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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5.

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

5.1 Introduction

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

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

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

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

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

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

5.2 (Dis)enchantment, modernity, and religion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

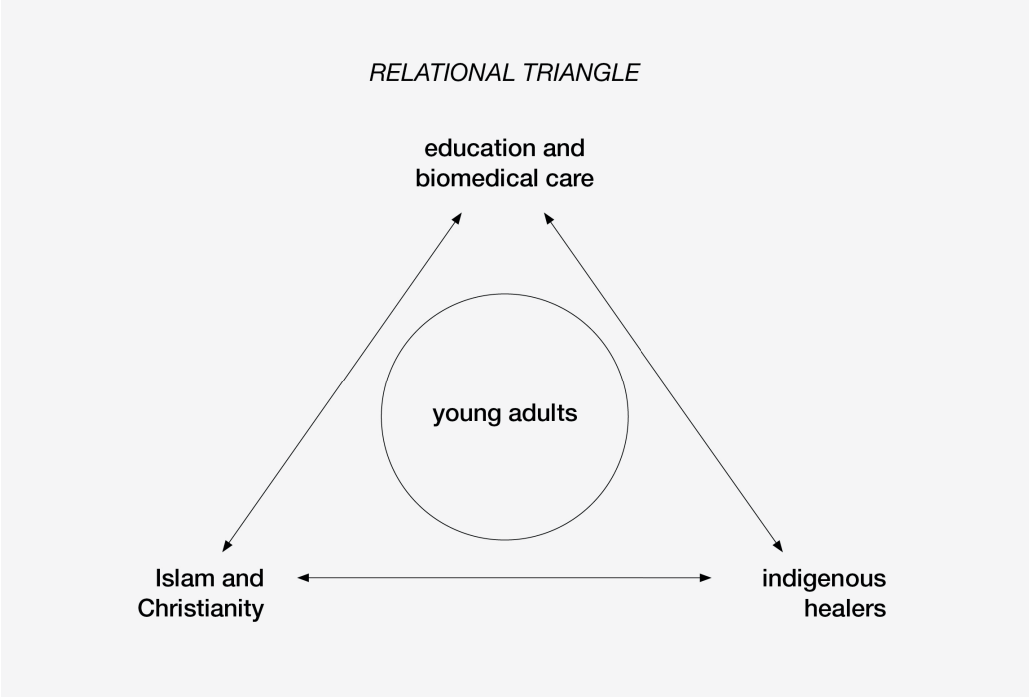

Figure 3 *Relational triangle between education and biomedical care, indigenous healers, and Islam and Christianity*

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

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

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

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

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

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

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

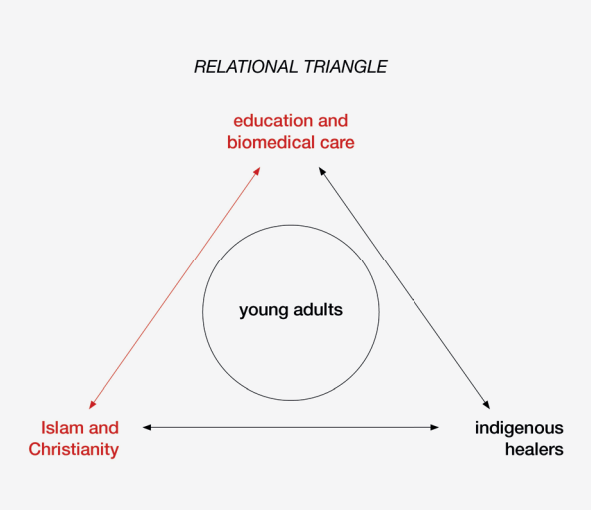

Figure 4 *Relation between education and biomedical care, and Islam and Christianity*

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

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

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

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

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

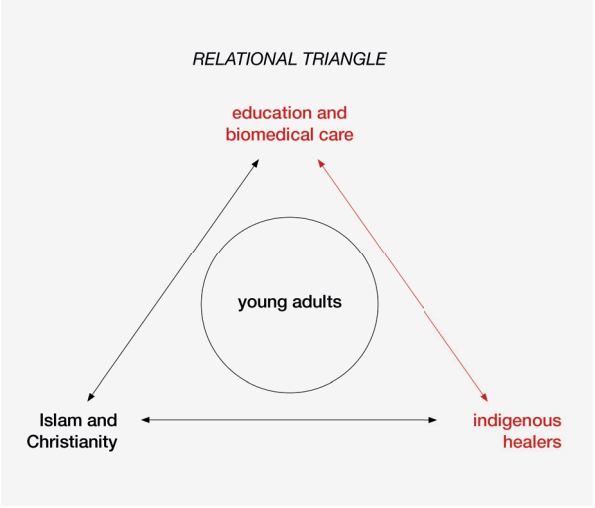

Figure 5 *Relation between education and biomedical care and indigenous healers*

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

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

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

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

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

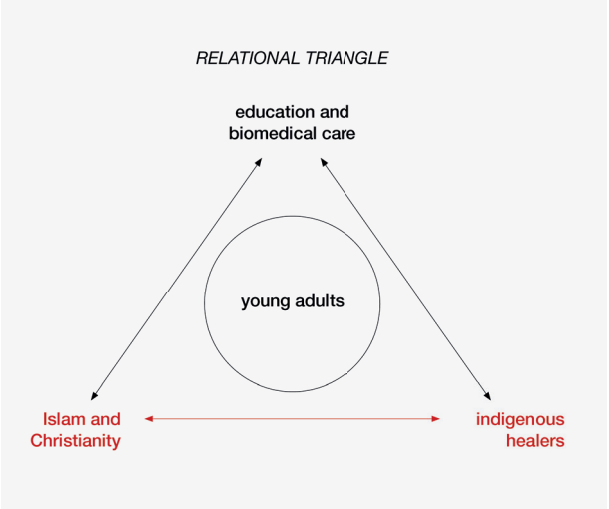

Figure 6 *Relation between indigenous healers and Islam and Christianity*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[110] The literal translation is European tree.

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

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

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

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

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

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

5.3.2 The role of disenchantment in the relational triangle

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

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

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

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

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

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

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

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

5.4 Conclusion

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

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

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

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

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

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

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

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