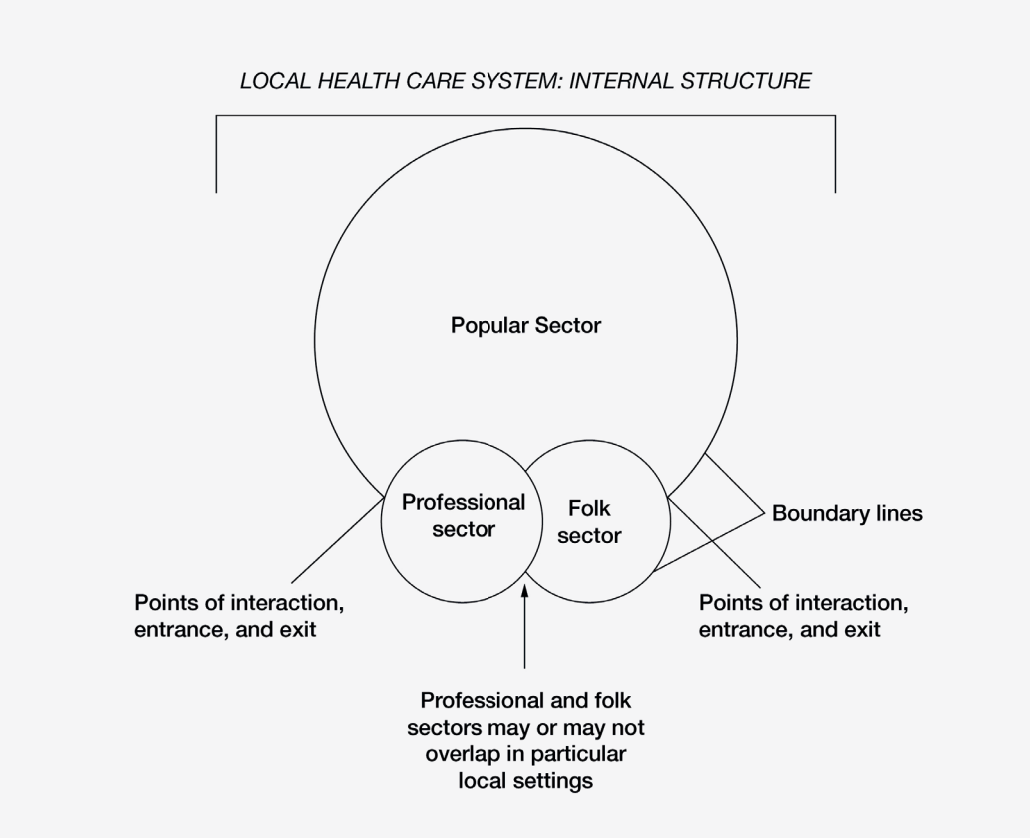


Figure 1 *Simplified figure Local Healthcare System: Internal structure (based on Kleinman 1980: 50)*

- Concerning the professional sector, which Kleinman indicates as the organised healing professions (ibid.: 53), I interviewed a few biomedical doctors, but there were also some nurses and other health professionals among my young adult interlocutors.

- In my research, the folk sector (according to Kleinman the non-professional, non-bureaucratic or specialists (ibid.: 59)) comprises different kinds of indigenous healers (the non-biomedical part of the medical plurality of Dodoma), which is the main focus of this chapter.

The division Kleinman makes between professional and non-professional may be problematic nowadays, since indigenous healers are also professionals. I see it more as a division between the biomedical and the non-biomedical sectors, which young adults navigate to find the best treatment for themselves and their young child(ren). Another reason for excluding registered healers from Kleinman's professional sector is

my decision to make a division based on the Swahili name for the healers, which does not indicate whether a healer is registered or not.

The three sectors that Kleinman (1980) describes can co-exist. Feierman mentions that different healing traditions within African medicine "co-exist with little capacity to exclude one another from the range of practical options" (1985: 80). He continues that governmental health ministries and national medical associations can define a legitimate physician, but that they cannot do the same for a popular healer, since, according to Feierman, popular healers "lack authority to exclude practitioners who are ill-trained, unethical, or incompetent" because they do not have access to government power (ibid.). In my research, I did encounter an attempt to make healers legitimate, in the sense that healers have been asked to register. But I sometimes heard from the indigenous healers I interviewed that it was too expensive to register. One female indigenous healer who works as a *mganga wa kienyeji* on the outskirts of urban Dodoma (interview 7, 16 July 2018) mentioned that the costs of registering (getting a certificate that is recognised by the government) were higher than the income she received as a healer, since she can sometimes go months without customers. And she said that she also does not get more customers by being registered. Related to this topic is the fact that indigenous healers rarely, or never, play a role within the biomedical health model. As indicated in the introduction of this chapter, Gessler *et al.* (1995: 146) argue that the biomedical and non-biomedical systems work on different grounds. Within the biomedical system, the focus is mainly on the medicine, while the non-biomedical system focuses on the relational causality of illness. Within the non-biomedical system, the efficacy of the healer who makes the medicine plays a role and it also affects the patient, "who has sent the illness" (Gessler *et al.* 1995: 146). As Leslie (1980: 193) puts it: there is an important difference between disease – which is seen as a biological reality – and illness – which is seen as an experience and social role. This perhaps explains why people visit indigenous healers in the city of Dodoma, since – as mentioned in the introduction of this chapter – people go to these healers for non-health-related issues as well, like stolen property or the protection of their home. This chapter will show the different reasons people visit non-biomedical healers as well as the different kinds of healers that exist within the medical landscape of Dodoma.

Within research on health, medical pluralism is an important and frequently used concept. Leslie (1980) introduced the concept and states that medical pluralism consists of different medical traditions, each of which operate as separate systems, with biomedicine often existing in parallel to local systems (or "alternative therapies," as he calls them), involving, for instance, traditional midwives or folk practitioners. As presented earlier, Kleinman (1980) presents three sectors of which folk healing is the key medical tradition within my research.

Olsen and Sargent (2017) write about African medical pluralism and state that alternatives for medical intervention are not automatically contradictory or mutually exclusive. People try different healing modalities in their search for therapies that work (ibid.: 1). They argue that African healing systems emerged from local histories as well as from global influences (Western and non-Western). The framework for diagnosis and treatment is shaped by widely shared cultural meanings, which can be seen in the local understandings of medical institutions, illness causation, and healing practices (ibid.: 4). They relate to Janzen (1978 as cited in: Olsen and Sargent 2017: 5) concerning the pursuit of health and well-being, in the sense that the healthcare choices that people make may reveal critical social relations and have broad social consequences. This can shape strategies for healing, both biomedical as well as other kinds of healing.

Olsen and Sargent furthermore argue that medical decisions in a context of medical pluralism are not an either/or process. When biomedicine was introduced, local remedies were not abandoned (Olsen and Sargent 2017: 7), as is also evident in Dodoma. While Olsen and Sargent call the co-existence of different medical decisions medical pluralism, Reis (1996) opts for another term. She writes about medical tradition (instead of medical systems) and medical plurality (instead of medical pluralism). She uses the word plurality to describe multiple traditions existing in parallel, while pluralism refers to – at least in Dutch, the language of the article – to a doctrine or politics in which that plurality is acknowledged or desired (ibid.: 29).

Even though Olsen and Sargent (2017) and Reis (1996) seem to adopt the same definition – i.e., multiple medical traditions existing in parallel – they use different words for that definition. Following Reis (1996), I opt to use the concept of medical plurality, which indicates that multiple traditions exist simultaneously. Patients can adopt different strategies when they are looking for a cure. This seems enacted in Dodoma since there are different kinds of healthcare options present in the city; but, as paragraph 3.4 on the different kinds of folk healing that exist within Dodoma will show, most kinds of healers have their own specialisation and do not borrow from each other's practices. And as paragraph 3.5 will show, in some cases, healers may refer patients to other healers or to a hospital.

Whereas practitioners of biomedicine and indigenous medicine may not collaborate and the professional and folk sector may function separately in practice, lay people's health seeking interconnects the different sectors in a pluralistic setting. This interrelation may be sequential, insofar as people suffering from illness may start going to one sector, for instance the popular sector, but subsequently seek help from healers and, finally, medical doctors. Or the interrelation may be parallel, whereby people may address their problems by combining solutions offered by different sectors.

Asampong *et al.* (2015) argue that "health seeking behaviour is influenced by certain cognitive variables as well as established mechanisms to minimize the occurrence of disease within a social system" (ibid.: 1065). As chapter 2 showed, health seeking in Dodoma is influenced by religion, education (whether higher-educated or not), mobility (people come from different parts of Tanzania to visit certain indigenous healers), accessibility (whether there are long queues or not), and expenses (whether it is expensive or not).

To summarise, the framework of my research is based on Kleinman's (1980) structure of a healthcare system and focuses on the folk healing in the urban environment of Dodoma. The research looks at how the medical plurality in Dodoma is composed in the context of folk healing, and for what kinds of reasons people go to which healthcare option, which relates to health seeking. In order to answer this chapter's research question, I will also look at each healthcare option that is available locally.

Paragraph 3.4 will approach the medical plurality of Dodoma through the Swahili language names mentioned by the interlocutors which leads to four areas of folk healing. But the chapter will first show how my research is situated in the literature on Tanzania concerning different kinds of healing and how people act in health-related situations.

3.3 Situating my study in the literature on the landscape of folk healing in Tanzania

In line with Kleinman (1980), two categories can be established in the domain of folk healing, namely, traditional and spiritual. In the introductory chapter of this thesis, I elaborated on the concepts of traditional and indigenous. As mentioned in that introduction, traditional medicine is defined by the World Health Organization (2013: 15) as "the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness." As argued, I opt for the use of indigenous healing since healers seem to adapt to developments over time, to changing expectations, a changing urban environment, and so forth, making it a highly flexible domain. Even though traditional healers adapt to the situation in which they operate, the term indigenous is more appropriate, since it better indicates that the healers use indigenous herbs and materials in their practice and also adapt to the city's modern conditions (as will become clear in, for example, 3.4.4). Meanwhile, the term traditional healer suggests that they stay within their tradition and do not adapt to new possibilities.

In Swahili an indigenous healer is called *mganga wa kienyeji*. The World Health Organization's (WHO) 1976 definition of *African traditional healer* is somebody who is "competent to provide health services, using plant, animal and mineral substances as well as other methods based on social, cultural and religious background. [Traditional Healers] utilize the prevailing knowledge, attitudes and beliefs in the community about physical, mental and social well-being, and the causes of a disease and disability" (p 15 as cited in: Nelms and Gorski 2006: 184). As will become clear in 3.4, the different kinds of indigenous healers use a variety of methods in their healing and protection practices. And within the medical plurality of Dodoma, several Swahili names are used to indicate an indigenous healer, including *mganga wa kienyeji*.

Modern medicine is a counterpart to indigenous medicine. According to Langwick (2008: 428), modern medicine in Tanzania is not seen as sufficient enough to be able to tackle all health-related complaints and concerns – not only in terms of patients, but also in terms of government representatives and biomedical practitioners. In my research, both the young adults interviewed and the religious leaders seem to share the view that modern medicine, in the sense of biomedicine, is sufficient enough for health-related purposes, but that, in some cases, it is also used together with herbal medicines, for example to maintain good health.

As indicated earlier in this chapter, there is a division between the way biomedicine views health issues (disease is seen as a biological reality) and the way other types of healers look at health issues (illness is seen as an experience and social role); or, as Vaughan (1994: 285) puts it: there is a "distinction between the 'cultural' and the 'biological'." She relates this distinction to the pluralism (or plurality, as I call it) of African healing systems in which the patient chooses between two different approaches. The choice depends on the diagnosis of the problem, and choosing for one approach does not exclude the other approach. She adds that one approach will not be enough to cover the plethora of illness and healing (ibid.: 287). Following Vaughan, during my research, it became clear that different kinds of healers co-exist alongside each other and that the choice to visit them depends on different kinds of problems. These kinds of problems relate to the four categories of misfortunes distinguished by Whyte (1997) – gender, failure of health, failure of prosperity, and failure of personal safety.[57] It also became clear that the healers interviewed have their particular areas of expertise, and cannot cure everything (see 3.5.2). Vaughan (1994: 291) suggests that African healing systems address both the pathology of the individual body and that of social relations in which damage caused by different kinds of misfortunes is repaired.

[57] I will elaborate on these four misfortunes in Chapters 4 and 5.

As mentioned in the introductory chapter, Marsland (2007) writes about 'modern' medicine and 'traditional' medicine. In her article, she mentions the different Swahili words for biomedicine, namely, modern medicine (*dawa ya kisasa*) or hospital medicine (*dawa ya hospitalini*), and indigenous medicine, namely, local medicine (*dawa ya kienyeji*), natural medicine (*dawa ya asilia*[58]) or trees/bush from the fields (*miti shamba*) (ibid.: 754). Marsland bases these words on her research done in Kyela, Southern Tanzania amongst indigenous healers. She adds that it is more difficult to make a distinction between 'traditional' and biomedical healers, since the Swahili term (*mganga*) is used to refer to both. The difference is often indicated by adding a noun after *mganga wa*, like *hospitalini* if it is a biomedical healer or *kienyeji* if it is an indigenous healer (ibid.).[59]

In addition to Marsland (2007), I also referred to Last (1992) in the introductory chapter, since he wrote about the difference between biomedicine ("Western" or hospital medicine) and indigenous medicine, but he adds the category of Islamic medicine (ibid.: 395) which according to him overlaps with "Western" medicine in its focus on herbal specifics, and with Islamic medicine in respect of spirits or *jinn*. I consider herbal medicine as a different category and it encompasses all herbs used for healing purposes. Within my research, herbal medicine is not only linked to Islam, but also to Christian people's use of herbal medicines – as shown in Chapter 2. As of 2017, I started asking the young adults in my study whether they use herbal medicine. I also asked religious leaders if the use of herbal medicine is accepted within Christianity or Islam.

Most literature on health in Tanzania focuses on one or a few aspects of the existing medical plurality, as will be discussed in the following part of the chapter in relation to my research. The main focus of my research is on the folk sector, as categorised by Kleinman (1980), but I want to mention Obrist's (2006) publication on health seeking within the popular perspective, since an important point within her research – and, indeed, in mine – is on good health. She did her research in Dar es Salaam – the de facto capital, as she calls it – on staying healthy, vulnerability, and resilience. The research is focused on an inner-city neighbourhood, a planned residential area where lower middle-class people live (ibid.: 66-8). The women Obrist and her colleagues interviewed were asked about 'good health,' and the authors related it to two dimensions: the state of the body and the state of the mind. Following this, the women indicated five main

[58] In my research, this kind of medicine was called *dawa ya asili*, literally the medicine of nature.

[59] My research did not specifically look at the difference in terminology used to indicate the biomedical healers. It was clear that the noun was indeed used to indicate the specific types of healers. In my research, I frequently heard the phrases *wa kienyeji* (indigenous) or *wa tiba za asil*i (natural remedies), see 3.4.

themes that relate health activities to urban living conditions: generating income; providing nutritious food; ensuring cleanliness; taking care of children; and providing healthcare (ibid.: 129, 169). In my research, I also asked the young adults I interviewed about good health[60], in relation to themselves and their young (under five years old) children. However, where Obrist linked good health to five themes relating health activities to urban living conditions, I link it to the kinds of treatments the young adults seek when experiencing health-related problems. Like Obrist, I conducted my research among people from the middle classes, but the focus of my research was different. While Obrist focused on the state of the body and the mind in relation to good health amongst a group of women, my focus was broader, in the sense that I linked the answers to the questions of good health to the medical plurality present in Dodoma, and I became aware of the contestation between what the young adults (say they) do, and what I observed while visiting and talking to healers from the non-biomedical healthcare domains.

Ample research has been done on different aspects of the folk sector in Tanzania. On indigenous medicine in general, Langwick (cf. 2008; 2011; 2012) and Erdtsieck (cf. 1997; 2003) have done extensive research, both in the more southern part of Tanzania. Langwick not only looks at indigenous medicine, but also relates it to hospital medicine, while Erdtsieck writes about a female spirit healer. Holthe (2017) writes about religious boundaries with a focus in the last part of her thesis on "traditional"[61] healing in Pangani, a city on the coast of Tanzania. My research has a focus on health and indigenous healing, but with a clear influence of religion and education on using objects for healing purposes, something that is not accepted, or is viewed as "improper" to use Holthe's terminology.

Literature on more specific areas within indigenous medicine in Tanzania can also be found, for example on Islamic healing (cf. Last 1992; Nieber 2017), herbal medicine (cf. Lindh 2015), and Chinese medicine[62] (cf. Hsu 2009; 2012). As mentioned earlier, Last (1992) added Islamic healing as a separate category to modern and indigenous medicine. A clear example of an Islamic healing method, but also healing related to religious objects, is provided by Nieber (2017), who did research on Zanzibar on drinking the water of the written and then washed off Qur'anic verses (which is called drinking

[60] I use the Swahili words *afya nzuri*, which Obrist translates as a positive notion of health (2006: 127).
[61] Holthe uses the term traditional healing and I therefore use that phrase here.
[62] During my research, I did not try to find Chinese healers in Dodoma, and I did not see any Chinese healing shops in the city. During my interviews with young adults, Chinese healers were also not mentioned, but other forms of indigenous healers were, especially in the sense of indigenous healers making the object of *ilizi,* which is the focus of Chapter 4.

kombe), and relates it to the conceptual boundaries between 'religion' and 'medicine.' Nieber gives a detailed description of the process of drinking *kombe*, which is seen as Islamic medicine, but is also used by Christian people. Unfortunately, I was not able to interview young adults who visited healers who used Islamic medicine, and I am therefore unable to say whether Islamic and Christian people in Dodoma used this kind of healing. I have not added Islamic healing as a separate area of healing, because I based the areas of healing examined on the Swahili language terms (see 3.4). However, amongst the healers I interviewed I did come across a healer who used Islamic texts and several of the healers were Muslim. Following Vähäkangas (2015: 34), Muslim healing is counted within the category of indigenous healing, since it tends to overlap in terms of theories and practices, but it also has practices based on Muslim theological ideas.

An important form of healing that uses herbal medicine, is explored by Lindh (2015), in the Dar es Salaam region, where she collected 249 plant species and identified those that were related to women's health and childcare. She also looked at the influence of urbanisation on the use of these kinds of herbal medicine, concluding that women in Tanzania depend more on commercial trade for their indigenous medicine. In my research I did not encounter the commercial trade in relation to indigenous medicine. Most (if not all) interlocutors I interviewed concerning using herbs for health-related issues received their herbs from their parental homes or they gathered the herbs themselves from their current homes. The influence of urbanisation, or as I call it the facilities present within the urban environment, is an important aspect in my research concerning how young adults deal with all the options present in relation to health-related issues and what choices they make.

The literature overview above makes clear that a wide variety of research has been conducted on different aspects within the medically plural system, but with a focus on the folk sector. My research framework concerns a focus on indigenous healing (instead of traditional healing) and aims to discern the medical plurality present within Dodoma, including herbal medicine and biomedicine. The research links the health-related problems from my interlocutors' narratives to Whyte's (1997) four categories of misfortunes and, in turn, these will be linked to the different healthcare providers. It also looks at a broader field in which, among others, indigenous healers, witchcraft, modernity, religion, education, and good health are addressed. It explores this from different angles: young adults; indigenous healers (among others *mganga wa kienyeji*); hospital staff; shopkeepers selling herbal medicine (*dawa za asili*); and religious leaders.

Paragraph 3.3 above gave an overview of the literature available on Tanzania's folk healing sector. The next part will present some cases relating to the kinds of indigenous

healing one can encounter in Tanzania. This results in the four areas of folk healing that my research in Dodoma is based on.

3.3.1 The landscape of folk healing in Dodoma

Within the literature and my research, different groups of healing in Tanzania are named. Vähäkangas (2015: 6) distinguishes four groups of healing: "traditional" healers; Muslim healers; spiritual churches; and biomedicine. My research focuses for the largest part on Vähäkangas's category of "traditional" healers, and can be seen as a second layer within the given categories. Among the authors who have also focused on the healers in Tanzania are Mshiu and Chhabra (1982 as cited in: Gessler *et al.* 1995: 145), who distinguish herbalists, herbalist-ritualists, ritualist-herbalists, and spiritualists. These categories tell something about the focus and methods of healing adopted by indigenous healers, but – as will become clear below – the division I propose is organised differently, albeit it includes elements such as herbs and spiritual healing.

This proposed division initially emerged from a small Focus Group Discussion I had with three medical staff members at a private hospital. A senior doctor informed me that there are five groups of indigenous healers who are all called *waganga* (pl. healers) (interview 44, 21 May 2015):
- those who use roots and herbs;
- those who are Muslim and write Arabic words with a certain medicine or fluid;
- those who sacrifice cocks, hens, or goats. They claim to be able to 'read' the intestines to see what the problem is;
- those who dream and get their information from their ancestors;
- those who have their own stools and have certain calabashes they use in their healing practice. The healer prays to their ancestor.

During my research, I encountered a somewhat different division, one that overlaps with some of the categories mentioned above, but one that also reveals a number of differences, three of which I will highlight here. Firstly, I found Muslim healers within the category of indigenous (or, as Vähäkangas (2015) calls them, "traditional") healers, but I also talked to Muslim healers who use roots and herbs, and who dream and receive information from their ancestors. This option is not available in the categorisation by Vähäkangas (ibid.), but would place them in the categories of both herbalists and spiritualists that Mshiu and Chhabra (1982 as cited in Gessler *et al.* 1995: 145) distinguish, which is not a separate category within the categorisation by Mshiu and Chhabra (ibid.). Secondly, midwifery is not mentioned as an area of healing, while I have encountered midwives in relation to health-

related issues. Thirdly, there are healers who may fall into Mshiu and Chhabra's (ibid.) category of herbalists, but who – like the Muslim healers in my research – adopt other healing methods, such as performing rituals. These options are not available within the categorisation of Mshiu and Chhabra (ibid.). The categorisation by the Focus Group Discussion encounters the same issues as mentioned above, in the sense that the healers I encountered during my research fall into several of the mentioned categories. As will become clear later in this chapter, I have interviewed an indigenous healer who uses herbs and roots, but who is a Muslim and also writes Arabic words for healing practices.

Because I encountered groups of healers who fall into several of the above-mentioned categories, I approach the sector of folk healing in Dodoma based on the Swahili language names used by the people interviewed. I have mainly used the Swahili nouns given to those type of healers, because in English the word indigenous healer encompasses people who use several different methods. This approach leads to the following four areas of folk healing,[63] whose differences will be explained more in section 3.4 on the health options in Dodoma:

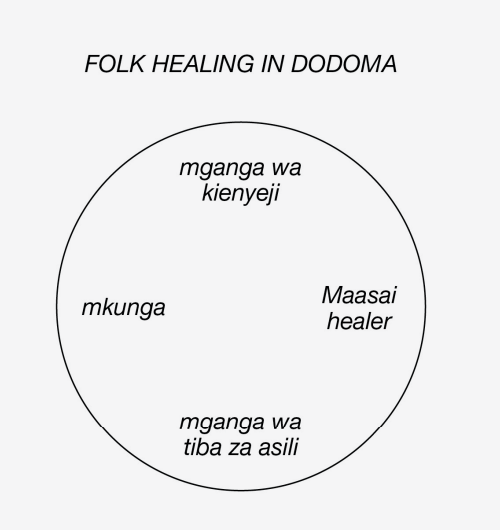


Figure 2 *Four areas of folk healing in Dodoma*

1. The *mganga wa tiba za asili*, literally translated as the healer of natural remedies (herbalist). Most of the healers I interviewed within this category were male and were Muslim healers who have a shop near a mosque or visible in the city centre. They use herbs and roots as medicine, sometimes branded herbs (*duka la dawa za asili*; shops with branded medicines) (3.4.1);
2. The *Maasai healer*: healers operating small stalls selling herbs and roots as medicine, visible near the main bus station and near the Majengo market in the city centre[64] (3.4.2);

[63] All four areas of folk healing are mentioned in singular form. It does not indicate the numbers of healers there are within a specific area. I do not want to imply that there are no other areas of healing present in Dodoma, but these are the areas I encountered doing my fieldwork.

[64] In 2018, the Maasai healers were moved about 50 metres, towards the roundabout in the city centre, because their previous site, the main bus station, was moved. They became less visible as a consequence of this change.

3. The *mkunga*, which means midwife: treats women for infertility (*wanapata mimba*) and menstruation issues (3.4.3);
4. The *mganga wa kienyeji,* literally translated as indigenous healer: works from home and tends to be located in wards outside the city centre, treating clients by offering herbal medicines, but also using Arabic words on paper and objects (3.4.4).

As of 2010, indigenous medicine has been institutionalised with the appointment of regional and council coordinators and as of 2013, indigenous healers in Tanzania have to register themselves with the Ministry of Health (cf. Langwick 2011: 39; Heuschen *et al.* 2023: 2). This also became clear from the interviews in Dodoma such as with the person who was responsible for the registration of indigenous healers and traditional birth attendants (TBAs). He informed me that while the majority of the healers are not yet registered (he only interacts with those who are) the problem is that most of the healers are mobile (interview 45, 22 May 2015). Overall, however, according to Mombeshora (1994), the Tanzanian government cannot authorise the indigenous healers to practice their medicine, and cannot forbid them from accusing people in the village of being witches. In 2009, after more than 50 persons with albinism were murdered in north-western Tanzania during a period of 14 months, Prime Minister Pinda announced that the licences of traditional healers were revoked (Nichols-Belo 2018: 722). According to Nichols-Belo (ibid.: 732), the government instituted a ban after the period of murdering people with albinism, and then renegotiated the terms, since the indigenous healers are able to provide valuable services.

The previous part of the chapter focused on medical plurality and gave more insight into health seeking and health systems. It revealed a great variety of literature on the medical plurality present in Tanzania and ended with a division of the folk healing sector into four categories. The following part of the chapter will explore these areas within the existing folk sector options that exists in Dodoma.

3.4 Health options in Dodoma

3.4.1 *Tiba la dawa za asili*

The first area of healing that will be discussed is *tiba la dawa za asili*. The Swahili term *tiba la dawa za asili* literally means "matter of medicine of tradition" and within this type of healing, mainly (if not only) herbal medicines are used. At the *duka la dawa za asili*[65], the shop, you can buy such herbs that are displayed on the counter

[65] It literally means shop of medicine of nature.

Photo 3.1 *Duka la dawa za asili*

Photo 3.2 *Shop counter with herbal medicines*

(photos 3.1 and 3.2), and there are shops where you can buy branded medicines made from herbs imported from Dar es Salaam and Arabia.[66] One person that I interviewed who sells branded herbs is a 30-year-old Muslim man with no formal education who called himself a *mganga wa tiba za asili*. The *maduka la dawa za asili* (pl. shops of medicine of nature) are very visible in the streets of the city centre. During interviews with other shopkeepers in 2014 and 2016, I asked them about the people who came to their shops and what kinds of problems they had. These shops not only sell herbs, but they also sell products like henna, olive soap, black seeds oil, candles, garlic oil, olive oil, vinegar, aloe vera juice, incense, massage oil, and cough syrup. During an interview with a shopkeeper in 2016 (interview 6, 10 May 2016), I asked him what was most commonly bought. He pointed to the herbs in front of him telling me that all the herbs he sells come from 'Arabia', which reveals a great degree of spatial mobility. He explained that the herbs can be combined and are to be boiled at home. The herbal mixture and preparation prescribed depended on the type of illness. I interviewed another shopkeeper with a similar kind of shop in the city centre on 28 July 2014. When I was doing the interview, I was standing just outside the shop. The shopkeeper was sitting down. People could see us (the shopkeeper sometimes seemed to whisper the names of the medicines), and I could see the people coming: men, women and boys. The shopkeeper was very secretive about what certain medicines consist of, but he gave me some examples of the medicines he sells:

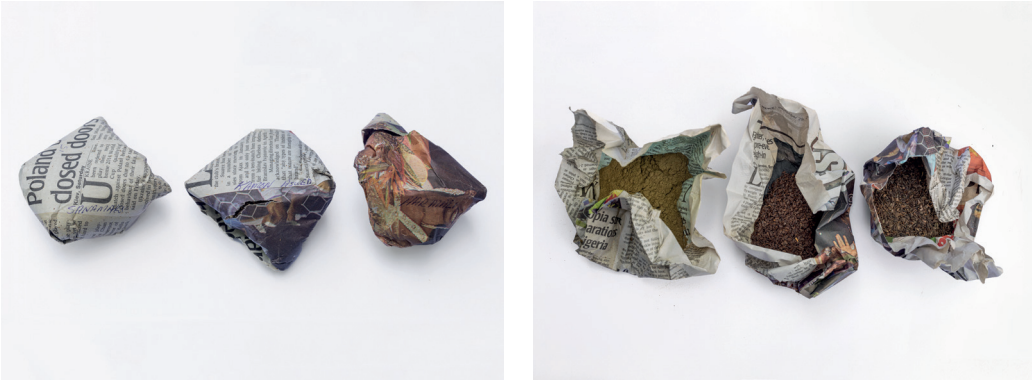
- *habit nuksi*, which is white powder and was stored in a large bucket, and looks like flour (but it is not the same). This powder is used for *kuondoa mikosi* ("to remove bad omen").

[66] See also Parkin (2014: 29), who writes about Muslim Swahili healers along the coast of East Africa who import their herbs from South Asia or Arabia. It seems that, from there, the medicines are further transported to Dodoma, thus crossing both international and regional borders.

- *habit soda,* which is put in tea or water and used as an antibiotic.
- *mafuta ya mkunazi,* which is coconut oil.
- *mafuta ya karafuu*, which is clove oil and is used as massage oil.
- *shimari*, which is used to relieve gas.

I also asked the shopkeeper about medicines for specific events, like when a woman gives birth, when she has had a miscarriage or when to keep the baby inside the womb of the woman. Dates (*tende*) are given to a woman when she had a miscarriage and a bottle with brownish fluid (see photo 2.15) which – according to the shopkeeper – is a super power and contains many different kinds of medicines. You put the fluid in water and drink it. In addition, I bought *babunaji, har mali, kamon aswed*, and *sanamaky*, which are the names the shopkeeper wrote on the paper in which the herbs were packed. Most likely, *babunaji* is chamomile leaves and is used to keep the baby inside the womb (see photo 2.16). When the woman knows she is pregnant, she starts drinking, half a cup twice a day. *Har mali* means bihidana or quince seeds; *kamon aswed* is probably *kamon aswad* which means black sunflower seed; and *sanamaky* is a yellowish powder, of which I do not know the translation (photos 3.3 and 3.4). I also asked him whether he sold medicine for children up to five years old. He explained that, in these cases, he mixes coconut vinegar with two ingredients that sounded like *sanamaky* and *sali*. He opened a jerry can and let me smell it. It had a weak smell, which I did not recognise. He told me that you use it when the child is ill. Because the child is so small, you only use a teaspoon of it, without water, three times every day, until the child is better (interview 28 July 2014).

During both interviews with the shopkeepers, I stood in front of the shops, in the same place as those people who come to the shop to buy something. The space behind the counter is only for the person(s) selling. During the interviews, when the shopkeeper



Photos 3.3 and 3.4 *Packages with sanamaky, kamon aswad and har mali*

had to help a client, I was able to look around and see what kind of people were coming in and what kind of things they bought. When I was having the interview in 2016, I saw someone buying vinegar, other people bought olive oil, a lady with her friend bought *udi,*[67] one man bought dark balls from the boxes on the counter. Another man bought white stones, a kind of crystal, a mix of two powders, and something that looked like branches with fluffy flowers. In a visit to another shop in 2014, I recognised clove and cinnamon sticks, but most other medicines were unfamiliar to me. In contrast to the shopkeeper I interviewed in 2014, the shopkeeper whom I interviewed in 2016 informed me that they do not sell medicines for children under five years old, because the owners do not allow that. Unfortunately, the shopkeeper did not know why it is not allowed, and the owner was not around to ask. Subsequently, I asked him what he himself does when he does not feel well. He explained that he uses medicines from the shop, but he also goes to the hospital. Indeed, he frequently visited the hospital, for a check-up and to obtain the medicines they use. He explained that whether he used hospital medicine or medicine from the shop depended on the kind of illness. I asked if the medicines can be used together. "*Yes*," he answered, "*you can use them at the same time*." When I asked him if he knew different kinds of healers in Dodoma, he responded that he only knew the *tiba za asili* healers (interview 6, 10 May 2016).

I interviewed another shopkeeper who sells branded medicines in May 2016. Like the two above-mentioned shops, this shop was also located in the streets of the city centre. However, it was a different kind of shop than the *duka la dawa za asili* mentioned above. Since the shop sold branded medicines that were made from herbs, I argue it is part of the *tiba la dawa za asili* healing domain. This shop seemed more luxurious than those previously discussed, in the sense that it was a closed shop with glass windows and a door, white tiles on the floor, and a counter of glass that displays the medicines (photo 3.5). This gives the client more privacy than an open shop like the previously described shops, where people stand next to each other and can hear what the other person wants. The seller can meet a patient privately, behind closed doors, to consult and prescribe medicine. I was directed to this shop by the man who is the shopkeeper's agent and who himself has a shop in the open on the corner of the same street (photo 3.6). My research assistant and I went to visit that young shopkeeper (27 years old) located on the corner of the same street. He informed us, firstly, that his profession of *mganga wa tiba za asili* differs from that of the *mganga wa kienyeji*, who looks at you, tells you what your problem is, and informs you what kind of medicine to take. When you go to this young shopkeeper, you do not come for a consultation, because generally you would already know what you want. I asked him what kind of people his clients usually are:

[67] Aromatic aloe wood; used as an incense for fumigation (Erdtsieck 2003: 418).

Photo 3.5 *Malaria medicine in shop selling branded medicines*

Photo 3.6 *Shop selling branded medicines on street corner*

> *Different people, who are sick. Women, sick people, men. They were at the hospital, but were sent to get medicine from here. Some use [medicines] in the hospital, suffering from typhoid, they don't get healed. They come here to get herbal medicine* (interview 3, 9 May 2016).

