

Ageing, Health and Care in Rural Tanzania

Dissertation

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Abstract

The PhD thesis explores what “growing into old age” means for women and men in coastal Tanzania and with whom older people engage in order to ensure care. It responds to a call for more medical anthropology research on care rather than cure and contributes to a small but growing body of ethnographic literature on ageing in Africa.

My study formed part of a larger research project with a rural and urban component. I was responsible for the rural component and conducted field research from 2009 to 2011 in the Rufiji District, more precisely in Ikwe Town and Bumba village. Following the comparative qualitative design of the overall research project, I carried out four complementary and partly overlapping sub-studies, moving from a stakeholder study, to a community study, a household study and finally an age group study. By selecting these two settlements, I wanted to find out whether differences in the types and location of the villages affected the older people’s lived experience of ageing, health and care.

A first finding is that older people in both research sites share a multi-dimensional concept of aging which is rooted in a similar way of life, dominated by the physically demanding tasks of farm work. Age was commonly assessed along six social dimensions: 1) the relative position of juniority/seniority along the life course; 2) the social status; 3) the kinship position; 4) the generational position, 5) the health status; and 6) work and leisure. Of critical importance for the (self-)assessment of old age was the link between the 5th and 6th dimensions, i.e. whether one has or does not have the strength to perform gendered routine activities and responsibilities.

With regard to care, I found that older men and women in both research sites actively engage with a flexible, dynamic and often only partly visible care network. At the

center of this network are socially close kin members, especially spouses, siblings, and children, whether they live nearby or at a geographical distance. Kinship and gender intersected in defining who could provide which type of care. When these relatives are not present or when they require some practical but not intimate or basic livelihood care, the older people negotiate help with neighbours, and in Ikwe Town also with friends and tenants. A notable exception is the *majosti*-relationship between older women in Ikwe which allowed a closeness otherwise reserved for kin.

In both villages, few older people with a serious health problem had a biomedical diagnosis, and more older people in Ikwe Town than in Bumba had contact with professional health care providers. Older people experienced the lack of adequate professional health care services in old age care not just as a practical, technical or financial problem. They questioned the new morality of commodity relations which have begun to replace social relations rooted in kinship and religion.

Most of the older persons who participated in this study faced good and bad days in terms of strength. I often became concerned when I saw them struggle but I also learnt to respect their pride and dignity. Older husbands were proud that they could still provide emotional care and company, and the wives and sisters who stayed with them did their best to provide at least some basic care. Older women who had lost their husband due to separation, divorce or death preferred to have a daughter move in with them, but they pointed out that their children also had to fulfil commitments to their own families. The dwellings and material belongings of many older people in both settlements were often modest, also by local standards. Still, they did not complain and emphasized that they were used to a harsh life since childhood.

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Abbreviations

| | |
|---------|--|
| AMREF | African Medical Research and Education Foundation |
| FGD | Focus Group Discussion |
| HDSS | Health and Demographic Surveillance System |
| NatHREC | National Health Research Ethics Review Sub-Committee |
| NGO | Non-governmental Organization |
| NIMR | National Institute of Medical Research |
| URT | United Republic of Tanzania |
| USD | United State Dollars |
| Yrs | Years |

Part 1 Introduction

In Part 1 of my thesis, I present my analytical point of departure, outline my anthropological approach to aging, clarify my understanding of the key concepts of age, health and care and then review recent anthropological studies on ageing in Africa (Chapter 1). I further provide background information for my study, such as the national policies and previous research on ageing and welfare in Tanzania, the overall research project of which I formed part, the Rufiji District as an administrative and geographical area and my methodological approach (Chapter 2).



Plate 1 Discussing experiences of ageing, health and care in Ikwiriri (Foto by Jana Gerold 2009)

Chapter 1 Theoretical approach and key concepts

1.1 Points of departure

Research on ageing has exploded over the past decades. Population ageing is seen as a major global trend of the 21st century which will transform economies and societies around the world. International organizations celebrate ageing as a triumph of development and emphasize both opportunities as well as challenges associated with the unprecedented growth of the older population worldwide (UNFPA and HAI 2012).

While international organizations increasingly advocate for a balanced view of ageing, emphasizing both opportunities and challenges, much thinking on ageing in science as well as in everyday life is guided by underlying notions of modernization. Very influential was the work of the sociologist Donald Cowgill and the anthropologist Lowell Holmes on “Ageing and Modernization” (1972). Their main argument was that the older adults once enjoyed high status and prestige in most societies, but with the technological advancement of societies, the positive and influential position of the older persons tended to decrease. Moreover, the norms and values that held society together became tested; individualism and nuclear families replaced the extended families. As a result, older people experienced more difficult encounters with less help from their relatives, and the care they received dwindled over time. The work of Cowgill and Holmes spurred a long scientific debate, research designed to prove or disprove its assumptions and the development of alternative perspectives (Street and Parham 2002; Aboderin 2004).

While ageing constitutes a problem to scholars, it does not inevitably do so to the subjects of enquiry, at least not in Africa (Makoni and Stroeken 2002). And even if it does, we are rarely presented

with substantial empirical evidence by the elderly themselves in which they described in their own words how they are experiencing aging, and what it is they understand as problematic experiences. Furthermore, rarely is it made clear whether these problems are peculiar to them irrespective of class, gender, and ethnic differences amongst them. It is important that we get a sense of how aging Africans themselves describe their own conditions in their own terms. (Makoni 2008:201)

As an anthropologist, I fully agree that we need research on older people's experiences of ageing, from their own "emic" perspective. I also concur with his further suggestion that such research should be carried out in the language the older people use in their everyday life in order to get deep insights into how and what they tell us (Makoni 2008:202). What I would add, though, is that such research requires more than a simple recording of "older people's voices". We have to go deeper and study the cultural construction of ageing in particular historical and geographical contexts, as suggested by Jay Sokolovsky (2009c), a pioneer and leading scholar in the anthropology of ageing. Such an approach will most probably show that the "modern versus traditional" trope has also become part of contemporary African vocabularies (Spitulnik 2002) and is commonly used in everyday discourses on ageing. To look behind the "lament discourse" – in scientific and popular discourse – we have to do ethnographic research as well as a theoretically informed analysis and interpretation of the data collected ("emic" perspective). Although African understandings of modernity are not only grounded in the Western modernization discourse (Spitulnik 2002:201), in this case a

link is highly probable, and this illustrates another dimension of anthropological research on ageing. The question here is “how the intersection of culture and globalizing contexts creates increasingly varied ways of experiencing late adulthood” (Sokolovsky 2009b:xviii).

My PhD project draws on the anthropological approach outlined by Sokolovsky (2009c). It uses a constructionist perspective to investigate how older persons themselves experience growing and being old in their everyday engagement with the social world around them. To sharpen our approach we introduce two additional concepts, namely “agency” (van Binsbergen 2007) and “vital conjuncture” (Johnson-Hanks 2002). These two concepts will help us to see how individual older people as social actors confront the realities of ageing, health and care as they unfold in different situations and contexts. Finally, to explore the intersection of “local” and “global” contexts, we will refer to the work on Appadurai (1996) and his notion of global cultural flows. The approach and the concepts will be presented more fully below (Chapter 1.1).

My PhD research, however, is not only interested in older people’s understanding of ageing but in the intimate links between ageing, health and care. Many people age in good health and remain economically and socially active throughout their lives. Others experience physical and cognitive limitations, and some lose the ability to live independently. As outlined above in more general terms, I am particularly concerned about older people’s experiences, in this case in their diverse and varied experience of health, illness, impairment and disability – and the associated care arrangements. Drawing on the classic work of Arthur Kleinman (1980), I am interested in the social and cultural construction of “health problems” and “care activities” in everyday life. Again I present my approach and the key concepts more fully below (Chapter 1.2).

In the last section of this introduction I will briefly review the studies on ageing, health and care in Africa which most inspired my PhD project (Chapter 1.3). Although not all of these studies covered exactly the same topics as my research, there is considerable overlap.

1.2 An anthropological approach to ageing

A social constructionist perspective

My general theoretical orientation can best be described as a social constructionist perspective. Without engaging in the philosophical debates underlying the theory of social construction developed by Berger and Luckman (1971), it seems clear that their approach brings us closer to the actors who are at the centre of our research interest, that is, the older persons themselves. We can approach individual older men and women as “social actors who interpret experiences of everyday life and thereby construct and reconstruct meanings and values in interactions with others, and in particular social and cultural contexts” (Obrist 2006:19). In other words, this perspective helps us to study the process through which meanings are created, negotiated, shared, maintained and even modified.

This approach sharpens our understanding of the lived experience of the older people from an “emic” rather than an “etic” perspective and brings us closer to the real world of the actors. This real world is socially defined through the subjective experience of everyday life (Andrews 2012). Older people, together with other social actors, constantly engage in defining these realities. This is done through interactions of various actors within society. A practice or action that is repeated over time becomes a pattern. This means that the ability of the actors to produce and reproduce different

realities through interaction and communication is enhanced. What once used to be an action becomes habitual, accommodated into routines that result in a reality. This reality becomes part of the everyday reality in the society that is shared during various actors' interactions. Every actor either reaffirms or modifies it according to the social environment to which he or she is exposed. This happens as actors actively rather than passively engage in constructing, maintaining and modifying the underlying norms and values in relation to ageing, health and care as social realities. As Sokolovsky (2009b:xxii) points out, "people are not just passive recipients of culture".

Conversation is crucial in constructing, maintaining, reconstructing and modifying subjective reality (Berger and Luckman 1971). Conversation helps the actors to share and negotiate the risk of redefining the constructed reality every time they interact. Through socialization, the significant others mediate a society's objective reality, render it meaningful, and in this way it is internalized by individuals. Furthermore, through interaction and negotiation, the possibility of confusion from multiple realities that are all meaningful is reduced.

Agency

Human agency that involves actions, or practice, has received little attention in social constructionist debates, although Berger and Luckman correctly illustrated how change is brought on by human activity (Andrews 2012:44). Berger and Luckman did not explicitly mention it, but their emphasis on different ways through which individuals and groups of individuals socially define the social realities can be taken as a base in the human agency discussion. However, human agency remains to be the least focused area

of social constructionism (Burr 1995, in Andrews 2012:44). In contemporary social and political theories, agency has become a central concept.

This PhD thesis refers to the concept of social agency by van Binsbergen (2007), which knits together the actions of the actors not as individuals, but as social beings. We contend that it would be bizarre to try and understand older people as lonely individual actors rather than focusing on different interactions and relations through which they construct their social world. They are not fully autonomous actors. Their deeds are influenced by many other actors in their particular environment. In other words, the agency of older people is shaped by cultural, social and political contexts. Furthermore, their actions reflect the practice of the others in the community in which they live. The process of reinforcement makes their practice social rather than individual.

Therefore, I take van Binsbergen's (2007) approach of agency that emphasizes the role of the social rather than individual actor in trying to understand the different ways through which actors construct social realities. However, this does not imply a denial of the individual actor's capacity to act or reflect; my point is that many other actors are engaged in the construction of the social realities such as ageing, health and care. According to van Binsbergen (2007:17, emphasis in original):

... agency is not so much the coming to life of social structure through actors' concrete social behaviour, but the freedom that actors take, in their interaction, to manoeuvre between the stipulations set by structure, and then agency becomes not so much the enactment, but the denial, the compensation, the improvisation *beyond* structure.

This theorization of agency is favoured for three main reasons. Firstly van Binsbergen moves beyond structural and functional debates. Secondly he draws attention to the

importance of the actors' freedom during interaction and the fact that actors navigate through social space such as the changing cultural landscapes of gender, kinship and family. This shifts the focus from the dependency of older people to their capacity and actions, without over-romanticizing their agency. Thirdly, the conceptualization of the actors' manoeuvrability during the interaction within and beyond structures enhances our understanding of different ways through which social realities are constructed. Underlying structural principles provide a backdrop against which older men and women manoeuvre, for instance, in defining their social status in the community. It is with reference to these structural principles that older people engage in the construction of ageing and health as social realities. They manoeuvre and navigate through these structural principles to suite their particular experience of ageing and health – a process that leads to different kinds of care arrangements. The present study, in other words, does not intend to dwell so much on the structural principles as such but on how older people as social actors manoeuvre through these social structures to define and redefine their ageing and health condition which ultimately results in care. As will be shown, older men and women engage in ever-changing social and family relations. Structural principles such as kinship are not fixed structures or systems. As Miller (2007:536) suggests we think of kinship as “an arena of flexibility, negotiation and experience”.

A similar stance is also evident in Finch and Mason's (1993) work, who also viewed kinship in terms of negotiated relationships rather than structural categories. Paraphrasing Finch and Mason we suggest approaching kinship as a social relationship by studying the practice of different social actors. In other words, we need to investigate what actors do to maintain and modify their relationships.

Following Finch and Mason's approach, this PhD thesis considers kinship as an underlying driving force in providing and receiving care during old age. Our focus is on

everyday practice, on different conducts of the actors rather than on fixed principles. This theorization further implies that we are interested in relations rather than categories. We benefit from this understanding when we examine relations through which older people as social actors evaluate their ageing conditions. Approaching kinship as a process rather than as fixed or normative categories helps us see how kinship ties can be developed, formed but also cut off through everyday practice, as recent writings on kinship suggest (Miller 2007:536).

Vital conjuncture

We would further suggest that ageing, as a social phenomenon, is flexible and not a fixed category. For this reason, we draw on Johnson-Hanks' (2002, 2006) study of motherhood to enhance and enrich the discussion by treating ageing not as a life stage event but as a "vital conjuncture". The concept of vital conjuncture helps us understand better the flexibility during the construction of ageing as a social reality. As Johnson-Hanks (2002:871) has put it: "The analytical concept of the vital conjuncture refers to a socially structured zone of possibility that emerges around specific periods of potential transformation in a life or lives. It is a temporary configuration of possible change, a duration of uncertainty and potential." We will suggest that the concept of vital conjuncture becomes especially useful when examining the intersections of ageing and health. Ageing is experienced differently by different individuals. It becomes contentious when its construction recalls the experience and social environment of the actors involved.

When an individual acts, his/her actions are guided by the prevailing cultural norms and values, which often become the principles that structure the everyday life. However, as

van Binsbergen (2007) illustrated in his work, these principles are not fixed. They are subject to change depending on the actor's ability to manoeuvre and navigate. Furthermore, the actors' actions are not independent; they sometimes reaffirm or contradict the actions of others. This is where sociality comes in: as social actors, individuals consider the moves of others in the social world. Often they do so by using their experience which is recalled to continually construct meanings. This means people as social actors manoeuvre to fit into the newly reconstructed social and structural principles as changes occur. Therefore, older people actively rather than passively engage in the everyday construction of social reality. This social process happens over time, and so their past experience enhances their degree of manoeuvrability. Similarly, past experience gives them the opportunity to construct ageing and health. In other words, they have the capacity to interact and change their social environment that determines who is old, what the meaning of health is, and how care should be provided and received. This resonates with the idea of fluidity in the construction of social categories such as motherhood, adulthood (Johnson-Hanks 2002:866), and we could add old age. Indeed, the idea of fluidity corresponds to van Binsbergen's (2007) idea of flexibility of social actors in his agency approach. Since the structural principles are flexible, the actors' encounter becomes much easier in that they can deny some of these underlying social structures in lending meaning to their social world.

Thus, we may argue that the social status of older people is not static, but fluid, the category being created through experience. This being the case, ageing brings the possibility of actors' creativity when they engage with the social environment and knowledge of past encounters. Similarly, the socialization they have gone through greatly influences how they construct their ageing. Thus, men and women become

engaged in the configuration of new ways of living (health and care) during old age, using their past experiences.

The two approaches, “vital conjunctures” and “social agency”, acknowledge not only time, but also the actors’ degree of manoeuvrability, their choices and capacity to interact and change their social environment. Thus actors become visible. Approaching ageing as a vital conjuncture, as highlighted above, helps us capture the meanings, norms and values that older people create in the construction of ageing. As social researchers our task is to seek and enter the social world and understand these meanings, norms and values. In other words, perceive how older people’s everyday lives intersect with the reality of the cultural setting.

Global cultural flows

It is beyond doubt that global processes are increasingly becoming part and parcel of the everyday life of people, regardless of their locality. Criticizing the anthropological tendency to confine the understanding of social phenomena within a single locality, Appadurai (1996) shifts our attention to the ways in which people, technologies, finance, information and ideology flow globally through diverse relations and interactions. Through these flows, he suggests, new relationships between different actors at different levels became possible. In the past, cultural transactions between social groups were generally restricted due to mere physical and ecological reasons, but also because of active resistance to interactions with other foreign social actors (Appadurai 1996:27). However, with today’s modern means of communication and media technology, the nature of global relations has become flexible. The physical and ecological obstacles became less relevant where social spaces bridged the existing gaps

(Appadurai 1996:28). Sharing between people, technologies, finance, information and ideology became possible and much quicker. In other words, the interaction and integration between and among people in different locations became real and active. Suddenly, there was much interconnectedness and sharing of ideas and information.

Appadurai (1996:27-47) used the term “disjuncture” to show different dimensions of global cultural flows and to challenge the territorially fixed ways of treating social actors. Those who engage in the phenomena become connected and their social interaction as well as dis-interaction is strengthened through the process of transforming global flows of meaning with the locals. Being located in different physical spaces, such as beyond (diaspora) as well as within (regional and district) country boundaries, the flows enable people to engage and establish diverse bonds and links. This process of globalizing and localizing or homogenizing and heterogenizing is complementary rather than distractive.

We are interested in Appadurai’s idea of global flow because it helps us to examine the relations between different actors who engage with ageing, health and care. The focus here is particularly on the macro-level in terms of shaping policy and regulations pertaining to ageing, health and care. Actors who share an interest in these matters become connected. They team up, utilize resources, technology, information and ideas about ageing, health and care in different locations. They exchange ideas that flow through these global relations, interact beyond and within national boundaries and thus become engaged in globalizing and localizing ideas and practices relating to the addressed concerns. This process is not smooth, and often tense debates and negotiations occur between and among actors before midway consensus is reached by those involved in the process. We note, in other words, a tension between cultural homogenization and cultural heterogenization (Appadurai 1996:32).

1.3 The social experience of ageing, health and care

From its beginnings, anthropological research on ageing has been sensitive to health aspects (Clark 1967; Clark and Anderson 1980), and in medical anthropology the interest in ageing and health has been steadily growing (Hurwicz 1995; Sokolovsky 2004; Helman 2007). Some anthropologists have contributed to the interdisciplinary field of cross-cultural gerontology, others have remained critical of what they see as a medicalization of old age (Cohen 1994; Helman 2007:8-12). Ethnographies on local perceptions and experience of health in old age are still few (e.g. Cohen 1998; Livingston 2003; van Eeuwijk 2003a, 2003b, 2006, 2012). As stated above, this PhD thesis attempts to contribute to this literature by emphasizing the links between ageing, health and care from the perspective of older men and women themselves. In approaching these abstract concepts in the field, we have been inspired by the following anthropological considerations.

Ageing

As the anthropologist Christine Fry (2007) has pointed out, age is “one of the most challenging phenomena to investigate simply because it is a temporal phenomenon”. Age is influenced by interrelated change along multiple dimensions. Age has a biological dimension because all human beings move from birth to death. At the same time age has social dimensions which organize how people move from birth to death in a given society. These “social clocks” (Fry 2007) may be related to work, education and leisure, but also to marriage, family and kinship or to community affairs and spiritual affairs. These social clocks are operating at the same time but not necessarily in accordance with each other, both in real and normative terms.

Which temporal structuring of ageing is relevant in our study sites will be explored along these and other dimensions. There is only one way to learn what ageing means for the older people in our study: we have to listen to what they say about it, either in response to direct questions or in spontaneous comments they make about each other, and to observe how these meanings translate into practice.

Health

It can be argued that health assumes a special meaning in old age. We feel more vulnerable than in younger years because we notice changes in our body and mind, face all sorts of health problems and become aware that the end of life is drawing closer. Recent research, also in non-Western societies, has been directed at a better understanding of old age vulnerability (Schröder-Butterfill and Marianti 2006; van Eeuwijk 2006). Such a perspective emphasizes interactions between advantages and disadvantages accumulated over the life course and the experience of threats in later life. Moreover, it acknowledges that the outcome of these interactions depends on the adequacy of the person's coping resources (Schröder-Butterfill and Marianti 2006:28-29).

In line with my general approach, I am particularly interested in how older people experience vulnerability and health in their everyday lives. I will thus draw on the old age vulnerability studies and on a study in Tanzania which explicitly focused on the experience of health in everyday life (Obrist et al. 2003; Obrist 2006). The latter examined what health (*afya* in Kiswahili) meant to coastal women aged 20 to 40 years in the Dar es Salaam, the largest city and commercial centre of Tanzania. My thesis investigates meanings of health among women and men aged 60+ in a rural town and a

remote village of Rufiji District. The age of 60+ was taken as a cut-off point to align our research with policy interests in Tanzania, but we shall take prior biographical histories into account.

Following Obrist's example (2006:30), we focus on how older people explain their health condition (*hali ya afya* in Kiswahili), and what it takes to produce, maintain or even lose health from their point of view. The analytical interest is thus not only on illness as a negative notion of health, but also on local conceptualizations of "good health" (*afya nzuri*) and the stages in between. Paraphrasing Obrist (2006:43) I further suggest that older people as individuals produce and reproduce the social experience of health in daily practice. By using her phrase "health practice" we emphasize that meanings of health are rooted partly in enacted knowledge, partly in discursive knowledge. By asking older people about health, we make them reflect and talk about shared meanings and understandings of health.

As we will show, older people's notions of health are closely connected with their notions of ageing, and vice versa. Treating health and ageing as separate dimensions of social reality blinds us from seeing how older people use their health experience in constructing the meaning of old age.

Care

Care is considered a natural part of life, yet is shaped by many debates (Phillips 2007). Political feminists and feminist researchers are acknowledged as the driving force behind a critical reconsideration of the concept of care. Through debates and research, they pushed for a new emphasis on the welfare and care work of women in everyday life (Waerness 2001). However, the effect of their efforts is felt more in the West than

in countries such as Tanzania, where care is still under-studied (Juntunen 2001; Meena 2009). Moreover, the findings of studies on care in the Northern hemisphere cannot be simply transferred to countries of the South (Niehof 2002; de Jong et al. 2005).

Care can have various shades of meanings, depending on who defines it and in what context (Kleinman and van der Geest 2009). As Tronto (1993:103) has observed “the activity of caring is largely defined culturally, and will vary among different cultures.” In line with our approach to ageing and health as a social engagement in everyday life, we shall try to figure out what care means in our study area “by listening to those who are directly involved in it and by observing their actions” (van der Geest 2002:9).

Even in the United States, care work is largely an affair of family, friends and neighbours (Kleinman 2009:293). In a pioneer study on old age vulnerability, close family members were also the main care givers (van Eeuwijk 2006:61). Carried out in Indonesia, the study found that older people suffering from impairments or chronic illness mainly relied on close family members, most often a wife and/or a daughter, for help with “activities of daily living” and therapies for specific illnesses. Similar findings have been reported from Ghana (van der Geest 2002:9). Kin by marriage or descent were mainly responsible for care. The most common care activities, i.e. activities for which older people needed the help of others, included: getting food, taking a bath, washing clothes, and going to the toilet. Other indispensable tokens of care were helping them financially and providing company. Perhaps the most important type of care was the organization of a fitting funeral when the elder died.

This brings us to an additional aspect of care: its relational dimension. As Pols (2004:154) has argued:

[T]he notion of relationality in care-practices incorporates a specific understanding of care-practice and a specific way of conceptualizing good care and improvement. Good care cannot be established at one point in time, once and for all. Practices are never perfect, but are under constant construction. And the patients, likewise, are never finished, but have to live with ups and downs. Changing situations, different patients and unexpected problems in care over time need flexibility and an ongoing development and adjustment of notions of good care.

From a relational perspective this means that care givers and care receivers are both part of the social construction in daily interaction. Or, in other words, old age care is created through daily social practices, relationships and interactions between and among actors. An older person as an actor negotiates care through the relationships he or she has. By doing so, he or she constantly interprets the social world. Furthermore, he or she shares ideas about care with others while, at the same time, receiving ideas from others. This reciprocal process of sharing emphasizes the emerging or evolving nature of care.

By focusing on social engagement, we can broaden our understanding of cultural meanings and social relationships through which care is provided and received. Indeed, this approach takes us back to what we mentioned before, namely that the conceptualization of ageing, health and care as social phenomena requires theoretical underpinnings that recognize the flexibility, fluidity, manoeuvrability and even the capacity of actors to navigate. Even if we analyse care as a practice that is shaped through structural principles such as kinship and gender, we are not bound to believe that these are fixed social categories.

Finally, we should bear in mind that older people often face a “triangle of uncertainty” that has social, economic and health dimensions (van Eeuwijk 2006). They cannot

count on the fact that kinship obligations will be fulfilled, that material and financial support will be provided or that they can enjoy good health until they die. On the contrary, the question we shall have to investigate is whether and how appropriate elder care can be provided “under circumstances of unreliable social networks, economic constraints, a steady increase in the number of chronically ill older people, and wholly inadequate formal welfare services” (van Eeuwijk 2006:63).

1.4 Anthropological studies on ageing, health and care in Africa¹

Over the past twenty years, several anthropological studies have examined the relevance of changing kinship relations for ageing, health and care in Africa. In Ghana, Nana Apt (1996) – a pioneer in research on ageing in Africa – conducted a rural urban study among the Fante (an Akan group) in 1988. Although guided by a modernization perspective, Apt was particularly interested in how older people were coping with old age in a rapidly changing cultural context. Her study documents the persistence of multi-generational households in rural and urban areas: Only 12 percent of the older study participants were living without relations and only 10 percent with maids. To secure support, women had developed at least three strategies: 1) transferring trade interests to the younger daughters, expecting care in return; 2) leasing domestic space to create income and secure services from relatives and non-relatives, and 3) offering child care services: men continue to have children by marrying younger wives, while women share space with the infants and children of their children and foster grandchildren (Apt

¹ In this PhD thesis we concentrate on developing an anthropological perspective on ageing, health and care in the study area, although we are aware of ongoing interdisciplinary policy research in this field (see e.g. Aboderin 2004a, 2004b; Apt 2005; Ferreira 2005; Cohen and Menken 2006; Aboderin 2010; Maharaj 2013).

1996:73, 87-95). Although the kinship network had shrunk, the older adults were socially active and very much involved in family relations, especially with “young” children (aged 15-39 years) and grandchildren. In fact, many of the children who stayed with them, also the adult children, were actually dependent on the older generation (Apt 1996:78-79). Older people reported participating in communal activities and duties, 60 percent in urban and 54 percent in rural areas (Apt 1996:81). The livelihood of the older persons depended on the rent of rooms, remittances and continued earning. Many of them were not able to meet their economic requirements adequately, but older adults in rural areas were better off than those living in urban areas due to the cash crop cacao and landed property (Apt 1996:100).

Also in Ghana, Sjaak van der Geest conducted research on kinship since the 1970s and on social and cultural meanings of old age since 1994, in the same rural town Kwahu-Tafo (van der Geest 2001, 2002, 2009, 2012; van der Geest and Sadler 2010). Much of his thinking about old age in this Akan society circled around respect and reciprocity, two core symbols in the lives of older people which take a central position in accounts of care and lack of care (van der Geest 2002). He found that both kinship by descent and by marriage matters in old age care and that children are considered as the ones who should take care of the parents when they grow old (van der Geest 2002:18-21). In real life, there was a kaleidoscope of care arrangements. A certain pattern which he could discern is that old men were usually cared for by their wife as long as possible. If she was no longer able and/or willing to do so, the children took over, sometimes by sending the grandchildren. In those few cases where no wife and no (grand)child was able/or and willing to care for the old man, other relatives moved in. However, since the older people commonly lived in their own house or in the house of the children, other relatives needed a permission to stay as part of the care arrangement (van der Geest

2002:24). Underlying these care arrangements was a logic of respect and reciprocity. The deeper meaning of respect in this Akan society was to care, i.e. to do all the things that an older person could no longer perform. Whether older adults got help in good quality and quantity depended very much on how they were regarded by others, including wives and children. A “silent book keeping” was going on, even within the nuclear family. Those who had worked very hard and taken good care of others, their children, their partners and other relatives would receive care. “The guarantee of care at old age is [thus] foremost a matter of reciprocity” (van der Geest 2002:28).

In Burkina Faso, a Swiss-Burkina Bé research team carried out extensive ethnographic studies on social security in a rural and an urban area from 2000-2002 Badini-Kinda (2005; de Jong et al. 2005; Roth 2005; Roth and de Jong 2005; Badini-Kinda and Roth 2007; Roth 2008, 2012). They found that kinship by descent and by marriage were the most important social security relationships in old age. Based on an “implicit contract” (Cattell 1997:159), children were the only relatives by descent who had an obligation to take care of their ageing parents’ livelihood, but what formerly exclusively applied to sons nowadays included daughters as well (Roth 2005:124). Marriage was a source of security, as long as enough resources were available, both the man and woman fulfilled their obligations and collaborated with one another (Roth 2005:128). In Kuila village these social security relationships still worked out for 90% of the older people, while in the Koko neighbourhood of Bobo-Dioulasso the situation was less clear and sometimes even reversed: one older man or woman out of two had to financially sustain his or her children, and maybe even grandchildren. Roth and de Jong (2005:168) attributed differences in kinship practices between the rural and the urban area mainly in terms of different impacts of the persistent economic crisis. In the rural area, the older men still owned land which gave them authority, while in the city, they had lost this possibility.

The adult children now earned their livelihood independently from their parents thus allowing them to negotiate the intergenerational power relationship. Social security in the city was thus increasingly based on a social network of relationships among relatives, friends, neighbours, members of religious congregations and social associations (Roth 2005:107). However, in the village as well as in the city, lacking resources placed narrow limits on kin and non-kin relations which caused conflict and tensions (Roth and de Jong 2005:169).

Several studies in Tanzania have examined how changes in the political economy have impacted on old age and care relationships in times of HIV/AIDS. Several studies were conducted by lecturers of the Department of Sociology at the University of Dar es Salaam. Reviewing some of these studies, Mwami (1998-2001) argued that colonialism undermined kinship relations which used to be the bedrock of the security system in the olden times and imposed new commodity relations in their place. These combined processes led to an unprecedented upheaval in the social fabric in these societies and were the root causes of the plight of the older people in rural and urban areas. In his study of witch killings among the Sukuma, Mesaki (2009) showed that older women were the main targets (Mesaki 2009:79), but not because of “tradition”, rather due to several interrelated and underlying causes which led to increased anxiety, fear and distrust in the face of poor governance.

