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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6.

Conclusion

6.1 Introduction

This thesis aimed to answer the following main research question:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.2 *Ilizi* as focal point

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.4 Challenges for further research

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

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

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

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

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

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

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

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

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