The shopkeeper orders his supplies by mobile phone. He has different places in Dar es Salaam where he orders the *miti shamba*, which are the leaves and roots of plants. These stores get their supplies from Arabia. The most common thing people come for are UTIs (urine infections), typhoid (*homa ya matumbo*), and rashes (*matatizo ya ngozi*). All customers are older than ten years. He refers any younger children to hospital. He explained that:

> *These young ones cannot explain what they are suffering from. That is why we refer them to the hospital* (interview 3, 9 May 2016).

When I asked the young shopkeeper what he does when he is ill, he answered that he goes to the hospital for a check-up. And if he has to take medicine, then he uses *tiba za asili* (herbal medicine) or hospital medicines. But he told me that the most important thing for him was to protect himself by doing exercises, drinking water, and eating fruit. In addition, he shares the following information:

> *It is very hard to get malaria. Maybe somebody can have flu because of the weather. Sometimes I have a headache or stomach problems. When I have a headache, it is because of stress, I go and rest. I do not go to the hospital or take medicine, because I know my problem* (interview 3, 9 May 2016).

Another shopkeeper whom I interviewed in 2018 was a 50-year-old Muslim who sold branded medicine and is a *mganga wa tiba za asili* (interview 3, 7 July 2018). He has a shop next to the mosque in the city centre, like most shopkeepers I interviewed who sell herbal medicines in the city. Next to the shop is a storage room with all the herbs and a big plastic jar with honey. He has medicines for young children when their stomach hurts, when they have a lot of gas, or when they have a stomach full of water. He started to learn how to become a healer from his *babu* (grandfather), who was also a *mganga wa tiba za asili*, when he was ten years old. He was trained in the place where he was born (north of Dodoma) and he gets his supplies from that place too. He would like to have more funding in order to buy machines to pound and pack the herbs, in order for him to be able to supply more. One of the medicines he sells is a jar containing pounded herbs from 70 plants, which claims to cure many ailments like malaria, typhoid, and headache (photo 3.7). He has a van in which he travels to different parts of Tanzania, like Arusha, Mwanza, and Bukoba in the north, Tanga on the northern coast, and Morogoro, which lies between Dodoma and Dar es Salaam (interview 3, 7 July 2018). Both the herbs and his practice demonstrate spatial mobility: the herbs come from outside of Dodoma and the healer travels to different places in Tanzania to perform his job.

Photo 3.7 *Medicine with herbs from 70 different plants*

In May 2016, my research assistant and I tried to contact a healer (photo 3.8) who has an office in the city centre but who also has offices throughout Tanzania (for example in Mwanza and Dar es Salaam). The office consisted of a waiting room and a treatment room on the ground floor of a building that consisted of several floors. Unfortunately, the healer was travelling, but we managed to interview his assistant. She is a Christian woman in her late twenties, with one young child, and was born and is currently living in Dodoma. She told me that she performs the services of the *tiba za asili*, which she learned from the healer who has owned the shop for the past three years. Now she can work herself and she provides care for men and women, young and old. For example, she provides different kinds of services for infertility (*pungufu wa nguvu za kiume*, which literally means deficiency of male potency), women

who cannot carry a pregnancy to full term, or who suffer menstrual pains. But she also offers services for small children: for instance, *pepo punda* (tetanus, but it is described by the interlocutors as 'when the eyes of a child go from left to right'), when the testicles retract inside the body, or if parents pass on a sexually transmitted disease to the child when its born. She only uses *miti shamba* to heal, containing many different herbs; she does not use medicines from the *duka la dawa* (pharmacy). She gave me an example of three different treatments for a child who has *degedege* (fever and convulsions), namely, *dawa ya kufukiza* (you cover the child with a blanket and the child inhales the smoke), *kukanda* (massage), and *kunywa* (to drink). It depends on the magnitude of the problem, but it is better to use all three when a child has *degedege*. According to her, the common diseases for children are *degedege*, malaria, the transmission of disease from mother to child, and bed wetting when they are a bit older. On average, ten children a day are brought to the healer's shop, a number of whom have visited the hospital first before coming to this healer. When she is not feeling well herself, she uses *miti shamba*, not medicines from the pharmacy, and she does not go to the hospital, since she is familiar with her symptoms and changes in the body (interview 11, 17 May 2016).

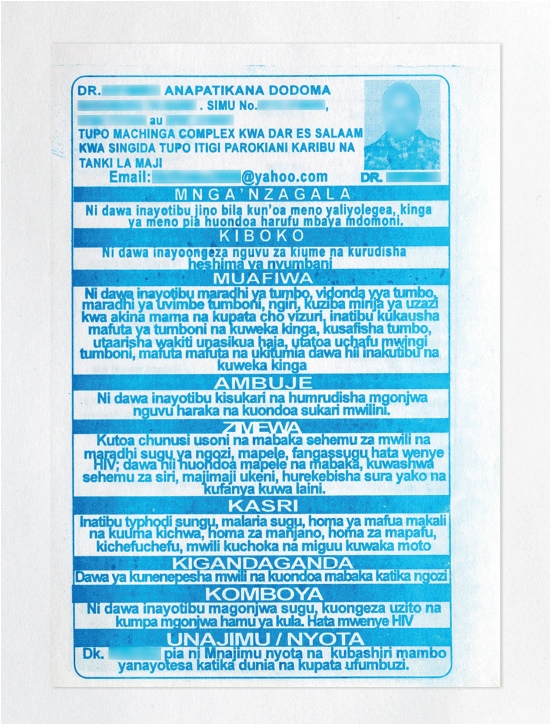


Photo 3.8 *Flyer indigenous healer working in city centre*

Herbs are the main method for healing within the *tiba la dawa za asili* domain. They are displayed on a countertop or pounded together and stored in a jar. The healers have both women and men customers and some have medicines for children but others do not as they feel unable to diagnose young children. The above-mentioned cases also make clear that these kinds of healers are both Muslim and Christian and can be men and women. The healers in this area of healing do not use objects, like *ilizi*, for healing or protection purposes, they only use herbs. These kinds of healers are easily found in the city centre, so if young adults wish to use herbal medicines, they can access to these shops with ease.

3.4.2 Maasai healer

The second group of healers are the so-called Maasai healers. It should be noted that my research is limited in this area as I only interviewed one Maasai healer, which means I am unable to assess whether the people working in this area of healing make objects for protection and healing purposes. The point however is that Maasai healers were definitely mentioned as a separate category of healers who provide objects for health-related issues during my interviews with young adults. In addition, the Maasai healers' medicine stalls are very visible throughout the city. I therefore want to add them as a separate category within the medical plurality of Dodoma. They are part of the young adults' narratives on health-related issues.

In 2015, I was able to interview a male, Christian Maasai healer in his early forties who had never been to school. Prior to this, I was introduced to another Maasai healer by a person responsible for the registration of indigenous healers and TBAs in Dodoma. We went to the bus stand where several Maasai healers sit next to each other with a small stand and signs indicating the kinds of illnesses they have treatments for. The first healer my research assistant approached agreed to be interviewed. The higher side of his stall displayed several kinds of roots; on the lower part were white plastic pots containing different kinds of medicine. According to the Maasai healer, most people who come to him are women who have heavy bleeding during their menstruation.

Photo 3.9 *List of diseases for which the Maasai healer has medicines*

I asked him if he knew of objects for certain diseases.[68] He mentioned

[68] This question followed my inquiry about whether he knew what *ilizi* is, which will be discussed in Chapter 4.

Photo 3.10 *Medicinal roots*

Photo 3.11 *Different kinds of medicines*

kakakuona (armadillo). A hole is put into a small piece of it and then a cloth is put through the whole. The object is worn around the neck, waist, or arm. He showed my research assistant and I two small pieces of *kakakuona* and said about his clients that:

> *They prefer using* kakakuona*, because it is a gift and a treatment. For example, when a person is walking on the road, and they see a* kakakuona*, they take the shield. It is used for different things, like curing a child, only for a child who fails to walk. Seeing a live* kakakuona *as the first person to see it, is a gift. Others are coming. But with the one who sees the* kakakuona *first, all things will become good.*

I asked him what the most common diseases are. He mentioned *chango* (stomach problems), which he treats with a yellow powder (*olisuki* – Maasai word) that can be mixed with water and then the child drinks it. He gave an example of a common problem for boys. When it is cold, the child's scrotum can retract inside the body. He uses a medicine called *odiloyai* (Maasai word) to treat this. The child needs to drink half a spoonful of the medicine mixed with water (interview 48, 22 May 2015). While this healer does use objects for healing or protection purposes, including a small piece of armadillo shield, he does not know how to prepare a material object like *ilizi*, and he does not know what is inside them (photos 3.9, 3.10, 3.11).

In addition to the interview with a Maasai healer, I also interviewed young adults who mentioned narratives concerning visiting Maasai healers for different issues, as the following narratives will show. One of my interlocutors, a 30-year-old Roman Catholic woman who works as a primary school teacher mentioned visiting a Maasai healer. She told me that, once, when she was passing by the Maasai healers on her way to school, she bought medicine for her asthma, but she thought it did not work.

The healer said the medicine consisted of *utomvu*, which is plant sap (photo 3.12). The interlocutor described it as follows:

> *You cut the cover of the tree and it brings a white substance. You boil it for six hours, without water, and then drink it. You take one teaspoon and wait three days before you take another teaspoon.*

She has forgotten the name of the plant. She bought two bottles, but stopped taking the medicine after the first bottle because of the bad taste and because it gave her diarrhoea. The tree is not found in Dodoma, but in Mara, Bunda, and the Serengeti (interview 4, 2 May 2017).

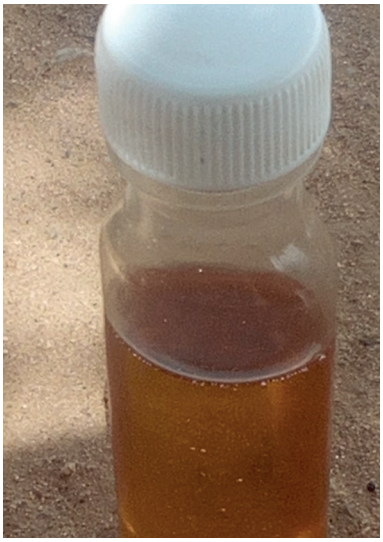


Photo 3.12 *Medicine consisting of utomvu*

A 27-year-old Muslim woman, whom I interviewed during a visit to a mobile clinic, mentioned that some women visit a certain Maasai healer nearby the *dala dala* stand who sells objects to help with stomach problems (interview 17, 14 May 2015). Another female interlocutor whom I interviewed during the same visit, a 35-year-old Muslim woman, mentioned that such objects for use on the body are available from the Maasai, many of whom can be found near the *dala dala* station (interview 18, 14 May 2015). A third woman, a 25-year-old Muslim woman, interviewed at the mobile clinic, told me that she used objects for protection of her firstborn. She used the object while she was living with her parents/relatives. At the time the interview was conducted, she was living with her husband and she told me she was not using any objects. She did not see any significant changes when she did use the object compared when she did not. Unfortunately, she did not know the name of the object that she used or what its meaning was. She only knew that it was black in colour and that she got it from the Maasai nearby the *dala dala* station (interview 26, 15 May 2015). All three women were Muslim and had attained Standard 7 level education, but they lived in two different areas of Dodoma and were from three different ethnic groups. These cases do not provide enough information to conclude whether people with a "lower" level of education use objects for healing purposes or whether the objects described concern *ilizi*. The one Maasai healer I interviewed said he did not make objects like *ilizi*, and instead used herbal medicines. The narratives provide a degree of insight into the separate area of Maasai healers and the mentioned narratives of the young adults show that the Maasai healers were a well-known area of healing within Dodoma and visited by several of the interlocutors and therefore are part of the common narrative of young adults.

3.4.3 *Mkunga*

Within this third area of folk healing I include different types of healers, who can be brought together on the basis that all of them deal with female health issues like infertility, pregnancy, or menstruation problems. One such healer is called a *mkunga*, which is the Swahili word for midwife. The WHO gives the following definition for a TBA (Traditional Birth Attendant) or indigenous midwife:

> *A TBA is a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other Traditional Birth Attendants* (Lefèber and Voorhoeve 1998: 5).

The oldest midwife I spoke to claimed to be 105 years old. She had stopped being a midwife but still worked as healer, helping women who could not get pregnant and those who miscarried. She used the same root (*mutimi* in Gogo language), which needed to be boiled, for both problems. A woman who does not get pregnant, must bring a chicken of any colour; a woman who miscarries needs to bring a goat. The medicine is added to a soup that is made from the chicken and the patient eats it. Previously, she had a lot of people come to see her, but at the time of the interview there were not so many. People came from Bukoba (in the North of Tanzania), Iringa (south of Dodoma), and Dar es Salaam. What also became clear from this interview is that the midwife dreamt about *mashetani* (spirits), who directed her to the medicine she needed to use to treat the patient. She was also directed by a doctor in Dodoma to do a study in order to learn more (interview 5, 13 July 2018).

In 2018, I interviewed a Christian woman in her late forties who told me that her profession was *mganga wa asili*, but also that she was in business (*biashara*), and that she helped women to get pregnant (*wanapata mimba*). My research assistant and I interviewed her in her home, where we sat on the sofa while she was sitting in a chair, dressed in a blue-white dress with a *kanga*[69] wrapped around her waist and wearing different kinds of bracelets. She saw her patients in the same room. She became a healer after her two children were born and when she had a dream about finding roots for treatment. The spirits came into her head and directed her to the roots she needed. When the spirits were inside her, she lost her appetite and only drank water. Her grandmother was also guided by the spirits, but it was not automatically transferred to her mother, and her grandmother also used local herbal medicines. The healer I was interviewing only treated women who failed to become pregnant.

[69] A *kanga* is a piece of printed cotton fabric that is worn in East Africa, mainly by women.

The patient had to bring preferably a white chicken, or any other colour except red, and the chicken was boiled together with a medicine that is called *mpapara* (pounded green leaves). The colour red is not good because the spirits do not like this colour. First, she listened to the problem, and then she started looking for the medicine, which she always boiled with a chicken. For stomach problems she always boiled *muarubaini* (see photo 2.2). The healer went into the hills to find medicine, and people could also see and consult her there. The healer did not advertise and did not go into town, because she also engaged in other activities like farming and childcare (interview 8, 18 July 2018).

The female healers I interviewed who call themselves *mkunga* mainly deal with female-related health problems and mainly (if not only) use herbal medicines. They did not make objects like *ilizi*. Even though the women use herbal medicine, I do not categorise them as *mganga wa tiba za asili*, because they did not consider themselves as such, and because they are only focused on treating female-related health issues. A few of the women healers in this area of healing were directed by spirits, which will be further discussed in 3.5.1 on how to become a healer.

3.4.4 Mganga wa kienyeji

The fourth area of folk healing within my research is that of the *mganga wa kienyeji* (plural *waganga wa kienyeji* – literally translated as "traditional healer"[70]). They are the focal primary group of my research within the health options available in Dodoma, precisely because they were mentioned many times as the type of healers that produce objects used for healing and protection. To be clear about this specific kind of indigenous healer, I use the Swahili term, since while all the healers mentioned in this chapter are indigenous healers and all have their own expertise, not all healers make material objects like *ilizi*. As *mzee* Ibrahim informed me:

> *You visit a* mganga wa kienyeji *for diseases but also for other things, and you only visit someone like* mzee *Ibrahim, a* mganga wa tiba za asili*, for diseases* (interview 10, 17 May 2016).

It is possible to distinguish two types of healing within *mganga wa kienyeji*, which I will divide into indigenous *spiritual* healers (3.4.4.1) and indigenous *herbal* healers (3.4.4.2). It seems that healers who have learned their craft from spirits are located in more hidden places, on the outskirts of Dodoma. The *mganga wa kienyeji* who mainly

[70] Translation from TUKI (2001: 200).

use herbs to treat their patients are more easily found in the city of Dodoma. My hypothesis is that since the primary religions (both Christianity and Islam) have not placed a taboo on the use of herbs, there is little reason to hide or be secretive about the practice, while healers who have learned from spirits (and are most likely the group of healers who make material objects like *ilizi* for protection and cures) are not accepted within Christianity and Islam, hence they work from more hidden locations.

3.4.4.1 Indigenous spiritual healers

During the several interviews I conducted in Dodoma in 2018 with the indigenous healer Hakeem, it became clear that people visit him for all sorts of reasons, from health-related problems to stolen property or the protection of their home. He explained what happens when a client comes to see him. The person sits on the sofa and the healer asks some questions[71] while looking in a mirror,[72] in front of which is a transparent stone (the healer calls it almas and says that it is gold that has not matured) with a 2 x 2 cm piece of blue Tanzanite on top of it. The healer looks into the mirror where he detects the whole body of the person and sees what the problem is (photo 3.13). He says he only uses *miti shamba* (herbs/roots) to cure people and has almost 700 different kinds of herbs; most of the medicines he has are for adults. Only one medicine is specifically for children under five years old: pounded green leaves (*mpapara*). These leaves cannot be found in Dodoma, but the healer gets them from the region where he was born. The healer not only cures issues

Photo 3.13 *Mirror and stones used for detecting problems*

[71] The healer writes the name of the patient in an exercise book, but he tells me it is not permitted to read the name if you are not the healer (fieldwork notes interview 4, first visit, 11 July 2018).

[72] The use of mirrors to detect what the problem is and in deciding what the treatment should be is common healing practice and can be found, for example, among the Mchape witchfinders in Malawi (cf. Van Dijk 1995).

related to health, but also helps retrieve stolen property and offers protection of a house[73] against malign forces (interview 4, first visit, 11 July 2018) (photo 3.14). Just like with the *mganga wa tiba za asili*, the herbs demonstrate spatial mobility, in the sense that the herbs are not from Dodoma itself, but are obtained from other parts of Tanzania.

Photo 3.14 *Miti shamba from the indigenous healer Hakeem*

I got the opportunity to visit Hakeem several times in 2018 and to sit in his compound to gain more insight into what kind of people visit healers, and also to talk to him and some of the patients to find out why they were visiting the healer. Hakeem also showed and told me about different kinds of medicines. The next case shows that young adults from the middle classes visited him (e.g., one man was a teacher, another man worked at one of the ministries) for problems related to well-being rather than health. It also shows that the healer was willing to share narratives, but that he also gave his clients privacy, by not letting me (and my assistant) sit inside the office, which was a designated space on the compound where the healer lives with his family:

> While sitting on a small stool in the compound of the healer, I wait together with my research assistant until customers come. There is a fence around the compound made of corrugated sheets mixed with, among others, cloth and plastic sheeting wrapped around wooden branches. Two leashed goats are in one roofed corner of the compound, eating leaves and branches and sometimes stretching as far they can to the big pile of leaves on the other side of the compound. Above my head is a large black piece of cloth, torn in places, probably due to the hot sun and strong wind. The office of the healer is opposite where I sit. The stools are placed in front of the hut where the healer lives with his last wife and their children. While two women and the healer's wife are inside the healers' office, we have to wait outside, since what the healer discusses with the patient is secret, as he tells us. At that same time a man enters the compound.

[73] The phenomenon of using an object to protect a home is also found in other countries. See for example Katsaura (2015: 286), who presents a case of a healer who uses *muthi* to protect a house or a car, ensuring that any potential criminal is gripped by fear. In the case of a stolen car, that same healer can also perform a ritual at the place where the car was taken in order to make sure it is recovered.

> He is wearing an orange winter jacket, light brown pants, slippers and a backpack. I estimate him to be approximately 40 years old. He gets a stool from one of the healer's children to sit on. He greets us and the wife of the healer. He holds his head in his hands, while sitting on the stool. A bit later he has his eyes closed and drops his head. When the women come out of the healer's' office, the man is asked inside. Unfortunately, the healer does not permit us to join them. After a while, the healer's wife goes into the office. After about 10–15 minutes, the healer's wife and the man leave together and walk outside the compound. The healer's wife is holding a transparent box with a light yellowish powder in it. The healer later explains that the medicine was spread on the ground and the things that were stolen were written down with a pen on a piece of paper. If you put the medicine (the yellowish powder) on the paper, it automatically burns. After a while, they come back into the compound. A while later, another man arrives on a motorcycle and enters the compound. He looks like he is in his late thirties, wearing a pair of red trousers, a white/red T-shirt and black pointy shoes. The healer does not allow us to join this man into the healer's office. When both men are gone, my research assistant and I are invited into the office. The healer explains that both men have had property stolen (fieldwork notes interview 4, second visit, 23 July 2018).

The above-mentioned case shows that people visit the indigenous healer for a variety of issues concerning well-being, namely the men came for stolen property and the woman had pain on the chest and another issue for which she was treated in private. The healer did not tell us for what the treatment was, but the woman came outside the office squeezing her eyes. The woman and the man in the orange winter jacket were treated that day. The other man came back to inform the healer that the stolen property was found. Both men were middle classes, since one was a teacher and the other works at one of the ministries. Unfortunately, I do not know if the woman was middle classes.

As the next case will show, people also visit the healer, Hakeem, for health-related problems, which the indigenous healer treats with herbal medicines in combination with elements of biomedical care. With this visit, my research assistant and I were accepted to be in the office together with the healer, his wife and the client.

> The client was a woman in her early fifties and was wearing a brown-white dress, with a blue-white *kanga* (a colourful piece of printed cotton fabric) wrapped around her waist and a blue-white cap, but without sandals. She told the healer that she felt pain in her knees, legs, and lower

back. There was a problem with her spiral cord. The healer took a small exercise book, wrote down number 1 and wrote her name in (it seems) Arabic. He used a medicine that he called *tambazi,*[74] which is used for contamination of the blood. The healer explained that when you go to European doctors in Ntyuka hospital[75] they get the pain out of the body by using glass and placing some cuts. Every doctor has their own method. At the same moment, his wife was preparing something so we waited for her to finish. One of the children came back with a pair of latex gloves and a piece of paper containing a razor blade. The patient removed her dress and sat on a small stool in a pair of wide jeans and the *kanga* wrapped around her chest. The wife used the razor blade to make three small cuts on the patient's body: on the lower back, upper back, neck, both sides of the knee, left and right side of the ankle, the chest, and upper side of the foot. After that, the healer smeared the medicine on those places with the bottom of a shell. The patient made small noises of pain. The wife put on the new gloves and wiped the medicines off the patient's body with a piece of cloth (torn from a bigger piece of cloth lying in the corner of the room between all kinds of things). The woman was given three cups of *musule*, the name of a transparent liquid that is boiled and drunk so it circulates in the whole body. The healer told me that the medicine is dangerous, which is why they have put on gloves and used the shell to apply it. The healer gave this treatment once, to clean the body. He was also going to give the medicine to the patient, so that she can boil it and use it herself. She pounded the medicine herself outside of the office. Back in the office, the healer smeared a bit under her nose. One tablespoon of the medicine was put in some water and boiled. When the patient drank the medicine, she made a face that suggested that it tasted bad (fieldwork notes interview 4, third visit, 25 July 2018). During our next visit a couple of days later, the healer said that the woman had come back to collect more medicine and to report back. And she came back a third time to finish the dose. During our fourth visit, he informed us that she was ok (fieldwork notes interview 4, fourth visit, 31 July 2018).

The *waganga wa kienyeji* get their knowledge on how to treat a client in different ways. As demonstrated in the previous case of the indigenous healer Hakeem, he used a mirror and two different kinds of stones, in combination with different kinds of herbs,

[74] *Tambazi* is translated in TUKI as extensive swelling of the body (2001: 309).
[75] See page 72 in Chapter 2 of this thesis.

to treat clients. The case of Tish, a female spiritual healer whom I visited in 2017 and in 2018, reveals different methods. I asked her about how she treats people and what role spirits play in the treatment. She explained that when a person comes, he/she tells the healer about the problems, gives them some clothes that he/she has worn and comes back the next day. During the night, the healer sleeps with the clothes and dreams about the person who came, and this process reveals which medicines she has to use. According to the healer, the Gogo spirits direct her towards which medicines she has to use to treat the person (interview 11, 9 and 13 May 2017). I visited her again in 2018;

> After a long walk through the area where she lives, searching for her, we find her at home. Her hair has become greyer. She is wearing two necklaces with white beads and a rosary, although all three are hidden under her clothes; you can only see the beads in her neck. A new house is being built about a metre from her house. The walls and roof are in place, but nothing else yet. We sit down on the same spot as the year before, at the side of her house, in the shade. The wind is blowing, just like it was in 2017. I wanted to ask her more, including about the *mashetani* Gogo (the Gogo spirits). When I ask her why she worked on the outskirts of Dodoma and not in the city, she answers that it was because of the spirits and because the conditions are good where she lives. She told me that, during the night she urinates in a small bucket. In the morning, she pours the urine outside. When the spirits come during the day, you need to drink a bit of urine. When you pour the urine outside, you need to take *kangala* (a kind of alcohol). When I asked her why she needed to drink that, she answered because of the *mashetani Gogo*. She needed to take it to calm down the spirits, who were inside her. Instead of eating *ugali* (a type of stiff porridge) or water, she took urine and *kangala*. And when the spirits come, you cannot have a bath for a whole month. When the spirits do not come, it is them giving you space to take food and take water. She informed me that the spirits were from her grandfather; he decided when the spirits come and go. He directed the spirits. Both her *babu* (grandfather) and *baba* (father) were dead. The spirits direct her where to get the medicine to heal people, but the spirits did not need to be inside her to be able to heal. Tish told me the following narrative about how the spirits first entered her body:
>
> *When I was very young, they came to my body, until I became married. I had to leave the school. When I went home from school, I disappeared and became invisible. They could not find me. I had to sleep in the forest, mountain, inside a baobab tree. Even my father went to the healers to find his daughter.*

> *My father had to apply medicine to get me from the baobab tree. I came with the roots which I got from the baobab tree. That is how it starts, the work of healing. The spirits could direct me what to do. When I got married, the spirits came back to my body, and they are in my body until now and they are very active* (interview 1, 3 July 2018).

In 2018, she told me that sleeping with a patient's clothes and then dreaming about their home is another way of healing, and that she cannot take *kangala*. Previously, in 2017, she had told me that the spirits were the ones who directed her to the medicine she needed (interview 1, 3 July 2018).

During an interview with a female Anglican indigenous healer, who was in her late fifties, she informed me that she uses an object for healing purposes, namely two pieces of cow skin. She treated women who have tried hard and failed to get pregnant or who have had miscarriages, but she also treated children for diseases like *degedege* and stomach ache. She treated them using what she called *ramli*. The healer is directed to the medicine through spirits who appear in dreams. She only uses *miti shamba* like roots and leaves. Healing using *ramli* concerns two pieces of cow skin (*ngozi ya ng'ombe*). The customer pays 500 TSH (approximately €0,50), which is placed on the skins. This satisfies the spirits who can then start providing answers, according to the healer. When I asked how it works, she told me:

> *Just the same way as you are writing there, I will be looking at these two pieces of cow skin as I read what the spirits are directing. However, it is only me who can read these words. The words are in Kiswahili and sometimes in Gogo* (interview 9, 18 July 2018).

I asked her: "*do you mean if I placed 500 TSH on these pieces of cow skin, you would be able to tell all about me?*" Yes, she responded. She continued, "*if for example there are bad people* [wachawi] *against you, the spirits will tell [me]. The spirits can identify the* wachawi *by names, but they cannot allow me to tell you of their names in order to avoid chaos that customers might cause against their rivals* [wachawi]" (interview 9, 18 July 2018).

The cases presented in this section show that some of the indigenous healers I interviewed get their information through other mediums than their knowledge on (herbal) medicines. Hakeem gets information via looking in the mirror in which he can see the whole body of the client and can detect the problem, or he can see where the stolen property is. In addition, he uses a piece of blue Tanzanite and a transparent stone (almas). The healer Tish is directed by the Gogo spirits to the medicines for

healing the patient. These spirits come to her in a dream while she sleeps with the clothes of the client. The third mentioned healer was also directed by spirits through looking at the two pieces of cow skin. As the cases presented for all three healers, the indigenous spiritual healers I have interviewed do not only use a mirror or are directed by spirits to heal people, but they also use a wide range of (herbal) medicines to cure or solve the problem of the client. During the interviews I have also asked both healers Hakeem and Tish if they know about *ilizi* and if they make the object. They have both heard about it and they both make the object. In chapter 4, a more detailed description of the object and the knowledge of the healers about the object will be given.

The next section will share more details about the indigenous herbal healers, who do solely have knowledge on the herbal medicines.

3.4.4.2 Indigenous herbal healers

The first indigenous healer I talked to was *mzee* Ibrahim, whom I met in June 2014. He began by giving me a kind of history lesson on the different ethnic groups in Dodoma, after which he told me several narratives about objects used for protection or to cure illnesses during the reproductive cycle. My second interview with him took place in May 2016. His shop in the city centre was unchanged and so was he, and he recognised me and was willing to share more narratives with me (and my research assistant). The third interview took place in 2018. By that time, he had an office in a different shop, but still in the city centre. In the years between the interviews, he had been travelling when I tried to contact him for another interview. He was willing to help me to arrange an interview with another healer, but that other healer was also travelling the whole time I was in Dodoma in the summer of 2018.

In 2016, we talked a bit about what kind of people come to the shop and what he did. He told me that he listened to them, he sometimes gave advice to people, and that he sometimes cured people by giving them a type of herb (he had eighteen types of herbs prescribed for drinking or for massaging the body). The difference between a healer like *mzee* Ibrahim and the healers from the shops selling (branded) herbs is that people ask him for advice and do not know how to solve their health problem, while the people visiting the (branded) shops do know what kind of illness or health-related problem they have. People who are sick (e.g., who have measles or typhoid) come to his shop, but they also come for other kinds of issues related to well-being (e.g., seeking protection during a hunt or to rid themselves of evil spirits (*mashetani*). The people who visit him have different kinds of issues. According to him, some people have already visited the hospital but failed to get a proper cure there. He gave me the

Photo 3.15 *Entrance office mzee Ibrahim in 2014*

Photo 3.16 *Medicines in the shop of mzee Ibrahim (2014)*

example of people who experience a type of paralysis. Most of them say they cannot get cured in the hospital. *Mzee* Ibrahim gives them medicine for three weeks containing a mixture of oils, herbs, and minerals, after which the patients were cured. He also told me how he cures toothaches. He has two types of medicines, the first of which is *jafari* root, which is made into powder. He showed me the root and let me taste it. It is very bitter. The treatment involves mixing the *jafari* powder with water and brushing your teeth with it. The second medicine is *shabu*, a type of salt (like baking soda), which is used to purify water. He also let me taste this, and it was a bit sour. After brushing your teeth with the *jafari* powder, you have to boil the salt in water and gargle with it. You must do this for five days (interview 1, 18 June 2014; interview 10, 17 May 2016; interview 2, 5 July 2018).

I also asked him if he has treatments for small children, since young adults with young children are the focal group of my research. He told me that the children go to the hospital for *degedege* (fever and convulsions), but that they do not get cured. Then, they come to him for treatment. He gives them garlic oil, which must be rubbed on the whole body, once a day for seven days, and then they get better. He showed me a small bottle of Al-jahur garlic oil (interview 10, 17 May 2016). Denisenko (2013: 73) indicates that *degedege* is related to *kifafa* (epilepsy) and biomedical malaria, and that following Kamat (2008b: 72) the condition is said to be caused by an evil spirit (*shetani*) and "takes the form of a bird and casts its shadow on vulnerable children on moonlit nights" (ibid.)

According to Kamat (ibid.), the Kiswahili word *dege*[76] is translated in English as bird.

When I asked *mzee* Ibrahim what types of healers there are in Dodoma, he told me about the *tiba za asili*, who are the same type of healer as he is. When I ask him about the Maasai healers he told me that they are different. Within the group of *tiba za asili*, there are small shops near the mosque who brand, but he did not brand his medicines.[77] *Mzee* Ibrahim explained that his medicines are composed locally. There are other shopkeepers who mix, label and brand local medicines. But you can only buy a whole bottle of their medicine. By contrast, he mixes his medicines to order and depending on the problem. Moreover, people only visit him for illnesses, not for problems relating to general well-being. The medicines he used came from trees and came from within Tanzania, but also from India (*white khada)*, Arabia (*yellow powder*), and Spain (olive oil) (interview 10, 17 May 2016) (photos 3.15 and 3.16). The use of medicines from other parts of the world indicates the spatial mobility of the medicines *mzee* Ibrahim used.

I told him that I had heard about the *mganga wa kienyeji* and I asked him what they do. He explained that they deal with different types of diseases and situations:

> *Let us say, these calamities, you have a fleet of cars, the car breaks down once in a while, you go to him or her. You go there for diseases and other things* (interview 10, 17 May 2016).

He told me that he knew some of the *mganga wa kienyeji*. When I asked if it would be possible for me to meet one of them, he told me that it is secret, that they do things that are not accepted. They would see me as a criminal investigator.

> *Those people do their job permanently in their houses. You need to go with a familiar person. Otherwise, they will object* (interview 10, 17 May 2016).

According to *mzee* Ibrahim, there are many such healers in urban Dodoma, for example in Chang'ombe (interview 10, 17 May 2016).

I have asked *mzee* Ibrahim if he knew about *ilizi*, and if he made the object himself. During our interview in 2016 I asked him about the object, and he informed me that he did not make it himself, because these kinds of objects were not accepted in his religion, and it was associated with *uchawi* (witchcraft). He heard that it was for

[76] The Kiswahili word *ndege* is translated as bird (TUKI 2001: 241), but *degedege* is most likely derived from this word, and is translated as convulsions (ibid.: 56).
[77] See, for example, earlier in this chapter for cases of shops selling branded medicines.

example used for children who cry a lot at night (interview 10, 17 May 2016). Chapter 4 will go further into the knowledge *mzee* Ibrahim has about this object.

Paragraph 3.4 presented an overview of the four areas of healing based on the Swahili names for these groups in order to find out which of these healers are involved in making objects for treating health-related issues. As became clear during the interviews with the different kinds of healers, but even clearer when talking to the young adults, the *mganga wa kienyeji* seem to be the only healers who make and use material objects like *ilizi* for protection and/or health-related purposes.