The German anthropologist Dilger (2010) conducted research on the everyday experience of HIV/AIDS in Dar es Salaam and rural Mara. He argued that the field of HIV/AIDS-related caring and nursing in Tanzania has been structured, on one hand, by the broader forces of an internationalization and privatization of health care, on the other hand, by acts of caring and nursing by people who do not have access to – or refuse to use – selectively established services. Since many Tanzanians have

consequently developed a sense of their government's limited ability to control the living conditions of the people on a daily basis, they have looked for help in kinship networks or religious congregations in urban centres. He shows in much detail how "relationships of care [...] are embedded in a complex web of processes and meanings that tie kinship conflicts to the dynamics of rural-urban migration, the political economy of healthcare and the massive social and moral pressures that are exerted on individuals, lineages and whole communities by the HIV/AIDS epidemic in Tanzania" (Dilger 2010:106).

Research on ageing has also a long history in Southern Africa, especially in South Africa (Apt 2005; Ferreira 2005). Of particular interest to my research was a study in Botswana. From 1996-1999 Julie Livingston (2003) explored changes in the negotiation of female old age associated with the increase of the life span and non-communicable diseases in urban and rural areas. She argues that the "normal" physiology and social position of older women have changed. Chronic illness is increasingly seen as part of "normal" old age, as is the lack of socio-economic and cultural power to command care.

1.5 Overview of the thesis

The aim of this thesis is to contribute to the small but growing body of literature on ageing, health and care in Africa from the perspective of medical anthropology, guided by a loose framework formed by the key concepts outlined above. The next chapter sets the scene for the current study. It starts from the notion of traveling ideas and practices and briefly reviews policies and research on ageing and welfare in Tanzania. It then narrows the focus and situates the current study in the larger anthropological research project of which it formed part and outlines the design of this project. The next section

zooms in on the rural research site of the current study and introduces the Rufiji District, located in the South of Dar es Salaam, on the coast of the Indian Ocean. I then present my ethnographic approach, reflect on some specific challenges of doing research on older people and address some ethical considerations.

Part 2 of my thesis examines what it means to grow old in Rufiji at this particular point in history. My particular interest here is on the links between ageing and health. Following the design of my study, I present my findings separately for Ikwe Town (Chapter 3) and Bumba (Chapter 4) but follow a similar outline. First, I take a closer look at the social dimensions of ageing and old age, paying special attention to intra- and intergenerational relationships, forms of address and social status. Secondly, I explore how people experience health in old age, introduce the concept of “critical health moments” and show how central the pathways from “having strength” to “not having strength” are in the social construction of ageing and health. To provide deeper insights, I illustrate each pathway with a case study. In the conclusions I compare my findings across the two study sites.

In Part 3, the analytical focus shifts to older people’s care negotiations in everyday life. I will show that older women and men need – but also give – care. Again I separate the presentations of my findings from Ikwe Town (Chapter 5) and from Bumba (Chapter 6) to allow for a comparison. Taking the concept of “critical health moments” as a starting point, I investigate what happens in these moments. This approach allows us to follow care practice in action, from its inception, through concrete activities of helping to the restoration of the routine or an adjustment. Beginning “at home” where care is practiced face-to-face, I gradually move outwards to those who are engaged in care but live in other parts of the same village, and finally to those who contribute from far.

Part 4 presents a summary view of my conclusions on ageing, health and care in Rufiji. I argue that the older people in Ikwe Town and in Bumba share multi-dimensional concept of ageing. Their concept resonates with the notion of a vital conjuncture suggested by Johnson-Hanks (2002, 2006). With regard to care, I argue that older people in both research sites actively engage with a flexible, dynamic and partly invisible care network. At the core of this network are close kin; they are responsible for the fulfillment of at least basic needs and especially for intimate care. In Ikwe Town, older people increasingly negotiate care with neighbours, friends and tenants as well as professional health care providers.

Chapter 2 Setting the Scene: Projects, Places and People

Drawing on ideas about traveling ideas and practices outlined in the first chapter, the second chapter briefly reviews policies and research on ageing and welfare in Tanzania. It then narrows the focus and situates the current study in the larger anthropological research project of which it formed part and outlines the design of this project. The next section zooms in on the rural research site of the current study and introduces the Rufiji District which is located in the South of Dar es Salaam, on the coast of the Indian Ocean. I then present my ethnographic approach and reflect on some specific challenges of doing research on older people.

2.1 Policies and research on ageing and welfare in Tanzania

Over the past decades, Africa has witnessed how global cultural flows have linked several actors and integrated them into global relations through the development of ageing policies. This has also been the case in Tanzania (United Republic of Tanzania 2003). At the start, the government of Tanzania faced a lack of resources such as finance, skilled personnel and information, and received support from the global community through the Public-Private Partnership Programme. Together with private and non-governmental organizations the government set up a platform for debates on ageing issues. These organizations helped with funding for the preparatory meetings, workshop discussions and for government representatives to attend internationally organized ageing-related meetings. The Tanzanian government, with the help of HelpAge International Tanzania, thus became gradually linked to the global community that aims at “building a society for all ages”, as the Second World Assembly on Ageing 2002 in Madrid propagated. Tanzania not only participated in the Second World

Assembly, it signed the Madrid International Action Plan on Ageing and was the first African country after Mauritius to come up with its own Ageing Policy in 2003.

Since then, the implementation of the Ageing Policy has become a crosscutting issue involving both central and local government authorities (United Republic of Tanzania 2003; also interview with the social welfare officer). The central government is responsible for the coordination of ageing-related issues, and local governments for screening who is defined as old and for ensuring their care. Social welfare officers have been assigned to supervise these activities and to oversee the welfare of the older people. There is a director of social welfare at the national level and officers at both the regional and district levels. The issues relating to the older people are communicated and channelled through these links. Other social actors are also involved in the process, especially voluntary agencies. At the lowest levels, villages and families are expected to link up with the government organization and voluntary agencies.

To further improve the welfare of older persons in Tanzania, another initiative has recently been implemented through the Public-Private Partnership Public-Private Partnership Programme. The Ministry of Labour, Employment and Youth Development, in partnership with HelpAge International Tanzania, conducted a feasibility study on a universal social pension for all the older people in the country. The aim is to “achieve income security in old age for all Tanzanians” (Ministry of Labour and Employment and Youth Development Tanzania 2010). This work was funded by the global community, whereby the idea was to incorporate elderly people’s issues into the National Strategy for Growth and Reduction of Poverty (MKUKUTA).

As social scientists we are part of the social world and thus are also influenced by the global flow of ideas. Many social scientists who have worked in Tanzania have engaged

in debates about social welfare and social security (Mwami 1998; Mchomvu et al. 1998)), paid or unpaid care work (Budlender 2008; Meena 2009) or social protection (Spitzer et al. 2009; Mboghoina and Osberg 2010; Spitzer and Mabeyo 2012). Through their publications, they inform policy makers and implementers beyond and within the country's borders. Their orientation towards development and policy-oriented debates helps global debates, and ideas take root in local contexts. They provide a forum for global connectedness. As they travel, attend conferences, read local as well as international publications, they are not only connected but informed on the flow of ideas across the globe. Through technology and the media they are informed about on-going debates and ideas about ageing, health and care. Often, either through research or consultancies, they write policy briefs and attend or even lead workshops or conferences. They provide a forum for spreading these ideas to the local level, leading to further ideational transformations.

Feminist movements and perspectives, for instance, have dominated care studies focused on the role or position of women. This can be seen in Meena's (2009) work on paid care workers in Tanzania, where she focused on the description of nurses and home-based caregivers. Although the influence of Meena's research on other actors could not be ascertained, one could say she shared her work. Through sharing she could have influenced many other actors. The fact that the work was commissioned and funded by the United Nations reveals not only the global relationship but also how her ideas on paid and unpaid care workers were dominated by the field of HIV and AIDS.

2.2 Project framework and design

The study presented here was part of an independent research project "From 'Cure to Care' among the Elderly. Old-Age Vulnerability in Tanzania" (2008–2011) headed by

Dr. Peter van Eeuwijk and supported by Prof. Dr. Brigit Obrist, both from the Institute of Social Anthropology of the University of Basel, Switzerland. Their Tanzanian counterparts were Dr Joyce Nyoni from the Department of Sociology/Anthropology of the University of Dar es Salaam as well as Dr Flora Kessy and Dr Honorati Masanja from the Ifakara Health Institute in Dar es Salaam.

The research project was funded by the Swiss National Science Foundation.² It obtained the ethical clearance from the Ifakara Health Institute and from the National Health Research Ethics Review Sub-Committee, a sub-committee of the Medical Research Coordinating Committee of the National Institute for Medical Research (NIMR)³ and the research permit from the Tanzania Commission for Science and Technology (COSTECH)⁴. Ethical clearance is required for health-related research in Tanzania in order to safeguard the dignity, rights, safety and wellbeing of all study participants and communities (National Institute of Medical Research 2014). This is of particular relevance for studies on groups which the government regards as vulnerable, and this includes older persons.

The objectives of the research project served as a broad framework for two tandem PhD studies in a rural area (Rufiji District in Pwani Region) and an urban area (Mbagala Ward of Dar es Salaam) in Tanzania. The first was conducted by myself; the second one by my colleague Jana Gerold (Gerold 2012, 2013, 2014).

² Swiss National Science Foundation Project-No. 100012-117857.

³ NIMR Clearance Nos. NIMR/HQ/R.8a/Vol.IX/137 and NIMR/HQ/R.8c/Vol.II/266.

⁴ COSTECH Permit-Nos. 2009-185-NA-2009-76 and 2010-299-ER-2009-76.

The objectives of the overall project, adapted from the original proposal (van Eeuwijk 2007) during the initial research phase, were:

1. To investigate how old people perceive, judge and represent “old age” and their ageing process.
2. To identify the household composition and dynamics of care relationships of old persons in relation to their social, economic and cultural environments.
3. To explore the significance of rural-urban relationships for households with old persons.
4. To find out the roles and burden of older caregivers.
5. To examine the nature and priority of care improvements for old persons from the points of view of caregivers and receivers.
6. To study the mobilization of resources by old persons and the capacities that strengthen their resilience.

In order to reach these objectives, both PhD projects included a set of coordinated sub-studies: 1) a stakeholder study, 2) a community study, 3) a household study and 4) an age group study. The four sub-studies were complementary and partly overlapping, as will outlined in the next paragraphs.

For the stakeholder study we identified international, national, regional and local key actors who worked in public institutions and private organizations on the improvement of health and social welfare of old persons. These included, for instance, HelpAge International Tanzania, Sight Savers International, AMREF, the Social Welfare Department, health facilities, local governments and community leaders. After mapping

these stakeholders, we arranged meetings and conducted in-depth interviews on specific issues, for instance, challenges in implementing the National Ageing Policy. With some of the stakeholders we kept in touch over the whole course of the research period and regularly reported to and exchanged with them.

Through the community study we gained a general overview of the rural and urban research sites. Topics covered included the history and ethnography of the area, the availability of health and social services, population statistics, environmental zones as well as geographical and administrative divisions. These topics were discussed with key informants and in focus group discussions with women and men of different age categories. Questions which evolved from the household and age group studies were also brought up for clarification in key informant interviews and focus groups.

The aim of the third study was to collect systematic information on 150 households in the rural and urban research sites, respectively. The selection criteria were that at least one person over 60 years of age lived in the household. For both PhD studies, a semi-structured interview guide was developed which concentrated on household composition and the division of responsibilities between the household members. Using a semi-structured interview guideline, we noted down the names of all the household members, their age, sex, marital status, religion and ethnic group, and then explored the relations between them. We then asked about the responsibilities of each household member in daily health practices, such as cooking, fetching water, washing dishes, washing clothes, taking care of the sick. Zooming in on the older person, we inquired into her/his health condition, the kind of care she/he receives, from whom and where these caregivers lived. We also specifically explored whether older persons acted as caregivers.

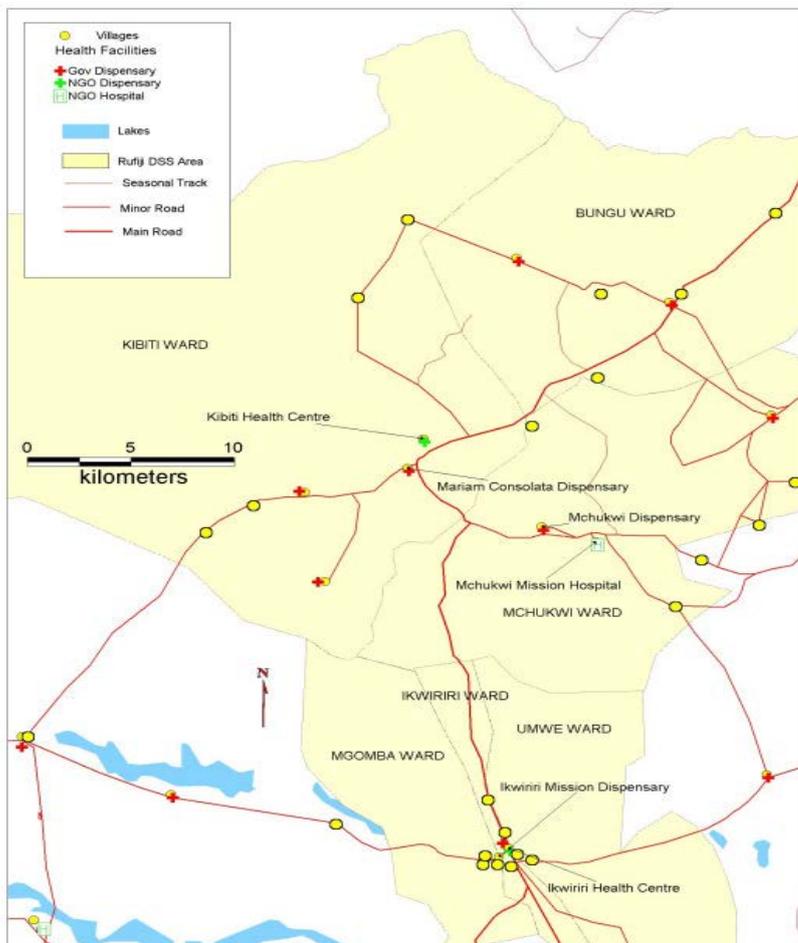
For the age-group study, we planned to draw a sub-sample of 75 old persons each in the rural and urban research sites for a follow-up over six months. This part of the research zoomed in on the everyday experience of the older people in the natural flow of life. The research team repeatedly visited these older persons and were thus able to study the dynamic relations of ageing and health as well as changing care relationships. During these extended visits, trust between the research team and the study participants was built up, enabling deeper insights into the real concerns of the older people men and women and of their caregivers.

2.3 Rufiji District: The rural research site

The Swiss-Tanzanian leaders of the research project selected the Rufiji District (see Map 1) as the rural research site because it had a particularly high proportion of older persons. This had been documented by the Rufiji Health and Demographic Surveillance System (HDSS) of the Ifakara Health Institute with headquarters in Dar es Salaam. The Rufiji HDSS was established in 1998 and tracks health, demographic and mortality events in 31 villages (Mwageni et al. 2002). The HDSS data showed that 11.5 per cent of the covered district population are over 60 years of age (average according to the National Census of 2007: 5.1 per cent) and that the average life expectancy at birth is estimated to be five years higher than the national average (van Eeuwijk 2007).



Map 1 The Rufiji District in Tanzania and the area covered by the Health and Demographic Surveillance System (Source: Mwageni et. al. 2002)



Map 2 Sampled health facilities in the Rufiji HDSS area (Map by STI and TEHIP 2008)

The Rufiji District is located about 178 kilometres south of Dar es Salaam. Together with Bagamoyo, Kibaha, Kisarawe, Mafia and Mkuranga districts it forms the Pwani (or Coastal) Region of Tanzania. The Rufiji District covers about 14,500 square kilometres and has six registered divisions, nineteen wards, ninety-four villages and 385 hamlets (United Republic of Tanzania 1992). By 2004, the district population had access to 57 formal health facilities: two hospitals, five health centres with in-patient facilities and 50 outpatient dispensaries (see Map 2). Over-the-counter drugs were available from many private shops and kiosks in the villages. People also obtained services from traditional healers including traditional birth attendants (de Savigny et al. 2004). Situated in the floodplains of the Rufiji River and its wide delta, the area is known for its fertility.

The Warufiji (people of the Rufiji River), as they are commonly referred to, consist of several ethnic groups (Hoag 2003:23-24). The Ndengereko form the largest group and are thought to be the original dwellers in the area. Other groups include the Matumbi, Nyagatwa (mainly in the delta), Ngindo, Pogoro, Makonde, Zaramo and Hehe. Over the past years, people from many parts of the country have migrated into the area (Bryceson 1995). While the Warufiji sometimes claim ethno-linguistic distinctions, they more often refer to a shared identity based on making a livelihood in a riverine environment (Hoag 2003:24). Most Warufiji are Muslims and are conversant with Kiswahili and the loosely defined coastal Swahili culture.

In 2011, 30% of the men above 7 years were farmers, 15% self-employed, mainly small scale traders, 36% were pupils and 4% were unemployed. For women aged 7 years or above, 45% were farmers, 6% small scale traders, 31% were students and 4% unemployed (INDEPTH Network 2011).

Agricultural success in the floodplain depends on flooding and rainfall, both of which are highly unpredictable (Hoag 2003:26-37). In a good year, the area experiences two wet seasons a year, with short rains starting in October/November and long rains between February/March and May/June. The failure of either of the two seasons often translates into crop failure. High flooding, on the other hand, may also induce famines (Hoag 2003:31). Floods are so central to the agricultural success that farmers recollect their history by referencing certain floods in the past. In my PhD study, the older persons often referred to floods when defining their age. In response to the high variability and insecurity of their environment, the Warufiji have developed an elaborate agricultural system which utilizes the fertile soils of the floodplain for the cultivation of maize and rice, and the poorer soils of the elevated hill regions for maize (Hoag 2003:33-36). Men and women of all ages participate in agricultural production, based on a gendered division of labour. During the flood season, farmers live near their rice paddies to protect the plants from wild animals such as elephants, hippopotami, monkeys, locusts and other insects. They stay in shelters built on stilts (*dungu*) and traverse the inundated areas by the way of dugout canoes.

Agriculture in the Rufiji Delta is similar to that of the floodplain, but the tidal fluctuations rather than the annual floods are the most important component in regulating the cultivation cycle (Hoag 2003:38-41). In the low-lying areas, farmers plant millet, maize, rice, cassava, cowpeas and cotton, on the higher lands coconut trees, and along the riverbanks tomatoes, pumpkins and tobacco. Since the Rufiji Delta is the largest mangrove swamp in Tanzania, men have long harvested mangrove poles for local use as well as for shipment to Zanzibar, from where it is exported to Southern Arabia and the Persian Gulf.

During the 1950s and 1960s, foreign scientists began exploring the economic development potential of the Rufiji River (Hoag 2003:87). In addition to the building of dams upriver, they suggested large irrigation schemes in the floodplains, once the river was under control. In 1962 and again in 1968, the flooding of the Rufiji was especially heavy and long (Hoag 2003:129-130, Chapter 4). The government under the newly elected Prime Minister Julius Nyerere assumed responsibility for coping with the famine caused by the 1962 flood but since the now independent nation did not have sufficient means, Tanzania had to accept 400 tons of food from the United States (Havnevik 1993:113). In 1968, the Tanzanian government sent aid from Dar es Salaam, but under one condition: to solve the problem of the Rufiji floods and associated famines once and for all through Operation Rufiji, the localized version of the forced “villagization” of the *Ujamaa* Period⁵. The government ordered all residents in the upstream area to relocate to new settlements along the north and south banks of the river (Hoag 2003:130-31). In 1974, when another flood hit farmers who had remained in the floodplain, the government ordered their resettlement in what has come to be known as “Operation *Pwani*”. Even residents of the delta who had in fact benefited from the large floods were ordered to leave their villages.

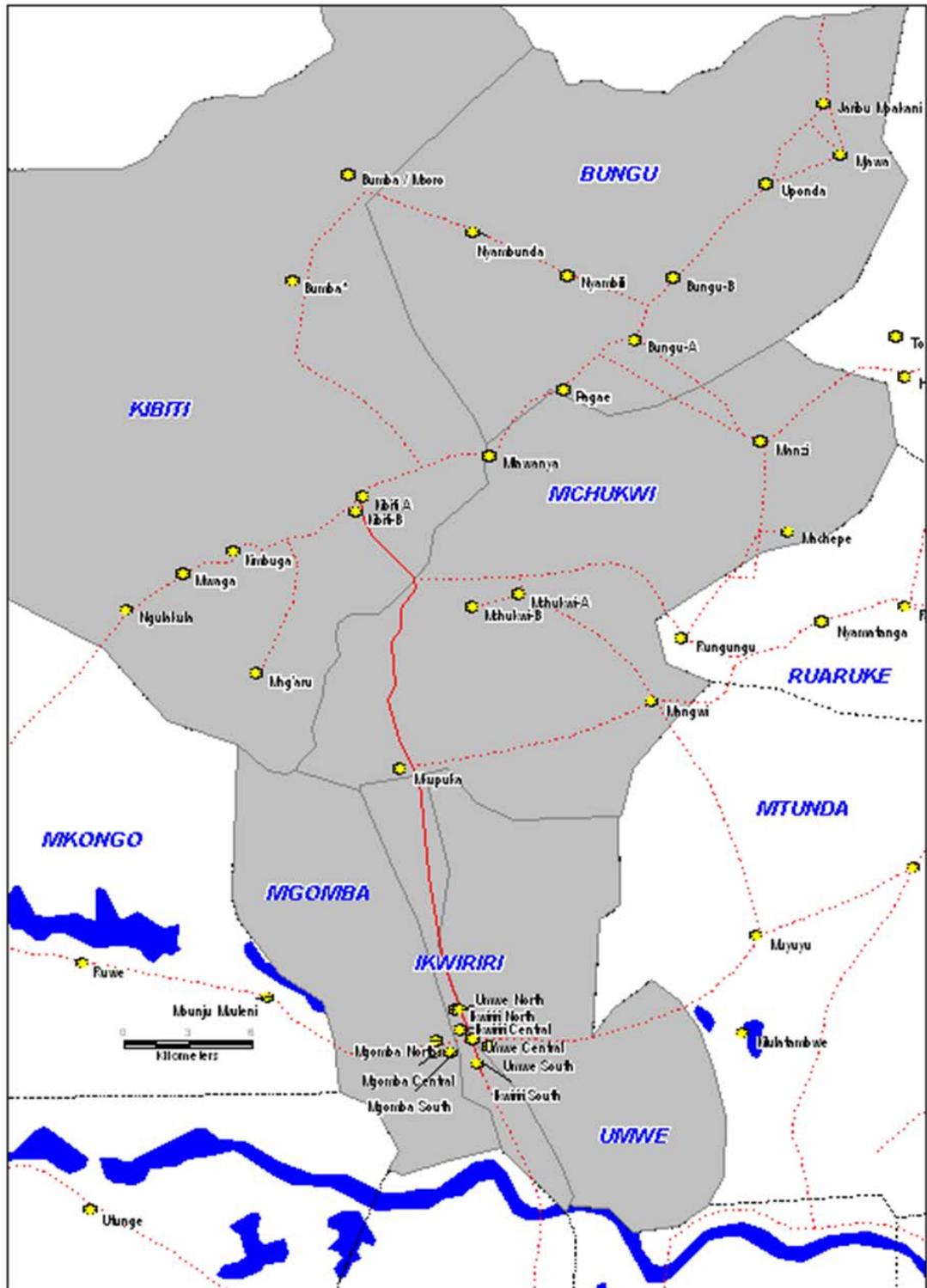
However, the “villagization”-programme was not beneficial for all farmers. While some villages like Ikwiriri were close enough to the floodplain to allow farmers to commute daily to their *shamba* (farms), others were up to seven miles away from the river, making farming in the floodplain difficult and uneconomic (Hoag 2003:156). Many farmers of the delta resisted resettlement, and many of those who were forced to leave began moving back and forth from their houses in the valley to the new *ujamaa*

⁵ *Ujamaa* (“familyhood”) was the concept that formed the basis of the late Julius Nyerere's social and economic development policies in Tanzania after it gained independence from Britain in 1961 (see Nyerere 1969).

villages (Hoag 2003: 157). All in all, the resettlement did not succeed in solving what was now considered as the Rufiji food shortage problem because occasional famine was replaced by chronic food shortage (Hoag 2003:132, Chapter 2). The resettlement disrupted the elaborate Rufiji agricultural system by forcing many farmers to move their fields from the rich soils of the floodplain to the poorer soils of the higher elevations.

Today, many Warufiji rely on farms that are far away from their homes. They cultivate cassava, maize, rice, millet, coconut and fruits. Most farmers commute to and from the *shamba* or live in small thatched huts (*dungu*) for days and weeks. This happens during the intense agricultural season and also involves the older and ill people who cannot commute daily to and from the villages. Some residents rely on fishing as the main source of income while others are engaged in small commercial activities like timber and carvings.

What we see today in Rufiji is thus the result of larger processes of change which have occurred in this region as well as in Tanzania. As outlined above, the “people of the Rufiji River” (Warufiji) consist of several ethnic groups. Their matrilineal kinship organization has been partly modified and even disrupted by Islamic faith, colonialism, forced migration shortly after independence, the *ujamaa*-politics and the profound economic transformations first to socialism and since the late 1980s to capitalism (Bryceson 1995, Hoag 2003). Moreover, people from many parts of the country have migrated into the area (Bryceson 1995), while many others have left Rufiji to live in the commercial capital Dar es Salaam and other regions of Tanzania. Christianity has spread into the predominantly Muslim area, and by now various moral worlds co-exist.



Map 3 The Rufiji HDSS area and the location of the two research sites
(Map by TEHIP Project, 2000)

2.4 Fieldwork methodology

From 2009 to 2011, I conducted extensive ethnographic fieldwork in two sites within the Rufiji District (see Map 3), representing different resettlement types: 1) Ikwiriri, a centrally located cluster of villages near the floodplains which is rapidly growing into a rural town, especially since Mkapa Bridge has been built across the Rufiji River, connecting the main road from Dar es Salaam with Lindi and Mtwara further south. 2) Bumba village, an isolated place off the main road in an area called Kibiti, consisting of a cluster of hamlets located about 80 kilometres from Ikwiriri in an elevated area far from the floodplains. The underlying assumption of selecting these two settlements was that differences in the types and location of the villages might affect the lived experience of ageing, health and care.

As shown in Map 2, the nearest larger health facility, Mchukwi hospital, is located 30 kilometres from the centre of Ikwiriri and 28 kilometres from Bumba village. It is a church hospital and has 100 beds with a total staff of 80 workers (<http://mchukwihospitalz.blogspot.ch/>). Primary care is available at a dispensary in Ikwiriri and in Kibiti.

The HDSS team and their database helped me to identify the boundaries of the two settlements and to identify the households with at least one person aged 60 years and more in each place. Together with my field assistants and with the help of village authorities, I then cross-checked these data by going from house to house in the selected settlements to establish the exact figure of the number of older persons in the villages. The cross-checking was necessary because the people of this area are highly mobile, especially during the agricultural seasons.



Plate 2 Field research team member in Ikwiriri (Photo by Vendelin Simon, 2010)



Plate 3 Reaching remote hamlets in Ikwiriri (Photo by Sigbert Mrema, 2010)



Plate 4 On the way to dispersed homesteads in Bumba (Photo by Vendelin Simon, 2010)

I spent nine months in Ikwiriri which is inhabited by approximately 20,000 people and divided into six villages. I call the village on which I concentrated 'Ikwe Town' because it includes the rapidly growing commercial centre near the Mkapa Bridge as well as remote hamlets. With the help of the HDSS team and the ward authorities, I was able to identify 380 out of 8,000 inhabitants who were older than 60 years. Of these 380 I randomly selected 92 persons (38 men and 54 women) as a sample for the first study and followed up on a subsample of 43 during the second study. Additional insights were gained from renting a room in a house owned by an old woman.

In Bumba village I spent six months. It only has 400 inhabitants according to the HDSS and the village authority records, and 84 older people were above 60 years of age. I selected 21 of these older persons (8 men and 13 women) for my study. For the Age Group Study I selected a sub-sample of 14 elderly (9 females and 5 males) to zoom into the older people's lives and experiences. The follow up lasted six months. During this

time I lived in a small but centrally located teacher's house assigned to me by the village authorities.

During my fieldwork in Rufiji, I was assisted by the HDSS team (Honorati Masanja, Sigbert Mrema, Liberatus Kayumba, late Mkilindi, Tatu Abdalah and Priscila Mlay). I further set up a small field research team to help me with data collection (Tumu Nindi, Fina Everest and Evelyn Mwera) and transcription (Priscila Mlay, Goodluck and Diana Ikula).

As outlined above, we conducted a stakeholder study, a community study, a household study and an age-group study. Especially during the semi-structured household interviews, I became aware of some of the drawbacks working in an area in which households were regularly visited by a HDSS team. In some of the households we visited, the people were tired of answering questions or gave only evasive answers. Based on the insights we got, I organized focus group discussions to follow up on issues of interest and made a selection of older persons for the follow-up study. In the focus groups we discussed access to the health and social services, neighbourhood relations and friendship, but also divergent ideas on meanings of ageing, health and care. Individual elderly, for instance, mentioned different signs of ageing, and it was interesting to hear how they compared their experiences and whether they agreed on the ranking of certain signs or not.

For me, the most important characteristic of my PhD project is that it represents a "qualitative search for meaning", as outlined by Jay Sokolovsky:

Typically cultural anthropologists have chosen to study...human variation by establishing themselves for long-term stays in locales where people carry out their everyday lives. Called “ethnography”, this prolonged, very personal encounter of an anthropologist with individuals in their community can provide a special insight into how people confront and deal with the cultural contexts life has dealt them [...] (Sokolovsky 2009b:xxiv).

Data collection relied mainly on the participation in the everyday lives of the older persons. Like van der Geest (2002:3) we came to recognize the importance of conversation and casual meetings. We often paid a short visit to greet an old man or an old woman, or simply spent time with them, usually during the morning and evening hours, when the sun was not so hot. These visits generated many of the insights presented in this thesis. Such short and regular visits are only possible if the researcher stays for a prolonged time “in the field”. As illustrated below, living with the older people enables the researcher to gain a deeper understanding “through shared sensory and bodily experience” (Förster 2011:6).

Settling and living in both sites proved easier than imagined, although I come from a very different area of Tanzania. And “being there” was essential for my research. “On site presence enables us to experience a given location, sometimes allowing us to participate in the activities, sounds, smells, sights, and so on that constitute that socio-cultural arena” (Sobo 2009:211). Being there while, for instance, care was being provided was not only an interesting experience, it also enhanced my understanding of its complexity. It provided moments to see not only the visible caregivers but also those who remain hidden and visit perhaps only occasionally or in the early mornings. Being there enables us to not only rely on what we are told, but to observe with our own eyes

and to hear directly what people talk about. It allows us to get closer to the real situations and gain immediate access to the actors and interactions that we study.

Another important aspect of my fieldwork was travelling, walking and accompanying the older people in their everyday social life. Slowly walking five kilometres from Ikwe town and even further from Bumba to their farms, through open fields in the burning sun, made me begin to understand what ageing means in everyday practice. By accompanying and moving around with older men and women, I also heard how they were respectfully addressed as *bibi* and *babu* by the younger villagers and witnessed how intergenerational relations were lived. I further learnt that older persons tend to reduce the weight they carry, for instance, using a five litre instead of a twenty litre bucket to fetch water.

