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

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2.

Young adults in the urban environment of Dodoma

2.1 Introduction

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

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

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

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

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

Photo 2.1 *Muarubaini tree*

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

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

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

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

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

2.2 The middle classes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.3 Mobility and borders

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

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

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

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

2.3.1 Spatial mobility and borders

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2.3.2 Social mobility and boundaries

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

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

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

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

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

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

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

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

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

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

2.3.3 Occupational mobility and borders

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

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

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

2.4 Dodoma

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

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

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

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

Photo 2.2 *Shop selling clothes*

Photo 2.3 *Stalls selling electronics and educational books*


Photos 2.4 and 2.5 *Fruit stands at Majengo market*

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

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

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

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

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[37] Dodoma city.

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

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

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

2.4.1 Occupations

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

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

2.4.2 Religion

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

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

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

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

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

Photo 2.6 *Sunni Mosque Nunge*

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

2.4.3 Education

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

Photo 2.7 *Institute of Rural Development Planning*

Photo 2.8 *University of Dodoma*

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

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

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

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

2.4.4 Health

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

Photo 2.9 *DCMC Hospital*

Photo 2.10 *Signpost at DCMC*

Photo 2.11 *Duka la dawa*

Photo 2.12 *Mobile clinic*

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

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

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

Photo 2.13 *Advertisement on an electricity pole*

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

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

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

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

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

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

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

[41] The Swahili word for healer.

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

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

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

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

2.5 Narratives on pregnancy and young children

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

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

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

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

2.5.1 Becoming or staying pregnant

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

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

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

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

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

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

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

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

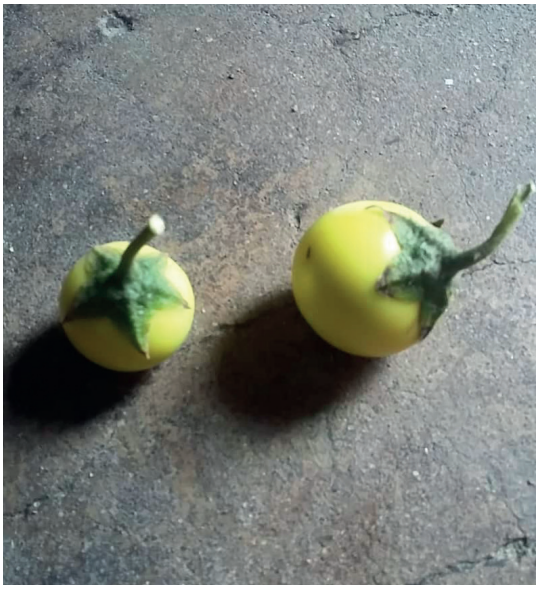

Photo 2.14 *Tula tula plant*

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

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

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

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

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

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

Photo 2.15 *Super Power medicine*

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

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

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

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

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

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

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

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

2.5.2 Miscarriage

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

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

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

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

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

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

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

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

Photo 2.16 *Chamomile leaves*

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

2.5.3 Young children

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

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

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

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

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

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

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

[50] A thick porridge made from corn flour.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other protective objects: Beads

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

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

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

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

Photo 2.17 *Strings of beads at Majengo market*

2.6 Conclusion

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

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

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

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

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

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

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

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

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

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