I argue that the presence of indigenous healers will remain relevant, which is supported by different authors. For example, Tabi et al. (2006) conducted a small-scale qualitative study in Ghana in June 2000, where people were interviewed about the use of indigenous and modern medicine. The outcome was that "some participants, especially those of Christian or Muslim faith, associated demonic influences with traditional medicine and thus preferred to use modern medicine" (ibid.: 55). The conclusion was that people do retain indigenous health beliefs in order to give meaning to their health experience while, at the same time, accepting modern medicine (ibid.: 57). The notion that indigenous healers may be able to provide help concerning issues for which biomedicine does not provide a solution is supported by Kale's (1995) three principles of how indigenous healers look at a patient: 1) the patients and their symptoms are taken seriously and enough time must be given to the patients to express their fear; 2) the patient must be studied as a whole by the healer, and the healer must be credited for not seeing the body and mind as separate entities; 3) the healer views a patient as an integral component of a family and a community (ibid.: 1183). These authors support my understanding – based on my research – that biomedicine and indigenous healing continue to exist in parallel in a modern urban environment like Dodoma.

3.5 Past and present

The previous part of the chapter gave an insight into the landscape of the folk sector, as distinguished by Kleinman (1980), present in Dodoma. The following part of the chapter explores the pasts of different healers, i.e., how they became a healer, to give more insight into the profession of folk healing today (3.5.1). The second part of this section explores the current situation of those healers working in Dodoma's urban environment, in terms of if and when healers refer a client to a hospital, and vice versa, but also when they refer their clients to other indigenous healers (3.5.2). This part of the chapter aims to give better insight into the lives of the indigenous healers

and the surroundings they live and work in – i.e., the urban environment of Dodoma – and it provides insight into how healers navigate and are influenced by modern urban facilities like biomedical care.

3.5.1 Becoming a healer

As the literature shows, there are different ways of becoming a healer in Africa, for example on becoming a *sangoma* (cf. Van Binsbergen 1991; Thornton 2009; Hooghordel 2021). Thornton (cf. 2009) clearly states that the *sangoma* tradition is changing as a result of being exposed to other healing traditions and to religious views (ibid.: 17). This is also the case in Dodoma, as discussed in this chapter. The misfortunes the *sangoma* provide medicines for are also similar to those treated by the indigenous healers of Dodoma, namely, theft, infection, loss of love, finding stolen objects (ibid.). What might be different is the religious background of the *sangoma* compared to the *mgnga wa kienyeji*, since, according to Thornton (ibid.: 20), the *sangomas* mostly belong to Christian churches, while the *wanganga wa kienyeji* can belong to Christian churches or Muslim mosques. To become a healer, a *sangoma* learns the herbal system and must also have a personal heritage that enables them to have and 'possess' ancestors, both their 'own' ancestral spirits and 'foreign' spirits (ibid.: 26). Becoming a healer can also be related to experiencing a serious illness (cf. Reis (2000) on the 'wounded healer'). The following part of the chapter discusses the different ways of becoming a healer that I encountered during my research.

As is clear from the above-mentioned narratives, it is not only the *mkunga* (3.4.3) who are directed by spirits on how to treat clients, but also the *mganga wa kienyeji* (3.4.4). Most of the indigenous healers I talked to experienced voices from clan spirits/spirits of the house. Tish, the older female healer discussed in 3.4.4, experienced spirit voices from her grandfather, which she called *mashetani*.[78] Her narrative is shared in 2.4.4.1 about how her grandfather and father directed her where she needed to go to get the medicine to heal people, and she tells how her father had to apply medicine to get her out of the baobab tree. When she came out of the tree, she emerged with some of its roots, and that is how the work of healing started in her case, and how the spirits began to direct her in what to do (interview 1, 3 July 2018).

Another healer who learned her craft through spirits is Angel, a Christian healer in her late forties who has four children (her husband died). She lived on the outskirts

[78] See also Chapter 5, page 196 for a narrative about *mashetani/jinns* collected from a Muslim religious leader.

of Dodoma, where she was also born, and was mostly a farmer but also a *mganga wa kienyeji*. We (both my research assistants and I) interviewed her in her home, where we sat in the middle room of three, close to the door where the light came in. On both sides of the room there were curtains to the other rooms. We sat on one side of the room, and the healer sat on the other side, together with her child who was eating the white fruit of a baobab tree. Angel's healing skills were passed down through the family – from her grandfather to her mother, who gave them to her sister and, when her sister died, she inherited the knowledge. She was possessed by the clan spirits (*mashetani ya ukoo*) in dreams, and they directed her to the medicines she needed to treat people. Her sister died in 1992, but it took until 2016 for the spirits to come and for her to begin practising as a healer. Angel dreamt that she was being told that the spirits were explaining the narrative to her grandfather, to her mother, and to her sister. They asked her to continue the services. They asked her to obtain a white sheep with a black head. The spirits also told her to exchange the sheep for her aunt's goats. She had to do this in order to start working. She followed these instructions. She had never met her grandfather, but her mother told her that she obtained the spirits from her grandfather. When the mother died in 1988 her sister became possessed by the spirits, until her death (interview 7, 16 July 2018).

The *mashetani* (singular is *shetani*[79]) spirits to which Angel and Tish refer to can also be found in the literature. Green (1994: 37) translates this Swahili word as foreign spirits and Gray (1969: 171) simply calls them spirits.[80] Both authors conducted research in Tanzania, albeit in different places. Langwick, who also conducted research in Tanzania, writes that the plural *mashetani* suggests Islamic evil spirits and demons, and that the singular, *shetani*, translates as Christian Satan. She describes how the healer has to talk to the *mashetani* in order to learn what is effective medicine (2011: 20). Holthe (2017: 82) distinguishes two kinds of spirits in her research in Pangani, Tanzania, namely *jini* (pl. *majin*i) and *shetani* (pl. *mashetani*). According to her, *mashetani* are seen as evil and demonic spirits who cause harm, and *majini*[81] are good spirits; indeed, if you accept them, they can bring you great fortune and knowledge. They are believed to be subject to the will of God. The word *jini* derives from the Islamic word *jinn,* which are also spirits. They are regarded as good "as long as you accept them" (Holthe 2017: 82), but they can potentially lead someone in the wrong direction, since they have a will of their own (ibid.). According to Owusu-Ansah (2008: 101), the *jinns* can be seen as evil. Langwick gives the example of *majini* in someone's body, who can protect

[79] *Shetani* derives from the Arabic word for the Devil, *Sheitan* (see e.g., Gray 1969: 173).

[80] Gray mentions that all children and many adults wear an amulet around the neck to protect themselves against the *shetani* (1969: 175).

[81] See also the narrative in Chapter 5, page 196 about the creation of the *jini* and *mashetani*.

that person from further *uchawi* (witchcraft) but who can also take control of her. The *majini* communicates to the person primarily through dreams and visions and advises her, for example, on therapies for particular people (2011: 97). It seems that (*ma*)*jini* start as good spirits, but may turn into evil spirits if you do not accept them.

Within my research, I came into contact with a few 'wounded healers'. According to Reis (2000: 62), following Eliade, a 'wounded healer' is someone who has experienced a serious illness, which is sent by the ancestors and which results in them becoming a healer. The wounded healer complex is the "complex of ideas pertaining to ancestor illness in chosen people and the transformation of sufferer into healer" (ibid.). This demonstrates a transition from someone who suffers to someone who becomes a healer, but it can also be seen as mobility of religion, as the following case shows. The youngest *mganga wa kienyeji* interviewed was a 29-year-old Muslim man who had a practice in one of the areas far outside the city centre. His office was about 50 metres from his house and consisted of two rooms, of which the back room was the office, where we sat to talk about his profession. A piece of red cloth was hanging on the wall behind the young healer. We sat on a dark blue/purple mat, with plastic pots with herbs on both sides of the mat (photos 3.17 and 3.18). The young healer started telling us how he had become a healer. When he was in form 4 at school he

Photos 3.17 and 3.18 *Medicines in the office of the young indigenous healer*

became seriously ill. At that time, he was a Christian and the Born-Again Christians[82] prayed for him. He remained sick for a long time, and his parents took him to various *waganga wa kienyeji*, but he did not get better. After going to the healers, they told him he was possessed by *mizimi ya nyumbani* (literally spirits of the house), but still he did not get better. He did not find it easy to accept that he had these spirits. He spent three years at home being sick. During that time, he continued to be a Christian and he rejected the spirits. Everything he did failed: the crops he grew died, livestock like goats and hens also died. He returned to the healer who told him that he had spirits. He also consulted two more healers. The last one told him that the answer was to become a healer, to get his own shop. Even though he was possessed by the spirits of the house, he needed to stay with these healers to be mentored, to learn more, which he did for almost two years.

The young healer dreamt about various medicines, but these dreams differed from the dreams we normally have. He felt like his head was heavy. Suddenly, voices directed him to a certain place to get medicine. He got his medicine from the place where he was born and from Dodoma. He used both *miti shamba* (herbs and roots) and the Quran. He wrote the words on paper, rinsed them off, and then washed or drank the water.[83] The young healer learned this method from the three mentor healers. He was still learning Arabic when I interviewed him. He converted from Christianity to Islam because he learned to use the Quran to treat people. This was a very challenging aspect of him becoming a *mganga wa kienyeji*. He did not want to change religion. After he suffered from serious illness, he had to accept to becoming an indigenous healer (interview 6, 14 July 2018). This 'wounded healer' not only experienced a transition from sufferer to healer, but also the mobility of religion, namely, from being a Christian to becoming a Muslim.

Mzee Ibrahim was the first person I interviewed when I began my field research in 2014. He was in his early seventies in 2018 and he gave me valuable insight into his job as an indigenous healer who uses herbal medicines. He worked for 35 years as a technician in the postal service in Dar es Salaam. He learned English from the many *wazungu*[84] he met during his work. When he retired, he became a healer and moved to Dodoma. His first shop was in the city centre. His second shop was the one where I interviewed him in 2014 and 2016. In 2017, he had to move to another shop, next to a mosque in the city centre, and I interviewed him there in 2018. *Mzee* Ibrahim is one of the few indigenous healers who I spoke to who has a shop in the city centre.

[82] A Born-Again Christian is someone who experienced a spiritual rebirth and have accepted faith in Jesus Christ.
[83] See Nieber (2017) for a detailed description of drinking the Quran by traditional healers on Zanzibar.
[84] *Wazungu* is the Swahili plural word for *mzungu*, which indicates a white person.

Photo 3.19 *Medicines in shop of mzee Ibrahim (2014)*

Photo 3.20 *Shop of mzee Ibrahim in 2018*

He has been in Dodoma for 22 years, and became very familiar there and prefers the city to Dar es Salaam. He was also an administrator in a mosque. The shop I met him in in 2018 was small, about one metre deep and about three metres long. There was a kind of book shelf on the long side with all kinds of white plastic pots in different sizes. Each pot had the name of a herb/root/ingredient on it. There were also bottles containing different substances and different kinds of (dried) plants (photos 3.19 and 3.20). *Mzee* Ibrahim mainly learned how to heal 25 years ago from a friend who was an indigenous healer, in addition to some knowledge he had learned himself. His friend was an indigenous healer in Dar es Salaam, and taught him how to use *dawa za asili* (literally traditional medicine). *Mzee* Ibrahim was not directed by spirits on how to heal and on what to use to heal.

Hakeem was a healer whom I visited frequently in 2018, whom I introduced in chapter 2.5.1.. He was in his fifties and lived relatively far away from the city centre, but he informed me that he had many clients from all over Tanzania. He learned how to become a healer from his parents. His grandfather was a healer and when he died his father inherited the knowledge. Hakeem himself started healing in 1993, quite suddenly. He discovered that he could spray people with water and it would cure them. He also used local herbs, which his father had told him about. He then became a healer in Dodoma and started his business on the same spot as where I interviewed

him. He came to Dodoma after curing a high-ranking official. When I asked him why he practised where he lived and not in town, he answered that he was known in Dodoma and in the whole of Tanzania. I guess that since he was well known, he did not need a visible place in the city. Hakeem became known for curing people when he was in the north of Tanzania. The wife he lived with (he had more than one wife) will take over the practice when he dies (interview 4, first visit, 11 July 2018).

Paragraph 3.5.1 gave more insight into the profession of folk healing and examined how people become healers, a process that can vary, as the cases showed. It also showed that becoming a healer (not only by learning from relatives, but also from spirits) is something that still exists today, and is not only something of the past or for older people. This was evident from the narrative of the 29-year-old healer. My interviews with different kinds of healers made clear that not only a *mganga wa kienyeji* and *mganga wa (tiba za) asili* are able to become a healer by learning from spirits, but also a *mkunga*. Even though the cases show that some people become a healer via traditional routes, as discussed in the literature, today's indigenous healers also relate to biomedical care and adapt to contemporary urban facilities, as the next paragraph will show.

3.5.2 Healer referrals to hospital or another healer

This chapter focuses on the indigenous healers working in Dodoma Urban. The previous section examined the issue of becoming a healer; this section focuses on the current situation and the influence of the urban environment, as well as the different kinds of health options available – of which biomedicine is the most important for the young adults from the middle classes (as made clear in Chapter 2). Even though the young adults say they mainly choose for biomedical care, it has become evident in this chapter that other health options do exist. But what is the interaction between the folk sector and the professional sector, two of Kleinman's (1980) defined categories, and how is it visible?

In Stroeken's chapter on the individualisation of illness (2017: 151) he writes that healers had to rethink what they were doing and that they had to find new areas of healing, areas in which the newcomers were not successful. These areas relate to a broader sense of health, since they concern the hope of becoming better when hospitals seem unable to provide a cure, and ways of coping. In my research, I encountered a number of cases where a healer referred people to a hospital. In other cases, people had been to the hospital but, having not been cured, they had decided to consult an indigenous healer from one of the four healing areas presented in paragraph 3.4, as also indicated by Stroeken (2017). Due to the focus on folk healing, my aim was to

interview indigenous healers, not biomedical healers. I therefore do not know their views on referrals to healers such as the *mganga wa kienyeji*.

The following narratives were collected from indigenous healers and relate to cases where 1) their patients indicated that they had been to the hospital prior to approaching them or 2) the healers referred their clients to a hospital or to another indigenous healer. This kind of (self-) referral indicates a form of social mobility between biomedical care and indigenous care.

The people who visit *mzee* Ibrahim also go to other healers, according to the *mzee*. He told me that it depended on the response of those other healers. Maybe the client had visited another healer first, but was not cured. They then abandoned that healer and came to *mzee* Ibrahim. He also told me that many people come back to him time and again. This may indicate a relationality between patient–healer; the efficacy of the treatment via the healer enables the patient to heal. *Mzee* Ibrahim informed me that he cannot cure all health-related issues. He was quick to add that not even the hospital can cure all diseases. He sometimes referred clients to the hospital or to another healer. For instance, if someone came to him with an eye infection. By asking questions like how it started, the healer determined whether he could cure the client. If not, he referred the client to the hospital. According to him, he did not have a specialisation, but rather general expertise (interview 2, 5 July 2018).

Mzee Ibrahim treated people who have *hurusi* (paralysis), but also a child with measles (*surua*). He used roots, and put them in a basket of water for two days and the child was then washed with that water. Within three days the child was cured (interview 2, 5 July 2018). *Mzee* Ibrahim confirmed that every healer has his or her own methods, which originate from different ethnic groups. There are a number of different ethnic groups in Dodoma, including Tanga, Sumbawanga, and Kigoma. Common to all the healers, though, was that they learned their skills from their father, mother, or their ancestors. When I asked him how he would decide which *mganga wa kienyeji* to refer me to if I had a problem, he told me that he would listen to what my symptoms were and decide who was the best match and the most likely to cure me.

> *Mzee* I: *They all have their own expertise. Some are surgeons, physicians. If you go to the expert, it will work.*
>
> GP: But what happens if you do not know who is the best and take me to the *mganga* you know?
>
> *Mzee* I: *Then the problem will not be solved* (interview 10, 17 May 2016).

I also heard from a female Roman Catholic healer in her late forties who treated women for, among other things, infertility issues. She always tried to identify the source of the problem and give appropriate medicine, but if she failed then she would direct the woman to the hospital (interview 7, 16 July 2018). It became apparent to me that most healers are aware of what they can cure and what they cannot, and, when they are unable to help, they refer the client to the hospital. But sometimes it works the other way round. Another female Christian healer in her late forties, born in Dodoma, treated women who could not become pregnant. Some of her patients visited her after failing to get the help they needed from doctors. She only used local medicines for treatment. She did not advertise her healing practices; rather, people saw her going up into the hills to find medicine and they communicated with each other about how to find her (interview 8, 18 July 2018).

The healer Tish, who we met previously, provides an intriguing narrative about referring an unwell child to a hospital:

> T: *They brought the child's clothes and I slept with them. I dreamt there was a woman who gave the child meat. The next day, I went on a* bodaboda[85] *to where the child was to remove any meat from the child. The child could not speak and fainted. I boiled roots medicine and gave it to the child and took the child to hospital together with the medicine.*
>
> GP: Why did you decide to take her to the hospital?
>
> T: *She had problems with her legs swelling, that's why they took her to the hospital.*
>
> GP: Were you able to remove the meat from the child?
>
> T: *There was meat in the stomach, chest, and lower back* (she touches the places on her body while saying the different parts). *I removed the meat. I sucked the meat out through the mouth of the child, the meat came out. It looked like small parts of a snake. I became drunk from the meat and fell down.*
>
> GP: Did you know why you had become drunk?
>
> *T: I knew I was drunk from her spirits. I was fighting with the child's* majini. *That is why I became drunk* (interview 1, 3 July 2018).

[85] The Swahili word for a motorcycle taxi.

This is a narrative that shows a case where biomedical care and indigenous care meet. The *mganga wa kienyeji* in the above narrative knows what she can cure and what she cannot. This is also what Parkin (2013: 129) experienced during his research in Eastern Africa: biomedical practitioners sometimes refer patients to indigenous healers, and the latter sometimes refer a patient to a biomedical practitioner, and even make use of biomedicines or equipment (like pills, clothes, stethoscopes, and premises imitating a biomedical surgery). I did not encounter any cases or collect any narratives where a healer had used biomedicines or equipment, except for the case mentioned in 3.4.4.1 where gloves and a razor blade were used.

Just like in Hooghordel's (2021) research concerning the *sangoma*, the healers in my research also seem to adapt to the current environment and changing dynamics within the city. As section 3.5.2 showed, some healers do refer patients to biomedical health options like hospitals.[86]

3.6 Conclusion

The aim of this chapter was to explore the medical plurality of the urban environment of Dodoma, to see which therapeutic practices the different types of folk healers offer and to find out which of these healers, if any, make objects for use in health-related issues. The chapter started by discussing the concept of medical plurality. It introduced the concepts of health systems and health seeking and explained Kleinman's (1980) model concerning the three sectors within healthcare (the popular, professional, and folk sectors) (3.2). The literature on different aspects of medical plurality within Tanzania, with a focus on folk healing, makes clear that extensive research has been done on these different aspects of medical plurality (like herbal healing, Quran healing, and Chinese medicine) and in different parts of Tanzania, like Dar es Salaam, Zanzibar, and north-west Tanzania (3.3). My research aspires to fill the current gap on health-related research done in Dodoma with a focus on objects used for health-related and protection purposes. My research also touches upon issues related to well-being, like stolen property or protection of a home. Not all folk healers use herbal medicines and make objects to be used in health-related issues. Indeed, it became apparent that only *mganga wa kienyeji* make and use material objects like *ilizi*.

[86] Gessler *et al*. (1995) also found referrals to hospitals by indigenous healers in their research on three locations in Tanzania, but only a few referrals from hospitals to indigenous healers.

As this chapter has shown, there is a diversity of health providers within Dodoma (3.4). Based on the different areas of healing that I encountered during my research, I distinguish four domains of folk healing present in Dodoma Urban, based on the Swahili language terms used. These domains are derived from the narratives collected from my interlocutors and from what I have seen and heard from indigenous healers who practice folk healing and whom I interviewed between 2014–2018. These four areas of healing are: i) herbs available in stores or through a *mganga wa tiba za asili*; ii) the Maasai healer; iii) midwife (*mkunga*) and healers only dealing with female-related health problems; and iv) the *mganga wa kienyeji* who not only uses herbs but may also make objects. I argue that different forms of non-biomedical healing do exist and can be found in urban Dodoma, but that these are no obvious options for young adults living in this city when they have a health-related problem, because it is forbidden by their religion and because they are higher educated. Biomedical care options are clearly visible within the urban environment of Dodoma, and the young adults say that they choose from these if they have health problems. During the fieldwork, it became clear that other kinds of healers have offices in the city or shops where (branded) herbs are sold. Maasai healers, who were initially very visibly near the main bus station of Dodoma later had to move to different part(s) of the city when the bus station itself was relocated. But most of the *waganga wa kienyeji*, especially those who learned from the spirits, seem to be living on the outskirts of Dodoma Urban, or were at least easier to find in those places, where the houses are further away from each other, and where there is more privacy. As a young 29-year-old healer told me: "*You need a secret place to keep the privacy of the people who come.*" In town, people might fear being seen visiting him (interview 6, 14 July 2018). These cases seem to confirm my hypothesis that, since the use of herbs is not prohibited by religion (both Christianity and Islam), it is not necessary to be secretive about it, while healers who have learned from spirits and who make objects like *ilizi* are not accepted within Christianity and Islam, hence they work from more hidden locations.

The final part of the chapter (3.5.1 and 3.5.2) presented cases illustrating how people become indigenous healers – either learned from spirits or from other people like relatives – and how they deal with modern urban facilities like biomedical care and incorporate those available healthcare options into their practice.

The next chapter will discuss one of the objects used for healing and protection purposes. This object, namely *ilizi*, has been one of the main themes guiding my research. It will be described via the narratives collected from young adults, indigenous healers, and religious leaders.

4.

Protecting and healing with *ilizi*: The social imaginary based upon an object

4.1 Introduction

Photo 4.1 *Ilizi found in front of Miriam's house*

Miriam is a municipal nutrition officer in Dodoma Urban. When I met her in 2015, she told me she had found an *ilizi* in front of her door. She showed me a picture of a black object (photo 4.1). She and her family looked at what was inside the object: inside the large part (on the right of the picture) there was a piece of paper with Arabic words and soil (*udongo*) around it. The small part (on the left in the picture) included charcoal, hair, and nails. She and her family are Christians and so they prayed and then burned the object. She did not know who had put the *ilizi* in front of her house, or why, but finding the *ilizi* did not scare her. When she was younger, she had seen people wearing these kinds of objects, and had heard that they can protect children, and that the people who used these objects believed in witchcraft. She did not use *ilizi* herself when she was young, since her parents are Christian and they apparently followed the Christian tradition of not using these kinds of objects. She told me that she had seen such objects in Dodoma, especially in the ward of Chang'ombe, which, according to her, was an area where many Muslim people lived and where many women were uneducated.[87] She believed that the use of the object was related to (lack of) education (interview 2, 6 May 2015). In December 2016, Miriam wrote to tell me that she had found another object in front of the door of her house. This time, the object was made of a piece of red cloth and contained mango peels, human nails, and some other things that the family could not identify. Miriam's son sent me two short video clips in which the object was visible and in which he opened the object to see what was inside and then burned the whole object. In an e-mail (1 January 2017) Miriam informed me that they burned the object because they thought it was associated with witchcraft (video stills 4.2).

[87] My research assistant translated it as being uneducated. But it is possible that it means not meeting the general state requirement.

Photo 4.2 *Video stills of burning the ilizi*

This case explicates the existence of different versions of material objects such as *ilizi*: both as an object left in front of the house and an object worn on the body. The higher-educated municipal officer relates the use of the object to witchcraft, (lack of) education, and Islam. During my fieldwork periods in Dodoma, different narratives about *ilizi* were told, and these narratives confirmed the introductory case that the object *ilizi* can be used for different purposes – both positive and negative – be it the protection of a child or preventing a rival from prospering.

Most of the narratives I collected concerned the object being worn on the body, usually in hidden places; but, as the narratives clarified, young children often wear the object visibly, e.g., around the wrist. *Ilizi* can be a combination of materials, selected and combined by the healer, who gives you this object in a kind of shell or cloth. One of my interlocutors explained the secrecy about *ilizi* and told me that everybody knows about it but that people do not tell and often feel ashamed to talk about it (interview 2, 23 June 2014). As Chapter 3 showed, the medical landscape in Dodoma is diverse, but out of the four areas of healing discussed, only a *mganga wa kienyeji* makes these objects and knows what is inside. What the narratives clarified is that most interlocutors do not actually know what is inside the object. I have spoken to a range of people who have used or received *ilizi*. Miriam's narrative made clear that she (and her son) was not afraid of opening the *ilizi*, to find out what is inside. However, they did burn the objects and said that the objects were associated with witchcraft. Chapter 5 will explore the issue of why the use of objects for healing is intentionally hidden in society despite the existence of narratives about both these objects and their hiddenness among young adults. It will also detail their views and thoughts on

such objects in relation to educational, religious, and other urban facilities. In order to be able to answer the why question, this chapter will first analyse the narratives on how and when *ilizi* is used in an urban environment where there is an apparent contestation present between the use of *ilizi* and the existing urban (medical) facilities and religious institutions. The narratives are linked to the themes of misfortunes, shame, secrecy, and witchcraft, thus giving them different dimensions.

Although the use of and narrative about *ilizi* is widespread throughout Tanzania, as is evident from the conversations with my interlocutors, in most academic literature it is usually only mentioned briefly, rather than being the focus of the research. Moreover, it is referred to as being used for different purposes than those talked of by my interlocutors. For example, a song that tells of an amulet being used by a member of parliament to stay in power (Reuster-Jahn 2008) or mentioning that *ilizi* is being put into food (Rasmussen 2008: 167). Another study notes its use as a protective amulet against witchcraft in an area where the object was seen as backwards and traditional and something only used by a Christian minority (Holthe 2017: 33). In my research, I also talked to young, Muslim adults, who said that the use of objects like *ilizi* was not accepted. Despite this, some Christian interlocutors told me that young, Muslim adults do, in fact, use these kinds of objects. Equally, a number of Muslim interlocutors mentioned that young, Christian adults use these kinds of objects.

In 2014, the fieldwork started with asking people if they knew any narratives about objects used for protection and/or healing. This produced a broad overview of the different kinds of narratives and objects known or heard about, which can be found in Annex B. One part of this overview focuses on *ilizi*, a name that was mentioned many times and which became a focal point of my research. The literal translation of this Swahili word is charm or amulet, and many interlocutors informed me that such objects are used for protection against and curing health-related misfortunes (e.g., protection of children against diseases like *degedege* (epileptic seizures) or against the evil eye). The object can also be used "in jealousy situations," to "gain political advantage" and to "get positions of privilege."[88] I decided to incorporate questions into the interviews about this type of object having heard that objects for protection and healing may be visible on small children and that people may be more willing to talk about those objects and tell me narratives about what they have heard or seen. Most interlocutors have grown up with narratives about *ilizi*: they heard the narratives from their parents, have seen neighbour children wear *ilizi* around the wrist, or they

[88] Translated from the Swahili words by one of my research assistants, and relates to getting privileges in political office.

have seen movies in which it appears. As several interlocutors informed me, they think that *ilizi* is mainly used in rural areas and not in an urban area like Dodoma. They were therefore surprised that my research was not taking place in the rural areas, but in an urban environment. However, this is exactly why it was more interesting to conduct the research in the urban environment of Dodoma, as it apparently addressed a seeming contradiction in the eyes of my interlocutors. Exploring how visible *ilizi* is in the city of Dodoma with its access to modern biomedical care, different options for education, and access to churches and mosques may offer insights as to how and why such contradictions seem to exist. This is at the same the leading problematic of this chapter; the contradictory nature of ideas and images that are expressed in narratives that revolve around the contested object.

Since the focus of research is on the narratives collected, I will relate these narratives according to the following themes: 1) misfortunes, because *ilizi* can be used for purposes other than health (4.2.1); 2) shame and secrecy, because the use of the objects is surrounded by these notions (4.2.2); and 3) witchcraft, because *ilizi* is mostly seen as a malign thing (4.2.3). The chapter first examines the concept of narratives and the social imaginary that arises from these narratives in relation to these themes.

4.2 The social imaginary of the narratives on misfortunes, shame and secrecy, and witchcraft

As outlined in the introduction to this thesis, and following Hydén (1997), I will use the narratives told by the young adults, indigenous healers, and religious leaders to explore the social world of the young adults living in an urban environment. The narratives that I investigate bespeak the concerns that arise when the young adults themselves or their young children are ill (see Chapter 2). In this context the interviews concern the narratives they know about objects used for healing and protecting, which is the focus of this chapter.

As an outcome of the narratives collected, I propose a social imaginary concerning the object of *ilizi*. According to Taylor (2002), social imaginaries concern how people's social existence is imagined by them, "how they fit together with others, how things go on between them and their fellows, the expectations that are normally met, and the deeper normative notions and images that underlie these expectations" (ibid.: 106). Taylor adds that the social imaginary is shared by large groups of people, that it is what enables the practices of society by making sense, and how "ordinary people 'imagine' their social surroundings" (ibid.). According to Taylor, this is carried in stories, images, and legends (ibid.). Moreover, he sees changes as slow and gradually shifting within

the imaginary (Taylor 2002). Vigh (2006: 483) states that "social imaginary relates to the way in which we comprehend the unfolding of our social terrain and our position and possibilities of movement in it." He suggests that it can be best "defined and analysed as the sum of our social horizons" (ibid.). According to Vigh, it is through this social imagination that we locate ourselves in the world (ibid.). Or, as Cochrane phrases it, it gives coherence, meaning, structure, and legitimacy to our social practices, something she calls "the sense-making system that gives structure and form to what constitutes our 'reality'" (2014: 25). The cases presented in this (and the other) chapter(s) show that there is a shift in thinking among young adults living in the urban environment, compared to – as the interlocutors themselves say – people living in rural areas or in other cities in Tanzania. Specifically, the young adults interviewed living in the urban environment of Dodoma say they do not use objects, like *ilizi*, for health-related and protective purposes or for other ends, like gaining (more) power. I argue that the social imaginary shared by higher-educated young adults is informed by a form of shame and secrecy. They feel ashamed and are secretive about going to an indigenous healer to get an object like *ilizi* to be protected or cured from different kinds of misfortunes. The reasons why the young adults refrain from using these kinds of objects will be explained in this chapter.

As Mattingly and Garro put it, "we try to understand who we are becoming by reference to where we have been" (1994: 771). In my research, it became clear that, having been exposed to an urban environment with many options for health seeking, education, and religion, young adults belonging to Dodoma's middle classes have adopted other ways of living or looking at the past. The use of an object like *ilizi* was referred to as something used by people from rural areas, and the young adults were quick to indicate a social distance from that rural world. I argue that the religious leaders, and perhaps also the young adults from the middle classes, talk about *ilizi* as a thing of the past and an object that has no place in modern Dodoma. As my research (and specifically this chapter) shows, however, the material object of *ilizi* does exist in urban Dodoma today. This results in the presence of a social imaginary concerning not using the object, which may contradict the existing reality, since the object does actually exist in the urban context and the young adults seem aware of that. This leads us to the main question of this chapter:

> *How is the social imaginary on* ilizi *constructed in an urban environment in relation to misfortunes, shame and secrecy, and witchcraft?*

This chapter aims to answer this question by looking at the use and description of the object of *ilizi*, by looking at the narratives told about this object and about how knowledge about it is transferred. The question will be answered by focusing on

three groups of interlocutors, namely, young adults, indigenous healers, and religious leaders. The use of the object is related to misfortunes, with a main focus on failure of health and failure of gender (Whyte 1997), as will be discussed in paragraph 4.2.1. The second part of this chapter will discuss the narratives expressed regarding feelings of shame and concerning a secret, hidden part of society (4.2.2). The third part of the chapter will discuss witchcraft, since it became clear from the interviews that the use of *ilizi* is often associated with witchcraft (*uchawi*). Indeed, in many perceptions *ilizi* is associated with evil and is mainly perceived to cause someone harm, although I also collected narratives about the object being used for good things (4.2.3).

Each section will present cases concerning the use of and/or narratives on *ilizi* related to the three mentioned themes, to illustrate what the view is of the three groups of interlocutors concerning this object. The aim is to show that the social imaginary is based on social expectations, influenced by the primary religions of Christianity and Islam, access to education, and biomedical care. At the same time, it is clear that Dodoma's young adults also have access to indigenous healers and have knowledge about what an object like *ilizi* can do. The chapter will first examine the theme of misfortunes from the perspective of the three focal groups of interlocutors.

4.2.1 Misfortunes

As mentioned in the introduction to this chapter, the object of *ilizi* can be used to cause someone harm, but it may also be used for something good, like the protection of a child. As the case of Miriam in the introduction to this chapter shows, she did not know why an *ilizi* was left in front of her house, but presumably it was to cause Miriam (and her family) harm. I relate such uses of the object to the four categories of misfortunes distinguished by Whyte (1997: 16-18), as mentioned in earlier chapters. The first is failure of health, which in Whyte's research was the most frequent misfortune mentioned by the diviners and relates to swelling of body (parts), skin decolouration and strange behaviour, fits, signs of possession, and insanity. The second is failures of prosperity, like poor crop yields, the death of cows and goats, and employment and financial problems. The third is failures of gender, which include problems of sexuality, reproduction, and marriage. The last category is the failure of personal safety, like being struck by lightning or being hit by a motor vehicle. The use of *ilizi*, based on the narratives reported within my research, can be mostly linked to failure of health (for example to cure trembling in small children or to protect a young child) and failures of gender (for example miscarriage(s), not getting pregnant, or experiencing problems when giving birth). The cases related to these two kinds of misfortunes will be discussed further in the rest of the chapter. During the research, I heard narratives

about the object of *ilizi* concerning the other two kinds of misfortune – failures of prosperity and failure of personal safety – and to present a more complete vision about the object, I will now share these cases.