It was also important to travel with the older persons in an Afif Bus Express to Dar es Salaam and to experience how they negotiate and find their way through the city of Dar es Salaam. Such journeys made me realize how stressful it can be for elderly people to reach the bus station in time and to get a ticket among a crowd of younger people. Delay does not only mean missing the bus, even more importantly it means losing money that has been acquired through hard work or by borrowing from neighbours and friends. Some elderly were surprisingly mobile; others tired easily and did not have much strength. Travelling with the older people gave me insight into the purpose of their journeys, for instance, their efforts to keep up relations with their children in the hope of receiving return visits. Accompanying them to health centres in the city were excellent occasions to learn about social relations of care. Who develops initiative and gets engaged, who does not, and why? Who provides what kind of support? What are the mutual expectations and anticipations? Are they fulfilled or not? Indeed, by

accompanying older people I often learnt more than during well prepared in-depth interviews.

In addition to the more casual methods, intentional observing was also fruitful. By staying in older people's home (*nyumbani*) and through daily participation in their everyday life, I was able to not only see, but also observe the older people visiting the water taps in Ikwe and the well in Bumba village. It was interesting to observe how different relations were played out during these occasions. Sometimes young people were eager to help the seniors, on other occasions they were rather unfriendly and pushed them to the side. In Ikwe, some neighbours gave water from their boreholes for free to older persons. I agree with van der Geest (2002a: 267) when he says, "Observation during these visits constituted a crucial element of the research as they added depth and context to verbal accounts."

In our research project we used the official cut-off point of 60 years as the age limit for selecting study participants. This was in line with the government's definition of *mzee* (singular for an older person) and *wazee* (plural for older people) (Spitzer 2009; United Republic of Tanzania 2003). However, we were fully aware that this "numeric and demographic definition" was not coincident with the local conceptions of age, ageing and older person (van Eeuwijk 2012:250). As we shall see, older persons' conception of age and ageing is primarily based on their interpretation of social roles, bodily changes and activities they can no longer.

In Rufiji, working with a numerical definition of age was often difficult. Few of our study participants had visited formal schools, although some had been reached by initiatives to improve "adult education" (*elimu ya gombaru*). The field research team therefore relied on a calendar that captured key events in the history of the place such

as the heavy floods of the early 1960s which forced the government to evacuate people using the army and “choppers” (meaning helicopter). Known years of hunger and of pandemic diseases such as plague or leprosy were also used. Events during the German and British colonial periods and the major resettlement operations by the newly independent nation were further reference points for establishing the chronological age of the older persons. Still, “global flows” (Appadurai 1996) locally referred to as *utandawazi* (openness) have started to influence conceptions of ageing in Rufiji. To establish the age of elderly who have attended the health services, registered for national elections or were regularly visited by the HDSS team was thus less challenging for my field research team.

2.5 Challenges of researching the older people

During the household study, stories of hardship, struggles, pains and nostalgic memories dominated the responses to our questions. However, with growing familiarity during the follow-up visits, when the older people began to call me “son” or “grandson”, they opened up and offered insights into their real social life. I partly attribute this to the fact that outsiders conducting studies in the area are first seen as representing development and health projects. In other words, they are seen as potential benefactors, in the sense that they may bring something. Moreover, through exposure to the widespread poverty and livelihood related research, older persons have begun to see themselves as suffering and being in need. Interestingly, I hardly encountered any “complaint discourses” in the latter part of my fieldwork. The longer I lived with the people, the clearer they realized that my research was different and that I was less interested in black and white pictures than in those painted in shades of grey.

Another challenge in working with older persons was related to the fact that anthropologists and other social scientists have long used them as a source of information about community life and history, but hardly ever considered older persons and their experience of ageing as a topic of interest. Only recently social scientists began studying old age (Sokolovsky 2009c). Although research on old age in Africa started thirty years ago, studies remained few and far apart (Apt 2005). There are still only few ethnographic studies on ageing in Tanzania (e.g. Mesaki 2009), while others have approached older persons from a developmental perspective (Spitzer2009). It is mainly NGOs who have addressed the concerns of the older people in their advocacy efforts and thus created distinct images and expectations.

Studying elderly can also be an emotional challenge. During my fieldwork I lost twelve older persons whom I had known, lived with and talked to many times over the three years of research. This is sometimes almost unbearable, even for an experienced and well-trained researcher. Balancing own emotions is not only difficult in the field but also when revisiting the stories during data analysis and thesis writing. All in all, however, I look back on many encouraging life stories. They have convinced me to look at the older people as actors who engage in the everyday social life as best as they can.

Some of the older people in Ikwiriri and Bumba were very old, others were sick. Interviews with them took more time and effort because they could not hear and/or speak well, tired easily and needed a break. Responding to their needs and adapting to their rhythm of life meant making regular short visits in the morning and the evening, when it was cooler and they felt stronger.

In cases where intimate and highly tabooed topics were discussed, for instance, questions relating to the body or sex, it was easier to do so if a joking relation had been established. Joking relations are common between grandparents and grandchildren, also in my own community. I could thus build on my own personal experience and assume the social position of a grandson or great-grandson, although in a generational sense I would have rather qualified as a son. This worked with both older men and women. Since their age ranged between 60 and 105 years, I could slip into many different roles, acting as a great-grandson, grandson, or son, as the situation required.

When discussing menopause as a sign of ageing with an old woman, for instance, I would change my relationship from son to grandson, thus becoming symbolically a husband to her. With my new social identity, we could discuss even the most intimate things that only married couples can talk about. Assuming the new identity may also raise expectations, especially in terms of care provision, but since it was enacted as a joking relationship, the bond did not last long. Entering joking relations reduced tensions and made the older people feel comfortable and appreciated.

2.6. Research ethics

In such special relationships, but of course also in ethnography in general, questions of confidentiality have to be carefully weighed and considered. In line with ethical standards of conducting ethnographic research (see AAA 2012), the field research team took great care to explain in Swahili to all the participants involved in the research project what the purpose of the project was. In compliance with the NIMR/NatHREC regulations (see Chapter 2.2) we used forms we had written in Swahili to obtain “informed consent” for interviews and photos from each participant. We loudly read the text or asked them to read it themselves, answered questions if a point was not clear,

and then asked them to sign the form. We also presented the research permits whenever requested. Some of the older people asked detailed questions about the “how” and “why” of our study, informed by their previous engagements with donor agencies in needs assessments or interventions by the government agencies or NGOs (see also Chapter 2.5).

In accordance with ethical considerations and for the potential future benefit of the older people living in Tanzania, summaries of initial findings and reflections were shared with stakeholders who work on ageing and health in Tanzania, especially during meetings with and at workshops organized by HelpAge Tanzania.

All audio files, transcripts and photos of my PhD project are accessible for the other team members on a workspace server to guarantee transparency within the overall research project. The field research team ensured the privacy of the older persons by using code names for the transcription of the interviews. To preserve some confidentiality, I use first names in the thesis which do not always correspond with the real names of the respondents. The photos are anonymized and used to illustrate a generic point.

2.7 Situating my thesis

In this chapter I presented and then reflected on the ways in which we conducted research and particularly my PhD study. While my study refers to a broader framework, the particular context in which I worked and the ethnographic approach I used turned it into an original piece of research. Moreover, I was actively involved in the final design and all the subsequent steps of the research project and was responsible for my own study.

We selected the Rufiji District because it seemed especially interesting for a study on ageing in Tanzania: life expectancy and the proportion of persons older than 60 years are higher in this population than in other parts of the country. Within Rufiji, we chose two settlements that represented the recent history of the area and contrasted in terms of size, location and infrastructure. Together with my research team, I conducted the same sub-studies in both settlements, putting the emphasis on extensive ethnographic fieldwork, repeated visits in the homes of the older people and participation in their everyday life. Although it was a highly rewarding experience to put the older men and women at the centre of my study, I also faced a number of challenges, which in my view are particular to doing old age research.

Part 2 Growing into Old Age in Rufiji

This part of my thesis inquires what it means to grow old in Rufiji. Following the design of my study, I present my insights and findings separately for Ikwe Town (Chapter 3) and Bumba (Chapter 4) but following a similar outline to allow for a comparison cross the two study sites. Within each chapter I first examine the social dimensions of ageing and show that old age is not just personal but social experience, constructed through intra- and intergenerational relationships, form of address and social status. I then shift the focus to the links between ageing and health, pay attention to critical health moments and identify common pathways from having to not having strength.



Plate 5 Social dimensions of old age in Ikwiriri (Foto by Vendelin T. Simon, 2010)

Chapter 3 Ageing and Health in Ikwe Town

3.1 Introduction

This chapter examines the social and cultural construction of ageing and health in Ikiwiriri, a small but rapidly growing rural town, located about 150 kilometres south of Dar es Salaam (see Chapter 2 and Map 3). Based on an ethnographic approach, it seeks to elucidate what it means to grow older from the perspective of men and women.

More precisely, the study focuses on an administrative division (a “village”) within Ikiwiriri which I call Ikwe Town. This “village” is a rather urban centre along the main road connecting Dar es Salaam in the North with Lindi and Mtwara in the South. Many shops, a market, administrative offices and small restaurants are lined up along the road. The nearest hospital is located about 30 kilometres from the centre of Ikiwiriri, and a dispensary, drug shops and kiosks provide basic health services in the town. Ikwe Town also comprises homesteads which are situated in the fields surrounding the commercial centre and along the Rufiji River (see Plate 3).

After the Community Study and during the nine months of field research in Ikwe Town, I first selected and visited 92 households with at least one person older than 60 years to get an overview of the living and health conditions (see Chapter 2.4). In a second step, I selected a sub-sample of 43 older persons (15 men and 28 women) for the Age Group Study which involved a series of follow up visits for interviews, informal chats, observations and participation in their everyday life and activities. This chapter presents a composite picture emerging from an analysis and interpretation of the data collected in all these studies and from my own experiences during my stay in Ikwe Town.

In the first section I present and discuss social dimensions of ageing. A central insight of this section is that becoming and being an old person (*mzee*) in Ikwe Town is to a large extent shaped by the social recognition by others. The second part of the chapter explores ageing in relation to the health condition (*hali ya afya*). In this case, health is described as the main realm through which ageing is experienced. The special concern for health (not just disease) fills a gap in the medical anthropology of ageing. In order to show the dynamic and diversity of older people's own view of their health condition (*hali ya afya ya wazee*), three main health categories are presented: firstly, having strength (*kuwa na nguvu*), secondly, at times with/without strength (*wakati mwingine kuwa/kutokuwa na nguvu*) and, thirdly, without strength (*hakuna nguvu*).

3.2 Social dimensions of ageing and old age

Questions and discussions about signs of ageing (*dalili ya uzee*) have shown that personal experiences of ageing in Ikwe Town are closely linked with ascription of old age by other actors. Ageing clearly has social dimensions. It does not happen in isolation, but in a social and cultural context (Sokolovsky 2009c). Often the older persons stated that "you cannot claim to be *mzee*; you have to be given that title" (M-87yrs). This means that, no matter how much one wants to be *mzee*, he or she has to wait for the appropriate moment. This kind of social ageing helps us differentiate it from chronological ageing that has dominated the welfare and development debates (cf. Mwami 1998). Further analysis reveals that no matter how chronologically old one is, he or she still has to wait for the respective ascription. This happens through various social relationships that are dialectical. These relationships range from inter- to intra-generational and find expression in many ways, through symbols, dress, naming and greetings, to name but a few.

Constructing old age through intra-generational relationships

Being *mzee* (singular for an old person) is an achievement, the qualification of which involves not only the individual him or herself, but also many other actors. These others act as a mirror that reflects the ageing condition. That is, as an older person negotiates his or her ageing position, which is “earned and one has to strive to get there” (M-94yrs in FGD). Indeed, it could be true that being old is an admirable status but the condition and the process is a different matter. The question that comes to mind then is how one earns this ageing. Well, one way could be through social status. The data from the discussion groups and interviews on the intra-generational reference to ageing reveal a general consensus. An older person uses mention of his or her generation as a frame of reference. An individual refers to his or her own condition in reference to the members of the generation he/she grew up with. Knowing them for a long time, they have a lot in common in terms of social life and, in particular, of growing up in the same era. In discussions, men and women illustrated the extent to which this reference is made. For instance, Ali claimed that, “you witnessed when a friend was born, saw him grow up, getting married as well as having children. This means when he or she becomes old, you are already far ahead of him or her” (M-92yrs in FGD). This means, he assesses his ageing condition with reference to his colleagues with whom he grew up. This mirroring of one’s own condition in reference to others of the same generation surfaced in almost all the formal and informal talks and discussions. All in all, as Aziza puts it, “seeing your own generation getting older means you are next in line” (F-102yrs) makes sense to most of the older people in the town. I should caution, however that in a large city where people hardly know each other this might perhaps not make sense. But in this rural town, many people have lived together for at least 50 years, or even more. They have known each other and developed bonds that have become a resource.

On one of my evening walks to the *shamba* – a routine schedule to capture moments when everybody was coming home to the village – I happened to meet a *bibi* carrying firewood on her head. Another *bibi* came up from behind, walking much quicker than the first. They started to engage in talk, attracting my attention. Their conversation went as follows:

Bibi Nuru: How are you, sorry about the work.

Bibi Amina : Thank you my dear, I am exhausted and tired.

Bibi Nuru: Oh! Let me help you because with your walk you will not make it before it gets dark.

Bibi Amina: Thank you loh! I am so tired.

Bibi Nuru: What do you expect! Look, we came behind you and we are already *bibi* just like you. You mustn't mourn but be happy that you are *bibi*.

The conversation shows us the necessity of understanding this intra-generational relationship in the construction of ageing. It challenges those who focused only on the inter-generational construction in defining the hierarchies and relations within the family. It makes us rethink and expand our anthropological interest in the whole question of generation (Alber et al. 2008). What interested me in the above discussion was how Bibi Nuru defined herself in reference to Bibi Amina who is apparently older. Admittedly, from my own observation I would say they looked approximately the same age but the fact that one regards herself and feels much younger implies the hierarchical relation even within the same generation. By saying, “look we came behind you”, Bibi Nuru suggests she is younger than Bibi Amina. Nevertheless, she admits to be a *bibi* just like Bibi Amina. Thus, they both fall into the *bibi* category. But it helps to prove our point of approaching ageing as a vital conjuncture that emphasizes the fluidity of the social categories.

Although I am aware of the distinctions between the Third and Fourth Age in social gerontology (Phillips et al. 2010: 213-217), this is not the point I want to make here. My point is simply that older people in Rufiji make distinctions within their own generation and that these distinctions refer to biological age, social age and personal experiences. They illustrate how older people define their age-related status through social construction where personal experiences and interactions with others are shaped by the broader cultural norms and values which in turn are shaped by these actors. It is a two-way or a dialectical relationship. As older men and women are engaged in this construction, they explicitly and implicitly refer to these prevailing frames and adapt them according to changing situations.

The reference to generation also came up in many other cases where a person would assess her ageing with reference to the ones born before her. An 85-year-old *bibi*, for instance, said during one of my unplanned visits and ensuing discussion: “I don’t remember anything, all of my generation are gone, they are dead and I am the only remaining here. So, the next will definitely be me.” This *bibi* sees ageing as a process but in relation to other social actors whom she has known in the course of her life. She draws her conclusions in relation to the experience of seeing others. She challenges our methodological and analytical skills in addressing older people’s issues. The case illustrates the fact that old age needs to be seen through life perspective lenses to make it more meaningful. Indeed, one could say she is mourning the death of the many others whom she was born with and who are now dead, but actually this is not the way she thinks. For her the most important thing is that she somehow knows that any moment she could die but that she has lived her life. She metaphorically illustrated this by saying, “death and *uzee* are like relatives or friends. They do not fear but like one another” (F-85yrs). Another woman explained: “The moment an older person sees the

ones born before them start to fall [die], and when they are invited to these events [funerals], it signals that the next is me” (F-102yrs). Indeed, I would argue that even creating this chronologically sound age is an art. It requires a painstaking process of recalling all the historical events. We tried this at the beginning of the research and I understand how hard it can be.

This further reveals the complexity of the meaning and, more importantly, the construction of ageing in any society. That is, it involves not only an older person, but many frames of reference, such as other actors, including fellow older people, children and the family. We can even expand this debate to the ageing policy, which assigned exclusively to the local government of Tanzania (village, ward and district authorities) the task of screening who is old, and who is not (United Republic of Tanzania 2003). Although one might criticize that their construction was based on chronological ageing, it indicates the importance of engaging other actors in creating this reality. Importantly, it helps us to see many dimensions that are considered in these creations. Similarly, it reveals the different actors that are engaged in the process of creating and defining ageing. This shows the older person’s ability to engage but also that his or her agency largely depends on many other actors in addition to the social and cultural environment. It has to be reflected in what others do and in the prevailing cultural norms and values. Thus I would say the agency of an actor is very much shaped by other actors with whom he/she interacts in everyday social life. Similarly, as Emirbayer and Mische (1998) emphasized concerning the aspect of temporality, the experience of the past significantly shapes how an individual perceives and engages in the formation of ageing. During the focus group discussions, the point of when one becomes old was raised. Several definitions were proposed but apart from actually being old (*kuwa mzee*), primary significance went to the fact of being recognized as old (*mzee*). That,

“even if you claim to be old, there has to be an appreciation” and “acknowledgement from others in the community” (M-82yrs). It shows that the influence of the same generation in the construction of ageing in a particular community cannot simply be ignored. The generational relationship is not the only important thing that can explain ageing but it helps us to unravel the black box of ageing. These relationships help us to see how people produce their own ideas in order to locate themselves in the age frame, or, as the case may be, to resist to this process of pigeonholing. The generational relationship is one dimension through which we see many facets and diversities of ageing (Alber et al. 2008).

Grandchild principle

Among the older people of Ikwe, the intergenerational relationship is also revealing as far as the construction of ageing is concerned. The younger generation, in particular grandchildren seem to be an important factor in enhancing our understanding of ageing. As mentioned above, the construction of ageing involves many actors. Not least it is the product of inter-generational relationships. Through the birth of a grandchild, a culturally defined sense or social formation of *uzee* becomes real. This is not only a culturally accepted social ascription of ageing, but also an automatic process. After the couple’s daughter/son has a child, they automatically enter into the category of older people (*wazee*). However, this kind of old age (*uzee*) is completely different from the one that involves great-grandchildren. Only having a grandchild is not sufficient to lay claim to the status of being an older person (*mzee*). Within the family, this role is less contentious. This reaffirms the complexity and heterogeneity within the same ageing population and the so-called cultural group.

Indeed, Ikwe, as a fast-growing town, attracts many people, making homogenization a looming danger. Treating the resident population as a uniform cultural group is not appropriate. Moreover, the social and cultural environment in which older persons live and act adds to the complexity. In fact, the Warufiji are well known for their practice of early marriage. It may occur as early as the age of 14 (F-74yrs). This means, if the grandchild principle is taken as the only definition of being old, then many people in their 30s and 40s could be classed as *wazee* (FGD with women). A similar trend is revealed during the recruitment process of the *wazee* further on in this research. It was quite common that the same household had more than two older people, for instance, a daughter and her mother both over 60 years old by our definition. If we were to apply the first grandchild principle to construct ageing, the picture could be completely different, as four to five generations are still alive. This means that at the age 30, the mother and father had their first grandchild, making them *bibi* and *babu* respectively. In other places, this could be regarded somewhat negatively, but among the Warufiji becoming an *mzee* is considered an achievement.

Nevertheless, this does not tell us anything about the social status and arrangement of the new *bibi* and *babu*. Other factors have to be considered if they are to be acknowledged and integrated into the real *wazee* category. Their social status is thus pending and limited through the first grandchild. They still have to wait for many other factors before finally entering into the category of old, which entails such privileges as being cared for or exempted from some types of work. While, on the one hand, it shows the agency of an individual, on the other, it reveals how the social and cultural environment shapes this agency. Importantly, it shows how ageing is fluid and not a fixed social category. This challenges the debates on ageing that define ageing by referring to only one social or even biological aspect. Importantly, it challenges

chronological ageing that does not consider other cultural definitions in the constitution of *uzee*. A combination of factors is usually relevant, depending on the cultural and social norms and values that guide this definition.

This reaffirms Johnson-Hanks' (2002, 2006) vital conjuncture approach, which argues that these social categories are flexible and often not fixed. They are negotiated and redefined, depending on the circumstances. Among the Warufiji of Ikwe Town there is no standard definition; one grandchild is not enough to be *mzee*, there have to be a number of grandchildren. As one woman recounted: "When I had my first grandchild, they called me *bibi* but a different *bibi*. I did not enjoy this achievement of having one grandchild. However, after I had three grandchildren, then there were many voices calling me *bibi! bibi!* Then I realized that I am now *mzee*" (F-82yrs). Similarly, a 98-year-old old man highlighted how the grandchild principle has a lot of drawbacks. It only shows maturity in the sense that, "I am now mature because I have a grandchild" (M-98yrs). For many older people this only shows you are a mature adult, but not yet *mzee*. You become mature when "you give birth to your own children. Then you are mature; this is followed by having a grandchild that signals that you are more mature, and when you have a number of grandchildren, that is *uzee!*" (M-98yrs). When grandchildren are born *uzee* starts, and only an *uzee* is socially recognized and acknowledged. There is "nothing to step in your way, challenging your *uzee*" (F-81yrs).

Therefore, referring to being *mzee* after the first grandchild is not enough. It tells us something about the relationship but it does not give a full definition of the social status of an individual. Thus, as contested by the Warufiji of Ikwe Town, having a grandchild is not enough to make a young *mzee* socially accepted. Within the family he or she is *mzee* but when it comes to the public, the status is different; he or she is still young. The

private and public definitions of ageing differ slightly but reinforce each other. The typical example of this paradox in the construction of ageing is made clear in the following conversation:

Interviewer: So! When did you first realize that you are now *bibi*?

Bibi Sofia: You mean *uzee*? They started calling me *bibi* when my daughter had her first child. Some were calling me *bibi kijana* (young *bibi*).

Interviewer: Why *bibi kijana* (young *bibi*)?

Bibi Sofia: I was still young but now I am *mzee* because my children are also *wazee* like me and we have grandchildren who are also getting old. Therefore, my generation and the younger generation are old. The children you have given birth to are old, what awaits you then, are you still young? You are already *mzee*. (F-72yrs)

We can draw more than one lesson from the above case which shows that ageing is a relative term that depends on the social and cultural context. Even though the case above indicates the automatic *uzee* status after the first grandchild, this does not seem to be enough to give the woman the full *mzee* status. This is revealed by the way others were referring to her as young *bibi* (*bibi kijana*). For one thing, she was not like many other *bibi* as she was still giving birth. Thus, she was still young. Nevertheless, it also reveals the influence of the many other actors in the reaffirmation of being called *bibi*. This cultural construction is felt by an older person – in this case a woman - as a real achievement, i.e. having one or more grandchildren. Nevertheless, as she said, it could be a process of excluding herself already from certain things, for instance, by saying your children have grown up, what awaits you, she illustrates how this hierarchical structure in ageing is important. Likewise, she is also communicating many other

aspects that she is now reconsidering, for instance having children like her daughter, but also skipping events that involve people of other generations. Such a view is not limited to women, it also involves men. During one of my evenings in town, an older man (75yrs) illustrated this inter-generational relationship that is widely considered in the literature. Our conversation went like this:

Mzee Bakari: Hei! Yesterday you were asking about *uzee*, do you see those grandchildren there?

Interviewer: *Shikamoo* [how are you]! I have seen them and they are joking about you!

Mzee Bakari: You see the grandchildren; look, others are behind you. They are the ones who call me *babu! babu!* This makes me a real and not an artificial *babu*. Today you have the answer.

Interviewer: Yes, but who is your oldest grandchild?

Mzee Bakari: That one is not here, he moved out, married and he too has grandchildren and he is *babu*, but not like me, he is young. There are nine grandchildren here from my children, cousin and others are great-grandchildren. I am real *babu* but not like the other young *babus*, not like my grandson who has his first child. He is *babu*, but not like me.

This conversation reaffirms the point about the social construction of ageing that is context based. In other words, this social change of having the first grandchild is only one among the many references to becoming an older person among the Warufiji. Similarly, after they become *bibi/babu*, the prefixes attached to the term indicate ageing and change in status. As Harubu remarked: “Now they have changed the way they address me, they are calling me *mzee* Harubu” (M-88yrs). When they started addressing

him as *mzee* he was reluctant and felt uncomfortable. However, today, he is very happy to be addressed as *mzee* as it shows acknowledgement of his ageing. This interplay of many elements makes the approach to ageing challenging and interesting.

Shikamoo

The above construction is only one of many ways through which the meaning of ageing is created and communicated. This goes hand-in-hand with the showing of respect in everyday relations and interactions. For instance, in the focus discussions and during the interviews, *shikamoo* (a respectful way of greeting someone senior) was revealed as one of the signs. That is, *shikamoo* is already a sign that you are getting older, as many of our study participants stated. However, just like the grandchild principle, how different people in the town address each other revealed a different scene: even among the younger generation you will often hear juniors saying *shikamoo* to a senior person. However, here *shikamoo* does not mean being *mzee* but being older than the one saying it. Thus, it does not explicitly tell us anything about being a *mzee*. It reveals a hierarchical relationship between an older (*mkubwa*) and a younger person (*mdogo*). However, it reminds us of the articulation of meanings that define a person as *mzee*. In this case, a combination of the grandchild principle as well as intra- and inter-generational relations and health conditions has to be considered. The latter will be discussed later. *Shikamoo* is used as a term of respect within and across generations. On the one hand, it suggests respect and, on the other, a way of addressing the older person (*mzee*). This complexity of how an older person is addressed and shown respect requires close attention. One always has to refer to the context in which a person is using *shikamoo*. Importantly, the interplay of other factors also has to be considered.

For older men and women, the moment you start receiving the greeting *shikamoo* is a clear sign that you are ageing but not necessarily of being *mzee*. It is the process of ageing (M-60yrs in FGD). Interestingly, the example of greeting relationships takes us back to our conceptual discussion on ageing from the life course perspective that acknowledges the role of the actor. Significantly, the social life of people is not only accessible through language, interviews or mere observation and similar methods, but also through participation. My evening and morning cross-sectional walks in the village provided an opportunity to establish close relationships. This not only enabled me to participate in the everyday social life of the people but also to come close to their engagement in the construction of the everyday reality that includes ageing. This participation provided insight into their relationships and how older men and women are addressed and greeted. Bib Halima explained: “If you walk along the street and there are many voices that address you as *shikamoo bibi! Shikamoo bibi! Shikamoo bibi!* it is an indication of ageing and being old (*mzee!*)” (F-82yrs in a FGD). Interestingly, her statement combines *shikamoo* as a form of address to someone older and *bibi* as an older woman. Thus the combination removes the ambiguity of being *mzee*. By getting closer to older persons and experiencing the circumstances in which *shikamoo* is offered, we were able to clarify this ambiguity. That is, by receiving *shikamoo*, ageing becomes a fluid social category. It is a vital event or conjuncture that lacks coherence, while there is no fixed way of defining it. This flexibility makes it even tougher to approach it. However, the combination of “working between individuals and the social” (Johnson-Hanks 2002: 866) helps to illuminate the many unwritten articulations as regards ageing in the local setting.

Political rallies

The above construction of *uzee* based on inter- and intra-generational relationships together with how older people are addressed, takes us to another important point, which is how these social recognitions are played out in everyday individual and public life. I will describe a few experiences of events I attended that revealed a more complex and dynamic construction of *uzee*. During public events such as political rallies, village meetings, funerals, religious gatherings, and many other rituals, these constructions are clearly played out, but in a very complex manner. This becomes more complex if one is not familiar with the cultural context in which they become visible in the public realm. When I tried to explain both facets of these social formations, I found that they were not easily understood, especially not by outsiders who had not taken part in these cultural practices. By participating in some of the events in Ikwe Town, I was able to capture these constructions in public space and use them as examples. As highlighted above, being referred to as *mzee* does not necessarily tell us anything about *uzee*, but rather about the status of the individual. This is what has dominated the ageing studies for decades, especially as far as the authoritative status of the older persons in their families and communities is concerned (cf. Hampson 1990; Creighton and Omari 1995; van der Geest 2002; Roth 2008a).

During these events, *mzee* could have several meanings, depending on context. These events further imply that the social status we have seen is only one of the opportunities through which the social formation of *uzee* is created. Similarly, the economic, political, administrative and religious position in the community qualifies one to be referred to as *mzee*. However, this formation is different from the intra- and inter-generational rules of address. The main difference is that anyone, depending on his or her position, can

become *mzee* in the economic, political, administrative or religious realm. Therefore, even a young teacher can be addressed as *mzee* followed by *shikamoo mzee* in this sense, regardless of his or her chronological age. These positions go with status. Similarly, a small boy such as the one who owns a small kiosk along Kilwa Road in town is addressed as *mzee* due to his economic position. Likewise, street and religious leaders become *wazee* through their administrative roles and responsibilities in town. This new social formation of *mzee* or *wazee* is fluid and it does not necessarily tell us anything about being *mzee* in the context of this study. Although our interest was in understanding *uzee* and *mzee* from the Warufiji's point of view, this new formation became visible through these public events. This further reveals multiple identities in the form of individual actors have to execute their agency. Those who are young at a particular point become *mzee* in another context, due to their economic position. This interplay of identities is what makes approaching ageing even more diverse. Importantly, it entails a specific relationship by the one referring to another as *mzee* through this artificial formation. It shows a dependency relationship between the *mzee* and the non-*mzee*. In other words, it does not necessarily imply *uzee* in our sense of the term, but in relation to the expectations both have towards each other.

This became apparent during many of the political rallies that took place during fieldwork. Being able to attend these rallies and seeing whom they met, and when and why, revealed a very complex picture of the older persons I was visiting. *Uzee* became even more complex. Thus, the timing of the fieldwork and the project in general not only captured the diversity but also sharpened my research skills. Similarly, the *wazee* and the *uzee* suddenly appeared to me as a black box that I had limited knowledge about. These events helped me to reflect on how I am often addressed in my own village by people who are younger or older than me. For me this felt like everyday

language that I never bothered to reflect on. This time the widespread use of *mzee* was an eye-opener. The way people of different chronological ages were addressed as *wazee* in this political context was revealing. The 2009 and 2010 the local and general election, respectively, challenged my established understanding of *mzee* and *uzee* in Ikwe Town. Further investigation revealed the dependency relationship created between the addressee (*mzee/wazee*) and those who address them. The addressees are expected to provide something in return. In this context, they become gatekeepers and provide a winning environment for the politicians. This time-bound reciprocal relationship was interesting to observe and hinted at the further diversity of approaching and defining ageing. Due to their political, economic, administrative and religious positions, they were expected to influence the community so as to vote for the one referring to them as *mzee* or *wazee*.

