Unbefitting healing objects? Relations to health and protection among young middle class adults, indigenous healers and religious leaders in Dodoma, Tanzania

Petit, G.

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.

---

[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.