Failures of prosperity

The first misfortune I discuss is failures of prosperity. In this regard, I have collected several cases that involve the use of an object other than *ilizi*, namely, a ring. Even though it is not technically *ilizi*, I do want to mention it because it indicates a new way of using objects for protection in Dodoma, and potentially may be seen as a new form or a replacement of *ilizi* by people from a higher class. What it has in common with *ilizi* is that only the *mganga wa kienyeji* can make the object. According to the narrative from Kharim, a young adult in his late thirties whom I introduced in chapter 2.5.1, concerning the ring, a blacksmith closes the ring containing the medicine. The purpose of the ring is to get power, political leadership, or become the boss. According to a young adult interviewed, rich people use a ring because they do not want to be seen wearing an object. The ring can have different shapes and the medicine is not always on top (interview 9, 11 July 2014). A ring is a commonly used object that blends in and might therefore not be noticeable as a material object containing medicine. It is not automatically associated with 'bad' things while *ilizi* is, at least within the social imaginary. Bessire (2009: 24-26) gives the example of an aluminium *hirisi*[89] camouflaged in a wristwatch, created in 1995, among the Sukuma in Tanzania. Secrecy is evident here, too, since the watch can be worn to divert attention from the person who does not want other people to know that he/she is wearing such an empowered object and does not want to be asked questions about why such empowerment or protection is necessary. In contrast to the original woven object, the wristwatch is long lasting, since the outer aluminium casing will not decay. It seems that new forms of objects are made, with the same purpose as *ilizi*, namely for empowerment or protection. But these new kinds of objects, are worn on visible places as the finger or wrist, and not hidden under clothes. However, the secrecy remains, since the medicines in the object used for empowerment or protection are hidden, and it is not visible for people that it is an object used for these purposes and containing medicine.

A second case concerning failures of prosperity does concern *ilizi* and relates to theft. One of my research assistants reported a narrative of a thief with an *ilizi* on his upper arm. The object was believed to give the thief protection when stealing, so that he could not get caught and would bring the thief prosperity. But the thief in this narrative did get caught. The thief apparently said that if they want to kill him, they

[89] I argue that this is the same kind of object as *ilizi*, or *hirizi* (see footnote 3 on page 15).

would have to cut him in the upper arm in order for him to die. So, they did, and the thief died (interview 1, 6 May 2015). Besides failure of prosperity, this case may also be seen as an example of failure of the purpose of the object, since the thief did get caught. As mentioned before, and as will become clearer further in this chapter, *ilizi* can be used for protection, not only against getting caught, but also protection in health-related issues like getting ill.

The final case of *ilizi* relating to failures of prosperity concerns the object being put – or rather hidden – in the upper arm. This case occurred during one of my visits to the healer Hakeem, in 2018. A young couple entered his office. The problem was that the husband's family did not want the young husband back because he was stealing from people. The healer looked into his mirror[90] and saw that the young man was indeed a thief, and that he was wearing a large *ilizi* on his upper arm. The healer told us that the *ilizi* would protect the wearer when they go out and steal, but that it could also cause the arm to swell if you did not go and steal. The healer removed the object. The wife of the patient had to burn the *ilizi* together with other rubbish. When she burned the *ilizi*, the husband's arm stopped swelling. A few days later, when we met the healer again, we asked him what was inside the *ilizi*. He told us that it consisted of a mix of *mkaa* (charcoal), *maganda ya kakakuona* (armadillo shells), hyena dung, and lion hair. We also heard from the healer that both the wife and husband received medicine (*kubiliti upele*, which literally means to cover the rash) in order for the couple to stop liking each other. It resulted in the husband leaving the wife (interview 4, fifth visit, 4 August 2018; sixth visit, 8 August 2018). In this case, the use of *ilizi* caused problems for the man in the sense that his family did not want him back home because of the stealing, and his wife also did not want to be with him. Clearly, the intervention by the healer was a kind of disclosure that revealed the immoral activities of the husband as being a thief. When using the *ilizi*, the thief may not have had the full knowledge about the consequences of what it means to use that object and what it can do. This narrative is one of a number illustrating the use of *ilizi* for protection and, in this case, it may have protected the man while stealing. However, this case also shows that the use of the object has other implications, like swelling of the arm when the person is not stealing, and a wife and family who do not want to have anything to do with the man because of the immoral implications.

[90] The use of a mirror in healing practices is a well-known phenomenon, as also mentioned in footnote 72. A mirror can be used for divination or for communication with ancestors. A healer can see the person(s) in the mirror who is doing the patient harm or who is doing the patient good (cf. Luedke 2007; Legrip-Randriambelo and Regnier 2014: 32). Luedke describes the history of the use of mirrors in Mozambique: the missionaries brought mirrors to show the viewer an image of the self, but prophets used the mirror to be able to see in places where the human eyes cannot see (Luedke 2007: 725). This is clearly what the healer Hakeem does: he looks in the mirror to see things that the human eyes cannot see.

Failure of personal safety

The second misfortune I want to discuss here is failure of personal safety. One of my young male adult research assistants had discussed a few topics relating to *ilizi* with two other people and reported a narrative regarding a thief who tried to break into a house that was protected by *ilizi*. The thief became mad (ill). To be able to cure the thief, the relatives needed to go to a healer who is more powerful than the one who made the *ilizi* to protect the house (interview 1, 6 May 2015). Another case where an object was used to protect the house was reported during a get together with three young women friends. One of the friends told me that *ilizi* is for protection of the house, and that it can be put under the pillow or a hole is dug in the floor and the *ilizi* put into it (interview 13, 8 May 2015). In these last two cases, the *ilizi* is not worn on the body or left in front of a house, as in Miriam's case at the start of this chapter (which was probably done with bad intentions), but rather it is used to protect one's own home and most likely put inside the home for protection, as the second case showed. As the first case of failure of personal safety showed, there is a hierarchy amongst healers, in the sense that one healer can be more powerful than the other and the more powerful healer can counter the effects of an *ilizi* made by another, less powerful healer. The efficacy of the healer (see for example Feierman 1985: 79 on the efficacy of a treatment) is clearly important in these cases. One can think that he or she is protected by an object, but if someone uses an object made by a more powerful healer that power can be overruled.

The cases of *ilizi* used for the two non-health related misfortunes make clear that *ilizi* is hidden, worn where it cannot be seen, like the upper arm, or concealed in the floor of a house. And the *ilizi* in the cases presented are all used for protective purposes, either protection of a house, or protection of a thief. The last case made clear that the protection of the house can be overruled by a healer who makes a stronger object for a thief.

As indicated in the previous part, the two misfortunes that were heard the most were failure of health (for example trembling in small children or protection of a young child) and failures of gender (for example miscarriage, not getting pregnant, or problems giving birth). In the following part, cases will be presented for both these kinds of failures in relation to the same three groups of interlocutors, namely, young adults (4.2.1.1), indigenous healers (4.2.1.2), and religious leaders (4.2.1.3).

4.2.1.1 Failures of health and gender: Narratives of young adults

One morning in May 2015, at a mobile clinic where I held some interviews, I spoke with a 24-years-old Muslim woman whose highest level of education was Standard 7. She had come to the clinic with her child to have the child weighed and measured.

Photo 4.3 *Ilizi on a young child*

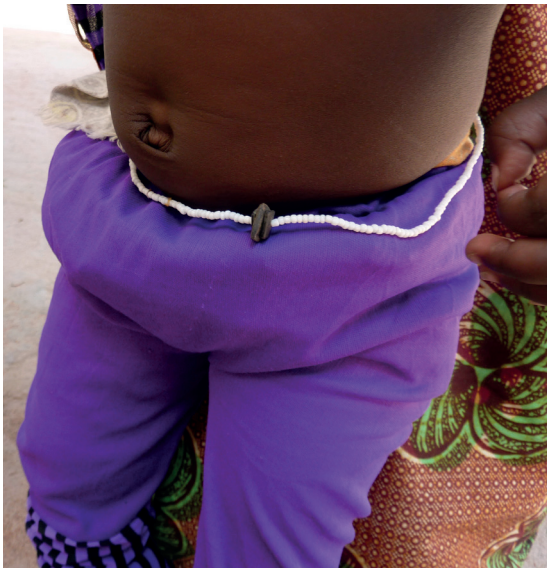


Photo 4.4 *Object of beads worn around the waist*

The woman explained that she goes to the hospital when necessary, but she also confirmed that her child was wearing objects on the body for protection (the child visibly wore a black piece of cloth around the wrist (photo 4.3)). The child wore this object for protection against stomach pain. The young adult mentioned that the object was made by her father and it contained medicine. The child also wore an object around the waist (photo 4.4), which, she told me, was to prevent the child from suffering or its growth being stunted if its father and mother ever divorced. The young adult explained that there are two different objects, one for men and one for women, and that the object around the wrist affords protection against the evil eye, witchcraft, and also against diseases like *degedege*. It is medicine wrapped in black cloth (interview 24, 15 May 2015). My research assistant tried to make an appointment with the interlocutor's father, but unfortunately he did not succeed.[91] Both objects around the wrist and waist are clearly used to counter failure of health. How the object around the wrist looks and its purpose may indicate that it concerns *ilizi*. This was the first time that I encountered such objects, but seeing them confirmed that objects used for healing and protective purposes are present in urban Dodoma.

[91] Unfortunately, as indicated in the introductory chapter, my book with fieldnotes was stolen that year, and I do not remember why my assistant was unable to make an appointment. It is likely that the father did not pick up the phone, which also happened when my assistant tried to make an appointment with a healer whose name and number were mentioned on a sign on a pole.

Another case of failure of health concerns the narrative I collected during an interview I held in a clinic with a woman who said she made the object herself – she had learned the technique from her *mama mdogo* (mother's younger sister).[92] She is a Muslim woman of 40 years old, with four children and Standard 7 as highest educational level. There were no objects on the body of the child she had with her at the clinic, but she told me that she did use an object on one of her other children (her oldest daughter). She used *mvuje*[93] (photos 4.5 and 4.6), which protects the child against *degedege*. She put it on the child's wrist or around the waist. *Mvuje* and onion/garlic are made into powder and then place in an elastic material (which the interlocutor calls *pepsi/lambo* and is made from a bag that could be bought in town). *Lambo* was used because it is waterproof. Consequently, when the child is washed, it stops the medicine from being ruined by water. You take a piece of black cloth and put it around the *lambo* with medicine inside, and then wrap it around the wrist or waist. This particular object had been used since the child was born until she reached the age of two. The woman confessed that she had not observed any effects of using or not using these kinds of object (interview 15, 14 May 2015). She does not know the name of this object but, based on the medicine inside it, it seems likely that it is *ilizi* used to protect the child against health-related issues.

Photos 4.5 and 4.6 *Mvuje (Asafoetida)*

The two above-mentioned cases are rare in the sense that they deviate from most of the other narratives collected that came from young adults who do not use *ilizi* themselves, as is the case in the following example. A Muslim man in his early forties had seen an *ilizi* and asked the person what was inside the object. That specific *ilizi* contained positive words to make it into a good omen. *Ilizi* can be used for a good purpose, for example for protection of a house or a person. The Muslim man explained

[92] During the interviews, it became clear that only specialists can make these kinds of objects. I do not know whether her mother's younger sister was a specialist.

[93] This is mainly made in India and the non-Swahili name is asafoetida.

that when people talk, they can praise a child, but children can also get sick from the words (they might be expressed as good words but not actually meant in that way). Such words are a bad omen. As seen in other cases, *ilizi* can be used for bad purposes, like harming someone. To change this, positive words are put into an *ilizi*. The *ilizi* is then worn from the neck to the waist, on the legs, and hand (interview 43, 21 May 2015).

Besides food and plant-related materials and positive words, human material can also be used inside *ilizi*, as shown in the introductory narrative of this chapter where nails were used. As several narratives show, nails can also be used to protect a small child. When a baby is born a lock of hair and it's first nail clippings can be taken, sometimes along with the umbilical cord, and can be wrapped in a piece of small black cloth. In addition to the hair or umbilical cord, medicine can also be added. The piece of cloth can be worn around the neck, wrist, or ankle. This object is called *ilizi* and is used for the protection of the child (interview 8, 9 July 2014; interview 4, 2 May 2017). One of my interlocutors, a female teacher at a primary school, who is a Roman Catholic, has the umbilical cord (solely that, not used in an *ilizi*) of her second child (according to her, the umbilical cord of her oldest child was probably thrown away by her mother). She will keep it until the daughter has her own house, and then she will bury it near the house for protection. According to her, you are not supposed to throw away the umbilical cord (interview 4, 2 May 2017).

Furthermore, *Ilizi* can be used if a woman has a miscarriage, which is an example of Whyte's failures of gender (1997). The female Christian interlocutor with a college Diploma and working as a secretary whom I referred to before, was born in Dodoma indicated the following: a woman can go to a healer (*mganga*) to ask why she is miscarrying so often. She will be given *ilizi* with medicine inside in order for the woman to stop having miscarriages. The healer knows which kind of medicine, but the woman does not. The woman wears it across her body on a chain or on a rope. My interlocutor takes a piece of paper and folds it around her necklace to show me how it is worn. It should be under the clothes (interview 7, 2 July 2014). This case illustrates how *ilizi* can be used to achieve a positive outcome, while it also shows that there is a seemingly shared narration about the object, in the sense that only the indigenous healer knows what goes in the medicine, and that the object is worn on a hidden place on the body.

The above cases demonstrate that young adults do know narratives about the use of *ilizi*, mainly for the protection of a child against, for example, the evil eye, witchcraft, and diseases like *degedege*, but also to prevent a woman from having miscarriages, thus helping to achieve a positive outcome. There appears to be a common narrative on what these objects look like, i.e., a piece of cloth with something inside. What goes inside can

vary from medicines, food, or plants, a piece of paper with words, human material like hair, finger nails, an umbilical cord, or *mvuje*. There also seems to be a shared narrative about where the object is worn on the body, e.g., on the wrist or around the waist.

4.2.1.2 Failures of health and gender: Narratives of indigenous healers

My research revealed that the *mganga wa kienyeji* is the indigenous healer who makes the objects of *ilizi*. In order to have a more complete picture of what the social imaginary is, it was important to interview different kinds of indigenous healers. As indicated in the introductory chapter, it was difficult to find healers, and not all healers I interviewed were *waganga wa kienyeji*. But it was interesting to learn more about what other kinds of healers know about *ilizi*. One healer, named Tish – who calls herself a *mganga wa kienyeji* and was introduced in chapter 2.5.1 – whom I was able to interview three times, discussed *ilizi* during our first interview in 2017. She is a Roman Catholic, in her fifties, working from home on the outskirts of Dodoma. I share the following narrative based on an interview and fieldwork notes:

> *Together with my two research assistants I walk on the dust road up the hill to meet the indigenous healer Tish. It is a windy but sunny day, which is quite normal in May. Having almost reached the top, we turn left onto a small path through the corn field until we reach a small house with some open soil in front of the house. The house has four rooms, whose windows are sealed with mud. A small, older woman comes out to greet us. She greets my assistants in Gogo* [the vernacular language]*, while I greet her in Swahili. We sit down at the side of the house to talk about her work as a* mganga wa kienyeji*. At one point, I ask Tish what she knows about* ilizi *and whether she makes the objects herself. The healer says that the name for the object used for a child is* kinga*, which is the Swahili word for to protect or protection. We ask her if it is* ilizi*. She confirms this and tells us it is worn on the wrist or on the neck. Cuts in the flesh are not called* ilizi*. There is another type of* ilizi *where a small piece of medicine is cut from a type of tree. The healer speaks to that piece of the tree to tell it what it needs it to do. You swallow that piece. We ask her if she knows about* mvuje*, and she confirms that she does. She uses it, also to make* ilizi *for a child. The healer uses* ilizi *to protect the body of the child. Older people mix* mvuje *with water and drink it when they have a headache. When I ask her if* ilizi *is only used for protection or if it is also used as a cure, she answers that it protects against and treats all diseases in the head, headache, and backache* (interview 11, 9 May 2017).

This narrative confirms those told by the young adults in the sense that in the common perception an *ilizi* consists of a piece of black cloth with a substance like *mvuje* inside, and that it is used for protection and healing purposes. The narrative mainly addresses Whyte's failure of health.

The clearest case I encountered when talking to a *mganga wa kienyeji* about *ilizi* was with Hakeem, the previously mentioned Islamic healer. He was in his late fifties, had his practice inside his compound outside the city centre, and I visited him six times in the summer of 2018. His youngest child was wearing a black piece of cloth on the left wrist, which the healer confirmed was *ilizi* (photo 4.7). It consisted of a piece of black cloth with the umbilical cord and the powder called *mvuje* inside and it was used for protection. According to Hakeem, the colour represents the darkness, which relates to doing someone harm. Anything bad cannot attack the *ilizi*. The healer made the object for all his children; the boys wore it on the waist, the girls on the wrist.[94] The object can disappear by itself, or it can be removed by one of the parents. The second youngest child, a boy, wore the *ilizi* around his waist from three months old until he reached the age of two. According to Hakeem, it is a Sukuma practice. Indeed, he had worn such an object when he was a child. He also made the object for other children, and it always consisted of the umbilical cord and *mvuje* (interview 4, fourth visit, 31 July 2018). In this case, the object of *ilizi* is also used to prevent failure of health. It is a black cloth containing a human part and some kind of food-related material, and it is worn on a visible place of the young child's body.

Photo 4.7 *Ilizi on the wrist of Hakeem's son*

When I asked a female Anglican indigenous healer who was in her late fifties if she used *ilizi,* she said she did not, but told me that instead of *ilizi* she has medicine that she boils to protect children. These medicines protect children immediately after they are born against evil people, against *degedege*, and other diseases that may affect the child when he/she is still young. When I asked if I may look at the medicine, she

[94] Unfortunately, I do not know why this differs.

answered that the spirits (who inform her what to do) would not allow this (interview 9, 18 July 2018). This case shows that not all indigenous healers make *ilizi*, but it does give an indication that healers know what *ilizi* is and what it can be used for.

The cases of the indigenous healers who do make *ilizi* confirm the social imaginary of the young adults in the sense that both groups perceive the object consisting of a piece of black cloth with something inside like *mvuje* and the umbilical cord of the child, and that the object is worn on the body (wrist or neck). The purpose of the object is to protect the young child against bad things.

4.2.1.3 Failures of health and gender: Narratives of religious leaders

In response to the interview with the indigenous healer, Tish, whose narrative was discussed in the previous section (4.2.1.2), and her mentioning that she is accepted by the church (she was clearly wearing a rosary and she said she attended church every week), we interviewed a few religious leaders to discover their views on indigenous healers who make *ilizi* and what their knowledge is of such objects. Rio *et al.* mention that Christianity "shares the human-centric belief that misfortune is caused by the malevolent intentions of others" (2017: 4) and uses prayer, redemption, renunciation, and sacrifice as a remedy. According to Rio *et al.*, the human-centric worldview of Christians includes the idea that evil influences always attack a person and this means that people need protection (ibid.: 4, 6). This strategy to confront such forces is evident in the narratives collected from religious leaders and some young adults, as the following cases will show.

Jabari is a married Roman Catholic in his mid-forties. He has five children, was born in Dodoma rural area, is a catechist,[95] and has heard about *ilizi*. He said he heard that people use it, but he had never seen it. And he himself had never used it. When we asked what he had heard, he told us that people went to the *mganga* to obtain it, and that they used *ilizi* for business and other things, for example for protection of the body. He could not say much about it, because he had not seen it, not even in a picture. But as a religious leader, he had talked to people who told him about these kinds of objects. He then quoted some sermons that preach against such practices, encouraging people to stop using these kinds of objects, because it is against Gods will (interview 16, 15 May 2017).

[95] Given that many of these Catholic religious leaders are married, it is likely that they are lay ecclesial ministers, and not priests.

Another Christian religious leader, who was in his mid-fifties, had seen *ilizi* himself; indeed, he had actually removed a lot of these kinds of objects from young children who were in the process of being baptised and were wearing the *ilizi* around the wrist, upper arm, or the waist. He had seen the black cloth but he had never opened one to see what was inside. Before the child was baptised, he asked what the *ilizi* was for. He was told that it was for protection and was inherited from the ancestors, the grandparents in particular. Any child wearing such an object was not allowed to be baptised. The preacher told the parents that they were objects that were used a long time ago, when there were no hospitals and the grandparents went to the forest to get roots or herbs for different diseases. "*Now the world has changed*," he said, "*we listen to the word of God, and it is therefore that the* ilizi *has to be removed*." After the object is removed the church leaders pray over it, sprinkle it with holy water and then burn it outside of the church, without looking inside. There was a certain hole which they put the *ilizi* into, along with other rubbish. According to the preacher, the church does not believe in the efficacy of *ilizi*. He said that when somebody wears this kind of object they cannot believe in God (interview 19, 19 May 2017). Praying over the object before it is burned seems to contradict the statement that the church does not believe in the efficacy of the object. This case clearly reveals the effect of the urban environment with its facilities, including the influence of religions like Christianity. But it also indicates that in the view of religious leaders one cannot be a Christian and believe in God and use *ilizi*. In the following parts of the chapter, the implications of this become clearer.

Since the primary religions in Dodoma are Christianity and Islam, we also interviewed some Muslim religious leaders about what *ilizi* looks like. One of the Muslim religious leaders responded:

> *It can be in any form of object. It depends on the person who has made it and the one who needs it. There are two categories: it can bring chaos; it can protect. The ones that can bring chaos are* manuizi *[Islamic word], which is the same as* lengo *or* nia.[96] *Something you think the object is going to do* (lengo) (interview 10, 19 July 2018).

This Muslim religious leader also said that it is not accepted to use *ilizi*, that God does not want it. According to him, anyone using it is not respecting God. Rather, it indicates that you are following multiple gods, and not one God. The narrative of the Muslim leader is the same as those of the Christian religious leaders in the sense that

[96] *Nia* can be translated as intention, aim, or purpose, and *lengo* as target or objective/aim (TUKI 2001: 245).

both primary religions prohibit people from using *ilizi.* In addition, as De Bruyn (2017: 18) shows, early Christian writings in the second and third centuries already began to associate amulets with danger and evil, and thus to causing harm. This contradicted, as he also indicates, the way in which people used amulets to heal themselves from sickness (ibid.: 26). I am aware of this longstanding history of Christian thinking about these matters, but I do not aim to give a historic analysis of Christian ideas on the use of objects. The research aims to present, among other things, the present-day views of religious leaders (both Christian and Muslim) on the use of objects like *ilizi* within the urban environment.

This section (4.2.1) discussed the use of *ilizi* in relation to two misfortunes, namely failure of health and failures of gender. As became clear, the young adults mainly have knowledge about what the object looks like and about the use of *ilizi* for these kinds of misfortunes, but most of them do not use the object themselves. The narratives of the indigenous healers and religious leaders seem to confirm the narratives of the young adults. The social imaginary between the three groups concerns: 1) what the object of *ilizi* looks – black cloth with something inside; 2) the use of the object – to protect a child against stomach pain or *degedege*, but also to prevent miscarriages with women; and 3) the placement of the object – on the body, i.e., the wrist, upper arm, or waist. There is also contestation: the young adults say they do not use the objects, but the *waganga wa kienyeji* say they do make the objects of *ilizi*, and at least one religious leader has seen *ilizi* himself. The narratives of the religious leaders reveal that whether Christian or Muslim, they share the same view on the use of *ilizi,* in the sense that it is not accepted because it is against Gods will.

4.2.2 Shame and secrecy

Within the narratives told, the existence of biomedical care, education, and religion are important factors. On the other hand, the presence of other sorts of healing creates a dilemma or, as I call it, contestation, which causes shame and secrecy. This will be the focus of this part of the chapter. When writing about secrecy, the concept of ignorance is important, since it embraces various forms of not-knowing, unknowing, and secrecy, according to Kirsch and Dilley (2015). They argue that non-knowledge should be treated as though it has a social life. The secret is a form of non-knowledge (ibid.: 1, 2), which they describe as the "unequal distribution of knowledge in a social field, with some people sharing a certain stock of knowledge and others being ignorant of its contents (ibid.: 3)." Ignorance of the contents of a secret "contributes to the social construction of reality" (ibid.), which also became clear in my research, as this thesis aspires to show. Last also mentions secrecy, but in relation to medical

matters, in the sense that practitioners "are not expected to describe their methods" (2007: 9), because they are trade secrets. According to Last, in his research about a Nigerian town[97] in the north of Nigeria, besides the secrecy among practitioners, there is also secrecy among patients, since they cannot discuss their illness (only with their closest kin), because if you let people know you are ill, you become an easy target for witches, since "witches are notoriously concerned for their victims and mourn them the most" (ibid.). I encountered this kind of secrecy during my research: people say that nobody knows what is inside *ilizi*, only the *mganga wa kienyeji* who makes the object knows. The other kind of secrecy relates to the patients, in this case higher-educated, religious young adults, since the primary religions do not permit going to an indigenous healer for an object like *ilizi*. According to Last, people do not know through a combination of three aspects: uncertainty, scepticism, and secrecy (ibid.). He argues that not-knowing originates "in the breakup of traditional medicine as a system," which developed "a secrecy to conceal the lack of knowledge and certainty," but also a "scepticism in which people suspect that no one really 'knows' that there is no system" (ibid.: 11). In Chapter 3, I discussed the different kinds of health systems in Dodoma, with an emphasis on folk healers. I propose that, due to the growth of Dodoma, including the dominance of religion (Christianity and Islam), more access to education and the availability of biomedical healthcare options have made secrecy more apparent in the capital city.

The chapter will now present a series of narratives on shame and secrecy in relation to the three groups of interlocutors, namely, young adults (4.2.2.1), indigenous healers (4.2.2.2), and religious leaders (4.2.2.3), aiming to show why young adults in particular feel so ashamed and are concerned by the secrecy and hiddenness of the object of *ilizi*.

4.2.2.1 Shame and secrecy: Narratives of young adults

The higher educated young adults from the middle classes living in Dodoma Urban developed their narratives on the object of *ilizi* while growing up (through relatives, neighbours, films, etc.). Yet for them it is also particularly shameful to use *ilizi*, especially when worn visibly, e.g., on the wrist. Most of the interlocutors share the

[97] According to the 1963 census, the town had a population of 17,000 (Last 2007: 2-3), the 2022 census showed a projected population of 326,900. (https://www.citypopulation.de/en/nigeria/admin/katsina/NGA021025__malumfashi/, accessed 9 May 2025). The town has a much smaller population than Dodoma urban, with a population of 1,087,745 according to the 2022 Demographic and Socioeconomic Profile. Even though the town has a smaller population, it is interesting to compare with Dodoma, since modern medicine became part of the medical landscape since 1960, as well as schools and better roads (Last 2007: 4) which is also applicable to Dodoma.

opinion that it is not accepted by their (primary) religion and that they do not use *ilizi* because they are higher educated. As one of my interlocutors with a master's degree and a job as health officer, puts it:

> *it is a sin to believe in witchcraft, because it is not accepted by their religion, seen from both Christianity and Islam* (interview 38, 16 May 2015).

I have asked many young adults about the visibility of objects worn by young children and, by contrast, why they are hidden among young adults. As a senior nurse informed me:

> *The child is small, they do not know anything. They do not understand the purpose of the object. But the adult knows the purpose. They do not want to be seen with that object. They prefer to put it in the pocket or in the waist* (interview 52, 25 May 2015).

I heard this argument from other interlocutors as well: that because of the innocence of a young child, because they do not know what they are wearing, it is more accepted for a young child to be wearing *ilizi*, but the parents will deny that the child wears *ilizi*, even if you have seen it.

I also asked young adults why people might be ashamed of using *ilizi*. One interlocutor, who is a teacher at a primary school, told me that:

> *She thinks they* [people who use *ilizi*] *might be feeling shy, because they are outdated* (zimepitwa na wakati). *And act in religious ways against those objects by preaching against those things. She thinks they are used in the past, they might not be used today* (interview 4, 2 May 2017).

Another interlocutor, who works as a secretary, informed me that:

> *people feel shy. By saying they use* ilizi, *they believe that they can become witches* (interview 13, 12 May 2015).

And a third interlocutor, a teacher at a primary school, told me:

> *Because these objects are against Gods will. They are preached as bad objects. A person may be a Christian person or not. I do not know how it looks like; I only hear about it* (interview 5, 3 May 2017).

In May 2015, when I held some interviews at a mobile clinic, I had an interview with a young woman who had converted from Islam to Christianity upon marriage. When the child was ill, she immediately went to the hospital. When I asked her if she wore any things on the body she said that she did not use these kinds of objects because she believed in God, and she was afraid. When I asked her why she was afraid, she told me that with her first born, a boy, she was advised by other people to use *ilizi* for protection against several diseases. One day, her uncle came and found *ilizi* on the child. The uncle educated the mother and said: "*You do not know what is inside, you do not know what it is for.*" She got the *ilizi* from the *mganga* (healer). The uncle took the *ilizi* and put it in the fire. The child continues to suffer even when the young woman was using *ilizi*. The *ilizi* apparently made no difference. It seemed the fear concerned the unknown: you don't know what is inside the object and what it is for. When I asked her who used these kinds of objects, she told me that many people in the villages do, but that in the city it depended on the person's perception and that it was not related to a specific ethnic group (interview 19, 14 May 2015).

During my research, I was also told by the municipal nutrition officer (whom we met in the introduction to this chapter) that they would visit villages to burn *ilizi* while casting out demons or praying for a sick person (personal correspondence via e-mail, 26 May 2015). I have spoken to someone who she introduced me to who told me a bit more about these kinds of field trips. They went one week a month to three villages, accompanied by doctors from particular areas in order to offer health services, especially to women and children. They also offered spiritual services as pastors and, as evangelists, they preached the word of God, told the people the good news about Jesus, and how to live a good life. He told me that "*there is belief in superstition*." He had seen *ilizi* on both adults and children, but said that it is easier to see with children, because adults hide it. When I asked why adults hide the objects, he told me that "*they do not want people to know that they believe that superstition. If I use, they fear that I am also a witch doctor, or not a good person.*" According to him, the objects found on children are only used to treat health issues, while adults use these objects for other purposes, too (interview 1, 5 May 2016). This case makes clear that adults feel ashamed and behave secretive about the use of objects – even in the villages – because they want to occur as a good person, and are not seen as one when seen with an object like *ilizi*.

In paragraph 4.2.1.1, I presented a case of a young woman whose child was wearing *ilizi* around the wrist (interview 24, 15 May 2015). When I asked if I could take a picture, the woman looked uncomfortable. I therefore proposed to go somewhere else, behind the mobile clinic, in order to take the photograph. She agreed. When we were behind the clinic, the mother showed me that the child was also wearing an object around

the waist. This is clearly a case of shame about the wearing of an object used for protection purposes. The *ilizi* around the wrist can be visibly worn, but the object around the waist, hidden under the clothes, is invisible.

The reason why young adults feel ashamed, became more explicit during the interview with Simon, a Christian male entrepreneur in his late thirties with one young child. He mentioned that if an adult is seen wearing *ilizi*, that person fears the community looks at him as a strange person, someone who performs witchcraft. At the same time, they see you being involved in religious activities and therefore the person feels ashamed. According to Simon, there are people who are half-believers, who do not believe in God entirely, and so they go to 'witch doctors' for other things, and their children wear those objects (interview 42, 21 May 2015). Based on the narratives, it seems it does not make a difference whether a person is Muslim or Christian. I also heard the above-mentioned arguments from people from different ethnic groups and birth places.

As one of my other interlocutors – a young Christian man with a university degree and no children – told me: "*Where I come from, they feel shy. This kind of practice seems to be that they do not believe in God. They have their own agenda in life. When someone asks about the purpose of* ilizi*, you cannot answer, because that person is going to ask more*." I asked him if the reason they hide the object is because they do not want to have to explain? "*Yes, they hide [them]*", he answered (interview 2, 7 May 2016).

The common narrative that is shared by the young adults in relation to shame and secrecy is that a young child who is wearing *ilizi* does not know what the purpose is; the young child is innocent. But a young adult does know the purpose of the object and its association with bad things and not being a good person. It seemed the shame and secrecy are caused by the unknown of the object (what is inside and the purpose), and by using the object, there seems to be social exclusion, since the use of the object is associated with performing witchcraft. You are not seen as a good person, when you use the object.

4.2.2.2 Shame and secrecy: Narratives of indigenous healers

I talked with *mzee* Ibrahim (an indigenous healer mentioned in Chapters 2 and 3) about *ilizi* and objects used for protection. He informed me during our first conversation, in 2014, that a piece of black cloth containing elephant dung, garlic and *mvuje* are put around the wrist. This object is meant to help a child who cries a lot at night – a child that cries because of devils. This object is worn until the child is five years old. He told me that there were two popular ethnic groups in Dodoma, namely, the Wagogo

(living in Dodoma's urban areas) and the Warangi (living in Kondoa region, but now settled in a specific part of Dodoma), and that both these ethnic groups used this kind of object (interview 1, 18 June 2014). During our interview in May 2016, I asked him if he makes *ilizi* himself, but he said he did not. He did now admit that there are four things contained in the *ilizi*: in addition to the above-mentioned three items something from the ancestors is also put into the black cloth. He had heard that it is used for a young child who cries a lot at night and that it is wrapped in black cloth and put around the wrist. He did not make *ilizi* himself, because he had not learned about it, and because it was not accepted in his religion (he is Muslim). He added that it is like doing *uchawi* (witchcraft), which is very serious. It is only the *mganga wa kienyeji* who makes *ilizi* (interview 10, 17 May 2016). My findings suggest that he means that with witchcraft you can do harm to people, and it is not something everyone can do. His views on witchcraft will be further discussed in chapter 4.2.3.2. I asked him if he was aware that people feel ashamed about using these objects. He informed me that most people go at night and are ashamed that other people might see them and talk about them. For example, if you are a boss of a company and are seen wearing such objects. I mentioned that I had heard that small children can be seen to wear these objects but that adults cannot. I asked him why. He responded: "*Who will ask the child?*" But if the person is an adult, people start gossiping. *Mzee* Ibrahim continued, "*when I would see a child wearing such an object, I know the parents or grandparents gave the object*." *Mzee* Ibrahim told me that they will deny it. "*Even if you have seen it, they will deny it*." He told me that children wear the objects, but adults do not. When I mentioned that everybody knows that there are adults who wear objects, he confirmed this (interview 10, 17 May 2016). My interpretation is that people do feel ashamed about the use of *ilizi*, as he indicated during our interview in 2016, and that they do not want to be associated with the object and with witchcraft – which is seen as a bad thing –, while, most likely, being a religious person at the same time. The narratives of religious leaders concerning *ilizi*, will be discussed in the next part 4.2.2.3.