During fieldwork, the Tanzanian president, who was also campaigning for re-election, visited Ikwe Town. They announced that he would hold a public meeting at three in the afternoon and then dine with *wazee*. The dinner was supposed to start at seven thirty in the evening. Unfortunately, the meeting was cancelled since the presidential candidate and his campaign team claimed to be tired. This happened when many *wazee*, neatly dressed for the dinner with him, had already gathered. What struck me was not the meeting but the hundred *wazee* who had gathered to meet that evening. Most of those who met that evening were in their thirties, forties and fifties; only a handful were clearly over sixty. This composition brought up several questions. First, whether my definition of *mzee* was right, and, secondly, whether there are additional contexts in which these definitions change. I then asked the leader of the *wazee*, a retired government worker. His story about that composition was interesting. He said:

My friend, in politics, *mzee* doesn't necessarily mean you have white hair, wrinkles, a bent back, and many others signs. Anyone can become *mzee* in politics, even a schoolchild can easily become one. We are more interested in how to influence the community than sticking to definitions.

This implies that these social formations are context bound. It further illustrates how the construction of *uzee* and *mzee* changes over time and place. It depends on who defines whom and for what reason. Stroeken's (2008) study on "Tanzania's new generation" referring to Tanzanian rap music (*bongo flava*) also gives us a hint of this diversity. Referring to the rap music that has conquered the younger generation, he explains how ironical the messages are in so far as they refer to corrupt politicians whose followers always respond by "yes, elder" (*ndiyo mzee*). Once more, *mzee* in this context has nothing to do with real ageing. It refers to the relationship that is artificially created between social ageing and those who share the code. These cases exemplify the great danger of not considering the social and cultural environment when giving a definition of ageing.

Indeed, this reveals why many efforts in public campaigns fail. If these differences are not taken into account, the chance of failure becomes real. In this sense, the social formation and articulation of *uzee* and *mzee* is not fixed, as said before. It could be that many were already *babu* and *bibi* in the sense of having grandchildren but at this meeting they also qualified as such by being called *mzee* or *wazee*. Even within the same community, meanings attached to ageing vary, reflecting the context in which they are constructed. This further challenges those who claim the social status of older person. Even here, an individual has to offer many more credentials before being granted this privilege. We have seen in the political realm how chronological age, otherwise widely considered the identifier of old age, is contested. In general, the

cultural context used by individuals and other actors to define meaning has to be considered.

Having seen this social construction of ageing through relationships, form of address and social status, the following section discusses the intersection between ageing and health. The same question that dealt with the diversity referred to above applies to this intersection. That is, by asking about what the signs and experience of ageing are, the responses show a close relationship between the two realities. It suggests that ageing is related to the health condition (*hali ya afya*). Indeed, this introduces the health perspective of ageing that is under-emphasized in most studies.

3.3 Experiencing health in old age

We approach the older people's health condition from their perspective and investigate how they assess and experience it. By asking what are the signs of ageing (*dalili ya uzee*), followed by a question about their experience, we were able to elucidate conceptual links between ageing and health. Apart from social and cultural ageing with regard to relationships, as shown earlier, most of the older men and women explained ageing (*uzee*) with reference to health conceptions.

As Obrist (2006, Chapter 3) suggests, health conceptions are often expressed in terms of health definitions (How can you tell somebody is healthy?), health explanations (What influences health?) and health activities (What is done to stay healthy?). In her study of Swahili women in Dar es Salaam, Obrist showed that health conceptions referred to the state of both the body and the mind. As my discussion below will show, many of the themes identified in her study were also mentioned by the older people in my research. With regard to the state of the body, strength as well as a portly, round or

plump shape, an attractive appearance and functional ability were considered as signs of health. Signs of a healthy state of the mind were joy, vitality and being free of worries.

When defining their experience of the health condition (*hali ya afya*), older people in Ikwe Town commonly referred to strength. We grouped their answers into three emic categories: 1) having strength (*kuwa na nguvu*), 2) sometimes having/not having strength (*wakati mwingine kuwa/kutokuwa na nguvu*), and 3) being without strength (*hamna nguvu*). Underlying these emic categories is a notion which the team of the overall research project decided to call “critical health moments”. These are moments when older people feel weak or painful and thus unable to carry out their gendered routines or tasks, such as attending to the farm, sweeping the compound, cleaning the house, cooking, doing the laundry and taking a shower. The term “moment” may be slightly misleading. We do not just think of a fleeting moment but rather of an interruption of common routines and activities. Such an interruption may be of short or long duration.

The notion of “critical health moments” and the three emic categories referring to “strength” (*nguvu*) reflect both the social and physical environment in which the older people live. It tells us about the influence of many other factors on how health as a social reality is constructed. The interplay of many circumstances such as other actors, relationships, socio-cultural background, socialization and daily social interactions has been acknowledged as having great influence on an older man and woman.

The context in which an older person lives shapes his or her experience of ageing. Similarly, it also influences how he or she perceives and defines his or her health condition. For instance, ageing and health are experienced differently by older men and women. Furthermore, much of this influence is associated with the cultural norms and

values that shape and, at the same time, are shaped by an individual and many other actors. The construction of this reality is dialectical. In other words, we cannot simply put older people into a category. Importantly, it challenges the widespread belief that ageing means a decline in one's health (Helman 2007).

In the sections below, we focus on people's health condition by looking at each of the three health categories to reveal the dynamic and diversity within each of the categories. We therefore use their descriptions of signs of ageing (*dalili za uzee*) and their narratives when they first experienced or noticed ageing. This is supported by observations on and participating in their everyday production and reproduction of ageing and health.

With strength

Not many older people assessed their health condition (*hali ya afya*) as "having strength" (*kuwa na nguvu*). Out of 92 older people, only 14 (8 men and 6 women) described their health condition as strong and their functional ability as not seriously under threat. They were still able to perform their routine activities. However, they periodically experienced moments when they were not able to do so. Unlike older persons in the categories "without strength" and "sometimes with or without strength", the men and women in this category experience these critical health moments temporarily. Their state of body (*hali ya mwili*) still allows them to carry out most of their everyday duties. These moments come and go. If it is pain, they feel it, but after the pain recedes, life continues as usual. Pain is not permanent as in the other categories. They experience fewer critical health moments.

In terms of their health condition (*hali ya afya*), the response was clearly “having strength”. Some went even further, revealing that they do not envisage reaching a stage where they did not have strength and could no longer work. Regardless of gender and age, their health condition was still strong. This does not mean that they denied being *mzee*. However, in comparison to many others in town, they could still manage their everyday activities. Just like many others, they are called *wazee* due to many other signs that grant them this status. Referring to the health condition (*hali ya afya*) and state of the body (*hali ya mwili*), the diversity in the health condition became obvious as they were physically fit, meaning they had functional ability. Some of them ascribed their strong body to their parents. A woman explained: “My body is just like this; I inherited this body from my mother. She died while young! Just like this, just like how I am now, and I am happy to have inherited it. I know I will die just like this, just like the way she died, she didn’t get ill or suffered from no strength” (F-78yrs). For older women like her, therefore, the experience of ageing in relation to the state of the body must be different. The fact that she thinks that her health condition is stable and the state of her body is in line with functional ability means that she can still do her work.

Importantly, again it shows the necessity of taking into account many other factors when defining ageing. If we define and approach ageing from the health condition perspective, her case shows that we will not understand much. She actually explained this in the presence of other older people whose health condition was similar to hers. This means we need other criteria to define ageing. When she was asked if she is an older person she immediately replied, “...yes, I am, and older than many others here but I am not as weak as they are” (F-78yrs). This implies that she knows that she is old with the help of other criteria such as having grandchildren, white hair and wrinkles. However, when it comes to health, she is fit and strong. Her case actually challenges

those who approach ageing through the chronological framework. Similarly, the older people whose health condition is still strong sometimes joke that when they walk with others who no longer have strength, they appear much younger although they are actually older. Once more this challenges the focus on chronological age. It reminds us of the importance of acknowledging the cultural and social construction of ageing. The age of older persons with strength ranges between 60 and 82 years, the age of those without strength between 60 and 105 years. Of course they are well aware that so and so was born before them and they acknowledge this. However, when it comes to everyday practice, it is more the state of the body than chronological age that matters.

Therefore, when it comes to health condition there are those who are younger than them, but without strength. They think what matters then is maturity (*kukomaa*). By maturity, they refer to experiencing how the state of the body is changing. For women, one of the typical signs referred to is the menopause, a significant sign of ageing for women across cultures and societies (Beyene 2009). These are the bodily changes women see and experience.

Bibi Amina explained: “You see the changes in yourself. You suddenly see your body getting dry. The blood, the cycle stops, you do not see your days anymore. When you see this condition, what is left? Then you know that ageing has come” (F-60yrs). A similar point was made by Bibi Maimuna: “Ageing starts when you stop giving birth, when you cannot conceive anymore” (F-80yrs). This sign adds to many other criteria used to define and construct ageing. However, the ending of the menstrual cycle alone would not be enough to say that ageing has started. It has to be in combination with many other criteria. In Ikwe Town, older women use phrases such as “being dry”, “not seeing the days”, and “months coming to an end”.

Women in particular seem to be concerned about the state of their body, not just in relation to physique but also in terms of appearance. The responses concerning appearance centre on skin, slimness and wrinkles. The older women commented that it is not “good to see the flesh gone and you are left with ropes in your own body” (*si vizuri kuona nyama imekwisha kwenye mwili wako na unabaki na kamba tu*). This was talked about more in the women’s focus group discussions. But even during the follow-up of two older women aged 62 and 82, their appearance clearly was an issue of concern. Showing her hands and thighs, Bibi Ashumta lamented, “look what has remained, you see! It is only these ropes [*pulling the skin and showing the dry skin and veins*] and no more flesh. I don’t look attractive anymore” (F-62yrs). The ropes are a metaphor to illustrate the state of the body and, in particular, the visibility of veins.

The state of the body (*hali ya mwili*) and being thin (*nyembamba*) came up a lot in the statements made by people in this category but not as a sign of an alarming health condition. Likewise, the relationship between the condition of the skin and ageing was also raised, as illustrated by Mzee Juma: “The skin becomes loose and you can pull it away from the bones” (M-67yrs). The skin gets dry and, according to Mzee Mohammed, “even if you use oil it doesn’t help; it becomes very dry and changes colour. It is like you don’t have water or blood anymore” (M-82yrs). Others insisted on the state of the body being “not intact anymore”, “everything starts to fall apart”, “the state of the body becomes like a stick”. All these phrases highlight how the state of the body becomes important as a marker of ageing.

Case study 3.1 Mzee Juma, 92 years old

As has been shown above, older people of the *nina nguvu*-category take both their health condition and social aspects of ageing into account when they reflect about their everyday experience of growing old. Although one case cannot represent all the 14 study participants in this category, it helps to contextualize the experience of ageing for at least one older man.

The most remarkable aspect about this case is: Although Mzee Juma is 92 years old and blind, he still considers himself as “having strength” and “being strong”, especially in comparison with other older men and women in Ikwe Town, because he lives in what we could call “enabling environment”.

I am old because I have a wife, children, grandchildren and great-grandchildren. It is unfortunate that my children with my small wife [32yrs] aren't old enough to have children, thus you have missed witnessing the *ngoma* (literally “drum”, refers to a special event, often with dancing) of being called *babu*. As I told you, I have another wife, much older than this one [83yrs]. We got divorced after she felt that I cannot look after her anymore. This was when I became blind. I have eight children with her, but three are dead. When those who are still alive visit with their children, this compound becomes full of them. Then the *ngoma* begins: you only hear *babu!babu!babu!* They tell me in many voices that I am not getting old but that I am old. These are my own children and grandchildren.

If I sit outside [of my house], you will hear the people passing by address me as Mzee Juma. Their voices send a very strong message that my days are numbered. My time is coming soon and that I have to give up in this world. This is because I

am called *mzee*. I cannot deny; it is true that I am *mzee*. No matter how much I disagree, they will just continue and even at times ask if there is something wrong with me that I don't want to admit being *mzee*.

You are asking about signs of old age? Look at my hair. It is white, isn't it! This means I am *mzee*. Look at my skin and face; they look different from that of a young person whose body is full of flesh and attractive. Mine is like a dried up tree. If you touch my body you can feel how rough it is, and the skin is almost coming off the body. An old person's skin looks like the skin of a crocodile: it is rough, hard and ugly. As an old person you also become lazy like a crocodile that has just caught and eaten a big fish. When you and I will get up from here, for sure it takes you only a second, but I have to think about how best to get up without hurting myself and then have to calculate my move. These are signs of old age, and I can see that I have them. However, I am better off than my friends who have worse health conditions. Some cannot participate in public events anymore. If it was not for the blindness, I would be everywhere. Since I get at least 20,000 Tanzanian shillings every month, I would do a lot and travel to many places. Now that I am blind, I can only do that with the help of someone else, but all in all, I consider myself strong, and old age hasn't pinned me down yet.

But looking at my own generation, I see that my age mates are old and some have even died. I have been receiving a lot of respect from them. Some have been addressing me as *mzee*, and I see that they are getting old like me. Those I respected have gone. Thus, if you see your own age mates going, you become aware that you will be next. I remember when I got married the second time, some of them joked that while they were getting old, I was getting young. Of course many did understand that I had to marry to continue enjoying life. I needed

someone to be with me, and I decided to go for much younger wife (35yrs). I am still able to look after the younger wife. I get money from the rentals, and this means, I can provide for her and the children. I am also very active. I can still satisfy her and make her happy. I am full of energy, I have strength. I am strong and my health is not as bad as that of many others in the town. Compared to many others in this town, I am very strong. My only worry was, when I got eye problems and became blind. But look, I can talk, walk, and even help to look after my son who has mental problems. He cannot talk or walk. I can also help my wife when she goes to the *shamba*: I [stay behind and] make sure that there is security here.

Sometimes with or without strength

A second category of older people have assessed their health condition as “sometimes having strength and other times not having strength”. For practical reasons we refer to this category as “sometimes with/without strength”. During our first visit, 52 older people, 18 men and 34 women, believed that their health condition was not very stable. To gain a thorough understanding of what this meant and how it could enhance our understanding of ageing and health, and later care, we further purposefully selected 19 of them (7 men and 12 women). We spent seven months in the field, following them up, trying to capture their everyday activities, moments when they thought their health was stable and moments when it was not. The majority were aged between 60 and 95. This shows that they were older than those in the “with strength” category but younger or equal to those in the “without strength” category. They were somewhere in between. It was mainly women who exceeded the mean age of 85 years. However, as mentioned earlier, chronological age is of less relevance in their everyday relations and

interactions. They only mention it when they are asked for their age by authorities, for instance, when they go to a health centre and during official registration.

Different from the older persons with strength, this middle category seems to experience critical moments more often. This implies that their responses to the question were more diverse. In fact, we could make sub-sub groups, depending on their status during the visit. Each visit revealed a different health condition, which they sometimes referred to as more stable and at other times not. Three sub-groups were established on the basis of their responses. First are those whose condition was always with or without strength. Each time they were visited the response was the same. The second group comprises those who mentioned their condition as “sometimes with strength” during our visits and follow-ups, then changed to “without strength”. When other follow-up visits were made, they considered themselves as “sometimes” again. In other words, their health condition changed each time they were visited. The third group comprises those “without strength” but later ranked themselves as “sometimes”. Overall, the recurrent use of words and phrases described their health condition as “sometimes with strength and sometimes without”, so that they can be grouped neither with the older persons “with strength” nor with those “without strength”. Their responses did not convince us enough to establish another group separate from the existing three, that is, “with strength”, “sometimes with or without”, and “without strength”. For this reason, we treat them as a mid-way category. Their health condition varies. Generally, they are better than those “without strength” but experience more critical health moments than those “with strength”. All this affects the type of care they receive, as shown in chapter four.

Once more, their responses take us back to the whole discussion on health condition (*hali ya afya*) but in particular to the state of the body (*hali ya mwili*). Their health

condition being “sometimes with or without strength” means that their state of the body is also affected. This is particularly true when they are experiencing critical health moments. For instance, by referring to the state of the body, they indicate how they see the difference, in the sense that, “the body I have now is different from the one I had when I was young” (F-67yrs), or “I am now mature” (F-85yrs).

Not having a stable but rather an ever-changing health condition implies that their functional ability is a dynamic process that is bidirectional in nature. Indeed, this group is more dynamic and diverse than the other two. It challenges the perspective that treats ageing as an inevitable and non-negotiable process. Although this is true in terms of functional ability, it does not mean the end as, for instance, the biological perspective would suggest. The state of the body in terms of physical fitness is complex. In fact, the phrases in relation to physical fitness do not suggest a complete failure but periodical downfalls, as in many other groups. The extent of engagement in everyday life is undeniably minimal. This means that their responses to the signs of ageing in relation to the state of the body are bidirectional: at times they are strong and at other times not. It all depends on the critical moments they experience. For instance, when they were ill or not feeling well, for whatever reason, they would say they have no strength. Similarly, during a follow-up visit, the health condition had improved and they felt better or even recovered, and so their response was that they had strength.

This shows not only a dynamic and diversity in their health condition, but a bidirectional process of describing or assessing their health condition. This does not conform with the often heard view that the health of the older persons is a deteriorating linear process that eventually leads to death. Through the “sometimes” category we see how this understanding is challenged. In terms of functional ability, it implies that there are days when they perform their everyday activities and others days when they fail to

do so. Bibi Asha is a good example: “Ageing, you know how it comes, you start to lose strength and sometimes this condition comes and goes. [...] I had strength and now I see I am getting weaker and weaker and some days I am better and other days I have absolutely no strength” (F-71yrs). Although Bibi Asha sees her condition as deteriorating (suggesting that she is in the “without strength” category), she also acknowledges that some days she feels better and carries out her everyday activities in the family. She falls between having and not having strength. Similarly, Bibi Zena assessed her condition as slowly getting worse, but at least she can still perform her everyday activities by reducing her workload. “I was very strong and was able to farm but I am now slowly finding it difficult, I can only manage a small portion” (F-89yrs).

The responses of men suggest the same trend of losing strength and slowly reducing the amount of work they do. Interestingly, their description of the signs is context-based, reflecting the social and cultural environment in which they live. They construct these signs with reference to the prevailing cultural norms and values. Importantly, they reflect their everyday activities and, in this case, the social world they are engaged in and have to confront. Mzee Hamisi said, “I was strong and could carry heavy things but now I have reduced what I carry to only five kilograms or even less” (M-65yrs). Being a farmer, he did not surrender what he did due to ageing, especially when his health condition was marked by critical moments such as pain, illness and the rest, but he found a way to continue working and meet his goals. Rather than “calling it off” as commonly referred to by those in the discussion who had despaired, older people like him continued working but reduced their workload. They know their functional ability, their strength, is tested. They know this has happened due to ageing and they remember the experience of other older people, which encourages them to continue working. Mzee Jumanne also described his health condition as sometimes having and other times

not having strength. His opinion in the discussion was that, “I was able to carry all the heavy loads but now I carry only small and lighter ones” (M-62yrs in FGD). Another man reported: “I cannot do business anymore. I cannot carry the goods and cannot run after customers. I have reduced my engagement with the business and I rely more on my wife and children to run it. I only give advice and keep an eye on them” (M-71).

Despite their functional ability being tested, especially when they are faced with critical health moments, they manoeuvre and continue to engage in their social world. In fact, these critical moments provide a window of opportunity in which we discover agency. We see how older men and women during these times are engaged and what kind of resources they have to continue with everyday life. Some, however, notice a decline in health. Bibi Rajabu stated it as a general rule: “As you are ageing, your body becomes weak” (F-78yrs). Bibi Habiba reflected on her own experience by saying, “I realize now that I cannot keep up with farming like in the past few years. I am just praying that my body remains like this and that I don’t get ill. This is my biggest fear” (F-95yrs). Clearly, it is not ageing per se but critical health moments, especially illness, that is feared.

Although they are aware that they are slowly losing strength, they are also very sure that this is not the end. They still have to manoeuvre for a new position. Their functional ability deteriorates not because of ageing but through a combination of many other factors such as illness, tiredness and pain. However, as Bibi Rukia observed, “Ageing comes with illness. As you grow old, illness also becomes part of your life” (F-67yrs). And Mzee Hamisi reported, “I first realized that I am ageing when I started to become ill. I knew I could not farm or work anymore as I used to” (M-102yrs)

For the older people in this middle category, appearance is important but what comes with a change of appearance is even more of interest to them. With the change of appearance, several complications in life set in. The appearance adds to the many other signs one has already seen or experienced. Words such as “shrink”, “losing flesh” (*manyama nyama yanaondoka*) and “thinness” are only some used to portray their experience of changes. Interestingly, what matters are not only these changes but the state of starting to lose and regain strength. The changes are just a mark and indicate losing, regaining, and for some even never recovering this state again. The latter fall into the category of the older people who do not have strength. Some of the phrases below clearly refer to their bodily appearance:

“The body drastically shrinks” (F-60yrs); “...see! I wasn’t like this; I used to have enough flesh and looked nice!” (F-89yrs); “...the body becomes flinched” (F-79yrs); “a thin body shows that you are ageing” (F-98yrs); “your body shrinks like the way you see me, look! There is little remaining” (F-67yrs). “I looked attractive, I was fattish, I didn’t look like this, I had a different body, it was big, but that body is gone now, I see it going every day and I have been fixing my belt every year now. I am getting thinner and thinner” (F-93yrs); “I used to be very attractive and fat” (F-80yrs).

These phrases point out that a thin body is not due to illness, but ageing. For instance, when a follow-up question was asked on the difference between a normal thin body and an ageing body, it was very clear that the interplay of factors and experiences is called on. Therefore, it has to be a shrinking and thin body plus other experiences such as wrinkled skin and white hair. Nevertheless, one also wonders about the difference between the older people in this mid-way category and those in the other two categories. Indeed, once more the difference is in the interplay of being thin and the

recurrence of critical health moments, plus moments when they are relatively well. It is the fragility of the health condition that makes them distinct and their construction of appearance different. Those in the “without strength” category could do less even when they were not seriously ill than those in this category.

Therefore, the state of the body (*hali ya mwili*) involving thinness implies being weak and lacking strength. The reality of being thin, weak, and lacking strength and, consequently, being unhealthy is socially created and accepted. However, this does not tell us the full story about the everyday life of the older people in their social world. The older people in this category, even though they are thin, some even thinner than those in other categories, they still engage in everyday activities. When the follow-up question was asked whether they were completely exempted, or had exempted themselves, from work due to the state of their body being thin, and thus being old, the response was overwhelmingly the opposite. Almost all are still working and not out of necessity but because they want to fulfil their responsibilities towards their families. Their time has not come compared to those in the last category. Often they claim “they are not completely at standstill or unfit” (*hawajakongoroka*) as a common expression goes. This metaphor implies their functional ability is not as impaired as those in the “without strength” category. Their health condition (*hali ya afya*) still allows them to engage in everyday activities in their social world. They can still work, travel and visit, and they can still actively engage in everyday social interaction and relationships.

Among the other signs that became apparent from older people’s construction of ageing as a reality is white hair. Although white hair sounds biological, its implication in terms of the state of the body signals an ageing condition. It changes the appearance and consequently makes an individual start to reconsider his or her social life. I must admit that sometimes identifying the connection between the health condition and some of

these signs is not explicit, but implicit. Overall, this is what makes ageing interesting, dynamic and diverse to deal with. The way white hair is perceived, and how they talk about their appearance, might give us a hint to the link. Generally, white hair is used to refer to the construction of this mid-range health condition denoted as “sometimes having and other times not having strength”. At least the response with regard to their construction of white hair tells us two things: first, one is ageing, and, secondly, complications of the health condition could start at any time. This means, there will be times when they will have or not have strength. Phrases like, “I have white hair, my health is not predictable anymore because I am old, don’t you see the hair” are commonly used to refer to this ageing condition. Often, the hair is used to refer to the state of the body and, in particular, how one’s appearance is changing. In this case, appearance refers not only to physique, it is also taken, as already explained in the other category, as a visible sign. For instance, Bibi Mariam illustrated this by exclaiming that, “...look at my hair! You see, isn’t it white? It was not like this before! This is a sign of ageing” (F-60yrs in FGD).

However, white hair is also a contentious sign. Some older people discount it and others insist on its connection to other signs. For instance, as in other categories, some older persons in this category are aware that their peers dye their hair. They do so, according to some older women, not to look young, but to look smart and healthy. This implies that white hair is not only a sign of ageing, but also of being unhealthy (*kutokuwa na afya*). According to the older women’s responses, those who dye their hair deny and try to hide their ageing status. They do not want to be considered old, and perhaps their health condition is much more stable. When taking a combination of factors, excluding white hair, they might have even assessed their condition and state of the body as satisfactory, even good. This group not only challenges the chronological construction

of ageing, it actually makes approaching ageing complex. They are implicitly denying being old and explicitly sending a message of not being interested in exemption and social status. A woman in a discussion group further highlighted that,

I tell you, white hair used to indicate ageing but you people nowadays make it complicated, you dye it and the hair becomes different like yours. This makes it difficult to realize if one is ageing from the outside. But all in all, the fact that one is aware and has to change the colour means it is ageing and it is just that some people want to remain young for their own reasons. (F-79yrs in FGD)

A critical reflection on this group further brings us to the important notion that ageing is a social construct but that individuals use their agency to test it. They are not only consuming what is already produced but are actively challenging and negotiating a definition that suits them better.

This takes us closer to the notion of *uzee wa kujitakia* (careless/irresponsible ageing). This aspect cannot simply be ignored when referring to the construction of ageing in relation to the state of the body. Appearance seems to be a widely debated aspect as far as ageing and health is concerned. This is particularly true since it affects how older people perceive themselves. Importantly, it also affects how they relate and negotiate their space within the community. For instance, *uzee wa kujitakia* can mean, “being rough”, “having a long beard”, “not shaving the hair on the head and private parts”, “wearing torn clothes” (FGD with men). Unlike other ageing conditions, this one is acquired and has more stereotypes. In one of our evening talks, Mzee Abdalah said that, “...some people like to be seen as old” (M-68yrs). Assessing their appearance, Bibi Amina concluded that, “...they look rough and this means they invite ageing. By being rough they are making themselves prone to illness, it shows they are not careful in

protecting themselves from potential illness” (F-89yrs in FGD). Being rough therefore implies, “you are appearing old! You invite ageing by yourself, long beard, long hair and when asked the response is, I am old” (M-97yrs). The women further described this kind of ageing by referring to the usually invisible or private parts of the body (*sehemu za siri za mwili*) that, “they don’t even shave their private parts, everywhere they are rough, they look old even if they are not yet that old” (F-74yrs). This discussion made the approach to ageing complex and diverse. Its assessment, even by the locals, is not coherent and definitely not homogeneous.

The discussion in relation to the state of the body (*hali ya mwili*) with reference to how it shapes ageing takes us back to the already mentioned skin and facial appearance in the other category. As in the other categories, there seems to be a mutual understanding that wrinkled face and skin indicate not only ageing, but other conditions soon to come. What is of interest is how these signs are used to prepare for the “uncertain” future. Interestingly, this construction is always in relation to the young state of the body. Bibi Mwajuma said, “Okay look at my face, when I look at myself in the mirror, I see a big difference. I was not like this; my face was not like this! It has many wrinkles now. If we are to stand in front of the mirror, you will not see wrinkles in yours” (F-81yrs). This is only one side of the story where she now sees wrinkles and that her face has changed and that her skin is different. Importantly, if we both stand in front of the mirror, we clearly see the difference. The second part, and perhaps most important to us, is how she relates these changes to her own health in the sense that, “...now you understand when I tell you that there are times I feel no strength and there are times when I am strong” (F-81yrs). She is not only clearly constructing ageing as a reality, but what comes with ageing. Therefore, the changes in the state of the body are obvious in everyday life. They tell them who they are and what action is to be taken against

these conditions. The social and health implications are much more interesting. Bibi Tumu stated that, "...when you see an older person you notice the face has many wrinkles. Therefore, when you start to see wrinkles, friend! Know that the time has come and you are now an older person. You soon start to fail to do something but also have moments when you will be weak and moments when you aren't" (F-67yrs).

The older person "with or without strength" also considered the appearance of the body (*muonekano wa hali ya mwili*) as important in defining ageing. Thus, teeth and the condition of the eyes are crucial criteria that illustrate ageing with reference to the health condition. One older person stated, "Teeth, you see! They are gone and I cannot even eat a piece of fish, I cannot chew anymore! I am *kibogoyo* [toothless]" (M-82yrs in Male FGD), another commented, "Ageing comes when you start to lose your teeth. This only happens if it is not an accident and an illness" (F-67yrs). These and many more phrases that one could cite are all shaped by the prevailing norms and values, which are also shaped by the older people by reference to frameworks that attest to their own construction of reality. Sometimes these references bounce back, sometimes they are absorbed. This is where the complication and the interplay, or combination, become apparent.

Many older people in this category believe that blindness comes with ageing, but of course not in the case of every individual. They know many people who are much younger but blind. It all depends on the health condition of the respective person. Nevertheless, they believe that at some point blindness complicates the health condition and "destroys the appealing state of the body" (F-78yrs in FGD). One's appearance becomes challenged and changes. This implies that the eyes "go inside", "the upper skin in the eye drops and covers it", "the black eye (retina) changes to white", "one looks ugly and the face becomes unattractive" (women's' reaction and discussion on the

aspect of eyes). Older men made comments such as, “even if you never had any eyes problems, with ageing you will experience them”, “they have to start losing some sight (*muono*)”, “you realize that you are seeing the clouds and finally it all goes black”, “you don’t see anything”, “this happens when you suddenly start to fail to recognize people”. Although this construction has nothing to do with their “strength/without strength” category, it is interesting to see how these constructions fare in relation to the other categories. Actually, it implies that an eye condition limits their everyday engagement in the production of health. Blindness becomes a critical health moment that triggers a new arrangement within the family. Most of all, it prevents older persons from keeping up with their duties.

However, another experience of ageing is not only complex, but also difficult to deal with. This is the menstrual cycle, which is not talked about openly but secretly among women. Interestingly, these cultural norms and values seem to be of less relevance in old age. Thus, the matter is openly discussed and referred to as one of the signs of ageing. Although they relate these changes to being unable to give birth/being unproductive, more focus is put on the ageing condition. The menstrual cycle was regarded a sign of ageing more than in terms of the loss of reproduction. This is communicated metaphorically and one already notices in the language that it is rather indirect. Often referred to as the “menopause” in many studies, the emphasis in relation to ageing is more on the psychological effect than on the social aspect. These studies focus more on the relation of menopause symptoms to childbearing (Beyene 2009). In this study we will try to relate the menstrual cycle to ageing and, importantly, the state of the body (*hali ya mwili*), as most older women stated that,

“...you see, the sign of ageing is when you realize your blood gets dry. That blood is what brings temptation and when it dries up then it means you are no longer a

younger person but rather you are ageing” (F-67yrs); “I first realized I am ageing when the dates stopped, first I was getting three normal days, then it was reduced to two and last to one. Then suddenly it stopped and I then realized I am growing old” (F-85yrs in FGD); “I told you the important sign for a woman to see that she is ageing is when her bleeding stops. This is when she realizes that she is ageing” (F-89yrs); “...during that time I realize that my blood has stopped. Loh! Then there was nothing more remaining in my body and I knew that is it, I am ageing! (F-95yrs).