The issue of shame and secrecy became clear when interviewing the *mganga wa kienyeji* Kareem about *ilizi* in July 2018 (see also paragraph 4.2.1.2 concerning failures of health and gender). During the first interview I had with him he responded negatively to my question about whether he had heard of and used *ilizi*. But during my fourth visit, I saw that his youngest child was wearing a black piece of cloth on the left wrist, which the healer confirmed was *ilizi* (interview 4, fourth visit, 31 July 2018). I did not ask him why he responded negatively the first time I asked him about the knowledge and use of *ilizi*, but my assumption is that he did not want to share that knowledge with me during our first meeting. During my fourth visit, I was more familiar to him (and his family) and it may have been easier for him to tell me about the *ilizi*, since he knew me better and perhaps a level of trust and confidence had been built. In

addition, he might have been open about the object due to my direct question when I saw the child with the object around the child's wrist and asking him if it was *ilizi*.

In her research on identities, tradition, and religion in a coastal city of Tanzania, Holthe distinguishes three examples of the presence of secrecy: secrecy resulting from boundary setting related to the religious practices, which are privatised; secrecy in the way indigenous healers practiced and operated; secrecy in the social field, where women took measures to avoid gossip (2017: 66-7). As became clear in Chapter 3 of this thesis, I also encountered secrecy relating to the practices of indigenous healers: it was difficult to find them; some of them stopped picking up the phone when my research assistant called; or they asked for large sums of money for an interview; and most healers interviewed were living and had their offices on the outskirts of Dodoma city. Even though the young adults interviewed say they are religious, and the object of *ilizi* is surrounded with negative connotations, shame and secrecy, the *waganga wa kienyeji* do exist in Dodoma, but are not located in the city centre. As indicated in the findings, they are located on the outskirts of Dodoma to avoid gossip from people like young adults and religious leaders, and to be able to practice their profession, like Holthe (2017: 66-67) mentioned. But in addition, to provide a private space to meet with clients, as one of the indigenous healers from Chapter 3 mentioned: "*You need a secret place to keep the privacy of the people who come.*" In town, people are more fearful of being seen visiting a healer (interview 6, 14 July 2018).

4.2.2.3 Shame and secrecy: Narratives of religious leaders

In 2018, two Muslim spiritual leaders (*shehe*[98]), both in their early forties, but living in different parts of Dodoma, were also interviewed on their vision about *ilizi* in relation to the mosque. I interviewed one Muslim spiritual leader on the porch of his house; the other *shehe* was interviewed in a kind of classroom between two buildings, which was partly covered some sort of canvas. Both religious leaders said that the use of *ilizi* is prohibited. As one of them told me: "*if someone is using it, it is not respecting God*" (interview 10, 19 July 2018). If someone is wearing *ilizi* or if someone is a healer who makes *ilizi*, religious leaders will preach to that person that they should believe in God, and make clear that there is only one God. According to one Muslim spiritual leader, the Quran says that if a person makes a mistake or goes against religious stipulations, he or she must be frequently reminded. If the person is found using these kinds of

[98] *Shehe* is used to refer to a Muslim religious leader (Rafiq 2022: 530), a religious scholar who is "knowledgeable enough to pronounce on religious issues" (Becker 2008: 14), and the literal translation of this Swahili word is sheikh or wise old man (TUKI 2001: 290).

objects again, the Quran permits that person from being barred from the mosque (interview 11, 19 July 2018). If you make or use *ilizi* it indicates that you worship several gods. According to one spiritual leader, a *mganga wa kienyeji* is not accepted in the mosque because the Quran is against the worship of multiple gods. Those people who wear *ilizi* cannot be given any leadership within Islamic religion, because they are not exemplary to the rest of the community (interview 11, 19 July 2018). According to the other *shehe*, a healer who makes *ilizi* can come to the mosque, but the *shehe* will preach to the healer that he/she has to believe in one God. If the healer uses his/her profession for good (for example by using herbs (*miti shamba*)) then that is acceptable, but if you use it in a bad way (for example by using *ilizi*) it is not good. Even medicine from the hospital, like Panadol, which is considered good, originates from *miti shamba* (interview 10, 19 July 2018).

The use of *miti shamba* is explored by Marsland (2007) who found that it generally is seen as a good thing and related to hospital medicine. She quotes a healer who is trained in Islamic and 'local' medicine who says that the tablets given at the hospital actually contain traditional treatments. According to that healer, the difference is that the healers dig up the roots and boil them, which takes a long time (2007: 758). During her research, Marsland discovered that people who are Christian nevertheless use *miti shamba* in secret. This is highly related to missionary views that do not allow its use because it is prescribed by witch doctors, who are linked to witchcraft (ibid.: 757). Some of the young, Christian adults that I spoke to confirmed using herbs for healing purposes (for example *ndulele* (photo 4.8) and *marembo*[99] to warm the body). One interlocutor – a young male school teacher – told me that he used to obtain herbs from his home area, but no longer uses them because they are not available in Dodoma. But he expressed the hope of being able to get medicine from his home area if he ever had a serious problem (interview 5, 3 May 2017).

Photo 4.8 *Ndulele*

[99] These are local not Swahili names. The herbs come from the avocado tree and are frequently sent by their parents (interview 7, 5 May 2017).

There is a clear and common narrative among the religious leaders concerning the use of objects, and it relates to shame and secrecy; namely, the use of *ilizi* is unacceptable because it indicates a belief in more than one God. By contrast, the use of herbs is accepted by religious leaders, because they are linked to biomedicine. The shame and secrecy are apparently directly linked to the associations between such objects and witchcraft, which is the focus of the next part of the chapter.

4.2.3 Witchcraft

Listening to the narratives, it became clear that people do think that misfortunes can be caused by witchcraft and that the local government tries to regulate the non-biomedical part of healing by obliging all healers to register – as explained in Chapter 3. According to Bukurura (1994), misfortunes and fears associated with witchcraft are present among the Sukuma and Nyamwezi rural communities in Tanzania, be it deaths, sickness, crop failures, or reproductive problems, all of which are attributed to the powers of witches. On the other hand, there is a powerful view that disregards such thoughts as outdated. But these thoughts persist and the government has tried to protect the part of the community that is accused and suspected of being behind such misfortunes (the 'witches') (ibid.: 65).

Ample research has been done on witchcraft in different areas and eras in Africa (cf. Evans-Pritchard 1976; Geschiere 1997; Ter Haar 2007a; Rio *et al.* 2017). Broadly, witchcraft means "harm to persons or their belongings" and "human-centric, relational ways of understanding health, well-being, and social processes" (Rio *et al.* 2017: 4), or it "is a manifestation of evil believed to come from a human source" (Ter Haar 2007b: 8). In the context of my research, the way that witchcraft is perceived primarily relates to doing someone harm and it is associated with darkness (or evil as Rio *et al.* (2017: 8) mention). The most repeated word used in connection with *ilizi* during my research was witchcraft.

Evans-Pritchard studied witchcraft in his work on the Azande people. He wrote about witches and sorcerers and made a clear distinction between them and diviners, oracles, and medicines that the Azande use to guard against both. He translates the Azande word *mangu* as witchcraft and defines it as "a supposed psychic emanation from witchcraft-substance which is believed to cause injury to health and property" (1976: 226). He also relates witchcraft to different kinds of misfortunes, such as a bad groundnut crop, a scarcity of game, or someone catching influenza (ibid.: 19). Geschiere (1997: 2) mentions that many Westerners see the belief in witchcraft as "traditional" and believe that modernisation will result in it

disappearing, but this view does not resonate with the actual developments in Africa today. More than twenty years later, his argument still stands, in the sense that, in my research, it became clear that the belief in witchcraft has not disappeared despite modernisation in Dodoma. European missionaries were convinced that witchcraft would disappear in African societies with the advent of Christianity (Geschiere 1997: 2; Iliffe 1995: 153). According to Moore and Sanders (2001: 20), witchcraft is "a set of discourses on morality, sociality and humanity" and it is a "form of historical consciousness, a sort of social diagnostics," that explains why the world is the way it is and the changes that are taking place. Witchcraft can have different causes, as Ter Haar (2007b: 1) makes clear: it can be caused by war, poverty, other forms of misery, HIV/AIDS, or a crisis of governance. Chapter 5 shows that there is a clear contestation between the existence of the primary religions, education, biomedical healthcare options, and the existence of different kinds of healers. Listening to the narratives of most of the young adults, it seemed that witchcraft is part of something of the past, but this section 4.2.3 will show how witchcraft is seen within the social narrative of *ilizi*.

Ample research has been done on witchcraft in different areas of Tanzania (cf. Abrahams 1994; Green 1994, 2005; Stroeken 2010, 2017). According to Stroeken, the concept of witchcraft has almost unnoticeably changed over time in rural Tanzania. He argues that there is a split of mind and matter, and that witchcraft now belongs to the domain of mental health. Stroeken described a change from collective village- or clan-based practices towards more individual treatment that is practised via an oracle and private ceremonies with healers (2017: 152, 166). Mombeshora (1994) shows the conflicts in generational relations with respect to witchcraft in a village in southern Tanzania. He states that the *waganga wa kienyeji* (he calls them diviners, I have used the word indigenous healers (see Chapter 1)) have claimed that they are the only ones who can treat the effects of witchcraft.

Within Tanzania, cases can be found for the use of medicines for witchcraft purposes. *Uchawi* is the Swahili word for witchcraft, and *mchawi* (pl. *wachawi*) means witch (pl. witches). According to Green (1994: 24-5, 44), *uchawi* embraces sorcery, witchcraft, and intermediate forms, but its usual translation is witchcraft. The Pogoro in Southern Tanzania (among whom she did her research) have a term for witchcraft that suggests the use of medicines, of many different types and classified in terms of how they are administrated. She also mentions *hirisi,* which, according to her, is "any medicine wrapped in cloth and worn on the body." According to Green, witches (both men and women) use their medicines in order to harm other people, and they derive their powers from using medicines (ibid.: 25). During my research, I often heard people talk about the connection between witches and medicines like *ilizi*, in the sense that *ilizi*

is used to protect young children against witches.[100]

In my research, witchcraft was an oft-repeated word in relation to *ilizi*, which relates to what Abrahams argues, namely, that "witchcraft is only one of a number of conceptions of the human capacity for evil and for doing harm to others" (1994: 10). As became evident from talking to my interlocutors, the object of *ilizi* is used for, among other things, protecting a young child against harm (for example, against *wachaw*i (witches), the evil eye, or crying at night), protecting the house, protecting a thief, or for being more successful in business. This latter goal is mentioned in an article by Mgumia (2020), which details how witchcraft is used to magically steal money from small businesses in Tanzania. The narratives about *ilizi* make clear that it can be used for both good and evil. The narratives of the three groups of interlocutors in relation to *ilizi* reveal that people are especially focused on such objects' 'evil' connotations and the associations with witchcraft.

As we have seen, *ilizi* is generally made using black cloth. The colour black is frequently associated with evil and/or doing someone harm. Turner (1970: 71) describes the associations of blackness within the Ndembu society in Zambia: blackness is associated with badness or evil, to have misfortune, to have diseases, witchcraft, death and night or darkness. Following the literature mentioned in this section 4.2.3, the next sections will focus on the relation between witchcraft and the three groups of interlocutors, namely, young adults (4.2.3.1), indigenous healers (4.2.3.2) and religious leaders (4.2.3.3) and aims to show how witchcraft is perceived in relation to the object of *ilizi*.

4.2.3.1 Witchcraft: Narratives of young adults

It became clear from the interviews conducted that *ilizi* (and also witchcraft) is mainly used in the cities in the north of Tanzania (for example Mwanza, Mwanga, Kigoma) or Tanga on the northern part of the coast. Sometimes, cities closer to Dodoma were mentioned, for example Morogoro, which lies on the way to Dar es Salaam. This was for example mentioned by Candace when talking about *ilizi*, and the use for small children who do not feel well or cry a lot. "*People from Tanga, Morogoro, Shinyanga, Kigomba*[101] *and in Dodoma use it,*" she says (interview 7, 2 July 2014). Some areas within Dodoma region were explicitly mentioned as places where *ilizi* is used, for example

[100] I did not ask about the relationship between witches and indigenous healers, and the healers were not referred to as witches. The focal point of my research was not who the witches were and what they did, but, as indicated in my thesis, witchcraft was rather part of the social narrative and related to the fear of witches and witchcraft.

[101] Shinyanga and Kigomba are located more in the west of Tanzania.

Chang'ombe (a neighbourhood in Dodoma city) and Kondoa (an area about 140 kilometres away from Dodoma City). "*Especially in Chang'ombe*," one woman told me, "*because there are many Muslim people and many women are uneducated*" (interview 2, 6 May 2015). She was one of several interlocutors who mentioned the wards of Chang'ombe or Kondoa as a place where *ilizi* can be found.

Several interlocutors related the object of *ilizi* to the topic of witchcraft. One told me: "*It belongs to witches*" (interview 14, 14 May 2015). An example of the narratives told in relation to such objects, witchcraft, and the colour black is my interview with a Christian woman in her late twenties, the mother of a young child. She had seen people use these objects, and also parents giving such objects to their child. She did not know what is inside the object but she was aware that it was worn around the wrist, neck, or waist, and that it is black. When I asked her why the object is always black, she answered:

> *Black is used because it seems that black cloth is associated to witchcraft. The* mganga [healer] *and* wachawi [witches] *are always wearing black. It is associated with evil and bad things* (interview 16, 14 May 2015).

During my first visit in 2014, one of my interlocutors, Kharim (a higher-educated Christian man whom I introduced in chapter 2.5.1), showed me a video of two witches who were caught in Mwanza, Northern Tanzania. He wanted to show me that witches do exist, and he told me that he believed in witches. The witches in the video were a young man and a young woman. The woman was pregnant. She wore a chain of large beads across her body (from the right side of her neck to the left side of her waist), an amulet around her neck, a short skirt, and something covering her breasts. The man wore a piece of cloth. Both of their faces had been smeared with something black. Their clothes and adornments were black and red. The woman flew through the air with an *ungo* (an object used to sift rice), the man with a spear/arrow. They also had a horn (smeared red) and three calabashes: one containing *dawa* (medicine), one with human flesh, and one that was used with the object that made them fly. The witches came from Kigoma (interview 9, 11 July 2014). Green (1994: 25) mentions that witches operate at night, because then they are invisible to ordinary people, and that they fly naked through the sky. The people interviewed during my research who mentioned witchcraft were clearly fearful of witches (*wachawi*), which, I argue, is part of the social narrative of *ilizi*. This also became clear in a small Focus Group Discussion with two female Christian friends. I asked them what they would do if I walked towards them, put my hand out, and said that I have *ilizi* on my hand? One said "*I will run; I am afraid. Sometimes they work, but I do not believe*." The other friend said she would be afraid too (interview 13, 12 May 2015).

The narratives also make clear that *ilizi* is associated with multiple gods. During the same small Focus Group Discussion with friends, I asked if those gathered knew what *ilizi* was. One person responded that "*people who have a belief in witches use* ilizi *as a second God"* (interview 13, 12 May 2015). This polytheistic aspect of *ilizi* and witchcraft also became clear when interviewing religious leaders (this will be presented in 4.2.3.3).

Most of the young adults I spoke to had heard about *ilizi*. One interlocutor, a secondary school teacher in his early thirties, told me the following:

> *Yes, I hear it as part of the sermons in church. These are things related to witchcraft. Normally talked about being burned. It is preached that it is not good. Bring it and burn it. I am in Dodoma for ten years now, for university and for work. I heard about it in Dodoma. When I was at university the Christian student's organisation gave fellowships. Their pastors have been preaching about* ilizi. *This is the only place where I have heard about it* (interview 5, 3 May 2017).

I also asked whether people are ashamed of wearing objects like *ilizi*. A young female interlocutor who is doing a bachelor study at one of the universities told me:

> *People use it secretly. They do not want people to know they use. They do not want to know, because it is not a good thing. People who use it might be seen as a witch doctor* (interview 7, 5 May 2017).

During an informal conversation with two friends about finding indigenous healers, I asked if they knew of the existence of *wachawi*. They said they did not but knew they were present in Dodoma. When I asked if they saw such persons a witch, they said yes, adding that witches are busy and they kill people by adding poison to food. I asked them how do you recognise a witch? One of my friends explained to me: "*a witch cannot look at you, the person looks down a bit skittish. When you talk to friends, you look at each other, but a witch does not look at you*" (fieldwork notes, conversation 10 July 2018).

From the few cases I explored of small children wearing *ilizi* for protection and or healing, it became clear that the object had been made by an older relative and that they had put the medicine contained in it inside the black cloth. From the narratives told by young, female adults it was clear that this person was usually the child's mother, the grandmother of the husband, or a neighbour who advised them to keep the newborn's umbilical cord for protection (for example buried next to a tree on the

compound or put in the black cloth worn by the child). I argue that in addition to the role that age plays in the use of an object like *ilizi*, access to facilities available in the urban city of Dodoma also has an impact on the choices of young adults. Most young adults interviewed had moved from other places to Dodoma, which is a city where facilities for education, religion, and biomedical health care are present.

As displayed in the introductory section 4.2.3, witchcraft is related to misfortunes, doing harm to people, and is associated with darkness or evil. Section 4.2.1.1 showed that *ilizi* is used in cases of misfortunes and doing harm. The current section 4.2.3.1 made clear that *ilizi* is related to witchcraft, and is associated with the colour black, and the belief in more than one God. As the narratives in the current section also showed, the belief in witchcraft did not disappear when Dodoma modernised and when urban facilities came to Dodoma.

4.2.3.2 Witchcraft: Narratives of indigenous healers

Mzee Ibrahim informed me that using *ilizi* is like doing *uchawi* (witchcraft). He explained that only the *mganga wa kienyeji* (which he is not) makes *ilizi* (interview 10, 17 May 2016). He is a *mganga wa tiba za asili*, a healer who uses herbs and alike to cure diseases. In 2018, I asked him if he could put me in touch with *wachawi* (witches), but he told me that he knew some but that "*they won't accept that you won't reveal their secrets*." When I asked him if they were in urban Dodoma he informed me that they were four kilometres from where we were, and he named two wards within Dodoma. He continued by saying that there are many *wachawi* in an area to the north of Dodoma (interview 2, 5 July 2018).

I interviewed the female healer Tish twice in 2017 and once in 2018. During my first visit in 2017, she showed me different kinds of medicines and ingredients, including the *miti shamba* shown in photo 4.9. She told me that you need to pound it and add water to it, and then drink the mixture. This concoction is used if one is bewitched and it is causing stomach problems. According to her "*you drink this and the thing in the stomach will come out.*"

In addition to the herbs she uses for healing practices, she also makes *ilizi*. The black cloth that is used to make *ilizi* is called *kaniki*. The healer Tish showed me a piece of this fabric (photo 4.10) and mentioned that it is only used for children (interview 11, first visit, 9 May 2017). I learned from two other interlocutors, young men, that the black fabric can be bought in town, in regular fabric shops. Tish also informed me that she used *mvuje* when making *ilizi* for children, as it protects the body. She told me that

Photo 4.9 *Miti Shamba from indigenous healer Tish*

Photo 4.10 *Kaniki from indigenous healer Tish*

older people drink it with water in order to cure a headache (interview 11, first visit, 9 May 2017).

The narrative of the indigenous healer *mzee* Ibrahim concerning witchcraft clarifies that witches are seen as bad people who are against you. They are people that you, or your young children, need protection against and objects like *ilizi* can be used for this purpose. The narratives also confirm what became clear in chapter 3, namely that the *mganga wa kienyeji* is the only kind of healer that can make the object, which is black cloth with something (like *mvuje*) inside.

4.2.3.3 Witchcraft: Narratives of religious leaders

During my first interview in 2018 with a Muslim religious leader (*shehe*), my research assistant and I asked what he had heard about *ilizi*. He said it was associated with witchcraft (*uchawi*) and that it usually consisted of threads with things inside (sometimes even living things like frogs), which are tied around the waist, upper arm, or neck. According to him, *ilizi* was used by old men and women who did not have any religious training, and by young people who had inherited the knowledge from the elders (interview 11, 19 July 2018).

As mentioned, the colour black is frequently associated with the objects of *ilizi* and with witchcraft. According to another Muslim religious leader that I interviewed, the colour black is used because it suffocates the heart (*fifiza moyo*) (interview 10, 19 July 2018).

One particular Muslim religious leader told me that:

> *it is a profession to make* ilizi. *It is like people studying geography, science, arts. The importance of learning Quran is to learn God. And to respect him and to praise him.*

He preached to the healers who make *ilizi* and told them that "*you believe in one God and God is one*" (interview 10, 19 July 2018).

Another Muslim religious leader mentioned that

> *it is strictly prohibited for such people* [someone who wears *ilizi*] *to be in the mosque. If they are found, they will be against the religion, what the Quran says. Because the Quran insists on worshiping only one God. They cannot be given any leadership within Islamic religion, since they are not exemplary to the rest of the community* (interview 11, 19 July 2018).

One of the Christian religious leaders informed me that

> *according to the church they do not believe in this* ilizi. *When somebody is wearing this, he cannot believe in God. They* [the religious leaders] *preach to him and remove the* ilizi. *They tell them that those things are from long time ago* (interview 19, 19 May 2017).

One Roman Catholic religious leader, who called his profession catechist, quoted some sermons that are against the practice of *ilizi*, calling for people to stop using it because it is against Gods will. He gave the example of a sermon about Adam and Eve, and the snake tempting them with the forbidden fruit[102]. He related this to *ilizi*, which is seen as a satanic thing:

> *The snake will always bite men in the legs. It is from there where sin has started and where God said the whole creation is cursed. Believe that the snake was a Satan that deceived men and led the sin to spread in the world.* Ilizi *is being prevented from being used, because it is a satanic thing. We have to believe in God. God did not use* ilizi. *Used only his own words to speak to men. He used words in creating all creatures and the world. Preaching against*

[102] This was also confirmed by another Roman Catholic spiritual leader, who mentioned that the narrative of Adam and Eve was related to evil, since the snake represents Satan (interview 19, 19 May 2017).

> *people from using* ilizi *so they can only believe in one God. By using* ilizi *it is like believing in gods. Yet they are supposed to believe in only one God who should serve them in the world, but also has to prepare themselves for the heavenly world, after life, as they die. They stop them from using* ilizi *they relate it to spirits, just like the snake who deceived Adam and Eve to go against God's plan* (interview 16, 15 May 2017).

As paragraph 4.2.3 showed, the use of *ilizi* is associated with witchcraft. The narratives of the young adults and religious leaders, but also those of some indigenous healers, like *mzee* Ibrahim, confirm that using *ilizi* is the equivalent of doing *uchawi* (interview 10, 17 May 2016). On the one hand, it is associated with witchcraft and evil, because of the colour black, which suffocates the heart, as one religious leader put it (interview 10, 19 July 2018). This linkage to the colour black, darkness, and witches is also clear from the young adults' narratives. On the other hand, the use of *ilizi* is linked to believing in more than one God. The religious leaders differ in their opinion about whether an indigenous healer is accepted in church/mosque or not, but they share the narrative that the healer is prayed for and entreated to stop believing in more than one God.

4.3 Conclusion

My exploration of the use of an object for healing purposes reveals that, even though most inhabitants of urban Dodoma were born in other places, most interlocutors have grown up with similar narratives about and have seen objects used for healing and protection purposes.

The interviews held between 2014-2018 clarified that, regardless of place of birth, religion, level of education, or ethnic group, most people know of narratives about *ilizi* from neighbours, relatives, movies, and/or television or they have seen objects of *ilizi* themselves. This chapter presented an overview of the three themes: misfortunes, secrecy and shame, and witchcraft, all of which are related to *ilizi*. These three themes were explored amongst the three categories of people interviewed, namely, young adults, indigenous healers, and religious leaders. My analysis of the narratives collected produces a social imaginary shared by all three categories. Young adults specifically seem to associate the use of the object with the past, and something that is used by older people. The use of *ilizi* is also associated with rural rather than urban areas.

The practices presented in this chapter are not unique to the purposes that *ilizi* is used for, like protection against the evil eye, theft, finding stolen property (cf. Thornton 2009) or to cure specific diseases. In addition, the objects come in many forms,

from Arabic words written on paper (cf. Owusu-Ansah 1983) to a ring. There are also differences in terms of what is put inside the *ilizi*, which can range from an umbilical cord (cf. Mukunya *et al.* 2020) to nail clippings to medicines. The picture that derives from these narratives can be seen as a social imaginary, which is built up of different elements and is related to misfortunes, secrecy and shame, and witchcraft. Young adults say that they have heard about *ilizi* – some have seen it in films or learned about it from neighbours in their home area – but they say they do not use the objects e.g., for healing purposes. My research shows that objects are used and made by a *mganga wa kienyeji*. The question about why people are secretive about using an object like *ilizi*, and why, in contrast to adults, children can openly wear such an object, is at the heart of this puzzle. The young adults say they do not use objects because of modern facilities like education, biomedical care, and access to religions like Christianity and Islam. According to the interlocutors, being religious can protect you against the influence of witchcraft. For example, as a religious person you can pray over such an object, to prevent it from having power over you. The primary religions do not claim that evil does not exist; indeed, they believe that it exists in the form of objects like *ilizi*, but by praying over and burning these items, a person cannot be affected by its (alleged) powers. This clearly indicates a confidence in their primary religious system. However, the young adults seem to have a fear for these objects, which may be the reason why they burn the objects. The same might be the case for the religious leaders who burn the objects, or the case of the municipal nutrition officer from the introduction of this chapter who goes to villages where these kinds of objects are burned.

Secrecy and shame surround knowledge about the purposes and making of objects like *ilizi*. Higher education and modern lifestyles within an urban environment are seen as one reason for young adults being shamed and secretive about the use of objects and visiting indigenous healers. Another reason can be found in the prominent presence of the primary religions and their values. The shift from using objects for healing purposes made by indigenous healers to using religious objects like holy water is discussed in the work of other researchers (cf. Nyamnjoh 2018). During my research, I have heard several interlocutors who indicated that they use religious objects, such as the Bible, holy water, rosaries, or prayers, in their daily lives for protective and health-related purposes. A question that arises by the use of these religious objects, is if Weber's enchantment shifts from using objects like *ilizi* to the use of the religious objects?

I argue that the influence of urbanisation, education, and primary religions also have an influence on the indigenous healers in the sense that, due to the shame and secrecy around the use of objects, healers have to hide themselves and do not openly

practice making *ilizi*. For the religious leaders, it is clear that believing in *ilizi* indicates a belief in more than one God, which is not accepted within Islam and Christianity. This may result in the indigenous healers who make the object moving to the outskirts of Dodoma Urban, in order to have more privacy to meet with clients and privacy to work as a *mganga wa kienyeji*.

There is clearly a difference between a young child wearing an object like *ilizi* and an adult. A young child may wear the object on a visible place of the body, while an adult should wear it on a hidden place of the body. This is because a young child does not understand the purpose of the object; or, put differently, it is impossible for children to participate in evil doing. Even if you see a young child wearing an object, the parents will deny that the child wears *ilizi*. I argue that the shame and secrecy of the parents relates to intentionality, in the sense that they do know the intentions of *ilizi*, namely mainly doing harm, and sometimes doing good. Whereas the adults are responsible for themselves and can be held responsible, the young children are not, and are not held responsible. However, my assumption is that the adults will be socially impacted if their young child wears an object, since the object has a negative connotation, and is associated with darkness, witchcraft and doing harm, and, in addition, the adult is responsible for the young child. By living in the city, people live close to each other and can therefore easier see what is happening with their neighbours and friends, and if they use an object like *ilizi*.

In his chapter on illness and bewitchment, Stroeken questions whether urbanity is the reason for the limited success of indigenous healing in mental health or if it is the specific local history of mental illness treatment (2017: 157-8). The same kind of question can be applied to Dodoma and my research: is the urban environment with its options for treatment via biomedicine the reason why fewer young adults with a higher education seek help from indigenous healers? My argument is that because of the higher level of education and the big role that religion (either Christianity or Islam) plays in the daily lives of the people interviewed, an object like *ilizi* is rarely used in the urban environment of Dodoma. This seems especially true in the case of health-related objects. As this chapter showed, these objects are made by the *mganga wa kienyeji* and can be found around the wrists of young children. Unfortunately, my research did not compare the use of these objects today with their use in previous times, but I have spoken to a few older people, one of whom informed me that due to better infrastructure and access to biomedical care, there has been a decrease in the use of indigenous healers.

In her thesis, Lindh (2015: 29) makes the assumption that children growing up in the city will "probably not have the same bond and relations to the people in their

parents' birthplace as the older generation." And she finds it possible that "the amount of medical plant deliveries to the city would decrease in the future" (ibid.). It would be interesting to see if herbs continue to be imported (currently this is done mainly through relatives in the home area). It would also be interesting to see what the narratives are of the next generation of Dodoma's regarding use of these objects. They will grow up in a city where the use of objects for healing and protection is decreasing but where indigenous healers who make the objects are still present, alongside religious leaders who preach against their use.

There is a clear social imaginary present about *ilizi*, but, according to the narratives, these objects are used less in the urban environment. What will the next generation in Dodoma know? Will they continue using biomedical care but, at the same time, hear narratives from their parents about *ilizi* and even see it when they visit rural areas? Or will they go "back to the past" and start using the object again, perhaps for non-health-related purposes? Or will they only use objects like *ilizi* for non-health-related issues like power or jealousy? There appears to be a cultural shift from traditional ways of living to daily life in which education and religion (either Islam or Christianity) play a bigger role and the use of objects for protection and healing is decreasing.

The next chapter explores the issues that emerge among young adults from the middle classes concerning what they want to make visible and what they want to keep invisible or hidden. This will be examined in the context of contestations between education and biomedical care – Christianity and Islam – and indigenous healers.

5.

Young adults and the relation between education and biomedical care, the primary religions, and indigenous healing

5.1 Introduction

Glory is a 25-year-old young woman, married to a man from the Sabbath Church,[103] who studies at Dodoma University and has a two-month-old baby. While we sit outside, just next to the building where she lives, which provides accommodation for several young women, we talk about what she does to keep her child healthy and what she does when the child is not feeling well. To keep her child healthy, she breastfeeds, or if her schedule prevents this, then sometimes she gives the child cow's milk. She protects her child from cold conditions by putting on coats, sweaters, and socks. When she bathes the child, she uses soap, oil, and a comb, which are not used by anyone else. She also participates in the compulsory vaccination programme. When her child is not feeling well, she first checks to see what the problem is and what she can do to make the child feel better. She explains: "*you first look at the child after taking a bath, to see if she is feeling ok or not. For example, if hotness seems the problem, I uncover her*". If the problem does not go away, then she goes to the hospital (interview 6, 4 May 2017).

Unlike the other young adults interviewed, Glory explained that she used to wear an object for protecting herself which her parents let her wear when she was young. The object was like a ring and consisted of black cloth and she wore it on her wrist and waist to protect against disease. She wore the object from birth up to when she was five or six years old. She did not know if there was something inside, and she said that her parents also did not know. It was used as protection, but she did not know exactly what for. She also wore black cloth around her waist, which was removed once she turned five. I asked her what the significance of being five years old was and she said that she believed that this was when the problems the object protected her against stopped. But she also said that the world has changed[104]; she did not use such objects like *ilizi* to protect her child. She said that her mother-in-law applied ashes to her daughter's stomach to help *chango* (stomach problems) but that she never did this herself because she was not concerned about her child crying at night. When I asked her if she would ever use ashes on her child, she answered that she might use them. The ashes come from charcoal and do not have a specific name. I also asked her if she used herbs for health purposes, but she said she did not (interview 6, 4 May 2017).

[103] The interlocutor called it Sabbath Church, but it most likely relates to the Seventh-Day denominations, like Seventh Day Baptists.

[104] I assume she means due to religions like Christianity and access to biomedical care, since those were the topics we were discussing.

Glory clearly stated that she did not use herbs for health-related purposes, and that she was only interested in making use of the biomedical options that are available in Dodoma. She did mention that some people do not use objects because of their educational background and that they trust that God will protect their child.

As described in Chapter 2, the young adults have access to different facilities available in the urban environment of Dodoma, such as higher education, Christianity and Islam, and access to different health providers – biomedical care as well as different folk healing options (as detailed in Chapter 3). At first sight, Dodoma is a city where science is present and where there is no magic. Weber writes about magic, or rather the decline of magic in the modern Western world and uses the word 'disenchantment' to describe this (Laermans and Houtman 2017: 93), or 'Entzauberung' as Weber calls it in his mother's language German (Weber 1921: 16). According to Weber (ibid.: 28) the most difficult for the young generation is to be able to deal with a disenchanted daily life. The young adults from the middle classes interviewed in Dodoma say that they do not use material objects like *ilizi* for health and protection purposes because of their engagement with religion and education. However, as indicated in earlier chapters, there is an apparent contestation between what the young adults say they do and what can be seen and heard from indigenous healers. The next part of the chapter discusses how Weber's concept of disenchantment, and the related concepts of enchantment and re-enchantment, may be useful for understanding this contestation in the light of the social transformation of the educational, religious and medical landscape in Dodoma and the influence it has on young adults.

5.2 (Dis)enchantment, modernity, and religion

According to Weber (in Laermans and Houtman 2017: 64), we, as people of culture, give meaning to ourselves and the world. Within a modern society, Weber says, religion is decreasingly providing individuals with meaningful frameworks and ethical codes of conduct. According to him, religion is less and less capable of explaining what things 'really' mean and of providing interpretations for the causes of social phenomena, illness or (mis-)fortunes (ibid.: 49).

According to Weber, many of the changes occurring in modern societies are the result of a disenchantment of the world. Disenchantment points at a process whereby people turn less to spirits and gods as avenues for what happens in their lives as a result of the integration of science and technical inventions.