The menstrual cycle having stopped does not immediately mean being *mzee* (an older person) but a process of *uzee* (ageing). As Bibi Rehema put it, “If you were a mother, when you see that you are not conceiving anymore, you try so hard to become pregnant and nothing happens then you have to know that the beauty of being young is over and you have started growing old” (F-68yrs).

Showing the importance of considering the interplay of the factors in constructing ageing, statements such as, “even if you are still having strength, you can work, you can do all the activities, the fact that you are not able to conceive is already a clear message that you are ageing” were common. The menstrual cycle mainly featured in women’s narratives and in response to the question concerning the signs of ageing and how they experienced it. The women in their discussion groups revealed this first shock of “not seeing the days”, “being dry”, “no blood”, triggering a reaction of, “Loh! I was seeing this but now nothing comes out”. They share this information among themselves to express their initial shock. By sharing and discussing the issue, they get assurance from others who have already gone through it. In this sense, their experience and process are shaped by other actors around them. These can be fellow women of the same age or *bibi*. The latter mark the generational importance in shaping the ageing condition.

Other signs in relation to the health condition (*hali ya afya*) are more in reference to what Obrist (2006: 133) has called the state of the mind (*hali ya kifikirira*). These signs were described as: “You talk to yourself”; “an older person has many *fikira*”; “an older person talks to him/herself”; “the words just come as you sit or even walk”; “sometimes you laugh and sometimes even cry when things aren’t working nicely”. Such signs indicate that the state of the mind is unhealthy (*haina afya*). The older persons in this category are also aware that it all depends on what comes into your life and how stressful life has become. Generally, there seems to be an understanding that an older person is always occupied by many thoughts (*fikirira*). As Mzee Hamisi explained, “Ideas (*mawazo*) occupy your mind” (M-81yrs). Furthermore, “Ageing comes when you start forgetting and mixing up things. You suddenly start to forget what day it is, and where you have put even your own clothes or cap” (M-83yrs).

Interestingly, the state of the mind hardly featured in the other two categories. It seems to be a big issue that comes with an unstable health condition. This further means, given a fragile health condition, the older persons find it difficult to plan their lives. This is because they sometimes have strength and at other times they do not. All this means that one is “constantly thinking about life, trying to come up with a viable solution” (M-72yrs).

Case study 3.2 Bibi Jika, 102 years old

Many of the older people who fall into the second category felt they are on alert as critical moments may happen anytime.

First my name is not Jika but Bibi Jika or *kuzima wapi* (where is life). I am *bibi* for many reasons and compared to many other *bibi* in our town, I have eaten salt. Throughout my life I have seen a lot, experienced a lot and have seen people coming and going.

I am *bibi* because my children have grown up and they are also called *bibi* and *babu* and this makes me consider and proudly claim myself to be *bibi*. Of course this wasn't an overnight thing, it took a lot of time. I was first called *bibi* when my son had a baby. Then they called me *bibi, bibi*. But this was a different *bibi* as I was 32 years old. Now I have seen many grand children who also have children. I am swimming in the pool of people and have lots of grandchildren.

I also noticed that I am becoming old when I lost my days, it just slowly dried up, two months, then an interval of three months and lastly nothing was coming. It wasn't a nice experience as you are used to lose your days when you are pregnant but this time you don't even know why and how and what to expect but it is the stage that we all have to pass as long as God gave us time to experience that age.

Other signs! Yes look at these eyes they are slowly going inside and disappearing, I am sure soon I will not see. My face is also different, I used to be the catchiest girl in this small town and I enjoyed playing boys minds, they will come with their nice words but at the end I just play and laugh, they went dry, not offered what they wanted. This turned out to be bad when I started getting old, suddenly no one was

looking at me, ah! The nice and much younger and attractive girls were born. If compared to the younger girls, I looked different, not nice, unattractive, white hair and wrinkles were visible. I then slowly realized the time has come.

All these never stopped me from being active. The worst signs of old age are those related to your health. My health has been unpredictable over the years now. You might remember that when you first came to my home I was with that couple, they came for medication. I am a healer but this all depends now on my condition. My health is not predictable; there are days when I am okay and some when I am not. When I am okay I can collect the medicine from the forest but when I am not I cannot go anywhere. This is becoming like part of my life now. It affects my patients because sometimes they will have to stay longer to get the medicine. It also means some do not come anymore because often when they come and it happens that I am sick they will have to wait until I get better.

Since I became old, illness has become part of me, it is impossible for a month to pass without feeling pain somewhere in the body. It is the knees, back, shoulders or even sometimes terrible headache. I go to bed with pains, spend the night with pains, wake up with pains, prepare and take breakfast with pains, lunch and dinner with pains and finally go to bed again with pains. It is a cycle, and it is difficult to avoid being in this cycle; at this age you have to experience and feel the drums and finally play the *ngoma* (dance). There are many others who cannot even walk out anymore, at least few of us are able and we can feel the pain but still continue with our work. The time hasn't come yet to surrender the tools. My health condition is very unpredictable. There are days that I have to move to the *shamba* and live in a *dungu* to look after the crops that they are not destroyed by the monkeys, birds, wild pigs and other wild animals. This is because I cannot walk fast anymore. It

takes me two hours to reach the *shamba* and this is too much, so I have to rearrange my *shamba* timetable.

Without strength

In my study, 26 older persons (12 men and 14 women) out of 92 visited in the household study categorized their health condition (*hali ya afya*) as “without strength”. Their descriptive responses were rather general, and so, in order to obtain more information on their health condition, 22 older persons (8 men and 14 women) from those first visited were selected and visited several times. The time spent together during the visits sharpened our understanding of how they refer to ageing in relation to their health condition (*hali ya afya*). Almost every older person revealed how ageing is experienced differently from individual to individual, and even in Ikwe Town there is no universal experience of ageing. Ageing differs accordingly, it is experienced differently but the construction is social.

The descriptive definitions and explanations by the older persons in the category “without strength” reveal the importance of the state of the body (*hali ya mwili*) in the construction of ageing in relation to their health condition (*hali ya afya*). All the older people’s responses in this category, regardless of age and gender, mentioned the state of the body as a sign of getting old.

They claimed to have experienced the first signs of ageing when the strength of the body began to deteriorate (*nguvu ya mwili ilipungua*). The first signs became noticeable when they started to fail in their everyday activities. A normal typical day for women starts with a series of activities such as getting up, sweeping the house and the

compound for women, preparing breakfast for the family and going to the *shamba* to work where the husband has already started. They then prepare lunch in the small hut in the field (*dungu*) during the agricultural season, or at home after harvest. Other activities include fetching water from neighbours who have boreholes, relaxing and conversing with family members or friends who come to visit or are visited. Other routine activities include taking a bath and, on a typical day, would end with preparing and eating dinner. Sometimes, they gather firewood from the lower river valley or buy it at the market. Prayers and participation in events (*matukio*) such as rituals and meetings also mark the daily schedules.

This state of the body could be mistakenly associated with illness, but the older persons are clear on this: “The body just like mine doesn’t have any illness and was never sick but slowly I was getting weaker and weaker and now I can hardly get out of bed. These days loh! I don’t have anything left; I stay inside, being fed and wait for the moment to die” (F-78). With reference to work, the “without strength” category also disclosed a complex picture. There are older persons who stay in bed due to loss of strength and are too weak to do anything. In an evening chat, one of them illustrated her condition as “useless... I failed to do all the activities and became of no help” (F-98yrs). Some are still able to do some minor activities in the house, others like Bibi Hado are “just sitting around doing nothing, completely without strength now...I cannot even lift anything anymore” (F-82yrs). And Hami explained: “Human beings are not like a machine, which has spare parts. We do not have them, every time and every day your body deteriorates. It is just a matter of time before complications start which mark ageing. This is how we are meant, with time you realise you cannot even lift your hand and this is already ageing” (M-98yrs). Several older persons pointed things out like, “ageing comes unnoticed” (F-60yrs), “it doesn’t knock” (F-89yrs), “it doesn’t ask, not for men

or women, when it comes it comes and you cannot stop it” (F-72yrs). A loss of strength per se is not a sign of ageing. After all, even younger people experience loss of strength but then it is usually associated with illness. Older persons simply get weaker and weaker, and their loss of strength may be complicated by an illness, as Mzee Shabani explained:

“When I was young, I was able to walk long distance doing my petty trade. I was farming and daily going to the low river valley before completely moving and settling in the town. But I slowly started to fail walking long distance with my goods on hand, secondly walking and farming became too much and I decided to stop business and completely move into the *shamba* during the agricultural season. I could not manage to walk daily anymore. This was further escalated by the illnesses, I had hydrocele, which was painful, and my scrotum was swelling and becoming bigger and bigger, finally I could not walk anymore and completely stopped walking and working. See this is ageing! It started slowly! Slowly! Until it pinned me down!” (M-78yrs).

Having no strength is not only about being at home all the time but also about being unable to engage in social events. Events such as rituals relating to death, initiations, birth, and even farming require a great degree of movement. Having no strength means an older person is somewhat cut off from these social interactions and relations. They engage with others through visits, often during evening hours or when there is a critical health moment. For the majority this is of great concern during old age.

Apart from the state of the body with reference to physique as a sign of ageing, the body’s appearance (*muonekano*) was also a topic in the statements offered by the older persons in responding to the sign of ageing. According to them, what the body looks

like (*muonekano wa mwili*) tells a lot about growing old. The older persons identified signs of ageing with reference to skin, wrinkles, visibility of veins and muscles, grey hair, loss of teeth and even blindness.

Bibi Asia remarked: “When I saw my skin drying up and sagging and the muscle tone gradually started to decrease, I knew ageing had started” (F-81yrs). These signs become clearly visible in places like the “chin, neck, face and even hands” (F-71yrs in FGD). In their discussion of skin as a sign of ageing, men concluded that it becomes dry. Women concluded that the outer layer not only becomes thin but also dry. Generally, the skin seems to be of more concern to women than to men. The older women always talked about the skin becoming dry, wrinkles appearing and that, no matter how much one applied skin lotion, especially locally made coconut oil, it does not help when it comes to ageing skin. That means that, when the skin starts to become dry, with wrinkles appearing on the chin and face, ageing has set in. Regardless of gender, the older people in the “without strength” category believe that a skin with wrinkles (*ngozi inakunjamana*) is a sign that you are getting old. Protruding veins is also a sign of ageing. Among the older women in the “without strength” category one participant commented on this by saying, “The veins become visible, this means you are now ageing, the skin develops wrinkles, it becomes dry and all the veins are exposed and become loose, then you know immediately, I am now getting old” (F-102yrs). The visibility of the veins implies loss of flesh. It further means the body becomes thin and different from that of younger people. This is illustrated by one informant whose veins were clearly visible and whose skin was very dry. He exclaimed,

“Look at me, look at my hand, chin, face and even thighs, what do you see! No flesh (*nyama*), it is all veins; there is no flesh anymore in me. All that now remains

in my body are veins and bones so that if I am taken to the hospital the doctor will have no difficulties finding veins for the injection (M-97yrs).

A similar point was made by a very old woman during one of the visits and conversations:

“...there is no flesh in my body anymore; it is all bones that are seen, and veins. When I visit the hospital for treatment, they do not even take time to inject me because everything is visible. You can count my ribs, you can see the veins and muscles even from afar” (F-102yrs).

If we carefully study their interpretation of the skin becoming dry and the veins being visible, it takes us back to the discussion on the combination of conditions in defining *uzee*. The visibility of the veins per se is not enough to show the ageing process. However, if it comes in conjunction with dry skin and a thin body, as in the next section, it is more likely to qualify as a criterion. During conversations and discussions the older people were very clear about what these signs mean. They often draw comparisons with young bodies which occasionally also display these traits, but their case is a different matter since the occurrence comes in combination with a host of other facets. It is actually an achievement, something positive, not feared as in the case of young people.

Another important aspect that resulted from the question about signs of ageing in relation to health condition and subsequently the state of the body is thinness. According to the older people in Ikwe, the body becomes thin (*mwili kusinyaa*) in advanced age. This construction is guided by general observation and how those with a thin body are addressed as in, “you are thin like *mzee*”. This culturally and socially produced understanding of a thin body is used to describe an older person. All our study

participants mentioned that having a thin body was one of the signs of ageing. The thin body is further associated with visibility of the veins, as illustrated by an example from a focus group discussion conversation where a woman said, "...as you become thin, the veins become visible and everyone realizes that you are getting old" (F-75yrs). Other statements of women in this group suggested that thinness of the body may also entail maturity. When asked to explain the relation between maturity and ageing, one woman said: "When the body becomes thin (*mwili unakuwa mwembamba*), it is a sign that the body is mature (*mwili unanza kukomaa*) which means ageing" (F-87yrs in FGD). Being thin becomes something uncontested in old age. It also addresses the topic of responsibility and exemptions from some of these duties. Therefore, it is "something positive even though no one likes to have a thin body" (F-89yrs in FGD). Thinness is influenced by and "drawn" from cultural norms and values. It is not necessarily something an individual has invented, rather it is acquired through communication, interaction and relating to many others. In other words, it is shaped by cultural norms and values which also influence how individuals respond to these signs of ageing.

In focus group discussions and during informal talks, men and women often made a link between a thin body and HIV/AIDS or tuberculosis: "You become thin like someone with HIV and AIDS or tuberculosis" (*unakonda kama una ukimwi au kifua kikuu*). It shows how the people's conception of ageing is related to real life experience. The social environment, everyday life and ideas shape the way they communicate and construct reality. One wonders if the same reference to the state of the body existed four decades ago before HIV and AIDS became a major public health problem. Interestingly, the thin (*mwembamba*) state of the body (*hali ya mwili*) is accepted and "naturalised and fixed" (Featherstone and Hepworth 2009: 138) as a cultural category in the everyday construction of ageing. It is expected that an older person's body is thin

and not fattish. In other words, the old body is conceptualized as small in size and shape and with less or no strength.

Older people in the “without strength”-category had mixed views on using “white or grey hair” (*nywele nyeupe*) as a clear sign of ageing. Although they agreed that *nywele nyeupe* is a sign of getting old, they see that more and more older persons are colouring their hair to remain and be seen as young. In our informal evening talk, Mzee Juma explained, “you don’t actually need to cover your head with *kofia*-cap anymore, you can use colour to hide the whiteness on your head nowadays” (M-98yrs). This shows how older people challenge the appearance of the state of the body through artificial construction. White hair does not tell us much about ageing anymore because even young people have it. This is because of the food they eat, the oil and lotion they use, which is all artificial. To them, it is of great concern that they will have difficulties when they grow old. Some even think they will not even reach their age. Thus, while, on the one hand, white hair is used, on the other, it is contested. This became clear during the focus group discussions and especially among women, who reprimanded older men for colouring their hair. According to them, “they want to be seen young so that they can seduce women, in particular younger women” (F-85yrs). The relationship between white hair and the everyday life of an older man seemed very clear to them. Their judgment is sharpened by the everyday challenge and the pressure that is exerted on them, in conjunction with their own expectations. The women’s responses had one thing in common, namely that older men change the colour of their hair to win over younger women. Bibi Amina lamented that, “the cashew nut season has started, soon we will be of no value to them, they will colour their hair to look young and seduce younger women” (F-67yrs in FGD). Other women commented that, “nowadays people tend to want to remain young, they change the colour of their hair, and thus the criteria

of identifying white hair as a sign of ageing doesn't really matter much" (F-88yrs). Some women were furious about this new development and even asked: "Who are they fooling! Is it us, their wives, or younger women?" (F-61yrs). This not only shows how the signs are contested but that ageing does not stop them from maintaining an interest. They become creative in order to shape and live up to the expectations of the new lifestyle and its cultural spaces.

The older people's response in relation to state of the body expressing signs of ageing also revealed how loss of teeth was important. This happens for many reasons. First, as a sign of growing old, and secondly, because they need teeth if they wish to remain healthy. Most of the food requires teeth for chewing. Therefore, if people are to remain healthy, they have to have teeth. But significantly, it is also about the appearance of the state of the body. Being aware of other older people reaching old age with intact teeth and some even dying with teeth, they again reiterated the importance of not generalizing. It all depends on the individual case and person concerned. Nevertheless, the analysis revealed a consensus that losing teeth is sign of ageing. This view is also reflected in daily life. During evening visits, especially when the grandchildren and even sometimes children are sitting and/or playing around, it is common to hear the words, "Come on! Have you lost your teeth like an old man (*umekuwa kibogoyo kama babu*)? Don't speak like an elderly! Increase the volume of your voice; you still have complete teeth in your mouth! Speak out!" These are the words that can be heard and it reveals how a soft voice is associated with the loss of teeth and accordingly used to describe ageing, even among younger people. The reference is to the state of the body of person who is not sick, but old.

The appearance of the body in old age is often described as "unattractive" (*haupendezi*). The wrinkled and dry skin, the visibility of the veins and the loss of teeth all suggest an

unattractive, ageing body (*mwili unaozeeka*). However, these signs are not taken to suggest being unhealthy. They are signs of ageing, and nothing can be done about them. As Bibi Hadija explained, “You cannot deal with ageing, when it comes! It comes! And the only thing you can do is to know how to face it. The illness is treated and there is always medicine and you can overcome it” (F-75yrs in FGD).

Nevertheless, for the older persons who described themselves as “not having strength”, illness was a big topic. Often in formal and informal discussions, they used phrases like “an older person’s body becomes home to illnesses (*mwili wa mzee ni nyumba ya magonjwa*)”. This was particularly referred to during follow-up meetings and also during my regular visits to check on their condition and, importantly, to capture moments when care is provided and received (dealt with in chapters four and five). It was interesting to see how they use similes to describe what they are going through: An old man explained: “Diseases during old age are like chicken, which go out in the morning as soon as they see daylight and come inside as soon as they see darkness” (M-86yrs). This has two implications. One is that diseases are signs of ageing, together with other signs. Secondly, as one ages, diseases become part of everyday life.

Pains also become part of life, but for me as a researcher it is difficult to record. Sometimes the older people just say the pains are felt all over the body (*mwili wote*), and if asked exactly where they will only mention a few places. The majority will still say the whole body. However, pains in joints such as the knee, lower back, shoulder or other parts seem to be a major issue. This made Mzee Ali conclude in one of our evening talks that, “diseases disperse during the day and come inside and sleep with us at night (*magonjwa hutawanyika mchana na kurudi na kulala nasi usiku*)” (M-92yrs). He explained his experience with the pain and diseases he is suffering from. This

confirmed what the older women mentioned above about diseases during old age being like chicken.

Due to these pains, especially in the joints, the older people's "functional ability" is challenged. For instance, Mzee Athumani expressed that,

"The knees becomes so painful, I cannot lift my leg. You will see when we are done here, it will take me up to two minutes to get up, I wasn't like this, and these changes came lately when I become old. I even have to choose the place and style of sitting so that it becomes easier to stand up when I want to, especially when I have to rush to the toilet." (M-86yrs)

Similarly, the older women complain of the same joint problems and of movement becoming a problem due to ageing. Their state of the body is weak and always in pain, which makes them have to plan their actions, where to sit and for how long. She commented,

I realized that I was ageing when I had severe pains in my waist. You have pains with little or no relief even after using the medicine, then this is already the sign that ageing process has started. There is little you can do, wait and use the coconut oil and warm water and some leaves. These legs, you will leave me here, come back and I will still be sitting here, I cannot move anywhere anymore. (F-98yrs)

For the older men, hydrocele and hernia are major problems. Not only do they feel pain but it is also embarrassing and unattractive. Hydrocele is prevalent in the coastal community due to mosquitoes as the carriers of filariasis. In the local perspective, the disease is associated with witchcraft. Moreover, women are said to prefer men with hydrocele because they are *Mamwinyi* (big men) and considered sexually attractive.

However, for men hydrocele limits their movement and is an embarrassment. In our study, 15 older men had this problem.

A weak bladder was another sign of ageing for men:

The complications at night, every time you want to pee... This was not the case [when I was young] but when I realized the frequency of getting up at night to go the toilet has increased then I knew oh! It has come. This means the veins have loosened up and cannot hold and the bladder becomes weak. (M-67yrs)

If it is a pain that comes on and one does not have any other signs of ageing, then he or she will say, “Ah! It is pains due to an accident that happened some years back”, or “it is the heavy load I carried last week”. But if it recurs then together with other signs it becomes a sign of ageing.

Case study 3.3 Mzee Shabani, 86 years old

The case of Mzee Shabani clearly illustrates the complexity and diversity in defining and understanding ageing even within the same category. Many signs mentioned in the above two categories pop up again. The difference comes when the older people think that they are slowly being confined to their beds and waiting for death as a new chapter in life.

I am old and would describe myself as not having strength anymore. You still remember when you first came here, I was renovating my house and my wife was helping bringing the grass. It was leaking almost everywhere. Despite the leakage I am now more concerned with my next life. When you first came I was able to renovate my house and help my wife. Look how I am now, my health and body have completely changed. I am more concerned with what happens when I die than

the condition I am going through. It rains, it leaks but it is less serious than not being prepared for the life after death. This is my concern, so more prayers now than ever and this is what I would like to work on and if possible renovate and fill in the holes that I made in life. This house is temporary and it is only the physical shelter but there comes another life which is permanent.

How many times have you visited me now? It is more than 14 times, right? Then look! Every time you come, there is something new. When you first came I was able to walk and at least visit my brother Mzee Sulle. This time, I cannot even come out of my bed anymore. Each day is different in my life, I can feel that yesterday is different from today and for sure tomorrow will also be different. Every day I feel being sick, weak, with no strength and the pains are becoming unbearable. However, since they are always here to stay with me, I cannot complain much about them; after all they are typical signs of old age. It is too embarrassing and shameful if you complain a lot about these pains. You just make others suffer and get frustrated.

I was a fisherman; I had a good time being on the ocean, on rivers and had really nice fishing experiences. It was the activity that made me run the family. I gave up due to sickness and old age. I have travelled to many places like Dar es Salaam, Mombasa, Oman, Somaliland and Egypt. I worked on an Italian ship. Unfortunately I had to give up this career due to old age and ailment. It is surprising to see how much old age can do to a person. I never imagined not being able to visit my children in Ikwiriri which is only 10 kilometers from here. The place has become too far for both me and my wife. My movements were limited at first within the district, community, village, hamlet, and compound and now inside the house and finally look! I cannot come down from bed. This is happening, it is

real, I am held on my bed and I see that a day will come that I cannot move my hands, legs and that I can only open the eyes and mouth to communicate to my wife and grandchildren who come every Saturday. I also have a feeling that the day is soon coming when even the eyes and mouth can't be opened; this will be the end of the 86 years in this world. I will then start a new life in an unknown world that I couldn't even describe.

You are asking about the signs? You actually don't have to ask. You can see by yourself how it is and what I am going through. I don't have any teeth left in my mouth, have become thin like a little kid, even a little kid is better because there is flesh but I don't have any, my body has come like a dry stick, hard like a dry stick. It has started to deteriorate and unfortunately there is no spare part. When one part is gone it is gone, you just look and look and wait. Therefore, if you have all these experiences and you have also seen the changes in your body, for sure you are old.

3.4 Conclusions

The literature often refers to the complexity of defining ageing and old age within and across cultural groups (see e.g. Chivers 2003; Cattell and Albert 2009). Makoni and Stroeken (2002:1), for instance, have pointed out that "older persons do not respond to ageing in a uniform way, nor do societies ascribe status to, accommodate, or care for older persons in a similar way." Inspired by these and other texts, I have tried to elicit ageing as a diverse and dynamic experience in Rufiji by studying everyday practices embedded in social interactions.

This chapter has highlighted that growing into old age can be considered both literally and figuratively as a vital conjuncture (Johnson-Hanks 2002 and 2006). Older people in Ikwe Town speak of old age as *ngoma* (a special event or drama, Case Study 3.1 and

3.2) which for us indicates that they consider it as a vital conjuncture (Johnson-Hanks 2002 and 2006). In our view, all the social dimensions of old age as well as the conceptual links between ageing and health converge in this vital conjuncture of old age. From their descriptions of the signs of ageing (*dalili za uzee*) we can abstract several social dimensions of ageing, which in many ways conform to studies in other settings (Fry 2007).

First, age is conceptualized as a person's relative position within the life course from birth to death. In this small town, many older people have known each other for a long time or they use well-known events to assess whether somebody is older or younger. This even applies within a generation. A person who is older along the life course dimension is called *mzee* in the sense of seniority.

Second, the term *mzee* is an achieved status. One cannot simply claim to be a *mzee*. It is a title given by others to designate social status. "You have to earn it and strive to get there," as one man put it. Similarly, the polite address *shikamoo* refers to status. Both imply respect, seniority and authority. But nowadays, seniority and authority also come with positions in economic, political and religious fields. In this sense, even a young school teacher or politician can be addressed as "*shikamoo mzee!*"

Third, whatever a person's status of seniority or authority, he or she cannot just be called or call himself or herself *babu* (grandfather) or *bibi* (grandmother). This term is reserved for those with at least a grand-child. However, since people have children at a young age in this area, even being a grandfather or grandmother is not necessarily a sign of *uzee* (old age). Somebody's status as *babu* or *bibi* becomes very clear though once many voices call him or her by these terms (i.e. when there are many grand- and

great-grandchildren). An important social dimension of age thus plays out along kinship.

Fourth, the health status is another social dimension of ageing. Drawing on the approach developed by Obrist (2006) in her study on Swahili conceptions of health as encompassing both the state of the body (physique, appearance, functional ability) and the state of the mind, we have examined the intersection between ageing and health. The three emic categories concerning the health condition among the older people complement each other rather than showing differences in how ageing is constructed in relation to health.

Since the older people in Ikwe Town emphasized physical strength as a key health concern, a finding which has also been reported from other parts of Africa (Fry 2007), we grouped them according to how they position themselves along a continuum from “having strength” to “not having strength”. In their view, their relative positioning along this dimension was caused by the ageing process and/or illness.

In all three categories the older persons also referred to physique, in this case the “thin body” which was considered as “normal” for older people, and other bodily signs, such as white hair, loose skin, visible veins, no teeth, impaired eyesight and hearing, and of course menopause for women. Appearance was mentioned more by women and referred to ways of taking care of oneself, for instance in terms of hygiene and dressing. Both men and women made remarks about the unattractiveness of old bodies. The state of the mind (*hali ya kifikra*) was mentioned by a woman in the middle category and a man in the “not having strength”-category. Not surprisingly, stiffness, pain, illness and even death were much discussed in the latter category (see Case 3.3).

The key criterion of their assessment was whether or not they were able to perform gendered routine activities or responsibilities. The first group thus considered themselves as still capable of performing these activities and tasks, the second group noticed an up and down in their capability to perform (see Case 3.2). The third group was no longer able of performing routines or tasks; they were confined to the house, some of them even to the bed. A surprising finding was that a blind man in Ikwe Town considered himself as belonging to the first category because his social position and wealth enabled him to still perform many activities (see Case 3.1).

In their assessment, they compared their health status with the bodily condition of others, linking the health dimension with the life course dimension. They were very much aware of the fact that the health status of people who were born around the same time ranged from one pole of the continuum to the other. At the same time, they admiringly noted that some people who had outlived many others were still able to perform their routines and tasks. For old people in all three categories, the “not having strength” category served as a reference frame in their own positioning. The awareness that they were increasingly likely to move into this category was also the cause of much anxiety and uncertainty, pointing to the potential fall into a “triangle of uncertainty” (van Eeuwijk 2006).

International categories based on chronological age are not (yet) of relevance to the older men and women of Ikwe Town but may increasingly become so if the age screening by the local government authorities and the cut-off point 60+ will provide free access to health services or to social pensions. Up to now, what counts for older people is not a conceptualization of age in terms of numbers but in terms of social status and health status and the engagement in everyday social relations and interactions associated with both.

Chapter 4: Ageing and Health in Bumba

4.1 Introduction

Chapter 3 examined how the social realities of ageing and health are constructed in Ikwe, a rapidly growing rural town. In this chapter, I will deal with the same topic but in the remote village Bumba (see Map 3). The nearest exit and entry point from and to the village is the small town Kibiti, located on the main road from Dar es Salaam to Ikwiriri, Lindi and Mtwara. People living in Bumba village have to walk 20 kilometres to get to Kibiti in order to access health and other services, buy basic necessities and get transport. Kibiti is also the place where the meetings that involve officials from the higher authority are hosted, as Bumba is too far away. A few people use bicycles to and from the village, but most of them walk. This also implies that older persons have limited access to the services in Kibiti town. A small kiosk at the centre of Bumba village sells basic goods such as cooking oil, sugar, salt, kerosene, sardines and other foodstuff. Moreover, the village borders on the Selous game reserve. At night, wild animals roam the area and present a threat for the villagers. The older people's construction of ageing and health thus happens in a demanding physical environment.

Just like in Ikwe town, during our first visit we established the number of inhabitants in Bumba village. This task was not the easiest considering the physical layout and structure of the village. It has three hamlets, the homesteads are dispersed and the man-made infrastructure is one of the poorest in the Rufiji District (see Plate 4). Together with the village chairperson, the whole field research team first marked the boundaries of the village. This took us two days, even though we could use the project motorcycle. As mentioned in Chapter 2, we first conducted a Community Study and then selected 21 older people (8 men and 13 women) for the Household Study to get an overview of

older people's living and health condition. For the Age Group Study I then zoomed in on a sub-sample of 14 older people (9 women and 5 men) and followed them up for six months. This chapter presents an analysis and interpretation of all the findings, including insights from my own stay in Bumba.

In order to compare the findings from Bumba with those of Ikwe Town, I structured this chapter also in two sections: The first section discusses the social dimensions of age, and the second presents links between ageing and health. Unlike the older people in Ikwe, issues such as intra-generational relations, grandchild principle, and respect are not explicitly mentioned by the older people in Bumba. However, they are raised in a different way in discussions about "not claiming to be *mzee*" and joking relations. Interestingly, it becomes clear that even though they were not the topic during our discussions, the phrases of the older people did point to similar issues as in Ikwe.

4.2 Social dimensions of old age

As in Ikwe Town, recurrent phrases suggest that ageing is both a natural and a social process. Men and women experience that they are growing older, but they have to wait for others to call them *wazee* (Plural form of *mzee*). This was made clear in a focus group discussion:

"You cannot simply claim to be *mzee*", or "you cannot force people to call you *mzee*", "they have to see if you deserve it". On the other hand, "you cannot protest against being called *mzee*", and "you cannot deny old age (*uzee*)". One can try to do so but then this often comes with negative consequences. The one denying it are hardly acknowledged or rewarded, and everything he or she does is considered "unfit", "not expected of him", "shameful" and "being childish". (FGD with men)

After being ascribed the social status of being *mzee*, a person is expected to act and interact in certain ways. If he or she does not observe these unwritten norms and values, depending on which context one is referring to, he or she will face some embarrassing (*anaaibishwa*) moments as a punishment. The “social clock” of old age thus ticks along norms and values (see Fry 2007) regulating what is considered “appropriate” everyday practice.