Weber perceives of the process of disenchantment as an important element in the

cultural development of a modern Western society. By this, he means the gradually decreasing importance of faith in a metaphysical reality, populated by supernatural powers and forces, which once formed the foundation of meaning. Important parts of this process include the decrease in the magical and the rise of modern science (Laermans and Houtman 2017: 84). The most important disenchanting power in the modern world is science, because science studies the world in terms of causal chains (like she 'is') and rejects normative claims (like she 'should be'). Science is also seen as an important post-religious source of 're-enchantment' (ibid.: 88), which will be discussed later in this chapter. The modern human being does not have to interact with magic, because, in a disenchanted world, mysterious forces play a decreasing role as a source of explanation (ibid.: 93). The problems that magic once offered an explanation for – becoming fertile, healing of illness, taking care of a good harvest – are increasingly addressed through technology based on scientific knowledge (ibid.). In addition, a decrease of religion can be seen within Weber's disenchantment, in which science cannot adequately fill the vacuum that is left by that decrease, as it cannot provide comprehensive answers to questions of moral value, which used to be answered by religion (Laermans and Houtman 2017: 93; Chua 2016).

Two further concepts relate to disenchantment, namely, enchantment and re-enchantment (often mentioned together). Jenkins offers a tentative definition of enchantment:

> [E]nchantment conjures up, and is rooted in, understandings and experiences of the world in which there is more to life than the material, the visible or the explainable; in which the philosophies and principles of Reason or rationality cannot by definition dream of the totality of life; in which the quotidian norms and routines of linear time and space are only part of the story; and in which the collective sum of sociability and belonging is elusively greater than its individual parts (Jenkins 2000: 29).

While Weber sees disenchantment as an important process in the modern world, Jenkins suggests seeing (re-)enchantment as a beginning, "as an integral element of modernity" (Jenkins 2000: 22), at the heart of the matter (ibid.). Jenkins (ibid.: 12) relates (re)enchantment to two linked tendencies. The first concerns the idea "that there are more things in the universe than are dreamed of by the rationalist epistemologies and ontologies of science" (ibid.). He relates this to everyday frameworks that, for example, can explain luck and fate or "traditional' spiritual beliefs" (ibid.). The second tendency "rejects the notion that calculative, procedural, formal rationality is always the 'best way'" (ibid.), and relates it to "collective attachments" (ibid.: 13) like intoxications and ecstasies, sexualities, ethnicity, and escaping by watching television (ibid.). Within

the environment of Dodoma amongst the young adults belonging to middle classes it seems that they assign a significant part of their decision making to their primary religion (either Christianity or Islam). Some young adults use religious objects, like holy water, and the Bible, for protection and healing purposes for themselves or their young child. This may be seen as a shift of using objects from indigenous healing to using objects within religion.

Jenkins mentions that "the 'objective' knowledges of Western science are becoming increasingly understood as (at best) contingent rather than permanent verities" (ibid.: 17). On the other hand, the decline of magic is not very evident. He continues that, superficially, this does appear to be the case: people go to the doctor first and do not go to a "wise-woman or a cunning-man" when ill (ibid.: 18). As Chapter 2 showed, most young adults interviewed also say their first port of call is the hospital or pharmacy; others never visit an indigenous healer at all. Based on the interviews with the young adults, it seems that the process of disenchantment is enacted in their lives and is influenced by science in the form of education and biomedical care. On the other hand, their lives are also clearly influenced by the primary religions of Christianity and Islam. In addition, when talking to indigenous healers, invisible and inexplicable things, to borrow Jenkins' words, clearly exist – as will become clear later in this chapter, and as was discussed in more detail in Chapter 4. This may indicate a process of, or rather a continuation of, enchantment.

Disenchantment can be linked to modernity, as Saler (2006) explains. According to him, modernity "is one of the most ambiguous words in the historian's lexicon" (ibid.: 694). He continues that modernity, broadly, "has come to signify a mixture of political, social, intellectual, economic, technological, and psychological factors, several of which can be traced to earlier centuries and other cultures, which merged synergistically in the West between the sixteenth and nineteenth centuries" (ibid.). But there is one characteristic of modernity that has been emphasised since the eighteenth century, which is that modernity is "disenchanted" (ibid.). Saler also mentions that when Weber talks of the disenchantment of the world he means "the loss of the overarching meanings, animistic connections, magical expectations, and spiritual explanations that had characterized the traditional world, as a result of the ongoing 'modern' processes of rationalization" (ibid.: 695). As indicated in previous paragraphs and earlier chapters, this seems to be the case in Dodoma amongst the young adults from the middle classes, in the sense that in some aspects they seem to have broken with the past and are choosing for an education and using biomedical healthcare options, which according to Weber's theory indicates disenchantment. At the same time, they also portray themselves as religious (Christian or Islamic), which seems to indicate a limited process of secularization. As Chapter 4 showed, the

primary religions of the young adults and their religious leaders play an active role in the way these young adults look at the magical aspects of indigenous healing and the role objects play in health-related matters. This chapter will further explore these dynamics of disenchantment and the role of the primary religions.

Meyer (1996), writing about modernity and (dis)enchantment focuses on the relationship between modernity, conversion, (dis)enchantment, and the image of the Devil. She argues "that Pietist missionaries' and Ewe [in Ghana] converts' image of the Devil lay at the base of a popular form of African Christianity that entailed both the modernisation and the enchantment of the converts' world" (ibid.: 201). She continues that Pietist religion integrated spirits of popular religion by saying that they are agents of Satan (ibid.: 202). This argument was evident during my research, especially when speaking to the religious leaders, as will become clear later in this chapter.

My earlier stated hypothesis relates to Meyer's argument that people visit indigenous healers when their problems cannot be solved by biomedical care or religion. At the same time, people apparently only feel able to do so in secret, for example by hiding the objects received from a healer.[105] Meyer gives us a clear example of this going back to "magic", but hiding the objects (1996: 217-218). She writes about a female congregation member in Ghana who is no longer in the congregation. She was pregnant and feared that something would happen to her or that she would have a stillbirth. She therefore went to the *dzo* people who tied *dzo* strings for her, which were put around her neck. But she hid these strings, so that people could not see them. This hiding of objects was also evident in the narratives shared during my research: if adults use objects for protection, they wear them around the upper arm or around the waist, a place on the body where people cannot see them.[106] For young children (under five years old), it seems to be more acceptable to wear objects used for protection in visible places, since – as one of my interlocutors put it – with a young child it acts like a protection, but with an adult it looks like he/she is performing witchcraft (interview 42, 21 May 2015 – as discussed in more detail in Chapter 4).

According to Meyer, the case of the female congregation member:

> clearly reveals the flaws of missionary Pietism if compared to traditional religion. We don't know when and why this woman converted to Christianity.

[105] This relates to shame, as mentioned in Chapter 4, and will be discussed in more detail later in this chapter.
[106] Hiding the wearing of the object was more important than the actual place where the object was worn.

> The only thing we do know is that when after three miscarriages she was pregnant again, she was disillusioned about the capacity of Christianity to help solve her problem. This case again makes clear that people imagined the Christian God on the basis of existing concepts and still expected religion to *work*. Doubts about the *effectiveness* of Christianity in retaining people's health were expressed in many other cases. Against this background, it is not surprising that "backsliding into heathendom" occurred much more among women than men (Meyer 1996: 218).

It was the goal of the mission to abolish the old religion, but they also had to make use of the old religion to demonstrate the meaning of Christianity, in which the Devil was an important figure in terms of making clear that the gods and other spiritual beings remain real powers. Therefore, the old religion did not disappear, but was instead looked at from a distance and through a particular filter (ibid.: 218-9). During my research, the visibility of both Christianity and Islam was evident, and I heard about religion's powers in terms of how and what young adults need to do and what not to do.

According to Van der Veer, "the modern understanding of religion and conversion is not only developed as an answer to political problems in Europe; it is the result of the expansion of the European world-system and the encounter with different religions and cultures that were gradually subjected to colonisation. Clearly, this globalisation was not only economic in nature, but also cultural and religious" (Van der Veer 1996: 5). As will become clear further in this chapter, young adults name religion and education as the main reasons for not visiting an indigenous healer when they or their young child is not feeling well. On the other hand, there is a clear presence of invisible or unexplainable elements that people value, as this chapter will show later, and as Chapter 4 on the object of *ilizi* demonstrated more specifically. These elements, which can be present in lived realities and in discursive practices, indicate a process of disenchantment that appears to be 'partial' in the way it appears in such current-day contexts. In this sense, remarkably, disenchantment can be enjoined by processes of (re-)enchantment if and when a process of disenchantment has not been completed in all domains of life.

What the young interlocutors told me fits well within Weber's concept of disenchantment, albeit that we need to recognize its partial nature. Within my research, the presence of Christianity and Islam was clear, as was the increasing presence of science in the form of education and biomedical care. The young adults say they do what the religious leaders tell them, at least in relation to health-related issues, which means using biomedical care and also herbal medicine, which is approved of.

My hypothesis is that young adults mainly use the biomedical care options available in the city for issues like infertility and healing of illness, but that in other cases – like gaining power or jealousy issues – an indigenous healer might be visited, because they believe that they can explain (and heal) the problems.

This chapter focuses on these apparent contestations that this partial disenchantment in Dodoma amongst young adults produces: they say they do not visit indigenous healers because it is not accepted by their primary religion (either Christianity or Islam) and they live in a modern world where science and rationality are important. On the surface, listening to the young adults' narratives, the use of education and biomedical care are clearly present and could indicate that Weber's process of disenchantment is in motion. However, when interviewing the indigenous healers, it became clear that objects for healing are present, and indigenous healing is used in different cases than only health-related. This phenomenon can be related to Weber's (re-)enchantment is present. In addition, the primary religions are clearly important in the lives of the young adults interviewed. These contestations result in the main question of this chapter:

> *How do young adults reconcile the relation between education and biomedical care, the primary religions, and indigenous options for health-related issues?*

To answer this question, the chapter will present cases related to the three stated aspects, which I bring together in a relational triangle with young adults at the centre, since they are the primary focal group of the research. This chapter aspires to show how the young adults see these aspects of the triangle in relation to disenchantment/(re-)enchantment and shame and secrecy, based on the narratives collected from the three groups interviewed.

5.3 The relational triangle of education and biomedical care, primary religions, and indigenous healers

The influence of modernity and the primary religions is clearly present in Dodoma, as evidenced by the increasing number of churches/mosques, hospitals, pharmacies, and schools. In addition, indigenous healers and providers of herbs (*miti shamba*) for protection and health-related issues also exist in Dodoma. The previous chapters explained how the lives of young adults are influenced by access to education and biomedical care, the primary religions of Islam and Christianity, and the presence of indigenous healers. Taken together, these aspects result in the following scheme of relations:

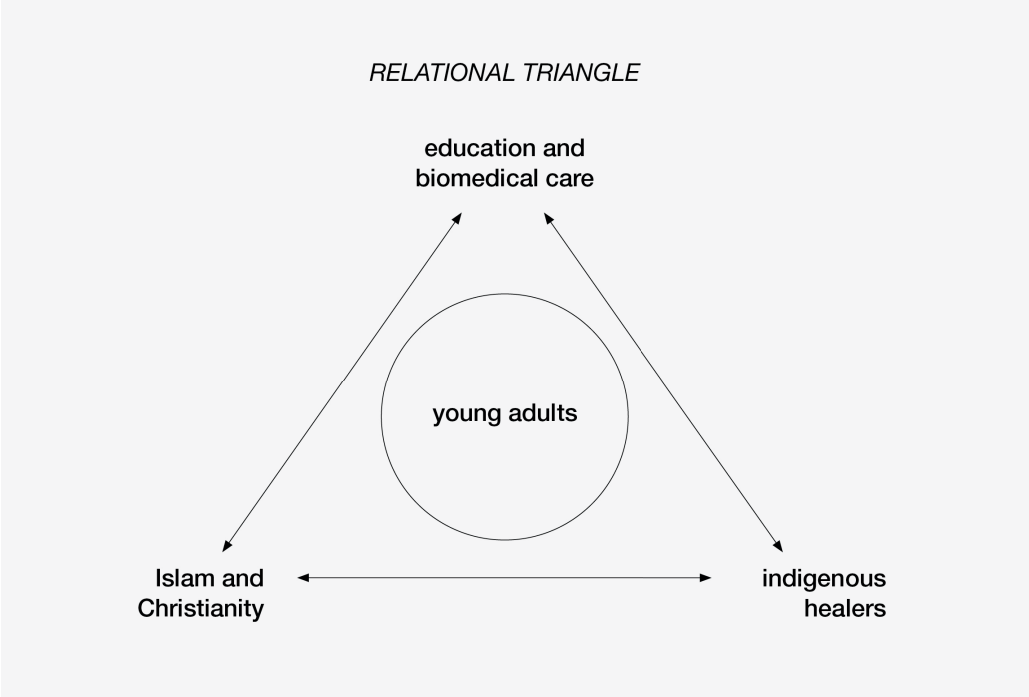


Figure 3 *Relational triangle between education and biomedical care, indigenous healers, and Islam and Christianity*

Each corner and side of the triangle has a different influence on the young adults, which I will explain in the following part of this chapter. As mentioned in the introductory chapter, interviews were held with young adults, indigenous healers, and religious leaders, and narratives were collected about what young adults say they do to keep themselves and their young children healthy, what they say they do when they or their young child is not feeling well, and narratives were told about objects used for healing and protection purposes.

The first side of the triangle I will discuss is the one relating to education and biomedical care and the primary religions of Islam and Christianity. To aid this discussion, I will present a case that relates not to a side, but to the corner of the triangle concerning Islam and Christianity, with the aim of showing that the influence of these religions in the lives of young adults can be seen in the processes of conversion and the rise of disenchanted notions, which people generally perceive as positive (see Van der Veer 1996: 18).

The case I want to present concerns Kharim, a higher-educated, Christian in his late thirties who has a steady job but is not married and who did not have children at the

time of the interview. His parents had six Christian, healthy children, of whom Kharim is the firstborn. He told me the following narrative:

> *When I was an infant (I could not talk or walk yet), I was laying in between the parents. This is the way it happens in Tanzania: young children sleep with their parents in bed. The next morning, the parents looked for me on the bed, but could not find me. I was off the bed, and was laying under the bed. After that, my father started to become a believer* (interview 9, 11 July 2014).

This case implies the involvement of witchcraft. The child falling off the bed could be seen as caused by occult forces, which turned the father of the baby into a believer, a follower of Christianity. This case concerns a change of religion. I assume that the father turned to Christianity because he feared for witchcraft hurting one of his children. As became clear in chapter 4, one of the aspects of witchcraft is to harm someone. In addition to the conversion to Christianity, I assume that education also played a role, since Kharim is a higher-educated man and most likely his siblings did have an education too, which indicates that his parents found it important that their children would be educated.

I will now discuss several relevant cases that concern and elucidate the various sides of the relations that this triangle presents. I will start with the relation that the triangle indicates between education and biomedical care, and Islam and Christianity by highlighting the case of *mzee* Michael (whom I introduced in Chapter 2, page 76). The case illustrates the changes that have occurred during his life in Dodoma throughout his life and the influence of biomedical care and religion. He told me that a long time ago it was not an option to take a child to the hospital, because when they vaccinated the child, the child often died. According to him, the hospital has now improved so much that he would take his child there if it was ill. In the past, people were not well educated and their awareness was low. He himself also went to the hospital for check-up for his asthma and to get

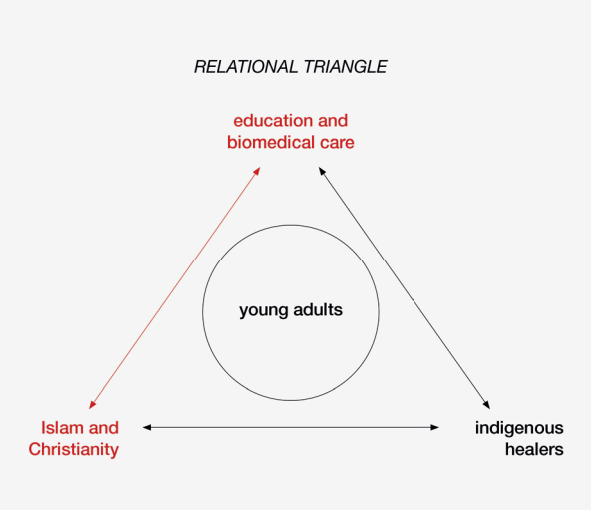


Figure 4 *Relation between education and biomedical care, and Islam and Christianity*

proper medicine. He told me that when you go to the *mganga*, there is no check-up. It is not advisable to take medicine without being checked. When his children were young, he did use objects for protection (*kinga*). The objects worn around their wrists just disappeared, but he kept the ones worn around the waist for each of his children. After his last child, he dropped the object in the toilet, and they started believing in God and he had his children baptised (i.e., converted to Christianity). At that moment, he also stopped going to the indigenous healer. At the time of the interview in 2016, *mzee* Michael told me that young people do not use objects. He put this down to the availability of medical services, and educated parents being aware of the need to keep their children healthy. "*They take the child to the hospital when it is sick*" (interview 7, 11 May 2016). For *mzee* Michael, better access to a higher level of biomedical care meant that he no longer visited indigenous healers and he converted to Christianity. He also mentioned that the level of education has become higher in Dodoma. The case demonstrates the intrinsic relationship between biomedical care and Christianity as both belonging to the idea of a modern identity and a modern lifestyle.

The case of Simon, outlined below, is the second case to demonstrate the side of the triangle between education and biomedical care and the primary religions of Christianity and Islam. Simon is an older young adult in his mid-forties and a member of the Sabbath Day Adventist Church. He told me that his father had become a man of good deeds, actively attending church, becoming the first in his family to pursue formal education, and eventually becoming a teacher. However, when his father was young, there were fears surrounding his well-being due to a what he perceives as being a "local superstition." His grandmother was pressured to abandon him in the wilderness because his first teeth emerged from the upper gums rather than the lower, which was seen as an ill omen. According to existing perceptions, she was supposed to place him in a clay pot and leave him to die. Defying this custom, she instead chose to hide him until his lower teeth came in, saving his life. Simon shared this narrative to explain that the things we believe are cultural. Based on that experience and reflecting on it, Simon became convinced that indigenous medicines do not have the same efficacy as the *dawa* (medicine), that they are not accurate. When he was not feeling well Simon therefore decided to go to the hospital. Reasoning about this he gave me the example that if you have malaria and you go to the *mganga*, you may end up being diagnosed with something else, since the *mganga* cannot test for malaria. He does not believe that all indigenous medicines are ineffective, but that they cannot be used for all illnesses, but also that they can be used for ulterior purposes. According to him, jealousy is a motive for people going to an indigenous healer. For example: a person who has no food can become jealous of someone who does have enough to eat (interview 8, 9 July 2014). He therefore clearly indicated that various dimensions can evolve across generations: 1) the value of education, as demonstrated by Simon's father, who grew

up with access to greater educational opportunities; 2) the importance of biomedical care, emphasising the value of tested medicines and accurate diagnoses; 3) the role of Christianity, associated with positive moral actions and "doing good"; and 4) the influence of beliefs around jealousy, which may lead people to consult indigenous healers. This leads to the conclusion that different aspects are influencing the views on using indigenous medicines for health-related purposes, namely education, religion and access to biomedical care.

The side of the triangle that connects education and biomedical care with Christianity and Islam thus shows that the urban facilities available in the city are important to the young adults because due to the large role religion plays in their lives. Access to religion, education and biomedical care serve as avenues for these young adults to give direction to their lives, and teach them how to deal with enchanted aspects within life, like the indigenous healers who make objects for different kinds of purposes.

The second side of the triangle I will discuss is the relationship between education and biomedical care and indigenous healers. Two different aspects are found, the first of which concerns the adaptation of these healers to the modern conditions of the city. As chapter 3.5.2 showed, there are indigenous healers who do refer patients to a biomedical doctor when the patient has a condition that they cannot cure. This may indicate a degree of disenchantment. A medical doctor I interviewed during a small Focus Group Discussion at a hospital mentioned that more indigenous healers use both indigenous medicine and biomedicine, and that they work together with the hospital and often refer patients to medical doctors in Dodoma (interview 44, 21 May 2015).

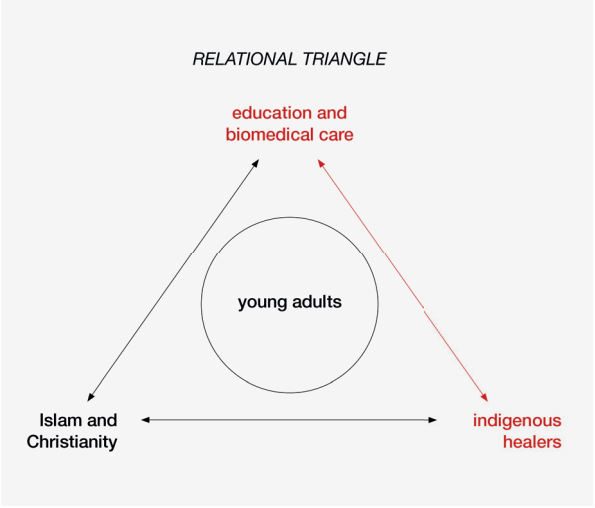


Figure 5 *Relation between education and biomedical care and indigenous healers*

The second aspect concerns the treatment of misfortunes. Both biomedical healers and indigenous healers in general can treat failures of gender and failure of health, as Chapter 3 showed. But there are other issues encountered in life, such as failures of prosperity and failure of personal safety (addressed in Chapter 3), which cannot be addressed by biomedical care, but which indigenous healers may be able to assist

with. Even though religious leaders do not advocate visiting indigenous healers, such healers clearly do exist and are visited by young adults.

One of my interlocutors, a young Christian man with a university degree, clearly articulated the contradiction between the modern environment with its facilities, like biomedical care, and the presence of indigenous healers by saying that "*they* [the young adults] *have a level of education, but also the belief of the family*" (interview 2, 7 May 2016).

This side therefore shows the choices the young adults are faced with between the modern, biomedical options on the one hand and the indigenous healers on the other. The narratives of the young adults indicate they say they only make use of biomedical options (as chapter 2 showed), while the narratives of the indigenous healers show that young adults do visit them (as chapter 3 showed), but that there is also a case of referral from the indigenous healer to the biomedical care option.

The third side of the triangle I will discuss relates to indigenous healers and the primary religions of Islam and Christianity. As the cases presented in Chapter 4 showed, visiting an indigenous healer to get an object for protection or as a cure is not condoned by either religion, since the common perception in these communities is that the use of this kind of object is seen as an indication that you are worshipping multiple gods. This informs a morality of choice that weighs heavily for the young adults because religion plays a large part in their lives as an avenue to deal with different kinds of options available in their environment, like access to indigenous healing.

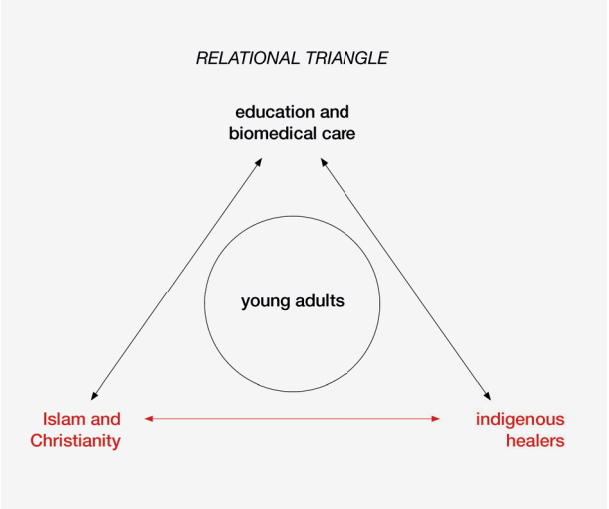


Figure 6 *Relation between indigenous healers and Islam and Christianity*

As chapter 3 showed, there were indigenous healers who use and/or sell herbs, and the use of these herbs were accepted by religious leaders. This also becomes clear from the case of Zuri, a Christian female from the Sabbath church, whom I introduced in the vignette in the introduction to Chapter 2. She was in her early thirties, had four children ranging between ten months and ten years, and she worked as a teacher at

a primary school. She used tree leaves when the child had stomach pain or diarrhoea. She mixed leaves from the guava and from the mango tree together with a medicine, whose name she only knew in her mother tongue and she did not want to tell me what it was called. She used the particular small plant, which can also be used for tea and has a strong smell, a bit like peppermint. She boiled the leaves together and when it was cold, she drank it. According to her, her religion allows her to use herbs, because it goes back to a belief in the gardens of Eden. The medicine is made from the leaves, which she used and prayed over. She did believe in these leaves as medicine, but she did not believe in using objects on the body (interview 9, 5 May 2017).

There seems to be a field of tension for the young adults in relation to that side of the relational triangle between the indigenous healers who make objects, and the primary religions of Christianity and Islam, which will be further discussed in 5.3.1 and 5.3.2.

The following part of the chapter will first discuss the three sides of this relational triangle in relation to the aspects of the corners of the triangle to explore the role of shame and secrecy in the work of reconciliation to overcome the contestations between the modern facilities and the indigenous healers (5.3.1). The chapter will then continue to discern whether (dis)enchantment is enacted and, if so, to what extent (5.3.2).

5.3.1 The role of shame and secrecy in managing the relational triangle

In the previous chapter on *ilizi*, it became clear that both using and making such objects is surrounded by shame and secrecy. This section goes deeper into the topic of shame and secrecy and aims to explore where and how these feelings and strategies are at work between the different aspects as displayed on the sides of the relational triangle.

What became clear from the narratives is that most young adults talk about shame[107] when asked about visiting an indigenous healer. Following Walker *et al.* (2013: 230), I argue that shame is felt individually, but is socially constructed. Walker *et al.* relate shame to poverty, while I relate it to visiting an indigenous healer for different purposes. The young adults' feelings of shame about visiting an indigenous healer are related to religion in general (either Christianity or Islam) and to having a higher

[107] On some occasions, I explicitly asked about shame; on others, the young adults brought it up themselves.

education. The cases presented in this section aim to endorse Roelen's (2017: 14) vision that "while shame is felt by the individual, experiences are framed and situated within wider systems, narratives and relationship."

Related to the concept of shame is the concept of secrecy, which can be understood as "one person concealing knowledge from another, implying the latter's passivity" (Bakuri *et al.* 2020: 394). However, Bakuri *et al.* argue that it depends on the interactions between the two parties (mutually constitutive) (ibid.). They explore secrecy "as the result of an interaction between those who obscure knowledge in creative ways and those who maintain a not-knowing" (ibid.: 394). In their article, they relate secrecy to kinship relations, for example intergenerational relationships or marriage, and refer to knowing and both to Kirsch and Dilley's (2015) not-knowing and Moore's (2013) un-knowing. The knowing relates to "when and how to keep certain aspects of private lives and relationships a secret to others" (Bakuri et al. 2020: 396). Relationships are maintained by upholding a not-knowing, because matters that could disrupt a relationship are actively not-known. It is seen as considerate not to share painful information with each other (ibid.: 396, 399), which is why people may deliberately prefer not to know about certain things, by not asking and by making sure things remain unspoken. I use secrecy in relation to the use of objects for healing purposes, in the sense that people who do use these kinds of objects are secretive about this. In Bakuri *et al.*'s research, not-knowing binds people together (ibid.: 408), which can also be seen in my research, in the sense that the young adults share a common narrative around secrecy and not-knowing. As the narratives presented in Chapter 4 showed, some young adults do have knowledge about the different kinds of objects, but act as if they are not-knowing, since the use of such objects is not accepted within their partially disenchanted worldview. In their research, Bukari *et al.* also encountered motivations to be secretive, such as fear of witchcraft, which was also related to avoiding triggering violence, jealousy, or anger (ibid.: 397). As shown in previous chapters, I encountered similar motivations in my research.

In several literature cases, secrecy and concealment are related to active not-knowing in kin relations (De Klerk 2011, 2012; Bakuri *et al*. 2020). Bakuri *et al*. relate it to Ghanaian-Dutch and Somali-Dutch communities in the Netherlands amongst, which maintain their kin relations and social networks through secrecy and relying on care for each other (2020: 399). De Klerk (2011, 2012) relates secrecy (and also refers to concealment) to people suffering from AIDS in north-western Tanzania. In her article on the compassion of concealment (2012), she writes that older caregivers preferred silence when she got to know them better. The older caregivers concealed the illness of a child depending on whom the narratives were shared with, and how. For example, when telling about the real cause of the illness (HIV/AIDS) they often talked in soft

whispers, with their heads close together. Caregivers and others also did not mention the illness, which is also a form of concealment (De Klerk 2012: S28, S33, S36). The secrecy I encountered in my research does not concern kinship relations, since most young adults have moved away from their kin when moving to Dodoma. However, those relations seem to be replaced by a social-moral control from people in their environment, like friends, colleagues and neighbours. As indicated before, by living in an urban environment, people live close to each other and can see what you are doing. Based on the interviews held with the young adults, it became clear that you do not want to be seen using an object like *ilizi*. The kinship relations were present in my research in the sense that most young adults told me that they had been brought up religiously and were taught the religious views on for example using objects for health-related purposes[108], they said that they did not visit indigenous healers, and that, when growing up, their parents did not use, or consider using objects like *ilizi* for healing purposes. This may indicate that a level of shame was already felt and secrecy was enacted when growing up: the young adults grew up with the knowledge that it was not acceptable to use objects for healing purposes and to visit indigenous healers. The kinship relations thus influence the way the young adults act living in an urban environment like Dodoma, even in cases where they do not live with their kin.

Secrecy was also practiced on another level, namely, directed towards me – people did not admit visiting an indigenous healer. As *mzee* Ibrahim informed me (interview 10, 17 May 2016), he suspected that some healers did not want to talk to me, since they saw me as a criminal investigator (because what they do is not accepted and must be kept secret). Fortunately, I was able to interview several different kinds of indigenous healers thanks to the efforts of my research assistants and a few female friends (see Chapter 3). Secrecy was also evident in the narrative of Hakeem, the indigenous healer presented in Chapter 4. He told me many stories about healing and the problems he solved, but during our first interview meeting, he concealed the fact that he made *ilizi* himself for his own and other children.

In earlier chapters, I proposed the idea that there is a social imaginary of concealment concerning the use and knowledge of objects: young adults know about the objects, but they say they do not use these objects in health-related issues. As chapter 4 showed, the religious leaders play an important role in conveying the message to the young adults that it is not accepted to use these kinds of objects. I will now present narratives from religious leaders from both religions to make clear what their view is on the use of the objects and also to create better understanding of why the young adults say

[108] See chapter 4 on what these religious views on the use of objects are.

they do not want to use an object like *ilizi*. The narratives will also give insight into the social-moral concerns the young adults need to live by, according to their primary religion, in relation to the use of objects and as a result in how to prevent shame as the young adults (say they) do not use objects for healing and protective purposes.

First, I would like to present some quotes from several religious leaders from both Christianity and Islam that clarify their rejection of the use of objects. This became clear from one religious leader's statement that: "*If someone is using it, it means he/she is not respecting God*" (interview 10, 19 July 2018). A Christian religious leader informed me that objects like *ilizi* were used long time ago, when there were no hospitals. "*Now the world has changed, we listen to the word of God*" (interview 19, 19 May 2017). A third religious leader mentioned that "*it is strictly prohibited for such people* [who wear ilizi] *to be in the mosque. If they are found, they will be against the religion, what the Quran says. Because the Quran insists on worshipping only one God. They cannot be given any leadership within Islamic religion, since they are not exemplary to the rest of the community*" (interview 11, 19 July 2018). The primary religions advocate for a rejection of the use of these objects, which may be seen as a discourse of disenchantment, even though religion is not part of Weber's disenchantment.

Chapter 4 explained that using an object like *ilizi* is associated with believing in more than one God. During an interview with the Muslim religious leader from the previous quotes, it became clear that *mashetani* (the Swahili word for spirits or demons) are associated with not believing in one God. He told the following narrative on the origin of demons:

> *Every human being has demons. These are issues related to Satan, such that each person, each human being has this Satan. At creation, God created human beings and the jinns*[109] (majini).
>
> *In the beginning, the jinns served as angels to the human beings. But at a given point, human beings started misusing the jinns and God decided to take the jinns away. And left each individual with only one jinn. Such a jinn started claiming/competing with man to be in charge over God's creation. That is why such a jinn goes into blood veins of the human being. God is trying to tell people that whoever serves this jinn, will be the one who worships one God.*
> *Those people who are possessed by these jinns, do not worship only one God. They are controlled by the jinns. Even before God took away these jinns.*

[109] This is the Arabic spelling; the Swahili spelling is *jini* (pl. *majini*).

Once upon a time, these jinns went high above to try and control between God and the human being. When Muhammed came with the Quran this helped to break the link. After breaking the link, the jinns came back to control men, they became bad jinns and control people who do not believe in one God.
The good jinns are the ones who were - amongst the ones breaking the link - near to God. They were doing God's will, and bad jinns were the ones against God's will.

When I ask him if the jinns are already in the body at birth, he tells me that *upon birth, a human being does not have such a jinn. The jinn enters after birth, when you are a baby. That is why a child cries. When the jinn comes into the body it is a good jinn.*

I ask him when does a jinn turns from good to bad? *Depending on how the child is brought up by the parents or guardians it might turn bad. If parents bring up the child outside religious teachings it might turn bad. The jinn remains good when brought up according to the religious teachings, and will set the person on a good path* (interview 11, 19 July 2018).

When I asked another Muslim religious leader about *mashetani* he smiled and informed me that the Quran has all the necessary explanations about *mashetani*, but also *ilizi* (interview 10, 19 July 2018). The Christian religious leaders I talked to also mentioned that *mashetani* are associated with bad spirits (interview 16, 15 May 2017; interview 19, 19 May 2017) and that people who become possessed by spirits use *ilizi* for treatment. When they fail to get treated, they can be helped and prayed over by the religious leader (interview 17, 16 May 2017). The above-mentioned cases about *mashetani* made clear that they concern bad spirits, and that a child may turn bad and use *ilizi* if he/she does not have a religious upbringing. In this way, it is portrayed as by being religious, you are good, and will not use *ilizi*, since you believe in one God. On the other hand, there seems a sense of fear connected to these narratives: if you do not believe in one God, you may become possessed by bad spirits like *mashetani* and start using *ilizi*.