Some of these norms and values concern the appearance, for example ways of wearing clothes or jewellery. Older men should not wear trousers sitting low on the hips, a gold necklace or earrings. This dress code, referred to as *sharobaro*, is acceptable for young men but not for *wazee*. Other negative terms are “foolish old person” (*kubwa jinga*) or “a never ageing elderly” (*zee halizeeki*). These terms are mostly used by the younger people who push older men away from their domain. They show that once a man is put into the category of *mzee* or *wazee*, his behaviour and practices are expected to be different from those of the younger generation or he faces embarrassment. While old men are not expected to wear the *sharobaro* style, old women are expected to cover their heads. Going through this kind of social transformation brings respect in the eyes of the others.

The older women were particularly interested in the appearance of the body. During formal and informal discussions, most of their talk about signs of old age centred around the appearance of wrinkles on the face, white hair and even bending of the back. Taking off her veil and showing off her hair, Bibi Tisho (77yrs) said: “Look at my head, it is not getting white but it is all white, this is old age, all of us here are white, except you!” Her description of old age which emphasizes white hair was supported by other women in the discussion. At the end of the discussion the signs seemed to range from white hair to wrinkles, losing teeth and not being able to fetch water. These signs per se

do not mean anything; they have to appear in combination with not being able to work, being sick, to mention a few. As it turns out, the chances of claiming the status of being old is minimal if one does not have multiple signs of old age.

Intergenerational joking and the construction of uzee

In Bumba village, where up to five generations live together, inter-generational relations are a central part of everyday interactions. We will focus on the joking relations and how they are used to construct and communicate the meanings of age in Bumba village. Through joking the relationship between grandparents and grandchildren is built. This relationship becomes activated during critical health moments. Otherwise, it is unreflected or at least not talked about. Since they see many grandchildren around and several generations, there seems to be less excitement about the generational relation. What is communicated through these relationships requires in-depth knowledge to understand.

When we asked the older people what signs made them realize that they were aging, they referred to moments, when “the grandchildren start to joke ‘you *bibi!* You are decrepit (*wajukuu wanakutania, wewe bibi! Ushakwisha tena*)’”, when “they started to joke (*nilipoanza kutaniwa*)”, or said “you are an elderly! (*ushakuwa mzee wee!*)”. When these signs are communicated in a joking way, it does not hurt the one who is addressed. Put differently, it is through the special intergenerational relationships that the strength of the words that sound insulting and disrespectful is neutralised. Phrases such as “you are decrepit (*umechakaa wewe*)”, “not well mentally (*huna akili nzuri*)” or “you are done (*umekwisha*)” become something to laugh about rather than causing tension and conflict. At least it is the best response to laugh and not to take them to heart. Asha illustrated that by saying: “Usually the best you can say and do is to laugh

and continue with your work” (F-94yrs). Others simply respond: “Thank you my grandchild and life goes on” (F-68yrs). Indeed, these joking relationships are embedded in norms and values. Not every older person is joked about. It is between and among those who know each other. Joking about somebody with whom one is not familiar is considered impolite.

Through these joking relationships, some older persons are not only seen as *mzee* but they become a companion to talk to, as an old man explained: “You are done, you are awaiting death (*umekwisha wewe unasubiri tu kufa*) and you don’t even become mad because it is true you are the grandparent and who else will they joke with if not with you?” (M-89yrs). Although not every joke directly applies to every older person, overall, it is true that these are the signs; this is what the older people experience and see. Therefore, when their grandchildren start to make “nasty jokes”, it is a sign of ageing.

Of course, these jokes are sometimes bad but the older people also know they did the same thing when they were with their grandparents. This is why they are less affected and they themselves laugh at these jokes. The old women commented: “Whom are you getting mad at (*unamkasirikia nini*)?” – “We made the same nasty jokes about our grandparents and it is now our time (*nasisi tuliwatania wazee wetu hivyo hivyo na sasa ni zamu yetu*)”. These are some of the phrases used in relation to the intergenerational joking relationships during the focus group discussions.

Some of the allusions are difficult to understand: One woman reported: “Sometimes they want us to be like ashes (*wakati mwingine wanakutania kwamba tunataka uishe kama majivu*)”. The meaning here is that the older person was once like a tree. After being old and dried up, a tree gets used for firewood which later produces ashes. Bibi

Halima explained: “Often the grandchildren will wish us to get old until we are completely done like the ashes. You know the ashes from firewood! You become depleted like ashes and this is how our grandchildren wish us!” (F-83yrs) This language shows the grandchildren wish that their grandparents will live longer. All in all, joking is “something to laugh about”, “there is little to be mad about”, “it is a joke and it is fun” (Male FGD). Joking is neither considered negative nor condemned as far as ageing is concerned. It brings the actors closer together in the process of continuously constructing meanings and affirming each other’s status.

4.3 Experiencing health in old age

As in Ikwe Town, older people not only interpreted signs of old age in social terms but also linked them with health. The social terms used to express old age as explained above are slightly different. Again they commonly expressed their experience of these links in the idiom of strength: Being strong (*kuwa na nguvu*), sometimes with or without strength (*wakati mwingine kuwa/kutokuwa na nguvu*) and without strength (*hakuna nguvu*). These findings clearly show that personal experiences of ageing and health do not exist in a vacuum but are shared and talked about among the Warufiji. They provide a frame of reference for the personal experience of ageing by individual men and women. Their reflections about signs of ageing indicate how important health is, particularly in old age.

With strength

Four older men described their health condition (*hali ya afya*) as “having strength”. Interestingly, it was only men who argued that they were still able to engage in

everyday activities. Indeed, during follow-up, it became clear how active they still were. During the time I spent with them I saw them renovating their own houses, going to the farm, cutting and bringing firewood home, cleaning the compound, and attending public events, for instance Friday prayers, government meetings and funerals. What was important to them was that they were relatively mobile. They experienced critical health moments such as illness just like many other old men but they still considered themselves as strong because they were active, mobile and able to find solutions. All four men in this category were members of the village executive committee overseeing the development of the village and welfare of the people.

The participants in the focus group discussions articulated certain ambivalence about strength in old age. For some, ageing also becomes noticeable when one starts to lose strength in the body (*kupungua nguvu mwilini*). But as long as the state of the body (*hali ya mwili*) allows a person to engage in everyday life, s/he is not yet old (*hajazeeka/hajawa mzee*). Bibi Amina for example said: “Your body is still active but not like in the past (*mwili wako bado unadai ila si kama zamani*)” (F-68yrs). Her statement gives us a hint as to how they differentiate the state of their body now (being healthy) from then, when they were young. It further implies that even if they feel strong, there is a difference in that “the state of the body changes (*hali ya mwili ina badilika*)” (M-83yrs). Others said: “Yes we are old! We have told you that! This is because we are not young anymore and not old, we are somewhere in between. We can still walk from here to Kibiti or to the farms” (F-89yrs in FGD). What is clear from their phrases is that they emphasize the capacity to continue working and being able to go to places such as Kibiti.

The judgment of their own condition depends on comparisons with other people. As Mzee Masoud put it: “Nobody lives in isolation, there are many others around you” (M-

79yrs). The old men and women constantly compare themselves with others. When they say “I am not old like others”, they imply that their health condition is strong and is not prone to multiple critical health moments like the conditions of others in the village. They are better-off than the rest. Sometimes they even name those with whom they make this comparison. It was actually interesting to observe how they sometimes clashed in the discussion groups if one made a false claim. They immediately contested the statements and explained why he or she belonged to the other category. Their contestation of categorizations depended on personal experiences of getting old, on their evaluation of the social and health status. Indeed, this is what makes understanding old age complex and interesting. The focus group discussions revealed how old age is a contentious issue even among those who experience it. Like the older in Ikwe Town, they do not consider old age as a category with clear boundaries and emphasize the diversity in experiencing old age, even within the “*kuwa na nguvu*”-category.

If the older people say they are somewhere in between, neither young nor old, they think of an old person as someone who cannot walk anymore. They refer to others who cannot go to Kibiti or fetch water (5 kilometres) and carry out many other everyday roles and responsibilities. It is interesting to note that these signs are context-based. They are shaped by the social environment and in relation to their work.

Fewer responses suggest the importance of appearance. Surprisingly, the older persons used the term flowers (*maua*) to refer to white hair. As to why they considered white hair as flowers is an open question that I could not clarify in the field. In other contexts, older people mentioned white hair as a sign of wisdom and maturity. Implicitly this means being approached during adversities in the family or village. With white hair, you are expected to be an advisor as illustrated in the discussions.

By claiming to have strength, the older people in this category thus point to three interrelated dimensions. First, they are still functionally able to contribute and perform certain roles and responsibilities. They are not yet claiming to be excluded from these roles. Secondly, their health condition is not yet alarming and they can still look after themselves irrespective of critical health moments. And third, their white hair signals to others that they can come to them for advice.

Case study 4.1 Mzee Salum, 68 years old

Below we present one case to show how several dimensions of age have to intersect before an older person in the rural area considers him or herself old. Mzee Salum considers his health condition as strong while at the same time admitting acknowledging many signs of old age such as white hair, grandchildren as well as being called *mzee* by others. His case further illustrates how he evaluates his aging experience with reference to others of the same as well as other generations, including his own mother, and concludes that he is not only old but strong.

I live with my wife and children. My mother lives with us but we have built her own house there. She is old but still capable of attending her own *shamba*, we only help when she calls for it. We see that she wants and enjoys her privacy.

My wife and I are still capable, we do everything by ourselves. We attend the garden around the house and other *shamba* outside the village centre. We help each other, she is more taking charge of the domestic activities and I do take charge of the outside activities such as cleaning the compound, providing for the family especially when someone gets sick as well as paying for the school fees for those in school.

I am the head of the household as I do provide money for all the costs. I cut trees, make charcoal and sell to the trucks that come from Dar es Salaam. I am happy that I am still able to do everything and look after my mother who is almost 100 years but still able to walk to Kibiti by herself. She is *kikongwe* but still able to do almost all by herself, impressive!

My children do help especially when I feel ill. My wife takes charge during these times. For instance, the last two weeks I was sick, had terrible pains in my back, the ribs. I think I lifted something heavy. This is what one gets when he or she becomes old. You might think you are fine but when you do something more than what your body can do, you suffer. When you are old, the body is not strong that much, so a little thing triggers the pains.

I am actually not very old. We have a group of older people in the village. We help each other especially during the agricultural season. I am the leader of the group and I see who is old and not in the group. I am still able to do almost everything and it is a shame if I say I am old. This group also grows cashew nut and rice, we organized ourselves and the idea came up after it became difficult to collect enough grains during religious festivals. We have just recently been introduced to WWF and they will be supporting the sustainable charcoal production. It is a campaign to preserve our forest; we are taught how to make charcoal without destroying the forest. We have been promised that if we maintain the group and demonstrate that we are growing, then we will be given access to loans from the banks.

When I compare myself with others, I am old but not the only one. There are more who are older than me, and those who cannot work anymore are given the task of advising and overseeing the management of the whole setup. I compare myself

with those who were born before me and those who came after me and I see that I am also getting old now. There are certain events in life about which I cannot say much but ask Mzee Ali and others, they will tell you all. They have seen a lot before us and have experienced life that we did not. There are also a lot of things that they cannot do anymore of which I am capable.

I am still able to walk and work. I visit my friends for instance Mzee Abbas (97yrs), Mzee Said (86yrs), Mzee Ali (97yrs), Mzee Saidi (95yrs) and Mzee Salum (71yrs). These were in the group but cannot participate anymore. I am still capable and don't need someone's help, I actually help others. When I look at them, they are of my mother's generation. They are older than me and I am their son. So despite the fact that I am old, my old age is still incomparable to theirs. They are neither working nor walking anymore. They stay at home. I am all over. I only get held at home when I am sick otherwise, I am everywhere. Therefore, yes I am old; I have a beard, white hair and grandchildren. Others call me *mzee*, especially the younger generation and these voices qualify my status of being old. Whether I like it or not I am *mzee* but what I am saying is that I am still capable of doing everything. Although I am old, I am still strong; I have the *nguvu* to do my work.

My mind is still active and it sometimes admires stupid things like luxury lifestyle and also sex. But this also depends because when others see me, they will start pointing at me and say "what is wrong with Mzee Salum". So being old depends on many things such as how others see and address you, how you react, but also you have to see where you fit best in the community. You have to consider the generation before and after you as well as your health condition.

Sometimes with or without strength

The data for the second category comes from 10 older people (8 women and 2 men). These are the older people who considered their health condition as unstable. We followed up on seven (6 women and 1 man) of them during the entire research period. During these follow-up visits they judged their health condition as either the same, better or worse than during the previous visit. They complained of pains in the joints, headache, stomach-ache, numbness, dizziness, and tiredness. However, these pains did not last long. Their health condition can best be described as unstable.

With regard to the links between old age and health, a woman explained: “*Uzee* is not a disease, losing strength does not mean you are sick but that you fail to perform some activities” (F-78yrs). Old age thus brings moments when the older people’s ability to perform activities is tested. Comparisons in ageing have a temporal dimension:

Ageing comes when you realise that the body becomes weaker and weaker. That is, previously you could fetch water using a 20 litre bucket. You lift the bucket on your head with no help and walk with it for one kilometre. Now I cannot do that anymore. I am fetching water using that small 5 litre container. (F-72yrs)

These are typical stories of how the older people construct ageing and importantly how they reflect about signs and thus not only refer to but actively contribute to constructing the social experience of ageing. There is again a temporal aspect in their agency. The older persons compare past and present experiences with the social and cultural environment in which they live. They see what they can and cannot do anymore. When they try to identify the possible cause of not being able to work or walk, old age becomes the main reason. However, the combination of other causes is also considered.

They also look into the future. They are aware of the fact that a time may come when

they will fail to work and execute their everyday activities. The women know they may not be able to fetch water, walk, attend to the farm, clean the compound, cook and look after their husbands. The men foresee a time when they will not be able to renovate their thatched houses, to clear the bush around the house, farm and provide for the family. The occurrence of more critical health moments will limit their engagement with many things. Bibi Zainabu remarked: “If I don’t die of any illness, I know my time will come when I cannot do anything anymore, like Mzee Ali. I will see my own body as too heavy to carry around, there will be no strength left anymore!” (F-78yrs). She refers to Mzee Ali who falls into the “without-strength”-category. She constructs her own experience of *uzee* with reference to her own future and to his co-presence. Both present a frame of reference in this construction.

Therefore, just like those in the “with strength”-category, the older people in the middle-category use those with no strength as a frame of reference. They assess their own condition with reference to those who are having multiple critical health moments. They know they are “better off” (*unafuu*) than those, and this makes them consider themselves as still having strength. In other words, they see their health condition as somewhere in-between. This does not suggest a linear ageing but a complex and diverse experience. Bibi Zaria (F-78yrs) and Bibi Zainabu (F-72yrs), for instance, reflected about the health conditions of two men and then told me: “We tell you that Mzee Saidi (M-95yrs) had his strength, he was able to work without help. Likewise, Mzee Ali (M-80yrs) was very tough, but now! Mzee Saidi cannot work anymore, he depends on his wife, he does not hear. Similarly, Mzee Ali cannot walk anymore, he shakes, his hands are not functioning anymore, and when he stands, he cannot walk upright! Ageing holds him down!” Both of these men fall into the next category. The two women have noticed the decline and attribute it to ageing.

Most older people in this middle-category mentioned that state of their body (*hali ya mwili*) was not complete anymore. Ageing becomes an umbrella that makes all these things happen but the signs could be a certain pain in the joints or not being able to walk to the farm. Some men would say: “The strength is lost (*nguvu imeisha*)” (M-82yrs), and refer to the fact that it now takes them five instead of two hours to walk to Kibiti to reach the nearest health service. Women also talked about the loss of strength and explained that they were no longer able to pound the grain, carry water to the toilet, attend Friday prayers and visit friends and relatives in the other village. They were, in other words, talking about limited mobility and reduced capability of performing routines and gendered tasks.

They also discussed white hair as a sign of ageing. While those in the previous category regarded white hair as flowers (*maua*), the older people here were concerned about the bad effects that medicated soap can have on the hair. Mzee Seif, for instance, attributed the white hair of younger people to their use of soap and oil” (M-82yrs). Several others agreed with his view, and Bibi Saida exclaimed: “Ah! Some of the white hair you see today is not due to ageing at all! These people are not careful about their own health condition. Their heads are white but if you look into other things they are still young” (F-68yrs in FGD).

Other experiences related specifically to women’s bodies, namely to the critical moment of menopause. Most of the information on this topic was obtained through spontaneous statements because it was difficult to ask about it in interviews. Firstly, the women in my study had passed this stage. Secondly, it is a sensitive topic that requires a well-established relationship between those who discuss it. Thirdly, often it is full of metaphors and one needs skills to understand and follow the discussion. It was in such

moments that my change of role from researcher to grandson and possible husband established a joking relationship and enabled me to engage in the discussion.

In the focus group discussion, men and women used metaphors to refer to the menopause and used phrases like the ‘river drying up’, ‘rains stopped’ or ‘not seeing the days’. Before mentioning them, they excused themselves. In the in-depth interviews, they felt more at ease. Older women believe that the stopping of the menstrual cycle means that something has happened inside, the production of blood becomes less and it is a sign that you are ageing. Therefore, it means *uzee* but not necessarily being *mzee*. It gives a signal that soon one will experience loss and therefore become unable to perform everyday activities. Therefore, like the other experienced health conditions and visible signs, the menopause became an important marker and one elaborated by women during the follow up.

In summary, the members of this middle-category were very much aware of temporal dimensions of ageing. They referred to their own state of the body in the past or in the future, and compared themselves with other persons who were in more advanced stages of losing strength. They further brought up new reasons why white hair alone is not a sign of ageing, and engaged in discussions about menopause as another and specifically female sign of ageing.

Case study 4.2 Bibi Zaria, 78 years old

As the case study below shows, Bibi Zaria still considers herself as strong, but not all the time. She sometimes has pains that limit her movement to the *shamba* and to events in the village. She has started selecting events to attend, work to do and all this is an indication that she is getting old. While she thinks that she is generally mobile, we learn that she could not go to Kibiti, Dar es Salaam and other places as they make her tired.

Long walking activates the pains that were made silent in the body by taking more rest and painkillers. The case is particularly interesting as it presents not only problems of old age but also ways of overcoming the critical moments that come with the conditions.

The signs of old age, well! Listen! I am still able to do most of my activities when I am not ill. I have a very unpredictable health. This is what I expect at this age. I have wrinkles, white hair, grand- and great-grandchildren around and that qualifies me to be *bibi* by all standards.

As you see I am fine today. I feel stronger today and have no pains and no problem! Last week we had to move to the *shamba* as we couldn't walk daily with my sister. I also had some pains in my hip and this was limiting my movement. So we spent the whole week in the *dungu* rather than walking home. Last week I went to Nassoro's shop to buy a pain killer, both me and the sister were sick, we had a headache and we had to use some medicine. We both feel better and continue with the work. Last month when you came, you remember I was sick, vomiting. I have no clue what I ate. After taking the medicine I felt better. I used those tablets with two colours, white and red, and I feel much better now.

Sometimes I would love being more strong again and to continue enjoying life. Unfortunately, time has gone and we cannot rewind. I wish I could go and visit my daughter's children in Dar es Salaam. It is becoming too much. First you will have to negotiate and consider how to reach Kibiti. It has become too far for us. We cannot walk anymore to Kibiti. It takes six hours to reach there and when you consider that distance and the hours you will spend to reach there you just say, ah! I better stay at home. Moreover, when you walk that far, you pay the price at night,

the pains hunt you all over the body, and you get sick. I limit my movements to preserve the little strength I have and continue doing my own stuff especially making mats and pots at home. I have left that [the trips] to other older people who are capable. When they go to Kibiti and Dar es Salaam they bring back the stories, and this is how we get the news. We only manage going to the *shamba* and the little kiosk in the village and sometimes to attend the meetings and rituals in the village, especially when there is funeral.

All in all, I am old and have retired from many things including attending the initiation rites. I am old, and I sleep a lot to get strength to continue with important things rather than running around like young people. I am selecting what to do; if someone is getting married then yes I will have to go because we are required to offer some teachings. Otherwise, I do stay home.



Plate 6 Learning about the experience of health in old age in Bumba
(Photo by Jana Gerold, 2010)

Without strength

Different from older persons in the previous two categories, the older people in this category are by and large experiencing multiple critical health moments. During our first visit, eight older persons (4 women and 4 men) described their health condition as not having strength. We then purposefully selected six older persons (3 women and 3 men) and followed them over the entire research period. Their health condition is more complex, and their response to the signs and experience of ageing was more straightforward, often centring on the changes in the state of the body and mind. They are older in chronological terms, ranging from 79 to 105 years. The oldest man is widely known and admired in the village.

The older persons in this category described how dealing with the everyday activities has become challenging. They emphasized having failed to work, living with pains in the wrist, hands, back, and knees. These pains kept them from being mobile and from engaging in everyday activities in and around the house. They had stopped doing basic family activities and needed someone to stay around and help them.

Participating in their lives provided insights into the meanings of “not having strength” in this particular rural context. I met the older men and women when they came outside to catch the morning or evening sun. We spent long hours together, casually chatting. I could see whether somebody was around to help them with the activities they could no longer perform. Through these shared moments I became acutely aware of the fact that physical strength is an important asset in a remote rural area like Bumba, with limited infrastructure and a demanding physical and social environment. Losing it means relying on others.

A very old woman told me that she had lived her life and “accomplished the responsibility of a child, daughter, wife, mother and now *bibi*” (F-102yrs). She thought that illness, weakness and numbness are justifiable conditions during such an old age. “You cannot have strength anymore! I am now different. What do I have left after 10 children and 40 grandchildren! They have drained, taken away all of my strength and I have remained with this scrappy body which is as light as paper” (F-102yrs). Indeed, the others made similar statement. Mzee Saidi (95yrs, see Case study 6.2) also thinks all his strength has gone to his children and grandchildren. As one gets grandchildren, he explained, one’s strength slowly diminishes; the grandchildren are eating one’s strength. He likened the children to branches of a tree. If a tree has many branches, they will eat the trunk which slowly gets old and bends, and falls or even dies. The branches therefore feed off the trunk. Similarly, just as a tree has a trunk, for the family he was the trunk, and his children and grandchildren have taken away his strength, and this makes them successful in life.

The older persons in this category were not alarmed about losing strength. They have lived their life and they have fed the branches. Death and *uzee* were believed not to be far from each other. Of course, this does not mean that death is caused by *uzee*, as illness and other critical moments are believed to be the cause of death. However, they will always add, “but he or she was *mzee*” when somebody has passed away.

Several statements of the older persons in this category also referred to the external appearance. As one ages, the appearance also changes, they remarked. The skin becomes dry like an ironed cloth. The muscles and veins become visible. “The face of the older people without strength has wrinkles, loose and dry skin (...*uso wa mzee asiye na nguvu umekunjamana, umelekea na ngozi inakuwa kavu*)” (F-102yrs). Therefore, by looking at someone’s face one can guess the health condition (*hali ya afya*). However,

female discussants cautioned using facial appearance as the only way of defining *uzee*. They raised the issue of many people using cosmetics (*vipodozi*) to remain young. Interestingly, they believe that this hiding (*kujificha*) could not last long. The body will resist at some point. As Salma put it: “The face of an older person is known. You can see it, and it becomes unattractive. It is full of wrinkles. Muscles and veins become visible in the neck” (F-98yrs). Another woman offered a different view: “The appearance of the state of the body on an older person has to be different. It is beautiful if it has wrinkles, dry skin and veins and muscles become visible” (F-100yrs). She challenged those who thought the older body was losing its beauty.

A new topic brought up in this category was that the state of the mind (*hali ya kifikra*) may change in old age. Especially care-givers reported that older persons have become mixed up and forgetful. Bibi Amina (F-87yrs.) was taking care of her husband who had become immobile and required someone to be with him, feed, bath and provide everything for him. She recounted that it was a daily struggle to ensure that he had eaten his food. She thinks these elderly “lose their appetite and see food and eating as a punishment”. Another woman, Bibi Tausi (F-72-yrs.) who also lives with her husband reported that he had started to forget things. “He sometimes puts food (*ugali*) under the bed thinking that it is the little locally made table.” These two old men have changed both physically and in their state of the mind. Their care-givers considered these signs as part of the ageing process, not as an illness.

Case study 4.3 Mzee Ali, 97 years old

The case below illustrates how the bodily experience and in particular the health condition is important in defining old age. The case focuses on the weak body, the body with less and finally no strength. It further demonstrates how older people regret not

being able to work, attend meetings and rituals. At the age of 97, Mzee Ali was really old according to the criteria used by other older people and they often referred to him.

I first met Mzee Ali in 2008 when we visited the village and invited a group of older for a meeting. He attended with his wife. Then, a year later, I met him again in the village for the household interview and subsequently spent much time with him during the follow up study in 2010. Over this period of nearly two years, his condition was deteriorating. He had been diagnosed as suffering from Parkinson and could no longer manage to walk to the village centre. The trembling in his hands, arms, feet and legs increased. It became strenuous for him to carry on a conversation. He just spent all day resting in front of the house. Towards the end of my fieldwork, he died

I am living with my wife Rehema who is 65 years old and my daughter and her children. Since I got this sickness I am confined to my home and the only task is to keep an eye on the house from the intruders. If it is left unattended some people might come and take the belongings and we lose. I also go outside and sit in the corridor to see if there are monkeys and wild pigs that come and destroy the cassava, millet and maize. I cannot run after them but will cough and that alerts them that there is someone watching them. So this is my main task.

Despite my ill condition, I am still the head of the house, I built it, but I don't know for how long I will be as my condition is deteriorating. I see that every day comes with a different thing, yesterday was different from today, and today will be different from tomorrow. This is how I see my health. If you come tomorrow may be I might not even be able to talk to you anymore. We will see when you are coming back.

The signs of old age! I am old and I don't have strength anymore. There is not much I can offer to my family, I cannot help them anymore, and this disease has held me down. I have been to Dar es Salaam for treatment and they told me that it has something to do with my brain and that I cannot be cured. I cannot stand still or be stable, I always shake. You will soon see because usually I cannot even talk for more than 30 minutes, every part of the body will be shaking like falling. I am old and this is the end.

My friends call me *mzee*, my age mates call me *mzee*. When they are done with the Friday prayers they all come here to know how I am doing. It is strange that being old makes you fail to even walk to the mosque. They have to visit me now. I have been very active in the mosque [when I was younger].

Do you see me, I am shaking. If I keep talking without a rest then you could see this part, the left part especially the arm is like falling off or it is like it wants to hit you. This is such a terrible disease and it is horrible. I tell you I see myself dying. Every day it is getting worse, it does not improve. If I am very tired then it is like I am collapsing anytime. Talking is also difficult and my chest is full of air and then I can't speak until after some minutes of rest then slowly I can again. It is tough and difficult. I have been to the hospitals and also used the traditional healers and now I have come to terms that this is the end. I am just losing money and disturbing my children and wife, it is very clear that this disease can't be healed. There isn't any traditional medicine that I did not try in my life. I have been to many places just trying to find the best healer but this is it. Last time I was in Dar and it was my children who took me there, they took me to the hospital and after the doctor checked my health he told us that it is called Parkinson disease, I have my certificates and then he also says usually it is difficult to get treated and that if I use

the medicines that he gave I can be improved. But to tell the truth it never got better. I can see myself very different from a year. You were here last year I remember we met at the school and we had the discussion in the classroom, you came with that white lady and we had juice and biscuits. But since then, my condition has never got better. Imagine last year we met in the school building but this year I can't walk there anymore. When you come next year may be I won't be able to come outside like this anymore and the year after you will only meet me in a grave. It is going too fast and it is getting me down so fast too.

Look, things have changed, I cannot even come outside anymore, now they put my food there next to the table and I eat and return to bed. I am caught up with the disease and I cannot even go to the toilet anymore. I cannot walk, there is no energy left in my body at all. This is what I mentioned when you came; that I see the end coming and it is there I see but since you are young you cannot see. When I stand and walk outside I fall and standing is impossible.

The ageing condition especially not having strength has made me quit the membership of the older's group in the village [see Case study 4.1]. This was a social group. We met every afternoon after lunch to catch up on few things but also to get informed about the stories from others. The group members offered advice to those who need it, depending on the issue one brings to the group. We helped each other during the agricultural season to cultivate, plant, weed as well as harvest. The one in need informed others and prepared lunch and people came and worked. This was a tradition which I have given up due to my condition. The condition has made me cut off as I cannot go out and interact and I hardly know what people are doing in the village. The only source of information is my wife who is still relatively

active. Honestly, I sometimes feel like being in a prison not that I did something wrong but that my health condition in relation to old age has made me so.

4.3 Conclusions

If we consider the social dimensions of age and their intersection with biologically grounded health experience in Bumba we see many similarities to what we found in Ikwe Town. Although the older people in Bumba did not always bring up the same points in the conversations and discussions as those in Ikwe Town, there are many commonalities in what they say and do. In this sense we can say that they share a multi-dimensional concept of age which is rooted in a similar way of life, dominated by farm work in usually far away fields.

Older people in Bumba speak of old age as *ngoma* (a special event or drama) which for us indicates that they consider it as a vital conjuncture (Johnson-Hanks 2002 and 2006). All the social dimensions of old age as well as the conceptual links between ageing and health - which we identified in Ikwe Town to converge in the vital conjuncture of old age - can also be discerned in Bumba.

Age was also conceptualized as a person's relative position within the life course from birth to death. It was again emphasized that the term *mzee* is an achieved status. Especially younger people in Bumba insisted that the achieving and keeping the *mzee* status depends to a considerable extent on appropriate appearance and behavior. An older person should not dress and act like a young one, as this would be shameful. The status of *mzee* can thus be thought of as a dimension of norms and values linked to positions along the life course.

The importance of a person's kinship position and the special relationship between (great)grandparent and (great)grandchild was also brought up again, this time especially with regard to the joking relationship between them. Grandchildren may say things to their grandparents which would be considered as an insult if they were mentioned by somebody in a different relationship with them. Another aspect of kinship is the idea that grandparents are like the trunk of a tree through which life forces pass on to the branches (children) and leaves (grandchildren). In this metaphorical sense, grandparents will eventually become firewood and then turn into ashes.

The older people in Bumba clearly link the kinship dimension of ageing with the bodily dimension of ageing. Again the typical signs of bodily ageing were mentioned, such as white hair, loose skin and few teeth. The most important sign was again "strength". For those men who claimed to still have strength, it manifested itself in the fact that they were still mobile, active and capable of finding solutions, also when faced with critical health moments. The latter point confirms what we saw in the first case study of Ikwe Town: Although this man was blind he considered himself as having strength because he was able to overcome his handicap (Case 3.1). Older people in the second category again reported that their health was not stable. In addition, they emphasized that - although still capable of performing their routines and tasks - they had to adjust to a loss of strength either by resting more, reducing the weight of what they carried, the distance they walked or the hours of work (see Case 4.2). An old woman in the third category felt that she had fulfilled her tasks - interestingly articulated in terms of consecutive kinship roles - and was now justified to rest. Another new aspect was that care givers referred to the state of the mind (*hali ya kifikra*) of some older people in this category, but in this case not in terms of worries but of confusion and forgetfulness. The case study (Case 4.3) not only illustrated that Parkinson - a non-communicable disease -

also affects people in this remote village, it further shows that some older people try very hard to obtain a biomedical diagnosis and treatment and how difficult it is to then live with this chronic and degenerative illness.

As in Ikwe Town, the older persons compared their bodily condition with the condition of others, linking the health dimension with the life course dimension. They were also aware of the fact that some people who had been born around the same time as themselves were much worse off while others were doing very well at a much later point in their life course. The “not having strength” category again served as a reference frame for their own positioning. This underlines that the relational dimension of age is relevant in daily life, not the chronological dimension

Part 3 Older People's Care Negotiations in Rufiji

As older people move along pathways from “having strength” to “not having strength”, they need – but also give – care. Part 3 explores older people's care negotiations in everyday life. Again I separate the presentations of our findings from Ikwe Town (Chapter 5) and from Bumba (Chapter 6) to allow for a comparison. Within each chapter, I start with older people's everyday experience of care provided by - and for - persons who are their kin, in other words related to the older person by descent or marriage. I then move on to older people experience of care provided by non-kin, i.e. by neighbours, friends and tenants as well as by professional health care providers.



Plate 7 A woman taking care of her older sister in Bumba (Photo by Vendelin Simon, 2010)

Chapter 5 Care Practice in Ikwe Town

This chapter presents and discusses my findings on old age care in Ikwe Town. As outlined in the introduction, it is difficult if not impossible to come up with a universal definition of care. In his study on old age care in southern Ghana, for instance, Sjaak van der Geest (2002:7) learnt “that care, both as a concept and as a practice, was highly ambiguous”. One part of the problem was that the person who receives care may evaluate the process differently from the person who gives care. Van der Geest further pointed out that the English term care carries emotional, technical, practical connotations which may not apply in an African context. In his Ghanaian study, the most common care activities, i.e. activities for which older people needed the help of others, included: getting food, taking a bath, washing clothes, and going to the toilet. Other indispensable tokens of care were helping them financially and providing company. Perhaps the most important type of care was the organization of a fitting funeral when the elder died.

Building on van der Geest’s study, we used our understanding of care as a “sensitizing concept” (Blumer 1954, in: Bowen 2006:7) in an empirically open inquiry. Moreover, we tried to figure out what care meant “by listening to those who are directly involved in it and by observing their actions” (van der Geest 2004:9). However, our study focus differs from the study of van der Geest in Ghana in that we concentrate again on the perspective of the older people themselves. We did not systematically follow up on accounts of caregivers but tried to look at them and their part in social interactions through the eyes of the older people.

The question with whom older people actually negotiate care helps us to avoid the trap of a modernization perspective which postulates a steady decline of kinship and family

ties and pervades not only gerontological and popular discourses but even ageing and care-related studies in Africa by anthropologists and other social scientists (see Chapter 1). It also allows us to move beyond oversimplified assumptions about the “African extended family” (Alber et al. 2010:44). Such an open-ended question opens a space for a careful consideration of normative statements. As van der Geest has put it: “There may be some rules about who should care for the old, but that does not yet predict unambiguously who will actually do the caring” (van der Geest 2002:23).

I take the concept of “critical health moments” as analytical starting point. As explained in Chapter 3.3, these are moments when older people feel weak or painful and thus unable to carry out their gendered routines or tasks, such as attending to the farm, sweeping the compound, cleaning the house, cooking, doing the laundry and taking a shower. It is in these critical health moments that someone else may or may not intervene to help. We thus set out to capture what happens in these moments. This approach allows us to follow care practice in action, from its inception, through concrete activities of helping to the restoration of the routine or an adjustment.

The data discussed here have been collected in Ikwe Town during the Community Study, the Household Study (n=92) and the Age Group Study (n=43) (see Chapter 2.4). From the outset, I paid attention to the daily use of Kiswahili equivalents of the English verb “to care”: *kutunza* (to provide health care; to protect; to keep), *kuhudumia* (to provide a service, also in hospital settings; to attend; to assist), *kusaidia* (to help) and *kuangalia* (to look after; to keep an eye on somebody). Moreover, the word *kusaidia* (to help) often goes with other words such as *kuhudumia*; *kuangalia*; *kusindikiza*; and even *kutunza*. We therefore adapted our questions accordingly and asked about who helps (*kusaidia*), often in combination with another word for care: *Nani alisaidia kukuhudumia* (who helped serving you, attending you etc.); *nani alisaidia kukuangalia*

(who helped looking after you); *nani alisaidia kukusindikiza hospitali* (who helped or accompanied you to hospital) and *nani alisaidia kukutunza* (who helped caring for you).

Since I found that kinship continues to play a crucial role in old age care, I start with a discussion of kin care. What was older people's everyday experience of care provided by and for different members of his or her kinship network.

5.1 Kin Care

We begin with care relations created through marriage and then move to care relations through descent. In real life, care is of course not neatly separated by such categories but occurs in diverse combinations of them.

Husbands as caregivers

Husband and wife commonly give care to one another, as long as both are still alive and not separated or divorced. We begin with care provided by husbands because they commonly remain invisible in studies on old age care. In Ikwe Town, older husbands are expected to make decisions, to provide the means and to organize care, especially if other actors have to get involved. This is regardless of the presence of sons or other adults. The older men also act as advisors because of their vast experience. Therefore, although they do not necessarily provide personal care, their engagement can be considered as a way of providing care in critical health moments. If, for instance, the wife cannot perform her usual routines and tasks, the husband takes control. He makes a new arrangement if it is something that requires another person to come in and help or,

in most cases, they perform the task themselves. That is, they temporarily and at times permanently help their wives who are *wazee* just like them.



Plate 8 Husband on the way to fetch water in Ikwiriri (Photo by Vendelin Simon, 2010)

The old husbands also give emotional care. Older wives have someone to talk to, a companion, and do not need to feel lonely. I became aware of this important aspect of spouse care when I followed widows who are living alone or those who had been

relocated for care after the death of their husbands. One big issue they always raised was being left alone, feeling lonely, and in combination with a complicated health condition, they required a new arrangement. In such situations, the gap left by the husband became visible in their life. Before his death, he had been helping and intervening when they needed help, especially in critical health moments, when they feel ill, were tired from work and too weak to carry out household activities. As one widow put it she now had “a life marked by no-one to lean on during problems” (F-74yrs).

In this case, care does not necessarily mean doing something but being there. This implies that the older people's concern sometimes is not only about someone providing food, cleaning the compound, bathing, doing the laundry. Having someone around, such as a husband, wife, children and other relatives gives an assurance. As one man put it, the wives have someone to “keep them warm” (M-95yrs). In this statement, “warmth” is used as a metaphor. It means a number of things, having someone to talk to, to share one's worries or to give relief. This is illustrated by the following example.

Bibi Asha lived with her husband, children and grandchildren. She regularly experienced pains in her joints. Often her husband gave her a massage to ease the pains. When the massage did not help, he asked friends for money and went to buy painkillers. Since he also had pains in his joints, they always shared the tablets he bought, breaking them in halves. What they needed was relief; they knew their problem could not to be cured.

The point I wanted to make here is how important Bibi Asha's husband is for her. Although he did not do much, he was resourceful and helped by giving a massage and by sharing her pain and medication.

If we conceptualise care along these lines then we see the old men's engagement in care giving in their role as a spouse. They can even continue to do so when they are physically weak and homebound. This point was made by Bibi Rukia "He doesn't have to cook for me, he can just sit and be there and talk to me when I need someone to talk to or ask and discuss when things aren't going so well" (F-85yrs). In such cases, care is actually given by both. For old men who were used to venture far, limited mobility is not only a physical and practical but also an emotional problem. They can hardly make it to the mosque, to events in the town such as meetings, rituals and men's chats at coffee places and to the homes of their friends. They feel bored. Some days may pass without saying hello or talking to any person except their wife. The same applies of course to older women. As a woman commented on older widows: "Nights become long without their husbands" (F-98yrs). They do not have someone to share everyday frustrations, stories and anger.

In terms of practical care, we have seen or been told about older husbands carrying water to the bath or toilet, making the bed and even doing the laundry. Indeed, they do this when they live alone with their wives. Such practical help is temporary. If the wife cannot perform her duties over an extended period, he is responsible for organizing someone else to come in temporarily or permanently for help.

Husbands who belonged to the first (having strength) or second (sometimes not/having strength) category (see Chapter 3) regularly went to their *shamba* (fields), together with their wives and children. The *shamba* work enabled them to fulfil their role as provider of food and money. Buying medicine and paying for a check-up and treatment in a hospital was something a husband is expected to do. Money from selling *shamba* products was further used for maintaining relationships with both children and grandchildren. Older men either gave their children some of the products they had

harvested or provided the children who had moved out with money to make phone calls. This gave them the assurance that the relationship was active and could be relied on during critical health moments.

Older men often said that their wives were responsible for care. However, a close follow up of their everyday life revealed a different picture. They often passed by the market and bought fish, sardines, flour, cooking oil and painkillers. If they did not have strength and were thus not able to work, they continued providing care for their wives and families. They utilised the many relations they had established during the course of their life as resources.

The 67 year old Mzee Abdallah had stopped selling fish in the local market, but each evening he joined his old fellows and younger people who continued with the business. They engage in stories, and he finally got a piece of fish for free and sometimes even money to buy kerosene or cooking oil for his wife. Through these relationships he provides not only food for the family but continues to care for his wife. He buys the painkillers that help ease her joint pains. She then continues with her everyday responsibilities as a wife.

Such care relations and practices are difficult to trace through interviews. They are part of enacted care, which can be captured by visiting the places where the older people meet or by following them during their daily movements.

Marrying a younger wife

Getting married for men seems to be an alternative when no-one is there to provide care. This is particularly true for those who described their ageing condition as having

strength. Similarly those whose health condition is at times with and or without strength also revealed how getting a second or younger wife could be a better solution than influencing the children. This means that care makes an older man redefine his position within the community. While on the one hand he is of an advanced age, by getting a younger wife he is sending out a mixed message. He is still able to provide but at the same time needs to receive care. The first is what did not come out clearly in the discussions. The latter, who is receiving care, is the main reason they give as to why they remarried.

Indeed, unlike women, men often would expect to be in marriage until they die. They expect some care from their spouses and this means that being in a marriage is not only an important social marker but also a safe heaven and the assurance of being cared for. If there is any critical health moment, they know the actors around led by the wife will intervene and negotiate better ways of providing and receiving care. For instance, Mzee Sulle, who has two wives, recounted:

When I first realised that both of us were slowly failing to look after each other, I proposed that I should marry Asia. Husna did not reject the idea as she also needed someone to be with us, and this was not a problem because even religion allows one to have more than one wife. I had already spotted Asia, and we immediately made the wedding arrangements whereby we called the Sheikh and everything went smoothly. We have been living together for many years now and, she is the one who cares for us, she does the laundry, fetches water from the river and firewood, cooks for us; she does everything (M-74yrs).

An older man remarries for two main reasons: First, after the death of the wife who was responsible for caring for him and secondly, when he thinks that the first wife cannot

take care of him and herself anymore, as in Mzee Sulle's case above. In this polygamous community, some older men think that their wives cannot provide all that they need. They are too old to fetch water to help with bathing and the toilet, to make the bed daily, or do the cooking and farming. *Uzee* and in particular the critical health moments associated with ageing pose challenges that makes them fail to perform their everyday responsibilities including caring for their husbands. Having a younger wife opens many opportunities. Five of our study participants had younger wives who were in their 40s. These wives became the main care providers. Interestingly, most of these marriages happen when the older men still have strength or when their health is getting a bit unstable. None came from the last category of those whose health condition is weak or without strength. The men who remarry have to provide some basic care for their wives, and this usually also means to satisfy them sexually. They have to at least bring in cash, be able to negotiate with the family and importantly have decision-making power.

Not all older men with younger wives live together with older wives. Often, the latter are separated and live an independent life from the newly formed family. As mentioned above, one of the main reasons why old men marry a younger wife is the pressure of having someone to provide care. It could be true that the wife is too old to provide care and the relationship with the children they had together is not so reliable. He then decides to have a new family that could possibly be reliable when he is too weak to do anything. Separation and remarriage is more likely, when the bond with the children of the first wife is not very strong. In other words, if an older man thinks that they can hardly provide care, then the alternative is to have another wife. These wives are often younger or of the same age as the children of the first wife.

One could expect the relationship between the *mama mdogo* (younger mother) and the children of the older wife to be tense. However, both cultural and religious practices in the area have become a cushion to absorb the expected tension between the older and younger family. Especially those men who remarry, while they still have older wives, need good negotiation skills. They not only have to balance the requirements of the two wives but also to handle the pressure from the children. If they have resources in terms of assets, the tension becomes even worse. For those few who married after the death of the older wife, the cultural and religious norms and values help to provide an environment in which future relations are discussed to come up with a better solution. This is done because at some point the two sides will need the help of each other. He will need the help of the children and other relatives of the older wife. Similarly, the children and relatives of the older wife need him not as a father but someone with experience of life, which means he has encountered critical moments of contingency.

Thus, an old man's experience becomes a resource that others can rely on and benefit from when they are faced with similar critical moments. During one of the evening talks with Kibanga's son, he illustrated how his father has become like a fence around him. As a fence, the father protects him from potential intruders in his life that would possibly destroy his future. The intruders are not necessarily people but a lack of life experience and not having someone to learn from. This makes him and the other sons who work in Dar es Salaam periodically visit Ikwe town to discuss life's challenges with their father. Therefore, the maintenance of the relationship is important for both parties.

Still, most older men who remarry find it difficult to do have smooth relations with their first family. During critical health moments such men have to make a lot more effort to

negotiate and receive care from the first wife and the children. The example of Mzee Juma is a case in point.

Case study 5.1 Marrying a young wife, Mzee Juma, 92 years old

Mzee Juma (see Case study 3.1, Chapter 3) is married to a 32 year-old wife. The two have 3 children aged 12, 8 and 4. After becoming blind, he was finding it difficult to live by himself in the town especially after the first wife went to Dar es Salaam to visit their children. She first went for a health check-up but the complications meant she had to stay longer. She has been there for more than fifteen years now. Unfortunately, this is not what Mzee Juma expected. Having seen this, Mzee Juma decided to marry a younger wife to help him with the domestic work but importantly to run after the tenants who rented three of the rooms in the house. The children and the wife are now taking him to places he wants to visit and providing everything he wants. The first wife and the children hardly visit. The children only do so when he is ill; otherwise, the relationship is too weak and so he does not expect any help during an emergency. The relationship actually turned sour after he married a younger wife. This is typical of the older men marrying younger wives. The five cases above had a similar story in that the relationship became bad between the new family and the old. Even if they come for help, he has to make a lot more effort in terms of negotiation. He has to be creative, exercising his agency by telling them of the nightmares and seeing himself dying so that they have to visit. Only through the life-threatening health condition he communicates do they quickly visit. Indeed, they have to, as they are also afraid of being ashamed if they do not come and he dies. This will be embarrassing for them.

Interestingly, the negotiation for care between those who did not have children by the first wife is not as difficult as those who did have children. Some of them in fact got married to younger wives to get children. This means that both the husband and the older wife have seen the importance of doing so as they need someone to care for them and the children will provide care for them when they have no strength anymore. Unfortunately, as in many cases in the town, this kind of care is not guaranteed. Even though they fantasize that the children will provide care, they have to work on this relationship and it is not automatically reciprocated. This means that, while the reason for getting married is to have children for future care, by having a younger wife they are assured of receiving care now. She cares for them, cooks, fetches water and cleans the compound together with the older wife.

Mzee Mohamed (71yrs) is married to two wives. The older one is 60 years old and the younger wife was 40 years old. He had decided to marry a second wife, as he did not have children by the first. When we met him, they had 4 children aged between 7 and 15. Although he receives care from his first wife, she is starting to lose strength and so everything comes from the younger wife. She cares not only for him and the co-wife but also the mother of the first wife who stayed with them after she had lost her husband. Mzee Mohamed has to negotiate the best way and advise the wives about life. He has been doing this for years and, according to him, the experience makes him handle not only the two relations but also the challenges that come with *uzee* now. He talks to them and always engages them in these discussions so that they all know their responsibility. This, according to him is “the only way not to let emotions and anger become a guest in the family”.

What we see here is his agency and being proactive in preventing anything bad from happening. He envisages the tensions that could build up and therefore immediately

tries to develop the social environment that favours him and in particular his care. He does a lot to negotiate for his care, as well as the mother-in-law and older wife, because he knows this is his responsibility. He knows the younger wife and the children are doing a lot for them but together with the first wife, they are also helping.

Indeed, what we see from these few cases is not care in terms of affection and companionship. It is the practical care, someone being there doing something. These older men need someone to prepare the bed, do the laundry, and take water to the bath or toilet, and someone to invite them when the food is ready. Therefore, it is about doing physically demanding activities such as preparing food from the *shamba*. Knowing how demanding these activities are, the older men try to use their experience in terms of what are the best ways of helping. Therefore, a new wife becomes one of the many options. They know that if they are not proactive, the relationship becomes sour. If the wife feels she can no longer fulfil her responsibility, she can demand a divorce or separation.

However, in discussion with the men and even during our formal and informal visits, they revealed that they are always reluctant to offer a divorce. Some of them lamented that, “divorce is the last thing to pray for and be offered during old age” (M-72yrs). This means that even when the older women ask for one, the men are reluctant to do so. They know they are on the losing side. They lose not only the care of the wife but importantly the help that seems to be trickling through the female’s line. As most of the help comes through children, especially material resources, the old men know by agreeing to a divorce they will lose the care of the children. This implies that most of the help from the children comes through their mother. Therefore, by divorcing he is completely out of this relationship and he misses all of its benefits including care. Mzee Shante illustrated this by saying that, “she continued asking until I surrendered and

asked my brother to come with a piece of paper and he wrote one for her and I signed it, but since then, neither she nor my children are helping. It is my cousin and his wife who are doing so. They came in after the cousin who lived in the delta started to fall ill. He decided to come closer to the health facility” (M-86yrs). Mzee Shamte’s case reveals the complexity and challenges that some older men face in relation to care. After their wives have seen that providing care for the husband becomes a difficult, they ask for a divorce or move out to the children’s *nyumba*.

No re-marriage for older women

Remarrying is more frequent among and accepted for older men; older widows and divorcees hardly ever remarry. At a younger age, separation and divorce is not uncommon among women. In fact, most of the older women in Ikwe Town have been married more than once: some have been in *mbilini* up to nine times. But now that they had reached old age, none of them was willing to remarry after the death of the husband or divorce.

Therefore, remarriage or having a new *mbilini* in later life seems to be uncommon among older women. Although this seems to be a trend among older men as we have seen above, older women do not consider it as a new opportunity that comes with ageing, to refer back to the concept of “vital conjuncture” by Johnson-Hanks (2002, 2006). For old men, we saw marrying a younger wife becomes a creative way of implicitly receiving care. However, for older women, remarrying in later life is not only burden but also a risk of losing help from the children. Therefore, whether they are divorced or the husband has died as in the case of many we contacted, remarrying is something they do not think is a solution to receiving care. For them, the cost of settling

into a new family is just too much, compared to what they lose from the former marriage. For them, changing from one *mbilini* (marriage) to another is not something they look forward to in old age. As Bibi Ubaya illustrated, “yes you get a man to live with, but he is old and you lose all the help from your children. One has to choose whether to have a husband or lose the children” (F-92yrs). This means that their biggest fear is losing the care of the children, which is an important relationship for them. This also means they are uncertain about new relationship that is, being with the new husband. Therefore, being single and relying on children and other relationships they have developed over time is better than entering into a new relationship. Indeed, many older women who remained a widow after the death of their husbands or single after divorce have already experienced several *mbilini*. They have married from three to seven times. They have experienced what establishing a new life means. The expectations of the in-laws are some of the biggest challenges. Comparing these hassles with maintaining what they already have, they think “it is better to stay with children or relatives whom one has known than entering into an unknown world” (F-73yrs). This kind of reasoning explains why older women either live alone or with their siblings or daughters, and only a few with their son’s family. These are the relations developed while with the husband was present, and they feel more comfortable and safe than starting new ones at old age. They know the best is to remain single, live the life and try to maintain the relationships and utilise them during critical health moments. They build on these relations to hold on to life and at the same time activate most of the relationships they think are important and resourceful. In some cases, they relocate and re-establish strong bonds with the siblings.

Older wives as caregivers

In Ikwe Town, older women provide care for their husbands and children who are over sixty years old by “doing everything”. This was a common phrase we often heard when we discussed care. As wives they cook, do the laundry, and take water to the bath for bathing and to the toilet. In fact, these are only some of the types of care that wives provide for their husbands in their everyday social life. Even when the husbands lose strength or have critical health moments such as pain, being immobile, have hydrocele, a stomach-ache, headache, dizziness and many other ailments linked with *uzee*, the wives continue to provide care. Although it is difficult to give a general picture of the ways in which older women provide every possible care for their husbands, we will mention a few that we were able to capture and observe and even at times help with.

The first example is how older wives continue providing food for their husbands. By food provision we do not only mean the food brought to the table but the whole process, from cultivation to feeding a sick husband. A wife continues to look after the farm by herself after her husband has failed to walk to the farm due to *uzee*. She cultivates food and cash crops that she later sells them to raise the cash for the family. This means, as an old wife she has a double responsibility. On the one hand, she continues to fulfil her responsibility as a wife, and on the other hand, she takes over that of her husband. If she cannot continue providing food for her husband, she organizes the children and other relatives to do so. They bring grains that are not processed or semi-processed food. This means that cooking has to be done in their *nyumba*. This is important for her to retain her status of being a good, caring and loving wife and to avoid tensions in the house and gossip (*kusemwa*) in the town. Therefore, even if they cannot afford to cook anymore, they will try to organize someone to do it to avoid “becoming a story in the town” (*kuwagumzo la mji*) as lamented by Bibi Asha (F-67yrs).

Moreover, some older men lose their appetite or develop a new attitude of not wanting to eat and so it becomes the responsibility of the wife to ensure that her husband eats. This means supervising and accompanying him while eating. The consequence of not doing this could be starvation and death, which again means shame and embarrassment for the *bibi* as an “experienced person in providing care” (F-68yrs). This supervision is what the older women would refer to as ‘doing everything’. Just like other family members, she is supposed to attend to many other activities. Having a husband who requires care all the time leads to more challenges. Luckily, none of the older wives in our study provided 24-hour care for their husbands. This gave them time to look for more opportunities and even sometimes continue to produce food for the family and the husband.

Procuring water is also an important aspect of care. This water is not only needed for bathing and after using the toilet but also for washing before prayers. In this predominantly Muslim community, the five prayers structured the everyday life. Also for the older persons, the prayers were very important events they hardly ever missed them. Even during the interviews, the hours for prayers had to be observed. They often asked for a break and came back after a short time and the discussion continued. This was particularly true of those older persons who pray at home. They wash themselves and always ask a wife or child or grandchildren to bring water before going inside to the specially prepared place for prayer. This observation reveals how important water is. Even when financial issues were discussed, they always mentioned money to buy water. Water is central to their life, and procuring water is an important care activity.

Usually, a small thatched hut near the house serves as a toilet cum bathroom. It is the wives’ task to fetch and carry water to this hut. Older women can ask children to do so. But if the husband needs help with using the toilet or with taking a shower, the wife

cannot ask children to assist. She has to do help if the husband is no longer able to take care of himself. She may bring a small chair (*kigoda*) for him to sit on and then pour water while he cleans the body. If it becomes too much to walk to the outside hut, older people may use their bedroom, which usually has an earthen floor, as a bathroom. This makes life much easier for them. This kind of care arrangement is negotiated between the two, the husband and his wife, depending on their health condition. As said earlier, husbands do consider the health condition of their wives. If they think that they cannot manage to carry the water, then a new arrangement has to be made that suits both of them. If he does not do so, the chances of complaining leading to divorce are high, as in Mzee Shamte's and Mzee Hemedi's case. They have to balance between receiving from and providing care for the wife. As we saw in Chapter 3, ageing is sometimes constructed as "being rough". Being rough here implies not being clean. If one does not cut the hair and shave the beard for men and the private parts for both men and women, he or she can look ugly and old. This means, cleanness is central to their everyday life.

Mzee Nusura's wife who is also old does all the domestic chores. She also boils water and carries it to the bathroom for her husband since he has no strength. She even massages his back and all the joints where he feels pain. If she does not do this, they cannot sleep at night because he will be crying out of pain. Apart from that, she also calls the relatives when he needs to see and talk to them.

This just reaffirms the elder-to-elder care and importantly the nature of care they engage in and how this is expected of them despite their ageing condition. In fact, as I have mentioned elsewhere most of these wives have almost the same health condition as their husbands.

Doing the laundry is another practical care task. Depending on the health condition of the older men, often wives and children do the washing of clothes such as the trousers, shirts and t-shirts. The special laundry such as the sleeping mattress is washed by the wife. If she cannot do it, she asks the grandchildren but not the daughters. It is an embarrassment for the daughter to clean the sleeping linen of the father. Some of the older men wash their huts, especially the one for prayers, and the praying cloth (*kanzu*). Bibi Hadija, one of the older women who cares for her husband, explained that, “as a wife I am responsible for his laundry, he has to look neat and clean” (F-76yrs). However, during the female discussions, it became clear that they could always ask someone else to help if they themselves cannot do the laundry. Similarly, “sometimes the older men who are still able to work and do some minor things can wash their own clothes, such as special clothes for prayers” (F-79yrs in FGD).

Letting the husband walk or even sit outside with dirty clothes is an embarrassment or shame for the wife, and indeed for the children and the entire family. Outside appearance and smartness is taken as a sign of good care. It is the responsibility of the entire family to invest in the smartness of an old parent or relative who lives with them. Most old men are concerned about their status which includes being nicely dressed. The role of more distant relatives is minimal in this case. They can bring or buy clothes but everyday cleaning has to be negotiated and done within the family setting, and even the everyday cleaning of the husband’s clothes that a wife used to do before failing due to her health condition and ageing has to be negotiated. This practice or type of care is therefore shaped by the social and cultural context.

Reunion of siblings

One of the important and resourceful relationships of the older people that is often neglected and undervalued are the siblings, who have continued to receive less emphasis in the literature on old age care than spouses, children and even grandchildren. Like many other relationships, siblings prove to be important for providing the emotional and material aspects of care. In old age, many siblings reunite and live together (see Plate 7). The biggest driving force behind this reunion is care. Indeed, cases where siblings came to live together have to a great degree been the children's influence. They negotiate the best ways through which first the siblings can care for each other and secondly, an easy way through which children can join forces and provide care for their ageing parents. These are the missing links that we usually do not observe in ageing and care studies. We easily conclude elder-to-elder living in a *nyumba* is due to the failure of the younger generation. Once more, this is the danger of not approaching care as a process. The children in those cases where the siblings reunited negotiate and convince their old parents to stay in a place where they can be provided with care. The number of such cases is in increase as a way of dealing with the absence of potential care providers.

Therefore, staying together becomes one of the means through which they look after each other. Importantly, those we had the opportunity to converse with and observe their life have children who were behind the move. These children are either in towns or have moved to bigger cities and built a decent house for their parents and other relatives. They asked their mother and aunts or father and uncles to stay together and be cared for. They organize a better environment for care that is easier for both the ones providing and receiving care. They either send money or organize someone to cook, renovate the house and do the shopping. Others negotiate that some of the unoccupied

rooms be rent out and the monthly rent becomes a resource during critical health moments. The money is used to run the everyday life.

Bibi Amina (72yrs) lives with her daughter and some tenants. She was asked by her sister who lives in Dar es Salaam to move to the newly built house thirty years ago. She has been living in the house together with her nephew who is also old. The two give each other company. Therefore, they do not feel bored or lonely. The sister and her children remit money when asked. They also rented three rooms inside the house, which gives them a monthly income, and the money is used to pay for water and electricity, and to buy food and medicine when they fall ill. The sister and her children in Dar es Salaam regularly visit. This new arrangement is important for Amina and her nephew as neither have children. The immediate care comes from the nephew. Only when some serious issues arise do they call the sister and her children who live in Dar es Salaam. During one of the visits, we had a chance to talk to the daughter. She works as a nurse in Dar es Salaam. After she retires she is thinking of coming back to Ikwe to live with her sister and nephew.

The last statement reaffirms that sometimes these arrangements are made in advance to proactively prepare for old age care.

Often it became clear that the absence of children, who were in big cities and towns, does not mean an older person lacks care. New arrangements that involve negotiations are made to tap other resources and relationships around. At times, reuniting an older person with siblings who live in Ikwe town or neighbouring villages is an immediate solution. Indeed, this is true of older people without strength, who need someone to be around most of the time to cook, fetch water, do the laundry, clean the dishes and even do the shopping. In the worst case, an older person is moved into the care provider's

home for care as became clear in more than five cases. This means the family concludes that the best way to provide care is to relocate him or her in the provider's vicinity. This relocation is indeed very common among the older people, especially when they have critical health moments such as an illness. Interestingly only the older women are moved to the care provider's homes for care. Often they temporarily move to the care provider's home during the time they are in need of care. However, with their health and ageing condition, they end up staying there. This seems to be a widespread phenomenon for those older parents with children and relatives in major cities such as Dar es Salaam and other towns where the health infrastructure is more developed. However, some of the older parents complained that they did not feel comfortable in these new homes and immediately asked to be taken back to their homes.

The 87-year-old Bibi Habiba asserted, for instance, that her siblings and cousins were always there when she needed them. "I am old and can't do anything anymore; they are providing care for me." The children do not feature in this arrangement. One cannot simply assume that children are the main care givers, as often claimed by politicians and even in studies on old age care. Kin care is diverse and dynamic; it changes just as the society itself changes. On the other hand, children may remain invisible in day-to-day care arrangements, even if they contribute from further away.

Invisible care networks

So far, what we have looked at elder-to-elder care. We have seen how and when husbands have to mobilise and engage others to provide care for their wives. Even wives who "do everything" sometimes have to ask their children and other relatives to come and help provide care. A wife may cook porridge for a husband who needs soft

food, but how about the many other actors who contributed until it became possible to make the porridge? This is what we mean by “invisible care networks”. Such a network may include people fetching water, collecting firewood, paying the water bills, buying the sugar and importantly all who remit money used by the older people to run their everyday life. The many actors who negotiated and advised until it became possible for the old wife to feed porridge to her husband often remain invisible, and they are commonly not mentioned in interviews. These are the challenges that the studies on care need to address. By focusing on the process when the critical moment happens, we were able to capture the network of invisible actors involved in negotiating and providing and receiving care.