I also collected narratives from young adults themselves concerning the role of the primary religions in their lives. The following case represents the general narrative of young adults and the influence of *ilizi* in relation to a religious person and her thoughts, and also her view on why people feel ashamed about using such objects. Sarah (whose narrative is also shared in the introduction to Chapter 1), is a Christian student at UDOM University and has a young child who is under one years old. We talked about how she kept her child healthy, and I also asked her if she had heard about *ilizi*. She had heard about it, but did not use it for her child, because she believed

in God. She told me that people "*believe that when a child uses* ilizi*, the child becomes good in health, and is protected. The child cannot become sick.*" Two friends had advised her to use *ilizi*, because it is not good to travel with a child on the bus for so long (she had to travel to the northern part of Tanzania). But she claims not to use it because she believed in God. "*God is everything*." When the child is sick, or when she was having problems, she would pray to God. Her parents, especially her mother, taught that: "*If you get a problem with different challenges, you pray to God.*" I also asked her about people being ashamed or whether she knew why people hid their use of such objects. She answered that "*people use it secretly. They do not want people to know they use. They do not want to know, because it is not a good thing. People who use, might be seen as a witch doctor*" (interview 7, 5 May 2017).

A second case in which the relation between indigenous healers and Islam and Christianity concerning material objects for health-related issues becomes clear is from Nabila, a young Muslim woman, who is a primary school teacher. In the area where Nabila was born, she saw young children under five years old wearing objects on the wrist (consisting of black cloth) or waist (sometimes black thread). Nabila believed in Allah and that her child therefore will be fine, the child was protected by Allah. She claimed that she did not use religious objects to protect the child. I asked her if she knew if people feel ashamed or that it is a secret for a young child to use an object: "*When they are in the same community it is normal, but when they moved to a new community they feel ashamed.*" When I asked her why they do feel ashamed, she answered: "*It is a belief according to the community. When they are in a new community, other people might think that person is a witch. Even with a small child*" (interview 1, 29 April 2017).

A final case within this side of the relational triangle concerns Timothy, who heard narratives about objects used for healing from his mother when he was growing up. His parents were familiar with using biomedical care for health-related issues, and Timothy was raised with the conviction that the use of objects was not accepted within their Christian religion. He remembered that there used to be a tree, *mti Ulaya,*[110] which you keep around the house to repel demons. Since his mother was very religious, she kept her children far away from people using objects. When I asked him if he knew why people felt ashamed or were secretive about wearing objects, he answered that it is supposed to be a secret. "*People do not openly admit, because most people are Christian or Muslim. It is religiously not accepted*" (interview 3, 1 May 2017).

[110] The literal translation is European tree.

The three cases of Sarah, Nabila, and Timothy aim to show that most narratives collected from young adults indicate that there is a shame and secrecy surrounding the use of material objects for health-related issues and protection, because they are not accepted by either Islam or Christianity. But as is mentioned in Sarah's case, it starts with the parents who live by the values of these religions, which are used when having problems, instead of going to an indigenous healer. I argue that because religious leaders associated visiting an indigenous healer – the ones who make objects for different kinds of purposes – with bad things, young adults are ashamed about visiting such a healer and if they do so they will try to hide it. In addition, the use of an object like *ilizi* is associated with not believing in one God and many believe that praying to God will solve the problem. Visiting an indigenous healer for health-related issues seems to have been replaced by the primary religions of Christianity and Islam and by access to biomedical care. In addition, Nabila's case shows a relation between these kinds of objects and witchcraft. Because the object is associated with bad things like witchcraft, shame and secrecy is an issue: the young adults do not want to be associated with an object like *ilizi*, since they may be seen as a witch, even when it concerns a small child. As indicated in the conclusion of Chapter 4 (page 175-178), my findings point to the young adults being socially impacted if their young child is seen wearing an object like ilizi, and as Nabila told me, may be seen as a witch.

In addition to religion, the role of education is also important in relation to objects like *ilizi*. As one of my interlocutors – a 24-year-old Christian woman with a bachelor's degree and one child – put it "*There are people who believe that, but I do not know what they exactly use. I am educated, I know it does not work*". According to her, you can see from the way people are dressed and talk that they come from the villages, and that they use objects. People in the city are educated and they know not to use them (interview 51, 23 May 2015). This case presents the assumption that young adults living in an urban environment like Dodoma who have a certain level of education do not use objects for healing purposes, but that people living in rural environments, and who are less educated, do use these kinds of objects.

The cases presented in this section 5.3.1 aim to show that the young adults recognise that shame is felt when using objects and that secrecy is used as a strategy to deal with the existing contestations within Dodoma city between education and biomedical care, Christianity and Islam, and indigenous healers. The young adults interviewed have knowledge about objects used for healing and protective purposes, but they say they do not use these objects themselves. Shame may explain why the objects worn on the body are hidden, as well as why the *waganga wa kienyeji* work from hidden places on the outskirts of Dodoma. Living in the city, where there is access to several levels of education, access to different kinds of religious institutions, and access to different

healthcare providers, gives young adults options other than visiting an indigenous healer and using the objects the indigenous healer makes and prescribes.

This section also aimed to show that shame and secrecy operate within the relational triangle and are visible in relation to the use of *ilizi*. Since the object is made by the indigenous healers, the shame and secrecy that features here has to do with the relation between these healers and the young adults and even between the indigenous healer Hakeem and myself, as the presented case aimed to show. The use of *ilizi* is associated with believing in more than one God, which is not accepted by the religious leaders. In addition, they preach that *mashetani*, bad spirits, are associated with the use of *ilizi*, and by having a religious upbringing a young adult will not be influenced by *mashetani*, and therefore will not use *ilizi*. In addition to the primary religions Christianity and Islam, higher education also plays a role in the sense that higher-educated young adults do not visit indigenous healers.

You may say that higher education teaches the young adults that objects for healing purposes do not work, but it does not take away the fear about indigenous healers and witchcraft and what he/she might (be able to) do. Or as Kharim puts it: "*I believe in witches, in the sense that they exist*" (interview 9, 11 July 2014).

5.3.2 The role of disenchantment in the relational triangle

The beginning of this chapter explained Weber's concepts disenchantment and (re-) enchantment and explained that the narratives of young adults show a worldview in which, I argue, partial disenchantment is applicable. On the one hand, they subscribe to a disenchanted world, in line with access to modern education and biomedical care. On the other hand, indigenous healers who make objects like *ilizi* for different kinds of purposes do exist within the urban environment of Dodoma and may fall under the "spiritual" or magical aspects of enchantment. In addition, Christianity and Islam play a big part in the lives of young adults, and advocate for not using an object like *ilizi*, as demonstrated in 5.3.1. This may reflect a discourse of disenchantment. This section presents a few cases from the three corners of the relational triangle displayed in 5.3 in relation to disenchantment and (re-) enchantment.

As mentioned above, based on the narratives collected from young adults, they seem to emphasize a partially disenchanted worldview, since most young adults informed me that they visit a pharmacy or hospital when they or their young child are not feeling well. In addition, the young adults mentioned that they have heard narratives about objects, but said they do not use objects themselves, which indicates they do

not engage with options that demonstrate an enchanted view of the world. One case in this regard is that of Timothy, an unemployed, higher-educated young Christian man in his late twenties. When he was not well, he visited the hospital. There was also a pharmacy in town, with a dispensary, where he went for check-ups. He used to go there with his parents. He always went there because it was somewhere familiar. He used Panadol when he had a headache or he used other medicines to treat issues like stomach ache. But when he had a fever he went to the hospital. He said he did not use objects for healing purposes, but he did carry a rosary, until he lost it while travelling (interview 3, 1 May 2017). This case may indicate a shift from using indigenous objects to religious objects. During the research, I also encountered some other cases in which religious objects were used for healing purposes. Malaika was a Christian woman in her thirties pursuing a master's study and she used the Bible: "*I have it close to me. When I have a new born, she sleeps with me in the bed. I have the Bible close; I believe she is safe then.*" She also used a rosary and holy water (*maji ya baraka*) (interview 10, 17 July 2014). Rasmussen (2008: 159) also spoke to people who used Christian charms, for example a woman who had a toothache and tried sleeping on a Bible. But when it did not work, she gave up on the Christian charm. During my research, I encountered several people who used Christian objects for protection, like a rosary, or spraying holy water on their children's bed, putting a Bible on specific places, but mostly people prayed to become better or to stay healthy. As one interlocutor explained, she used blessed water in the room after praying at night. She did this for protection against disease and bad dreams. The children also wore a rosary to protect them against an attack from different kinds of illnesses, to show that they believed in God, and to help them to grow in good faith (interview 9, 11 July 2016). But a Muslim woman also mentioned that certain prayers are said when a child is born. The prayer is to have the child grow up in good faith and with good morals. And they perform other rituals when a baby is born, for example, slaughtering a goat and then burying its bones at the side of the house. The aim of this ritual is to protect the child from any kind of evil or accidents (interview 43, 21 May 2015). As also indicated in the conclusion of chapter 4, and in chapter 5.2, there seems to be a shift from the use from indigenous objects to the use of religious objects in health-related issues, of which the latter fits within what the religious leaders advocate.

Alongside biomedical care, the narratives of young adults and religious leaders showed that herbal medicine (*miti shamba*) may be used in health-related issues and that their use is accepted by religious leaders, as Chapter 3 showed. It also became clear in Chapter 3 that the shops where you can buy herbal medicine are visible in the city centre. Nabila offers us a case of a young adult who used herbs (I introduced her in 5.3.1 in relation to shame and secrecy). She is a Muslim primary school teacher in her late twenties with one young child. When I asked her how she kept her child healthy,

she answered that she has health insurance, which is deducted from her salary. When her child is sick, she first gives it paracetamol, but if the child does not feel better, she goes to the hospital, and she named three hospitals that she can choose from. I asked her in what circumstances she might visit which hospital. She explained:

> *It depends on the services given. I went to one of the hospitals when my child had a fever, but they did not diagnose well. I therefore decided to go to another hospital. All those three hospitals receive the health insurance card* (interview 1, 29 April 2017).

She did use herbs when her child was 3–4 months old[111] and had stomach problems. She did not remember the name of the herb, but she used them with cold water. She first had to boil the water, then let the water cool down, and after that mix the medicine with the water and drink the liquid. Within the partially disenchanted worldview of the young adults, it seems that the use of herbs is accepted by the young adults, and also by the religious leaders.

As section 5.3.2 showed, the young adults have a partially disenchanted worldview, in the sense that they make use of the facilities of the urban environment, like biomedical care and education. On the other hand, the young adults are religious and do not visit indigenous healers, even though these healers are present and are visited for all kinds of different problems in relation to the four misfortunes presented by Whyte (1997). The presence of the indigenous healers who make objects like *ilizi* indicate that enchantment is present. As indicated in this section, it seems that the indigenous objects are being replaced by religious objects like the Bible and holy water in health-related issues like the protection of a young child.

5.4 Conclusion

The young adults interviewed in Dodoma live in a city with numerous urban amenities, including access to diverse medical care and education. Based on their accounts and the urban resources available in Dodoma, it appears logical that Weber's concept of disenchantment might be at play. However, it also became clear that indigenous healers are present in Dodoma, both visibly and discreetly. Those healers who operate more covertly often create objects like *ilizi* and are referred to as *waganga wa kienyeji*, as outlined in Chapter 3. In addition, a variety of religious practices is also present in Dodoma.

[111] At the time of the interview, her child was five years old.

As Chapter 5 explored, there exists a relational triangle involving education and biomedical care, the primary religions (Islam and Christianity), and indigenous healers, with young adults at the centre, navigating these different facets. This chapter examined the roles of shame, secrecy, and disenchantment within this triangle. Young adults expressed a reluctance to visit indigenous healers due to religious disapproval and their educational backgrounds, suggesting an element of secrecy within the urban environment. Nevertheless, as previous chapters indicate, some young adults still consult indigenous healers.

Within the dynamic between education, biomedical care, and indigenous healers, two key aspects emerge. First, urban resources influence referrals made by indigenous healers to hospitals. Second, indigenous healers address issues outside the scope of biomedical care, education, or formal religions, such as matters of prosperity or personal safety – issues that biomedical institutions cannot always resolve, like home protection or stolen property. I therefore argue that indigenous healers will remain present within the urban environment of Dodoma.

The interaction between indigenous healers and the primary religions, Islam and Christianity, reveals areas of tension, as these religions generally prohibit the use of objects for health or protection, which are provided by *waganga wa kienyeji* who clearly operate in Dodoma. Young adults' claims that they avoid health-related objects suggest a level of disenchantment. However, visiting indigenous healers, as observed among the young adults from middle classes central to this study, also indicates an ongoing presence of enchantment.

Another dimension is the substantial role primary religions play in the lives of these young adults, who, by their own accounts, follow the guidance of religious leaders – particularly regarding the use of indigenous healing practices or objects for healing or protection. For most health concerns, they prefer biomedical facilities such as pharmacies or hospitals. This shift from indigenous healing to biomedical care reflects not only the influences of religion and education but also the urbanization that makes biomedical facilities more accessible. Following Olsen and Sargent (2017), my findings suggest that young adults in urban settings adopt different healing strategies than those in rural areas, thanks to readily available biomedical resources – a view corroborated by my conversations with participants.

This chapter aimed to show that, based on young adults' narratives, their worldview does not strictly align with either disenchantment or (re)enchantment. I therefore argue that a partial disenchantment is present, since aspects of both are present: disenchantment through science (biomedical care, herbal medicine, and education) on

one hand, and an enchanted perspective through the existence of indigenous healers who make objects like *ilizi* on the other. In addition, the young adults are religious (either Christian or Muslim), which plays a large part in the social-moral choices of the young adults, namely young adults in Dodoma largely adhere to biomedical care, benefit from higher education, and refrain from consulting indigenous healers or using healing objects. It seems that these religious leaders advocate for a discourse of disenchantment. The young adults navigate these contradictions, and follow the advocacy of education and their religion to balance shame and secrecy within their daily lives: the more they do what the religious leaders advocate, and the more educated they are, the less shame and secrecy seem present in their daily lives. However, this does not make the fear for the objects and certain indigenous healers go away. And as indicated in the findings, the indigenous healers remain present. I therefore argue that a partial disenchantment will remain present in the daily lives of the young adults in Dodoma belonging to middle classes.

6.

Conclusion

6.1 Introduction

This thesis aimed to answer the following main research question:

> *How do young, educated, urban adults belonging to the middle classes express their own and their young children's health concerns in relation to healing objects?*

The first part of the thesis dealt with the concepts of the middle classes, social narratives, modernity, and healing, which form the basis of this study. These concepts have been explored in relation to three main groups of interlocutors – young adults, religious leaders, and indigenous healers. Based on the narratives of these three main groups, the core part of the thesis deals with the daily lives of the young adults from the middle classes, the medical landscape present in Dodoma, the object of *ilizi*, which can be used for healing and protection purposes, and, finally, it uses Weber's concept of (dis)enchantment as a tool to explore the existing contradictions and contestations within the urban environment of Dodoma. This final chapter presents a summative argument that combines the premises put forward in each chapter and concludes with some future research challenges.

Dodoma lies in the centre of Tanzania and, as the country's capital, it is a growing city. The growth is largely due to people coming to the city looking for job opportunities or an education, but it is also the result of the relocation of government ministries from Dar es Salaam to Dodoma. The focus of my research is young, higher-educated adults (25–39 years old) from the middle classes who have a steady job or are studying at university. Following Van Dijk (2020a) and Kroeker *et al.* (2018), I look at middle classes as a pluralistic rather than a singular phenomenon, since, during my research, I found that young adults were influenced in different ways by factors such as urbanisation, migration, education, and the primary religions of Christianity and Islam. As a result, different kinds of lifestyles exist amongst the middle classes of urban Dodoma. Taking these middle classes as a starting point is important because of their significance in the development of cities such as Dodoma, and because it affords us a better understanding of their decision-making when it comes to matters such as health and well-being. Because of their increasing significance in present-day socio-economic developments, the position the middle classes take in the context of a pluralistic medical landscape requires careful analysis, to which this thesis contributes.

The concerns of the young middle classes are therefore complex and require careful analysis. This complexity derives from the fact that as middle classes they have a lot to lose and a lot to gain and are required to take decisions on important matters such as dealing with health and illness in careful ways. Illness can deplete (financial) resources easily, but

importantly also confronts them with moral questions about where to look for treatment and care, and to base their choices on considerations that are framed by rationalities that are related to education and allegiance to their Christian or Muslim faiths.

Dodoma is a city with many facilities relating to: education – from primary school up to university; the primary religions – there are many mosques and different denominations of Christian churches; and health options – pharmacies, private and governmental hospitals, shops selling (branded) herbs, and indigenous healers. The questions I asked during interviews were directed at the health of the young adults and their child(ren) under five-years-old, and the different options available in the city and their home area. In order to understand their considerations when decision-making in a rapidly changing medical landscape, the focus of the research concerned narratives on the use of objects for healing and protective purposes, which coalesce around the use and non-use of the object of *ilizi*.

Mobility and borders play an important role in the lives of young adults, and life in general in Dodoma. Firstly, many interlocutors moved from other parts of Tanzania to Dodoma in order to get a higher education and/or find a job, which can be seen as occupational mobility. Secondly, there is also a spatial mobility of objects, medicines, herbs, ideas, and images. A third form of mobility that was found, is social mobility in the sense of giving direction to what you can do as a young adult belonging to middle classes or what should or should not be part of the life of young adults from middle classes. An example is leaving the parental home for educational purposes or not visiting an indigenous healer because of religious convictions (either Christian or Muslim) that prohibit the crossing of a socio-religious border that consulting these healers appears to imply.

As indicated, the research is based primarily on the narratives collected during interviews from young adults, indigenous healers, and religious leaders. The narratives reported are not literal observable actions, rather they are actions that say something about the social reality of the daily lives of young adults in an urban environment. The narratives focus on the general behaviour of the young adults and relate to that of the two other groups concerning illness and healing or protection of the body to stay healthy. Through the narratives, the interlocutors reveal their options and choices, express their considerations, and explain various moral imperatives. As Chapter 2 shows, the narratives of the young adults who have a higher education and are religious (either Christian or Muslim) make clear that they make use of biomedical care and do not visit indigenous healers. They make use of all the facilities that exist in the urban environment, and, as Chapter 3 shows, there is a broad medical landscape in Dodoma. The narratives presented in the thesis demonstrate who these young

adults are and how they position themselves within the diverse urban environment in which various forms of healing and medical care are available, intersecting with different religious identities, educational opportunities and occupations, and prospects for living a middle-class lifestyle. This condenses into a narrative in which the young adults interviewed express the notion that they do not believe in the work of indigenous healers and, indeed, they express their fear that something bad might happen if they did visit a healer. At first sight, it appears that this narrative is dominant and indicates the position and identity of the young adults. However, when talking to the indigenous healers, it became clear that (some) young adults do in fact visit these healers. While the reflections of the young adults on their position and their options show some variety, they indicate a number of important commonalities that inform the choices of young adults.

Following Neubert and Stoll (2015), I took into consideration socio-cultural differentiation when looking at the young adults belonging to the middle classes. To analyse the data, I looked at the socio-cultural 'milieus', i.e., people from sub-groups of a certain socio-economic position who share the same lifestyle and values, since the narratives collected made clear that certain groups of people did share the same values. My aim was to determine one social macro-milieu based on the narratives collected from young adults, religious leaders, and indigenous healers. I call this social milieu 'young, urban adults from the middle classes.' This social macro-milieu is comprised of 'milieu building blocks' related to the young adults and the choices they make in their daily lives. One of these blocks is called 'ideals and role models,' which, in the case of the young adults in my research, concerns a partially disenchanted worldview (not visiting indigenous healers, being educated, and using biomedicine) and, at the same time, being religious. Their lifestyle differs from, for example, the young professionals in Nairobi, Kenya, that Spronk (2006) describes as financially independent and who delay marriage, have a trendy lifestyle, and the basis of their social life is inter-ethnic.

Based on the narratives collected from the three groups of interlocutors concerning the young adults in Dodoma, a social macro-milieu of 'young, urban adults from the middle classes' is formed, and we can deduce a collective representation resulting in what I call a social imaginary (Taylor 2002). A social imaginary concerns how people's social existence is imagined by them and is shared by large groups of people. This form of 'sense-making' enables the practices of society and shapes how "ordinary people 'imagine' their social surroundings" (ibid.: 106). This social imaginary is based on the following elements:

- young adults from Dodoma's middle classes claim not to use material objects for healing and/or protection purposes;

- the young adults are higher educated and religious (Christianity or Islam);
- young adults claim that they only use biomedical care options when they or their young child are not feeling well, but at the same time, occasionally resort to prayer, a rosary, or spraying holy water on the bed for healing purposes;
- people interviewed during my research who mentioned witchcraft demonstrated a fear of witchcraft (*uchawi*), which is linked to and part of the social narrative on *ilizi*.

These building blocks represent a template for understanding how the young adults perceive themselves and reflect on their decision-making: religious, higher-educated, making use of biomedical care, and distancing themselves from the past in the sense that they claim not to visit indigenous healers and they claim not to use material objects for healing and/or protection purposes. This results in the social imaginary of a partially disenchanted worldview in which magical powers have diminishing importance and to which the young adults aspire to belong.

In addition, the relation between the three issues of education and biomedical care, Islam and Christianity, and indigenous healers form the sides of a relational triangle, and locates the young adults at the centre of a set of relationships if not contestations between world religions, indigenous healers and biomedical care/education, as indicated in Chapter 5. This relational triangle, based on the narratives of the young adults, religious leaders and indigenous healers, showed where shame and secrecy were present, and which aspects were seen as disenchanted or enchanted.

By using the narratives as a method to gain insight into the daily lives of young adults and their young children in relation to these three relationships, but particularly in relation to health, and by having material objects as a focus, the contestation between aspects of disenchantment and enchantment becomes clear. These contestations transpire in the narratives, and provide a possibility to reflect on these relations and contradictions: between word and practice (what has been said and what can be observed) and religious versus indigenous practices (the primary religions do not accept indigenous practices such as the use of an object like *ilizi*, but it does exist). By adopting this method, and by focusing on material objects, this thesis offers insights into the daily lives of young adults belonging to middle classes in a specific context. Both the religious leaders and young adults I spoke to advocate for biomedical care and education, and against obtaining objects from an indigenous healer, suggesting a clear link with Weber's disenchantment.

Chapter 3 shows that medical plurality is present in Dodoma. I argue that the facilities available make the indigenous healing options more peripheral, since indigenous healers do exist in current day Dodoma, but the healers who make objects like *ilizi*

typically work on the outskirts of the city. The biomedical doctors and religious leaders are aware of the existence of such objects, because they have encountered them in their personal and/or professional life. I have heard that indigenous healers do send clients to biomedical doctors in cases where they cannot help, but I have not heard that doctors ever send patients to healers. A question that arises is what would these young adults do if biomedicine does not provide a solution? They perhaps need to be flexible in their convictions, since – as Chapter 3 shows – there are health options that offer solutions in cases where biomedicine cannot provide a therapy. Such cases could include those involving stolen property, becoming more powerful, or when a husband is a thief. I therefore argue that biomedicine and indigenous healing will continue to exist next to each other in Dodoma.

I argue that the process of disenchantment takes place on the level of making use of the urban facilities that are present. I show that this leads to different degrees of visibility and invisibility of the various forms of indigenous healing. Because herbs also form the basis of biomedicines, religious leaders do not preach against the existence of indigenous healers who provide these kinds of medicines. It seems that because it is accepted within a society influenced by the primary religions, the *mganga wa tiba za asili* is located in visible places in the city. However, the *mganga wa kienyeji* – the healer who makes an object like *ilizi* – is (mostly) situated in hidden places within the urban environment of Dodoma. The reason why these healers are located in more hidden places seems partly related to the influence of the primary religions which do not condone visiting an indigenous healer like the *mganga wa kienyeji*. In addition, the narratives of the young adults indicate that they say they do not believe that the objects made by indigenous healers can harm them because they are higher educated and religious. Within this narrative, different layers can be found. Firstly, the young adults do seem fearful of the powers of both the healers and the objects made by these healers. Secondly, the young adults interviewed all say they are religious (either Christian or Muslim) and within these religions the use of an object from an indigenous healer is not accepted. Thirdly, because of their higher education and religious convictions, the young adults might feel a moral obligation to say they do not use and believe in these indigenous healers and the objects they make. A final layer can be found in how the powers of the healers and objects can affect the young adults, in the sense that say they do not believe, but when they encounter an object (like Miriam in the introduction of chapter 4), they do burn the object. Or the example of one of my friends who told me that she would run away if I would approach her with an object on my hand, because sometimes the objects do work (see chapter 4.2.3.1) (interview 13, 12 May 2015). It seems the young adults want to be sure the object does not cause harm to them, and therefore they keep away from the objects, or burn them. On the other hand, narratives of young adults showed the use of religious objects like

a rosary, holy water or the Bible as means to protect and/or cure themselves or their young child from illnesses. It therefore seems like a shift is present from the use of indigenous objects to the use of religious objects.

Furthermore, the question of different levels of disenchantment also plays out in view of how biomedical practice may interact or not interact with indigenous healing in a medical plural landscape. Approximately thirty years ago, indicated in her article on epilepsy and collaboration between indigenous healers and prophets in Swaziland, Reis (1991) indicated that some authors believed that a collaboration between biomedicine and some healers – who Reis (1991, 1996) describes as technical healers (midwives, bone setters, and, in some cases, herbalists) – is possible. However, a collaboration between biomedicine and so-called inspired healers (Reis 1991, 1996), like *sangomas,* is not possible. Interestingly, the same tension can still be found within my research in a different country and amongst a later generation, most of whom grew up in a city with urban facilities and with clear middle-class ideas. The modernity that is present within Dodoma is one where both technical and inspired healing – following Reis's division – can be found within a similar medical plurality. Based on my research, I understand that the world the young adults in Dodoma belonging to middle classes live in will continue to be enchanted by the presence of indigenous healers and in addition that a strong presence of the primary religions will remain. I therefore argue that the young adults are partially disenchanted, since they adhere to the religions and a higher education in the sense that they say they do not visit a so-called inspired indigenous healer for health-related issues. This implies that the young adults will continue to be faced with the earlier mentioned and inherent contradictions between their modern convictions and local (healing) practices. Some enchanted aspects of these practices may take place in a hidden way, especially those of the indigenous healers who make objects like *ilizi*.

6.2 *Ilizi* as focal point

Throughout the research, I collected multiple narratives about objects and herbs used for healing purposes – see Annex B for an overview – but the primary focus became the material object of *ilizi*, which is mainly discussed in Chapter 4. During the first fieldwork in 2014, it became clear that most narratives about objects used for healing and protective purposes concerned *ilizi*. By looking at the interrelationship between the middle classes and health-seeking behaviour from the angle of a material object like *ilizi*, the research gains insight into the choices young adults make for themselves and their young child(ren) concerning their health options. The object mainly consists of black cloth with something inside, like elephant dung, garlic, *mvuje*, and umbilical

cord, but charcoal, hair, and nails can also be found. The material object can be used to protect a young child against, for example, stomach pain or *degedege*, or it can protect a house, catch a thief, or even harm someone else. The narratives collected relate to the following three themes: misfortunes, shame and secrecy, and witchcraft. The type of misfortunes these objects relate to can be divided into the four categories presented by Whyte (1997): failures of gender, failures of prosperity, failure of health, and failure of personal safety. During my research, it became clear that most narratives were related to failure of health and failures of gender.

The fieldwork showed that the narrative on the use of material objects concerns hidden issues in the sense that the object is surrounded by shame and secrecy and the narratives of both the young adults and religious leaders are associated with evil things like witchcraft and also Satan, with whom the young adults do not want to be associated. The young adults say they have only heard narratives about such objects from others, seen it in movies, or have seen neighbours wearing an object; almost all said that they do not use such objects themselves. The secrecy around the object has less to do with knowledge about the existence of the object and how it looks, and more to do with the use of the object by themselves and others. It is impossible to tell whether someone is using an object for health-related purposes unless the object is worn on a visible place like the wrist. This mostly happens with young children under five years old.

During the first fieldwork period in 2014, I was informed that people may be willing to talk to me about children using objects, since they tend to wear such objects visibly, while adults often hide these kinds of objects. Throughout the research, it became clear that an object like *ilizi* is surrounded by shame, which leads to certain practices such as concealment of the object or secrecy about its use. It is deemed acceptable for a young child to wear such an object, however, since the child is not aware of what is going on and does not have a say in what happens. By contrast, young adults do know the purpose of *ilizi* and, based on the narratives heard, and as shown on page 209-210 of this concluding chapter, one element within the social imaginary concerns young adults not wanting to be seen with *ilizi*. Wearing such objects can result in social exclusion, because it is seen as a sign that the person is worshipping more than one God, which is not accepted by either Christianity or Islam, as indicated by the narratives reported by religious leaders. By wearing the object, a young adult is indicating that he/she is rejecting the moral imperatives of their faith. In addition, as a higher-educated young adult belonging to the middle classes, wearing such an object may indicate that he/she visits an indigenous healer and believes in the efficacy of the object made by that healer. And especially by living in a city, where people live close to each other, it seems more difficult to conceal wearing such an object and/or visiting

an indigenous healer who makes the object. The findings indicate that being able to have a life within a social context and to be able to move freely within that context, it is therefore important to say that you do not use an object like ilizi, or do not visit an indigenous healer. As indicated before, the use of ilizi is associated with bad things like witchcraft, with which a young adult does not want to be associated with and is also fearful about it.

The object of *ilizi* is only made by an indigenous healer. As Chapter 3 demonstrates, different kinds of healers can be found. Based on the groups of indigenous healers within the folk healing I encountered, I propose four areas of folk healing in Dodoma urban using the Swahili names (in the singular), since in English the word indigenous healer encompasses several types. This division reveals the difference between those indigenous healers who only use natural remedies (herbs) for healing purposes (*mganga wa tiba za asili*); those healers who focus on female health problems (*mganga wa kunga*); the general category of Maasai healers; and finally, those indigenous healers who use herbs for treatment in addition to objects like *ilizi* (*mganga wa kienyeji*). The last group of healers treat problems that occur within all four categories of misfortunes distinguished by Whyte (1997), and appear to be working in areas outside the city centre. By creating these four categories of healers, based on the Swahili names, I have been able to show which kind of healer makes *ilizi*.

While there is a narrative on the hidden nature of objects like *ilizi*, the knowledge about who can make these objects and what they are used for is not hidden. The *mganga wa kienyeji* makes the *ilizi*, knows the specifics regarding what the object looks like and what is put inside the object. Through the cases presented in this thesis, it is clear that this kind of indigenous healer can be a man or a woman, either Christian or Muslim, of different ethnic groups and of different ages. In some cases, knowing where to find these healers is shrouded in mystery, since the narratives of the young adults and indigenous healers make clear that the object of *ilizi* is connected to bad things like witchcraft and is surrounded with shame and secrecy. The connection of both the object and the healer to these bad things may be the reason why these kinds of healers are located outside the city centre. And the *mganga wa keinyeji* who works in the city centre is usually located in a hidden location.

The narratives reported clarify that the interlocutors from all three groups have knowledge about what the object of *ilizi* looks like and what it can be used for, and that the *mganga wa kienyeji* is the kind of healer who makes the object. This indicates that there is no secrecy around the knowledge of the object, it is apparently acceptable to have this knowledge, because, as such, it does not reveal whether you actually use the object or not. On the other hand, the contestation concerning the

use and existence of the object is revealed in the sense that the object is made by indigenous healers and existed during my fieldwork period. I propose that these young adults use the urban facilities present in Dodoma to help shape their moral choices: to show they adhere to the religious conviction as preached by the religious leaders; to show they have knowledge that certain aspects from the past – like the use of *ilizi* – do not fit within a modern lifestyle; to show that the use of biomedical care is sufficient in health-related issues. In summary, to show they live the life as it should be in the urban environment with all its facilities and within a social context where people live close to each other. The findings therefore indicate that the use of material objects like ilizi are unbefitting for the lifestyles, context, and morality of the young adults. The contestations and contradictions that exist in urban Dodoma are discussed in the next section.

6.3 Common narratives, contradictions, and contestations: Developing the triangle

The thesis is composed of narratives with a focus on health-related issues, to demonstrate the social reality of the daily lives of the young adults. The cases presented in this thesis reveal different dimensions within the narratives reported, and also different subjects, as will become clear in the next paragraph. The narratives lead to a social imaginary that concerns a form of shame and secrecy shared by higher-educated young adults about going to an indigenous healer to get an object like *ilizi* to be protected or cured from various misfortunes. However, the presented cases make visible a contestation between what the young adults say they do (which is the focus of Chapter 2) and what can be seen and heard while talking to indigenous healers (which is the focus of Chapter 4). What the young adults say they do form the social imaginary, as concluded in Chapter 6.1, and concerns education and biomedicine. Equally, the practices of indigenous healers show the existence and use of material objects for issues concerning health and well-being.

There are different dimensions within the narratives concerning the material object of *ilizi* that make the contestation clear:

- there is a common narrative within the social milieu of Dodoma's middle classes about knowledge of what the material object looks like: it is black cloth with something inside;

- there is a common narrative on the use of these kinds of objects: they can be used to protect a house or a young child against evil spirits, but also to harm someone;

- there is a narrative of contradiction concerning the use of *ilizi*: the young adults and religious leaders I interviewed say they do not use the material object, while the indigenous healers I interviewed say they do make this object and provide these to young adults – and I have also observed this myself;[112]

- there is a common narrative concerning where to find the healers: the *waganga wa tiba za asili* are visible and easily found in the city centre, while the *waganga wa kienyeji* are mostly located in hidden places on the outskirts of Dodoma.

As indicated earlier in this concluding chapter, based on the contestation between what the young adults say and do and what was seen and heard when interviewing the indigenous healers, in Chapter 5, I propose the scheme of a relational triangle formed by: education and biomedical care, the primary religions Christianity and Islam and indigenous healers, with the young adults at the centre and the focal group of my research.

On the surface there seems to be one narrative relating to each side of the triangle. However, even within each side, multiple layers can be found. For example, in the case of indigenous healers, chapter 3 showed that there are several kinds of indigenous healers, of whom only the *mganga wa kienyeji* the kind of healer is who makes objects like *ilizi*, and should not be visited by young adults, which was confirmed by the religious leaders. However, it was accepted by the religious leaders that indigenous healers who only use herbs in their practices can be visited, and may explain why these healers are visible within the city.

Within Weber's theory on disenchantment, religion is not seen as part of science. However, as became clear through the narratives of the young adults and the religious leaders, the parts of Weber's science are important: you make use of biomedical care and get an education. For this reason, I posit that aspects of both Weber's disenchantment and enchantment are part of modernity and life today for Dodoma's young adults belonging to the middle classes, and that the young adults are partially disenchanted. The relational triangle can be perceived as a kind of 'mental map' in which the aspects of the decision makings by the young adults are displayed. By looking at the three sides of this relational triangle, we can trace and follow the decision making of these young adults; it offers a perspective on their (social-moral) positionality. The young adults belonging to middle classes are higher educated, have a steady job or are

[112] I do not wish to imply that all young adults and all religious leaders do not use a material object for healing and protective purposes. Some people may use these kinds of objects in particular contexts, for example when a disaster takes place or when biomedicine cannot provide a solution.

following higher education, are religious, and have access to biomedical care options. These aspects give input to the young adults in how to deal with aspects from the past, like indigenous healers who make objects for healing and protective purposes; these aspects give the young adults ways in how to explain their choices and also in how to prevent feeling shame and secret.

My earlier framed hypothesis is that young adults mainly use the biomedical care options available in the city for issues like infertility and healing of illness, but that in other cases – like gaining power, jealousy issues, or stolen property – they may visit an indigenous healer, because they believe that they can explain (and heal) the problem.

I started out with very little knowledge about material objects used for healing purposes. Through the interviews with young adults belonging to the middle classes, indigenous healers, and religious leaders, I gained insight into the daily lives of these young adults in relation to the health concerns of themselves and their young children. As this thesis shows, the young adults have a disenchanted worldview, while aspects of Weber's enchantment are present in the form of the active presence of both Christianity and Islam and the existence of indigenous healers who make material objects like *ilizi*. The method used to gain this insight involves recording narratives from three different groups in order to provide understanding, from different angles, on the subject of health-related issues in relation to material objects. Living in an urban environment, belonging to the middle classes, having a higher education, and having access to biomedical care all add to a somewhat disenchanted worldview and enable the young adults to cope with the contestations that are present in urban Dodoma. They also incorporate the primary religions of Christianity or Islam into their daily lives to deal with the presence of indigenous healers and material objects such as *ilizi*, and, as this thesis shows, the *waganga wa tiba za asili* and the use of herbs in health-related issues are accepted by the primary religions.

A key takeaway of this thesis is that the young adults belonging to middle classes in Dodoma navigate between the modern facilities present in the urban environment and aspects from the past like the presence of *waganga wa kienyeji* who make *ilizi*. The modern facilities of education, biomedical care and religion provide answers in how to deal with these aspects. These facilities provide the young adults alternatives in health-related issues: biomedicine to cure a child when he/she is ill; a higher education to stop believing in the efficacy of the objects; using prayer, the Bible or holy water to protect a young child; not visiting an indigenous healer. By collecting narratives as a method, with the focus on a material object, I gained insight in the daily lives of these young adults belonging to middle classes and the choices they make concerning health-related issues.

6.4 Challenges for further research

In this thesis, I adopted a narrative approach to examining the health-related issues of young adults and their young children in the urban environment of Dodoma and its different facilities and medical plurality. In the final part of this thesis, I address a few challenges I incurred during my research, and make some suggestions for further research questions.

Due to the way I conducted the research, i.e., short fieldwork periods divided over multiple years, it was not possible to conduct in-depth research of the type done when doing research over long periods of time in the same place. In order to maintain the quality of the research, I had to gain the trust of my interlocutors so that they felt comfortable enough to share their narratives with me (see Moen 2006: 8). By focusing on the objects, I heard narratives about the daily lives of the young adults and their young children in relation to health-related issues. In order to gain knowledge about the interlocutors the context is essential, or as Moen (2006: 8) phrases it: "to understand a human being, her or his actions, thoughts, and reflections, you have to look at the environment, or the social, cultural, and institutional context in which the particular individual operates." By visiting Dodoma over several periods divided over a number of years, and going to different parts of the city, I believe that I gained a better grasp of the environment and the context the young adults of Dodoma live in.

During the study, a number of issues emerged that gave me additional insights into the research I conducted. I will discuss them briefly:

- The research was mainly focused on the indigenous healers even though biomedical doctors, among them young adults (e.g., nurses) were interviewed. Adding a more in-depth perspective from the biomedical doctors on the use of *ilizi* would provide additional insights from another angle.

- Exploring the role of witchcraft (*uchawi*) among the young adults living in Dodoma may give more insight into underlying fears that seem to exist among the young adults.

A recommendation for future research would be to return to Dodoma in approximately ten to fifteen years to interview people who were young children during my research and who were born in Dodoma Urban. The research would aim to understand the influence of growing up in an urban environment with parents whose daily lives were shaped by the facilities and services of the city, like access to biomedical care, higher education, and religions like Islam and Christianity. It would also seek to understand

any changes in the role of and narratives on material objects like *ilizi* and the role of and narratives on the *mganga wa kienyeji*.

A follow-up question to the research conducted concerns the specific context. The study took place in the specific context of Dodoma. But what would the narrative be if the research was conducted amongst the Tanzanian diaspora in the Netherlands, i.e., among young, middle-classes adults from Tanzania, but in a different context from Dodoma? In the Netherlands, there is access to biomedicine as first line of medical care as there is in Dodoma, and the presence of disenchantment seems even greater than in Tanzania due to the smaller role that religion plays within Dutch society.

Another possible follow-up question concerns the hidden issues. The research conducted made the hidden issues that exist in the context of Dodoma more visible. Do we have access to hidden narratives? And do those hidden narratives relate to hidden issues? Could using the narrative method and focusing on material objects to gain insight into the daily lives of young adults shed new light on and perhaps gain more insight into hidden issues and hidden narratives?

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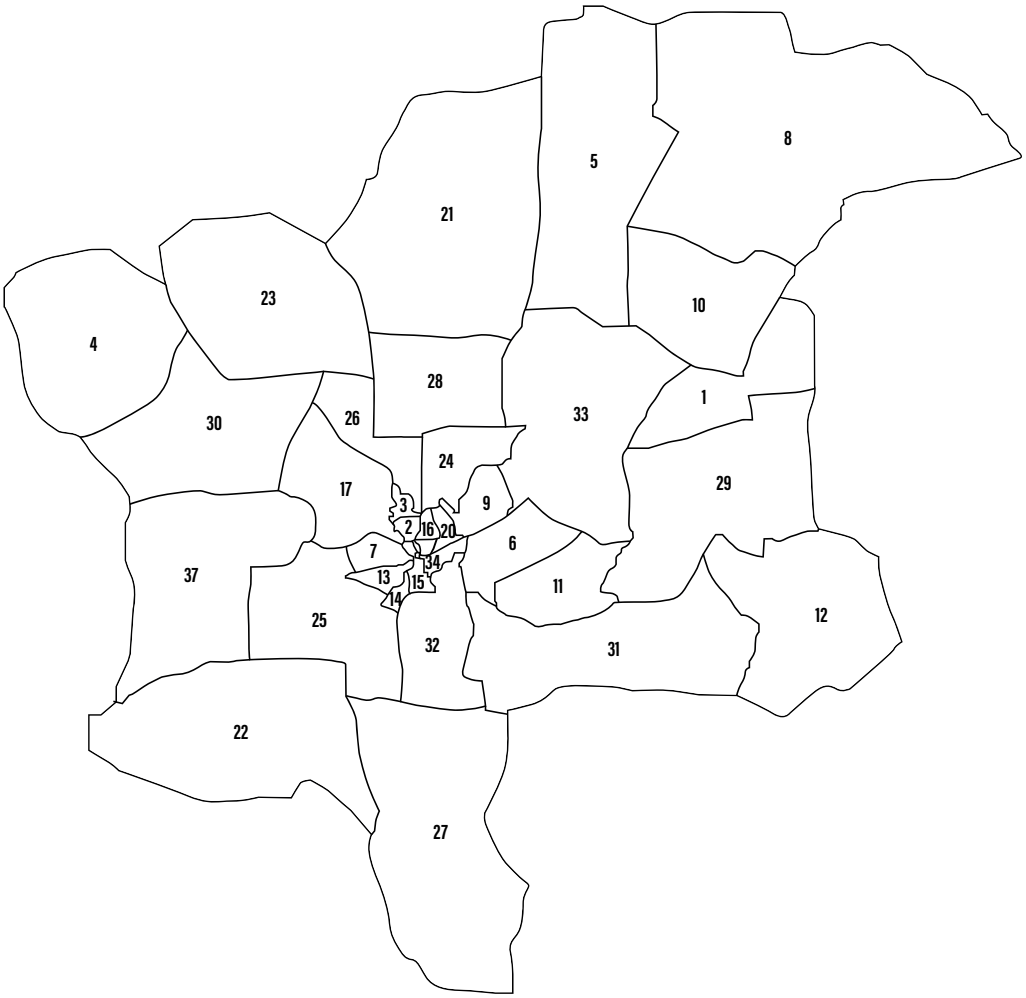
Map 1: Wards of Dodoma[113]



1 Chahwa
2 Chamwino
3 Chang'ombe
4 Chigongwe
5 Chihanga
6 Dom-Makulu
7 Hazina
8 Hombolo
9 Ipagala
10 Ipala
11 Iyumbu
12 Kikombo
13 Kikuyu Kaskazini
14 Kikuyu Kusini
15 Kilimani
16 Kiwanja cha ndege
17 Kizota
18 Madukani
19 Majengo
20 Makole
21 Makutupora
22 Mbabala
23 Mbalawala
24 Miyuji
25 Mkonze
26 Mnadani
27 Mpunguzi
28 Msalato
29 Mtumba
30 Nala
31 Ng'hong'honha
32 Ntyuka
33 Nzuguni
34 Tambukareli
35 Uhuru
36 Viwandani
37 Zuzu

[113] Based on Figure 1 Sumari *et al.* (2025: 2166).

Annex A: Glossary

Swahili	English
Abdalasini	Basil
Afya nzuri	Good health
Babunaji	Chamomile leaves
Biashara	Business
Bodaboda	Motor cycle taxi
Chango	Stomach problems
Choo cha kijani	Green poo
Dala dala	Minibus share taxis
Dawa	Medicine
Dawa za uzazi	Literally: medicine of birth
Dawa ya mitishamba	Herbal medicine
Dodoma mjini	Dodoma urban
Duka la dawa	Pharmacy
Duka la dawa za asili	Literally: “shop of traditional medicine”; shop with indigenous herbs
Fifiza moyo	Suffocates the heart
Har mali	Bihidana or quince seeds
Hurusi	Paralysis
Hirizi (Ilizi)	Charm, amulet, talisman
Jini (pl. majini)	Spirit (pl. spirits)
Kakakuona	Armadillo
Kamon aswad	Black seed sunflower
Kaniki	Black cloth
Kanisa la Mungu	A church of God
Kanisa la Biblia	A church of the Bible
Kifaduro	Whooping cough
Kifafa	Epilepsy
Kinga	Protection
Kubiliti upele	Cover the rash
Kukanda	Massage
Kuondoa mikosi	To remove bad omen

Kuroga	To bewitch
Madini	Minerals
Madukani	In the shops
Mafuta ya mkunazi	Coconut oil
Mafuta ya karafuu	Clove oil and is used as massage oil
Maganda ya kakakuona	Armadillo shells
Maganga karanga	Roasted groundnuts
Maji ya baraka	Holy water
Mama mdogo	Mother's younger sister
Mashetani	Spirits or demons
Mashetani ya ukoo	Clan spirits
Mchawi (pl. wachawi)	Witch (pl. witches)
Mganga (pl. waganga)	Healer (pl. healers)
Mganga wa kienyeji	Indigenous healer
Mganga wa tiba za asili	Herbal healer
Miti shamba	Herbs (literally: trees of the field)
Mizimi ya nyumbani	Family spirits
Mizizi ya tulatula	Roots of the tulatula plant
Mizizi ya mbaazi	Pea roots
Mji mpya	New city
Mkaa	Charcoal
Mkunga	Midwife
Mpapara	Green leaves of mparara tree
Mti Ulaya	European tree
Muarubaini	Neem tree
Mvuje	Asafoetida
Mzee	Older man
Ndulele	Local name for a certain plant
Ngozi ya ng'ombe	Cow skin
Nia	Intention, aim, or purpose
Pepopunda	Tetanus (when the eyes go from left to right)
Pumu	Asthma
Shamba	Field or farm
Shehe	Muslim religious leader
Sindano	Injection
Surua	Measles

Tangawizi ya unga	Powdered ginger
Tende na maziwa	Dates with milk
Tumbo la wazazi	Literally: stomach of the parents
Ubuyu	Baobab nut/pith
Uchawi	Witchcraft
Udongo	Soil
Ugali	Type of corn meal made from maize or corn flour
Unga wa sufa	Almond flour
Ungo	Winno-wing basket/sieve
Ushituka	Trembling
Utomvu	Plant sap
Wanapata mimba	To become pregnant

Annex B: Overview objects used in health-related issues[114]

Herbs (Miti shamba)

Local name	Translation	Material
Aloe vera	Aloe vera	Plant-based
Babunaji Photo 2.16 page 84	Chamomile leaves	Leaves
Kubiliti upele	Cover the rash	Yellow powder, from the flowers of small avocado trees
Mafuta ya kondoo	Fat from the sheep	White substance
Maganga karanga	Groundnuts	Shell
Mapande (either Swahili or Gogo name)		Herb
Mapande		Herb
Marembo (local name, not Swahili name)		Avocado plant

[114] Some of the names are noted phonetically, and some may not be Swahili names. It is indicated when known from which ethnic group the name is.

	Purpose	How used
	Malaria	Drink with cold water
	To keep the baby inside	Half a cup, twice a day, every day. When becoming pregnant, start drinking
	If someone is possessing spirits (*mashetani*), the spirits go out It can also chase away spirits in the mine in order for people to start mining	Together with glycerin and *tanganite* (black powder) on the ground and it catches fire. By adding the yellow powder, the flame gets larger.
	Constipation	
	Cure sores on the tongue	Pick the shells that were already used, an empty match box plus the sugar cane strings which are left after chewing and the core of the maize. Burn these things together to get the ashes and smear it on the tongue
	When parents meet for sex	Wash the child once to keep the child healthy
	Protection for disease (child is too thin (*kukonda*), diarrhoea, fever)	Wash the child with the herb in order to become fat
	Warm the body	Used with cold water, 1 cup, spread all over the day

Local name	Translation	Material
Mpapara		Leaves which cannot be found in Dodoma, but in Geita region
Mtulu and mweze (Gogo names)		Roots
Mtundi la mwewa (Gogo name)		Roots
Muarubaini Photo 2.1 page 50	Neem	Leaves of a tree
Mvuje Photos 4.5 and 4.6 page 153	Asafoetida	
Ndulele (local name, not Swahili name) Photo 4.7 page 156		Comes from the avocado plant[115]
Ndulele		
Omgilirima		Roots of the tree

[115] This might be the bitter-apple (solanum in Latin), and not the avocado plant (see Veldman *et al*. 2019: 24).

	Purpose	How used
	For children under 5 years old when the child is sick.	Use the pounded leaves in the tea (*chai*) in the morning and evening, for 3 days
	To help a person who failed to get a job or who has bad luck	Pound the roots, and put them in water. The person bathes one time in that water.
	To help a woman to get pregnant	Boil the roots and drink the water. After 5 days, return to the healer with a hen. The healer boils the hen together with the medicine, like soup. The hen has no specific colour. The woman takes the soup once, and eats the meat. She goes back home, and after one month she becomes pregnant
	Clean unwanted material from the body	Heat the leaves, take 3 glasses a day, for 3 days
	It helps to protect the child against *degedege*	Put the *mvuje* on the wrist or waist
	Warm the body	Used with cold water, 1 cup, spread all over the day
	Help the child grow. Gets it immediately after birth	Together with *mvuje* and *mafuta nyonyo* (sweet custard) tied in a piece of cloth, sawn and put on the wrist of the child.
	Chango (the child has pain in the stomach)	The cover of the roots is pounded and put on a teaspoon with some water. When a child sneezes, apply it in the nose, and also do this when the child shows signs of *chango*

Local name	Translation	Material
Omuyonga *(Haya name)*		The medicine is made of the grass which gave the child the rash, which is burned, and makes it black
Tula tula plant Photo 2.14 page 79	Most likely nightshade	A yellow fruit when its ripe, green when unripe
Tula tula plant		Roots

Animals

Local name	Translation	Material
Kakakuona	Armadillo	A small part of the scale
Kakakuona	Armadillo	Living animal

	Purpose	How used
	When a child is sitting on the grass and gets a rash on the body	Smeared on the body, or the child needs to bath in it
	For children and adults. To cure stomach pain; to get pregnant	Take as a whole or lick the powder
	Hernia in the stomach	Use the roots of the plant mixed with vinegar. Drink it once a day for two weeks

	Purpose	How used
	When the eyes go all sides – because they follow a certain bird	Worn around the neck
	Predict future	Put things next to armadillo, people leave the place, whichever the armadillo chooses, there will be more of that in the future. For example, if the armadillo is seen with the crops, the person who sees the animal will get more crops.

Objects of other material

Local name	Translation	Material
Mkaa sana sana	A lot of charcoal	Black charcoal
Mkaa sana sana	A lot of charcoal	Black charcoal
Shabu	Comes from Kilimanjaro, it is from the mine	White stone
Shanga Photo 2.17 page 90	Beads	Beads
Shanga	Beads	Beads

Ilizi

Local name	Translation	Material
Kaniki Photo 4.9 page 173	Black wrap worn by women (TUKI 2001: 127)	Black cloth
Ilizi Photo 4.3 page 152 and photo 4.7 page 156		It is always in black cloth and it is beating, like the heart. It has always something inside.
Ilizi		Black cloth, with different things inside

	Purpose	How used
	When the child is not feeling well, or is crying a lot	Put it on forehead, before going to sleep
	To keep the child safe from thunder and lightning, when the child is part of a twin. It is dangerous to be a twin, because one is positive, the other is negative. Then there will be rain with thunder	Put it on forehead in the middle
	If the water is contaminated, the water becomes clean	Put the medicine in the water
	To increase sexuality	Wear a string of beads around the waste
	Wear for leisure (by Maasai)	Wear it at wrist, neck or legs, both by men and women

	Purpose	How used
	Protection for the child, against disease, the eye of the people (if a bad person looks at you, you can die)	Wear it around hand, neck, waist and always wear it, up to the age of 5 years old
	Protection for the child against diseases	The child wears it around the waist for protection against disease *degedege or surua* (measles), these are common diseases and dangerous.
	Protection for the child against witchcraft	

Local name	Translation	Material
Ilizi		Black cloth, with different things inside
Ilizi		Black cloth, with different things inside
Ilizi		Black cloth, with different things inside
Ilizi		Black cloth, with different things inside

	Purpose	How used
	Protection of thief	There was a thief with *ilizi* inside his upper arm. People will not see the thief when steeling, the thief cannot get caught.
	Protection of house	A thief tries to break in the house, but the house is protected with *ilizi*. The thief becomes mad (ill).
	Protection of house	Put the object in the centre of the house, hidden.
	Achieve more in business	*Ilizi* can also be used in business. People with small business use it to achieve more.

Summary

All people long for good health. Especially when they have children, they hope those children will remain healthy. This thesis focuses on young adults and explores how they deal with illness in their children. In the city of Dodoma, Tanzania, they have several options: obtaining medicine from a pharmacy, visiting a hospital, or turning to an indigenous healer for an object such as an *ilizi*.

This thesis is based on qualitative methodological research and approximately eight months of ethnographic fieldwork, conducted between 2014 and 2018. Three focus groups were central: young adults, indigenous healers, and religious leaders.

The introduction outlines the theoretical framework and background of the research. On one hand, the thesis examines young adults belonging to middle classes, with a higher education and access to health care, religion, and education facilities in the urban context of Dodoma. On the other hand, the study explores their knowledge of and access to material objects used for health and protection. In particular the object of ilizi is central in this study. This is studied through narratives from three different groups: young adults, indigenous healers, and religious leaders. I deliberately use the term "middle classes" (plural), instead of the common term "middle-income class," because not only income, but also parameters such as education and (stable) employment determine whether someone can be considered part of the middle classes.

Chapter 2 analyses young adults from the middle classes in Dodoma and their narratives regarding the choices they make in the field of health, based on their access to occupations, healthcare, religion, and education. The chapter delves into the concept of the middle classes and the various forms of mobility that are present. In analysing these young adults belonging to middle classes, I look at the 'socio-cultural milieus', which are defined by a combination of building blocks such as demographic and social position, religion, and aims in life. From this emerges the milieu of 'young, urban adults from the middle classes.' Mobility and the crossing of borders - spatial, social, and occupational - prove to be crucial in understanding their position and health-related choices. Dodoma, the capital of Tanzania since 1973 and located in a semi-arid region, features a significant religious dynamic, extensive educational opportunities, and diverse healthcare options.

Chapter 3 focuses on the medical landscape of Dodoma, with an emphasis on folk healers. It maps out which healers are found in the capital and which among them make objects used for health-related issues. Based on the narratives of young adults, indigenous healers, and religious leaders, four categories can be distinguished, based on their Swahili names: *mganga wa tiba za asili* (healer using natural remedies), *mganga*

wa kienyeji (indigenous healer), Maasai healer, and *mkunga* (midwife). Within the *mganga wa kienyeji* category, a distinction is made between indigenous spiritual healers and indigenous herbal healers. These are the ones who create the object known as *ilizi*.

Chapter 4 centres on the material object *ilizi*. *Ilizi* mostly consists of black cloth containing something inside, worn on the body (usually hidden), but it can also be placed in front of a house. *Ilizi* can be used for both positive and negative purposes: for health and protection (such as protecting a child from illnesses like *degedege*), or for other aims such as gaining power or preventing a rival from achieving success. The visibility and role of *ilizi* in the urban context of Dodoma - with its biomedical facilities, educational institutions, churches, and mosques - offer insight into the apparent contradictions in the narratives of young adults, religious leaders, and indigenous healers. I relate these to three themes: misfortunes, shame and secrecy, and witchcraft. Based on this, I propose a social imaginary in relation to the object *ilizi*. Referring to their access to modern facilities such as education, biomedical care, as well as their religious convictions, young adults say they do not use *ilizi* due to a sense of shame and secrecy. The *waganga wa kienyeji* – the indigenous healers who make these objects - are therefore mainly found on the outskirts of Dodoma. Moreover, Christian and Islamic leaders are of the opinion that *ilizi* implies belief in more than one god, and its use is therefore not accepted.

Chapter 5 introduces Weber's concept of disenchantment and enchantment. According to Weber, the decline of magical thinking and the rise of modern science are core processes in the cultural development of modern societies. This chapter focuses on the contestations that arise in Dodoma: adults say they do not to visit indigenous healers because it is not accepted by their primary religion (Christianity or Islam) and because they live in a modern world where science and rationality are important. However, my research shows that objects for healing are present, and indigenous healing is used for more than just health. In this chapter, I introduce a relational triangle of primary religions (Christianity and Islam), indigenous healers, and education/biomedical care, with young adults at the centre. The chapter explores various cases within this tension and the role of shame, secrecy, and disenchantment.

Chapter 6 presents summarizing arguments and suggests future research challenges. The narratives of young adults, indigenous healers, and religious leaders provide insight into the role of health and material objects in the daily lives of young adults and their young children. This thesis demonstrates the contradiction between disenchantment and enchantment among young adults: on the one hand, a worldview dominated by modern science, and on the other, religion and the continued presence of practices involving material objects such as *ilizi*. I therefore argue that there is a

partial disenchantment present among young adults belonging to middle classes in Dodoma. Modern facilities in education, biomedical care, and religion offer alternatives to indigenous practices - such as those of the *waganga wa kienyeji* who make *ilizi* - but do not completely erase them.

Samenvatting

Alle mensen verlangen naar gezondheid. Zeker wanneer zij kinderen hebben, hopen zij dat die gezond blijven. Dit proefschrift richt zich op jongvolwassenen en onderzoekt hoe zij omgaan met ziekte van hun kinderen. In de stad Dodoma, Tanzania, hebben zij daarbij meerdere opties: medicijnen halen bij een apotheek, een bezoek brengen aan het ziekenhuis, of zich wenden tot een lokale genezer voor een object als *ilizi*.

Deze dissertatie is gebaseerd op kwalitatief methodologisch onderzoek en ongeveer acht maanden etnografisch veldwerk, uitgevoerd tussen 2014 en 2018. Drie focusgroepen stonden centraal: jongvolwassenen, lokale genezers en religieuze leiders.

In de **introductie** wordt het theoretisch kader en de achtergrond van het onderzoek uiteengezet. Het proefschrift bekijkt enerzijds jongvolwassenen uit de middenklassen, met een hogere opleiding en toegang tot voorzieningen op het gebied van gezondheid, religie en onderwijs in de urbane context van Dodoma. Anderzijds gaat de studie in op hun kennis van, en toegang tot, materiële objecten die worden gebruikt voor gezondheid en bescherming. In het bijzonder staat daarbij het object *ilizi* centraal. Dit wordt onderzocht aan de hand van narratieven van drie verschillende groepen: jongvolwassenen, lokale genezers en religieuze leiders. Daarbij gebruik ik bewust de term *middenklassen* (meervoud), in plaats van de gangbare term midden inkomensklasse, omdat niet alleen inkomen, maar ook factoren zoals onderwijs en een (vaste) baan bepalen of iemand tot middenklassen gerekend kan worden.

Hoofdstuk 2 analyseert de jongvolwassenen uit de middenklassen in Dodoma en hun narratieven betreffende de keuzes die zij maken op het gebied van gezondheid, op basis van hun toegang tot werk, gezondheidszorg, religie en onderwijs. Het hoofdstuk gaat dieper in op het concept van middenklassen en de verschillende vormen van mobiliteit die aanwezig zijn. Bij het analyseren van deze jongvolwassenen uit de middenklassen kijk ik naar de 'socio-culturele milieus', die gedefinieerd worden door een combinatie van bouwstenen zoals demografische en sociale positie, religie en levensdoelen. Hieruit volgt het milieu van 'jonge, urbane volwassenen uit de middenklassen'. Mobiliteit en het overschrijden van grenzen - ruimtelijk, sociaal en professioneel – blijken cruciaal om hun positie en gezondheidskeuzes te begrijpen. Dodoma, sinds 1973 hoofdstad van Tanzania en gelegen in een semi-aride gebied, kent daarbij een belangrijke religieuze dynamiek, uitgebreide onderwijsmogelijkheden en diverse opties voor gezondheidszorg.

Hoofdstuk 3 richt zich op het medische landschap van Dodoma, met een focus op volksgenezers (*folk healers*). Het brengt in kaart welke genezers er in de hoofdstad te vinden zijn en wie van hen objecten vervaardigen die worden ingezet bij

gezondheidsproblemen. Op basis van de narratieven van jongvolwassenen, lokale genezers en religieuze leiders zijn vier categorieën te onderscheiden, gebaseerd op hun Swahili namen: *mganga wa tiba za asili* (genezer met traditionele medicijnen), *mganga wa kienyeji* (lokale genezer), *Maasai healer*, en *mkunga* (vroedvrouw). Binnen de *mganga wa kienyeji* wordt onderscheid gemaakt tussen spirituele en kruidengenezers. Zij zijn degenen die het object *ilizi* vervaardigen.

In **hoofdstuk 4** staat het materiële object *ilizi* centraal. *Ilizi* is doorgaans een zwarte stof met een inhoud, dat op het lichaam wordt gedragen (meestal verborgen), maar kan ook voor een huis worden geplaatst. *Ilizi* wordt zowel voor positieve en negatieve doeleinden ingezet: voor gezondheid en bescherming (zoals van een kind tegen ziekten als *degedege*), of voor andere zaken zoals verkrijgen van macht, of voorkomen dat een rivaal voorspoed kent. De zichtbaarheid en rol van *ilizi* binnen de stedelijke context van Dodoma - met zijn biomedische voorzieningen, onderwijsinstellingen en kerken en moskeeën – geeft inzicht in(schijnbare) tegenstrijdigheden in de narratieven van jongvolwassenen, religieuze leiders en lokale genezers. Ik relateer deze aan drie thema's: tegenslagen, schaamte en geheimhouding, en hekserij. Op basis daarvan stel ik een sociaal denkbeeld (social imaginary) voor met betrekking tot het object *ilizi*. Wijzend op de toegang tot moderne faciliteiten als onderwijs, biomedische zorg, evenals hun religieuze overtuigingen, ontkennen de jongvolwassenen gebruik te maken van *ilizi*, vanwege een vorm van schaamte en geheimhouding. De *waganga wa kienyeji* - de lokale genezers die deze objecten maken - zijn daarom ook vooral te vinden in de buitenwijken van Dodoma. Bovendien zijn Christelijke en Islamitische leiders van mening dat *ilizi* wijst op het geloof in meer dan één god, en wordt gebruik ervan daardoor niet geaccepteerd.

Hoofdstuk 5 introduceert Weber's concept van onttovering en betovering. Volgens Weber vormt de afname van magisch denken en de opkomst van moderne wetenschap een kernproces in de culturele ontwikkeling van moderne samenlevingen. Dit hoofdstuk richt zich op de paradoxale situatie die in Dodoma ontstaat: volwassenen zeggen dat ze geen lokale genezers bezoeken omdat het niet wordt geaccepteerd door hun primaire religie (Christendom of Islam) en omdat ze leven in een moderne wereld, waarin wetenschap en rationaliteit belangrijk zijn. Uit mijn onderzoek blijkt echter dat objecten voor genezing nog steeds aanwezig zijn en lokale genezing wordt gebruikt voor meer dan alleen gezondheid. Ik introduceer in dit hoofdstuk een relationele driehoek van primaire religies (Christendom en Islam), lokale genezers en onderwijs/biomedische zorg, met jongvolwassenen in het centrum. Dit hoofdstuk onderzoekt de verschillende casussen binnen dit spanningsveld en de rol van schaamte, geheimzinnigheid en onttovering daarin.

Hoofdstuk 6 biedt samenvattende argumenten en suggereert toekomstige onderzoeksvragen. De narratieven van jongvolwassenen, lokale genezers en religieuze leiders geven inzicht in de rol van gezondheid en materiële objecten in het dagelijkse leven van jongvolwassenen en hun jonge kinderen. Dit proefschrift toont de spanning tussen onttovering en betovering bij jongvolwassenen: enerzijds een wereldbeeld waarin moderne wetenschap domineert, anderzijds religie en de blijvende aanwezigheid van praktijken rond materiële objecten zoals *ilizi*. Ik beargumenteer daarom dat er sprake is van een gedeeltelijke onttovering onder de jongvolwassenen uit de middenklassen in Dodoma. Moderne voorzieningen op het gebied van onderwijs, biomedische zorg en religie bieden alternatieven voor lokale praktijken, zoals de *waganga wa kienyeji* die *ilizi* maken, maar wissen deze niet volledig uit.

Curriculum Vitae

Gitty Petit (1977, Heerlen) spent part of her early childhood in Mukumu and Kakamega, Kenya, but has lived most of her life in Leiden, the Netherlands. She attended high school at the Bonaventura College (1989-1996) in Leiden. She obtained master's degrees in both Cultural Anthropology (1996-2002) and African Studies (2000-2002) at Leiden University. After her studies, she worked at the National Museum of Ethnology, Leiden University, and the African Studies Centre Leiden.

In 2013, Gitty embarked on a self-financed PhD trajectory at the African Studies Centre Leiden (ASCL), where she was also employed as a Project Manager, assisting and advising researchers on externally financed research projects. During her PhD, she was part of the Graduate Programme in African Studies and contributed to the establishment of the ASCL Collaborative Research Group on health. Additionally, she presented papers at the European Conference on African Studies (ECAS) in 2015 and in 2019, and completed multiple transferable-skills courses on academic writing, communication, and external funding.

Currently, Gitty works at the Leiden Academic Centre for Drug Research (LACDR), Leiden University, as a Finance Specialist for second- and third-stream funding.

Young adults belonging to the middle classes in Dodoma have access to various facilities: education, religion, and healthcare. These facilities all contribute to shaping the social imaginary of young adults regarding their health and that of their young children. As this thesis will demonstrate, multiple narratives emerge around health-related decisions from the perspectives of three focal groups: young adults, religious leaders, and indigenous healers.

While many young adults say they do not use protective or healing objects – such as *ilizi* – due to their religious convictions, higher education, and reliance on biomedical care, this research reveals a more complex reality. Despite their stated positions, some young adults do visit indigenous healers and use such objects. This disjuncture between what is professed and what is practiced forms a central point of contestation explored in this thesis.

By examining these narratives as windows into the everyday lives of young adults and their young children in relation to the issues of education and biomedical care, Islam and Christianity, and indigenous healers, but particularly in relation to health, and by focusing on the role of material objects, the contestation between aspects of disenchantment and enchantment becomes evident. These contestations surface in the narratives and offer an opportunity to reflect on the relations and contradictions between spoken convictions and observable practices, as well as the friction between religious and indigenous practices (the primary religions do not accept indigenous practices such as the use of an object like *ilizi* while knowing it exists). Both the young adults and religious leaders interviewed advocate for education and biomedical care while denouncing the use of objects from indigenous healers, reinforcing a narrative aligned with Weber's concept of disenchantment.

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