Case study 5.2 Invisible care network, Mzee Shabani, 86 years old

The case of Mzee Shabani will illustrate these points. We have already described his situation when his condition had reached the stage of *sina nguvu* (Case study 3.3.).

Mzee Shabani, 86 years, lived with his wife Rehema, who was 76 years old. They stayed more than 5 kilometres from the centre of Ikwe town near the old ferry. During my first visit, he was renovating his thatched hut, which is only one room. It was the rainy season and it was leaking badly. During the second and third visit, he was staying inside and complaining of pains, dizziness, stomach-ache, headache, being weak and not being able to go out anymore. During my first visit, he illustrated how important his wife was to him because she was doing everything. She cooked, kept him company, did his laundry and told the neighbours if they had any problem. During the next visits, grandchildren entered the story. They came every Saturday from the centre of Ikwe Town where they lived with their parents. They fetch water, cleaned the

compound and brought food. Grown-up daughters, the mothers of these grandchildren, moved into the picture. I was told that they visit and provide everything, although they do not live with the old couple.

Indeed, the daughters were responsible for the new arrangement and made sure that the grandchildren visited every Saturday. They themselves only came if there was an emergency. As food vendors in the town, they had work to do. From evening until midnight and again in the early morning they sold food to truck drivers, bus drivers and business people who commuted between Dar es Salaam and the Southern regions. During the day, they went to the market and prepared the meals to be sold for dinner and next day's breakfast. This food vending was done every day except when they were sick or if there was a major emergency.

During my final visit, I found neither the thatched hut nor Mzee Shabani and Bibi Rehema. By asking around I learnt that Mzee Shabani had died, as he had actually foreseen. Bibi Rehema was now living happily in Ikwe town with her daughters. What surprised me was that these were not the daughters I had heard about earlier. As it turned out, Mzee Shabani and Bibi Rehema never had children together. After Mzee Shabani's death, Bibi Rehema was relocated back to her children with a first husband. The adult daughters who had taken care of the old couple were actually Mzee Shabani's daughters with his ex-wife.

This case again shows how dynamic and flexible care relationships are. Relations that remain invisible for a certain period may be activated and become a resource later on. If I had visited Mzee Shabani and his wife only once, as one does during a cross-sectional survey, I would have concluded that they are lonely, left alone, forgotten about in their small hut. It was only through a series of visits which allowed me to get closer and look

deeper that I realised they were in fact comfortable and happy with their care arrangement.

Inter-generational care

As we saw in Chapter 3, inter-generational relations are important in the everyday life of older people in Ikwe Town. In critical health moments, these relations are activated to provide care. This process is not automatic but rather involves negotiations that sometimes result in tension and conflict but, at the end, are more uniting. The older person as a social actor has to make some effort to make the relationship active and useful during his or her care. Therefore, when an older person is in need of care, the children often communicate and arrange for the care of their parents. This happens whether the children are physically present or not. Generally, they are involved in the decisions and negotiations and so they sometimes “remotely organize and control” the care of their older parents (M-72yrs).

As we shall see below, the daughters are more visible than the sons when it comes to the provision of practical care. However, this does not mean the sons are not providing care. As shown above for the husbands, we see men’s responsibilities if we consider care as a process encompassing negotiation when a critical moment happens.

Responding to the economic pressures of today, many adult children have to move, leaving the older generation alone in rural areas. The remarks, comments and reflections of the older people reveal that this disengagement is not necessarily something negative but also positive. As social actors both the older and younger generation negotiate better ways of maintaining the bond that becomes a resource

during critical health moments. In the following section, we will illustrate this inter-generational relationship by focusing on the care provided by the daughters. However, we are not referring to young daughters but mainly to adult, married and unmarried daughters and even to daughters above the age of 60+.

Daughters as caregivers

The daughters are very much present and visible in providing physical and emotional care for their parents. They seem to put greater emphasis on their relationship with their parents, especially with their mothers and after losing or leaving their husbands. We noted a widespread practice of daughters returning home and living with the parents or bringing their old mother to their vicinity for care. This could mean two things: First, the daughters feel more concerned about seeing their parents providing care for themselves. Secondly, the daughters themselves need a certain amount of care from their parents, because they are “insecure” in their lives.

This brings us back to the instability of marriage (*mbilini*) in Rufiji. As we have seen above, many of the older women in our study had been married more than once, and this also applies to their daughters. If the marriage did not work out or if they got divorced, many daughters moved back their parents, bringing along their children and grandchildren. Therefore, even if they were providing care for their parents when we met them, we cannot claim that the main reason for returning home was to provide old age care. More likely, many of them ended up as care providers while searching for security in their own lives.

In Ikwe Town, the relationship between a daughter and her parents tends to be strong. During their lives they maintain relations through various rituals, such as the birth of a grandchild, regular visits and even at times cultivating a piece of land in the town even after they have migrated elsewhere. This means they did not have to put much effort into re-integration as the relationship has always been there. The Ikwe daughters and their *wazee* are not building and maintaining these relationships for economic reasons. Economically dependent daughters are not necessarily replacing the sons but they are helping and fulfilling their role as children in providing care for their parents who are now *wazee*.

Daughters largely take responsibility for the domestic chores. This means, apart from affection, they “do everything” during critical health moments. To their mothers they become the primary care providers. They cook, do the laundry, clean the compound, cook food and sometimes help feed those older people who are bedridden. Apart from giving practical care, daughters chat with their mothers, bring them news, keep an eye on them, accompany them to visit a friend, a health facility or the fields. They also coordinate help with the other relatives if necessary. As older women pointed out, their communication with relatives becomes easier because the daughter can easily influence other children and relatives. Bibi Amina said, “their voices are more easily heard than ours when they call for more help” (F-74yrs). To be heard by the children was a major concern of older people. One woman remarked: “When we call, they immediately conclude that it is the same story, it is the everyday call and even if it is something serious they will not immediately react because we complain and ask for many things from the children, especially those who live in the cities” (F-84yrs).

Daughters can help their mothers by massaging the body massage because of the pain, taking them to the toilet, making their beds, and doing their laundry including even

sensitive items like underpants. Mothers and daughters often take a bath together in the evening. This reveals how close they have become even after many years that the daughters have been away. Therefore, the mother-daughter relationship is re-established. Rather than the mother helping the daughter, it is the other way round.

For instance, Bibi Saida (67yrs) lives with her two daughters and grandchildren. She lost her husband ten years ago. Her health condition falls into the second category, those with an unstable health condition. Therefore, there are times when she feels ill, tired, and weak or has a headache. This often happens after she has repeatedly worked hard like visiting friends, going to the *shamba* and carrying heavy things such as fetching water and firewood. Therefore, she experiences both movement and health condition problems. Her two daughters, aged 40 and 50, live with her together with their children. They are divorced and came back to their parents' home. Since they came back, they have been helping Bibi Saida with all the domestic work such as cooking, cleaning the compound, doing the laundry. She claims that she is "happy to have many hands around". They take her to the hospital or buy and give her painkillers when she is ill or has back pains. The two daughters bath with her in the evenings after they have come back from their daily work; they eat together and gossip about life. This according to her is what she missed after the death of her husband and after slowly finding it difficult to visit the neighbours, friends and *mashosti* (close friend or confidante).

Daughters move in with their children, grandchildren and even friends as in the case of Bibi Zainabu (102yrs). After the daughter was divorced she decided to come back to her mother's house even at the age of 78 years. Together with her friend and another daughter, she is now providing care for the mother. They also take care of each other when they are experiencing critical health moments such as pain, limited movement and

failure to do some activities. Zainabu, like many other older women, is happy to have the company of her daughters. Similarly, the daughters too are happy to have this relationship active and resourceful during these uncertainties.

Divorced or widowed mothers may also find a home with their daughters. Bibi Zena who is 87 years old was brought back to the house of her daughter three years before fieldwork. She had been living alone for years after the death of her husband. The daughter who was also of advanced age had lost her husband some years ago. Seeing how difficult life became for Bibi Zena, the daughter decided to bring her to her own house so that they can care for one another. We should not assume that the daughter-parent relationship during old age care is simply one-directional. Although this case is not a sibling reunion, a similar pattern becomes clear. The relationship that both parties have invested in for years becomes a resource when there are critical health moments.

The care of daughters for fathers, however, is limited. According to social norms and values, daughters are prohibited from providing intimate care for their father, such as touching, massaging and helping with bathing and going to the toilet. The joking relationship between the grandchildren and grandparents however makes intimate care culturally acceptable. The granddaughter becomes symbolically the wife and the grandson becomes the brother to the grandfather. As a “wife”, the granddaughter can massage the grandfather, take him to the toilet, help him with bathing, make his bed and even do his laundry. If a daughter lives with a father who does not have a wife, and there are no children, the daughter has to make a new arrangement. She has to call the brother or ask the child of a friend to come and help. If this is difficult then the uncles are asked to come and help. This reaffirms our point at the beginning that care is provided by a combination of social actors. It is misleading to link it to only one actor.

For instance, Mzee Hassan (87yrs) lives with his wife and two daughters who came back after their divorce with their children. His wife, whose health condition is stronger than that of the two daughters, provides much of the care for him and the daughters. When she moves to the *shamba* for an extended period of cultivation work, the family has to make a new care arrangement for Mzee Hassan. The daughters are culturally prohibited to bring water to the bath or toilet room for him, to make his bed or do his laundry. It is too personal and affectionate. Therefore, the grandchildren have to provide intimate care. The daughters can cook, bring him food and even eat with him but the body touching care is unlikely and is shameful if it happens. It would show how inactive and unfriendly the whole family is. It is the biggest embarrassment and something to be avoided. Unfortunately, his wife died during the follow-up study, followed by the daughter. To the surprise of many in the family and the neighbours, he too died within the same month, although he was not sick. The timing of these deaths was the talk of the town as it appeared that he died after the closest and main care providers had died.

The older people in Ikwe Town are positive about their daughters being around and providing care. Although we did not see older couples living in their daughter's home, the fact that daughters come back and provide care is something positive for older people. From the daughter's point of view this is not what they expected, that is coming back and providing care for the parents. This happens after divorce, as the reunion saves them from further uncertainty. However, this does not necessarily mean that if they are living with their in-laws they will not provide care. As it turned out they provide care but not every day. They would provide care from a distance, as we will reflect on in the next section. This means the sons and daughters-in-law would be responsible. Indeed, the parents are happier to receive care from their own daughters than their daughters-in-

law. The older people who live with their sons and being provided with care for during critical health moments reluctantly expressed how they lack freedom. When they become ill, it is shameful for a daughter-in-law to clean the toilet, help with bathing or do the laundry. This makes them either live alone or with other relatives. As a result, even for those who went for a short time to cities such as Dar es Salaam for health services felt embarrassed living and being cared for by the in-laws. They immediately ordered that they be returned to the village. They are not free and seemed locked up in this daughter-in-law relationship. Interestingly, the older people would rather have a different care arrangement during critical health moments, which means the in-laws providing care from a distance rather than living in the same *nyumba*.

Case study 5.3 A multi-generational home, Mzee Ali, 83 years old

If daughters faced problems with their husbands, were divorced or left behind, mothers and fathers encouraged them to come back and stay with them, often long before they actually needed old age care

Mzee Ali lived with his wife (83yrs old) who still went to work in the rice field, an unmarried daughter (57yrs old), a divorced daughter (52yrs old), her two divorced daughters and their seven children. “This makes up my family of 13 members, this is more than football team has,” he remarked with a twinkle in his eyes. “I enjoy having all these soldiers around, and there has never been a day when I felt lonely or unattended. I always get the attention I need, either from my three daughters or from my grandchildren or great-grandchildren.” While Mzee Ali was frail, his wife was still able to do farm work. Indeed, both men and women in our study continued their livelihood activities as long as they were physically able to do so. Another interesting point is that the multi-generational household of Mzee Ali is dominated

by women, and he explained why: “My girls, before being divorced and when they bring their cases to me, I always call them and then we sit and discuss. If I think the man is too stubborn, I never hide my feelings towards them that they should give a *talaka* [to divorce] because they won’t make it and I don’t want to see them suffering. Usually my words are very clear and short: if you think you can’t make it work, come home. There is no need to suffer.”

In other multi-generational home, the sons-in-law had moved in with their wives, or adult, unmarried sons continued to live with their parents and sisters.

Long-distance kin care

Apart from the spouse, children, grandchildren and other relatives who live with the older person or nearby, there are kin members, for instance children, who also provide some type of care, but from far away. This “remote control” care, as it is called in Ikwe Town, complements care at home (*nyumbani*). On one hand, distance care indicates agency on the part of the older people who is able to engage kin members who have moved out. On the other hand, it shows how those kin members are still actively engaged in negotiating and providing care even from a far. Those who provide care from a distance mainly do so by visiting, making a phone call and remitting money.

I recorded many stories about visits. By paying a visit, a son may show that he cares and is ready to fulfil his responsibility. The same son is a resource, even if he stays in Dar es Salaam because he is someone to turn to when there is a critical moment. This is clearly evident from those older people who have been to Dar es Salaam for a health service.

By staying and getting close to the older people in their everyday social world, one realises how much care comes from outside. They talk of being in different towns for cure and care when they were ill. They reveal receiving help in terms of money to renovate and run their farms from the children who are in towns. Others even share the gifts they have received from those children and relatives. During a one-time-interview, these relationships and actors will hardly feature.

By visiting and being visited, receiving gifts and receiving calls from these social actors, the older people feel assured of care. They know that if there is any moment when they need care from the children and other relatives who are not necessarily living with them they can receive it. Therefore, it is more important to assess care arrangements than living arrangements. People do not necessarily have to be there to provide care. This further shows the agency of the actors who have moved out for various reasons and the older people who have to work at maintaining and re-establishing these relationships even if they are weak.

Indeed, almost all the older people we interviewed and spent time with have this kind of arrangement. They have a web of “invisible” care providers who are not living with them. At many times, these are even more important care providers than the ones living with the older people. They are more important than the daughters, grandchildren and spouses. This is particularly true since care is not only about being physically close to each other but the quality of the relationship. Most of the older people are clearly happy that their children and other relatives visit or send gifts and call just to know how they are doing, how they are progressing with their health condition, if they have had a critical health moment, and wanting to know about new developments. This, according to most of them, marks the basic element of care rather than living in the same *nyumba*.

Some invisible care providers who live within the vicinity, others further away. This means they communicate through mobile phone or send letters through the commuters and when necessary they visit. Although one has to acknowledge that this kind of care is unreliable, especially during emergencies, the fact that there is constant contact between the older people in this rural town and the care provider somewhere in the town resolves a lot during critical health moments. This also means that when it comes to negotiating the provision and receiving of care, even those actors who are not around are involved and consulted before a decision is reached. Most often, they are the ones who provide material resources. What they remit has a big influence on the lives of the older people in a rural village. It means that they can buy food, kerosene, cooking oil, sugar, clothes, water and many other services. Their remittance and contacts makes the older people feel less burdened during critical health moments. Through remittances therefore, the children and other kin members who have moved to big towns and cities maintain their presence in the everyday care social engagement and relations. As the older people said in our conversations and discussions: “We see them”, “we feel them”, “we hear them”, “we talk to them” and “we rely on them”. Their presence is experienced in many ways, through visits, gifts and talking on the phone.

However, for these invisible care providers to be visible, the older people have to exercise their agency. They continuously engage in strengthening this social bond in order to daily benefit from it. This further means that the older people, like many others, invent new ways of keeping this relationship active and resourceful in their everyday lives. Apart from calling them regularly, the older people use the resources to capture these invisible care providers. For instance, because of the economic and social hardship of the children and other relatives in the cities and towns, the older people offer them a piece of land back in the rural town. They ask these invisible care

providers to cultivate it without any charges. Usually, these pieces of land cost around 50 USD if rented per year. On top of that, they are given free accommodation when they are cultivating the land. This means that an older person knows he or she will always receive a gift when these invisible care providers come and they receive care during their stay in the *nyumba* while looking after their crops. Since the season lasts up to 4 months a year, this is enough time to have company, affection and love and importantly being relieved of most of the work. Therefore, what looks on the surface as a mere need for food crops, there are a lot of underlying calculations by the older people. This inventive way of getting attention is a lot cheaper than making regular calls. Importantly, with the huge crisis of land in the cities and with most of their relatives in cities like Dar es Salaam earning little, often from casual work, the older people do not have to put much effort into influencing these invisible care providers. The fact that the land is not for rent is already enough to persuade them. In this way, the older people maintain contact while at the same time having some people around during critical health moments. Finally, care in terms of relationship and practice is guaranteed. Indeed, this explains why sometimes in the year, the *nyumba za wazee* (the elderly's homes) are full of people and not at other times. This further explains why the number of people in the house of an older person during a critical moment increases. Often there is movement and new faces appear at this time, new arrangements and negotiations are made that include all the invisible care providers. These are the care providers that can hardly be captured by few visits.

The numbers of mobile phones on the walls, written in charcoal or scratched, indicate not only the relationships that are invisible but also the agency of the older persons. Indeed, this is the best way through which the older persons keep a record and importantly the most important ones during critical health moments. It is the way they

maintained contact and children-parent relationships. If there is a critical moment or an emergency or 'events' as they largely call them, these numbers become a resource. They get activated and having them on the wall makes it easy for the older persons to call someone for help, as happened often during our visits. Behind the numbers lies a wider network that was established, maintained during the older person's life that include children, relatives, friends, ex-wives and people they came across and helped each other who remained to be important in their life. Therefore, having the numbers on a paper or wall make it easier for the older person to send someone to the little kiosk along the main road to make a call.

Therefore, even if children and in particular the sons have moved out, this does not limit the older people from getting their attention. When they need to see them, or they want to receive soap, food, clothes, sugar, and kerosene from them, they can easily make a call. Similarly, this makes them less fearful in the absence of close kin members, in particular the children. As said earlier, through numbers they close the gap and create the social space through which they communicate during critical health moments. That the numbers are there is an assurance. They become important, activated and a resource during the critical health moments.

In this section I tried to make the web of social actors who provide care in Ikwe town more visible. By doing so, we tried to reveal the agency of the older people in ensuring that care is provided and received. The older people still keep in touch and regularly communicate with their children and other kin members who have moved out for various reasons. Not only do they use new technology such as mobile phones, but they also use their experience to influence the children not to cut off the relationship that is a resource. Therefore, although children are in major cities such as Dar es Salaam and big towns this does not limit the provision and receiving of care. As social actors, both the

older people and the invisible care providers invent new ways in which to provide care. They ensure that during health critical moments parents get care by either sending someone to visit or by bringing the older person to the city where medical facilities are much better. All this depends on the nature of the critical moment.

So far the chapter has focused on the kin relationships that have largely turned out to be a resource during critical health moments. We particularly focused on the spouses, children, grandchildren, some of whom are invisible care providers. The next sections will mainly focus on the engagement of other social actors who are not necessarily kin members. Therefore, we move to the social actors who are important in the everyday lives of the older people in Ikwe town. This fills the gap left by the changes taking place in the town. They intervene and provide care during emergencies and/or critical health moments.

5.2 Care by non-kin

So far, we have continuously claimed that care relationships go beyond kin members. Especially in critical health moments, the non-kin ties of older people people become visible. This is particularly true when close kin does not live nearby or is temporarily absent, for instance because they stay in the *shamba* for extended periods of intensive agricultural work. Help may thus also come from “outside” *nyumbani*. In this sense, neighbours, friends and tenants become involved in care and are an important resource during critical health moments. The non-kin relations complement the kin relations, they do not replace them. Close kin were always informed if neighbours, friends and tenants come to help during critical health moments.

The sections below present the roles of neighbours (*majirani*), friends (*marafiki*) and tenants (*wapangaji*) and on the resourcefulness of these non-kin relationships during old age care in Ikwe. We explore what kind of care they provide and what the underlying expectations are. As in the previous sections, we consider concrete episodes of care as an interaction which is based on longer-term social processes and thus bi- and even multi-directional. The kind of care an older person receives depends to a large extent on previous experiences of those involved. The connections that an older person has established over time may become a resource in old age care. Such an approach allows for an examination of the agency of those involved in a care network.

Good neighbours care for each other

The notion of neighbourhood (*ujirani*) is not something we envisaged before fieldwork. However, during the follow-up study and during evening and morning visits, it emerged as an important social space in the lived experience of the older people in Ikwe town. Most of the older people mentioned the potential help of neighbours during critical health moments. Through observations it is clear that care comes from the neighbours.

The importance of neighbourhood can be partly seen as an outcome of the resettlement operation organized by the newly independent government in the early sixties and the formation of the communal villages (*vijiji vya ujamaa*). As we explained in Chapter 2, new settlements such as Ikwe were formed all over the country to bring social services and development closer to the people by the post-independent and socialist government. People who had lived in dispersed hamlets were brought to a central place and ordered to build a village without paying much attention to the disruption of family and kin ties. While the hamlets had been formed by kin groups, people were now assigned plots next

to people with whom they did not have any relations. The plot of each family was about 300 to 400 square metres. Over the years, a sense of neighbourhood developed in Ikwe Town and other parts of what now is Ikwiriri, especially among those older people who have known each other for forty to sixty years, have shared these experiences and have become members of the newly evolving community.

Therefore, neighbours are not necessarily kin and can therefore not be expected to take full responsibility for providing care. However, they are a potential resource of care because they easily notice if something is unusual or an emergency happens. As an older woman remarked, relations with neighbours are open-ended: “Establishing a good relationship with the neighbours is always something to look forward to even if you are not sure of how it will turn out” (F-85yrs). From several conversations and observations I learnt what a “good” relationship with a neighbour means, namely that intimate things and secrets of the family are not exposed to others. Older people clearly expressed a reservation about how much a neighbour can be welcomed.

All the 43 older persons in our age group-study have received some kind of care from the neighbours. Some neighbours give them water without having to pay. This is particularly true for those older persons in the first and second category, the ones who make it to the boreholes in the neighbourhood. Usually someone stays at these boreholes that belong to the better-off families. This person does not charge the older persons. They get 20 litres for free every time they go and fetch water. Others even arrange for their children to bring water to the older person’s *nyumba*. However, this arrangement is not automatic, as with many other relationships above, an older person has to make an effort to maintain and negotiate for this arrangement of care. As illustrated by Bibi Maimuna, “most often, just a mere visit and saying hello to a

neighbour is enough to get their care” (F-74yrs). That is, “by visiting you exchange ideas, you ask about each other’s condition and how everything is in the family. This means you are strengthening the bond which then becomes important when you need help” (F-86yrs). Indeed, while it seems easier for older women to have this kind of an arrangement, the older men who receive care from their neighbours seem to put a lot more effort into it. They not only visit but also give advice when the neighbours have critical health moments. They do not miss out if the neighbours have events such as rituals, death, illness and other big events. This makes them linked and continuously in receipt of the neighbours’ help.

In the late afternoon, it is common for older men and women to sit outside, on the veranda or under a mango tree, to catch the evening sun and to see and hear what is happening in the neighbourhood. They are often visited by other older people who are still mobile. The intention of these visits varies from simply passing by to greet to gossiping, bringing news of other older people, asking for something and finding out about progress maybe after they have heard of an illness. Similar exchanges between older men can be observed in coffee places, mosques or in the market. When they fail to see somebody who usually joins them, they make a visit to know if there is something special. For them this is care, not in practical but in emotional terms. The one visited does not “feel bored”, “lonely” and “left alone” as the old men explained in a group discussion. When the reason for a visit is related to an illness, they are likely to bring something that they think could help. They bring kerosene to light the lamp at night, sugar for special porridge for an ill person and give an advice on the best way to handle this critical health moment. Since most of them have experienced or are experiencing such moments, they shape not only the care this older people receives but also possible solutions in case more help is needed, such as informing the relatives, calling the

children and other people. In some cases, the neighbours arranged for treatment by fetching the traditional healer. This kind of closeness makes the neighbours easily notice “anything unusual” in the neighbourhood (M-86yrs).

In Chapter 3 and in the previous section, I shared the story of Mzee Shabani and his wife Rehema who lived outside Ikwe Town. Their story illustrates not only how invisible kinship networks matter but also how important neighbours are because they are alert in case something serious happens. After Mzee Shabani’s death at night, his wife informed the neighbours who immediately spread the news to the daughters and other relatives who lived 5 kilometres from their *nyumba*. Through the good relationship with the neighbours, the wife got help and the same night, only a few hours after his death, the children and relatives began to gather and to organize the burial ceremony.

Neighbours may be the first to help in emergencies. Again, by approaching Mzee Shabani’s family through the living arrangement one could hardly capture the network of actors which is activated by a critical health moment. Approaching them with the concepts of “care arrangement” and “care network” in mind I was able to learn not only about the grandchildren and daughters who lived in town but also about the close relations Mzee Shabani and his wife had cultivated with their neighbours over many years.

However, as Rekdal (1999) has rightly demonstrated in his ethnography of my own ethnic group, the Iraq, living in the northern part of Tanzania, neighbours cannot only be a resource they may also turn into the worst enemies. This is also true for the older Warufiji. As mentioned above, even sixty years after their resettlement, they approach the relationship with neighbours with great care. Clearly, the neighbour’s involvement

in old age care remains limited. Somehow, they remain strangers and cannot be fully counted on. They can only be of help but not fully responsible. Some old men appeared rather bitter when it came to the help of neighbours. As Mzee Mohamed put it: “The irony is when you are sick, no-one comes to visit or bring something, but when you die, the whole place will be full of people” (M-82yrs). Two lessons can be drawn from his outspoken statement. Firstly, that he does not have a good relationship with his neighbours with the result that they never help during critical health moments. This may mean that he never invested in this relationship or that the relationship turned sour due to negative experiences. Secondly, his expectations may be too high, in that he wanted the neighbours to be around all the time, replacing the kin relations. Interestingly, he acknowledges that they gather around when there is an event such as death, which is also a kind of care (see van der Geest 2002).

Therefore, neighbours as social actors become important for providing care for the older people. However, their engagement does not mean that it replaces but complements the care of many other actors around the older people. As one of the many relationships that the older people have, neighbours have an important, but also clearly defined and bounded role to play. It is a special relationship that the older people and the neighbour have to work on. Both have to see its relevance and usefulness during critical health moments. If this does not happen, it becomes like the stories of Mzee Mohamed, who did not think that neighbours had any value at all during old age.

We illustrated that our focus is not mainly on the physical but the social space. The relation and interaction that was established and maintained becomes a resource during old age care. At the same time, the neighbourhood can be seen as a physical space in which older people socialise with others who may offer help. In the next section, we

will continue with the same topic but focusing on friends. Like the neighbours, they are not always visible in the everyday life of older people.

Case Study 5.4 Good neighbours, Bibi Jika, 102 years old

We have already introduced Bibi Jika in Case study 3.2. She is 102 years old and as active as her instable health allows. She was proud to be a good neighbour.

Bibi Jika is a traditional healer and the neighbours turn to her when they face critical health moments. She does not ask them for money but expects them to visit her. She thus has company, is not lonely and knows they will help her if there is any emergency. In the worst case, for instance, when her son got tuberculosis and came back to live with her, she asked the neighbours for a loan and promised to pay it back after receiving payment for her healing work. “This only happens because I am a good and reliable neighbour to them. They know that I can help them even if they don’t have money and I know that if I have problems like now with my son they can lend me some money or even fetch water for us.”

Friends providing care

Just like neighbours, friends are also an important resource during old age care. Sometimes, it was difficult to distinguish between neighbours and friends during discussions and interviews. At times, the older people would just mention the name and we then followed up to see whether he or she meant a neighbour or a friend. Therefore, the difference is mainly captured by relying on what they said. In order to come close to their construction of friends, the evening visits and sometimes participation in their everyday social life helped to capture moments when they interact with friends.

Therefore, for the older men, sitting with them on the veranda in the early morning and late afternoon helped us to see these friends. Similarly, for those who fall into the first (with strength) and second (with/without strength) categories of health conditions, we were able to accompany them when going to their preferred visiting places, such as the market, having a coffee and or sometimes sitting beside the main road that connects the southern and east and northern regions of the country. These are the common venues where older men mostly meet and socialise. Although we did not intend to capture the quality and length of their friendship, it was clear that they have known each other for a long time. Relationships with persons who turned out to be a resource in old age care have developed in different ways. This makes it dynamic and complex. As we probed to find out how they developed their friendship, many responses were about the experience of being mothers, neighbours, age mates and parents, and having ethnic ties. The majority developed their friendships after they were relocated to what was then a village and is now a town.

Most have been lifelong friends who all moved to the town fifty to sixty years ago during the formation of the community villages. They help each other as much as they can, especially making regular visits when one is ill. During these visits, they share their experiences, encourage one other about life but generally about the condition one is going through. By visiting, the older person do not feel lonely, especially when he or she is left alone at home when the rest of the family members have gone to carry out their everyday activities. As Mzee Rashid illustrated, “through friends we get company and an update on what is going on in the town” (M-77yrs).

The care through friendship sometimes involves even the friend’s family. That is, the friend’s children help to fetch water, do the shopping, and call the relatives who live in the cities. This further adds to how complex providing care can become. Therefore, the

point that we are trying to make here is not that friends replace other social actors in providing care. The point we want to insist on is that friends complement the care the older person receives from others. Indeed, many times the friends turn out to provide the basis for understanding more about old age. When they sit down and share ideas, they talk about losing strength and share the experience. Through sharing, they inform each other about better ways to engage continuously in everyday life. Through friendship, as some of them claim, they “understood themselves better” and that “what they are experiencing is not unique” (F-102yrs and 76yrs). A friend experiences similar critical health moments.

Do friends also provide intimate care such as helping with bathing, making the bed, cleaning the room, cooking and sometimes helping to feed those whose health condition is completely without strength? This depends on the nature and quality of the friendship. Although in the focus group discussion the older people clearly and categorically claimed that “this is not what is expected of friends”, the follow-up visits revealed a mixed picture. The older people with whom we spent time, in terms of sitting and conversing with them, and sometimes accompanying them, revealed how intimate a friendship can become. It seems that sharing among female friends is a common practice. This makes sense as sometimes older women especially share even intimate things. These female friends as *mashosti* (confidante) share everything. They show each other their bodies, ask for and give a massage and reveal how frustrating it is to be old, especially when children and other relatives do not react immediately to their calls for care. This means, as *mashosti* they are more than normal friends. They can do everything that is supposed to be done by a kin member. Such friends are a resource through which an older person receives love (F-72yrs).

Older men have a completely different opinion. They believe that care from friends has to be limited. For instance, Mzee Harubu illustrated that “bodily touch or a very intimate thing is not expected of a friend” (M-88yrs). Other older men are stricter, saying that “friends neither observe nor come close to the arena where intimate care is provided” (M-82yrs). In the men’s discussion, intimate care such as massaging the joints and/or the body with coconut oil which is commonly used in the area is “considered not only a taboo but it marks a high degree of shame” if a friend does it (M-72yrs). One can understand why older men categorically deny this kind of care arrangement through friendship. It implies they have failed to negotiate the provision and receiving of care. One who relies on friends has failed to “get married to a younger wife who can do so” (M-67yrs) or “has failed to negotiate with children and other relatives” (M-80yrs).

For men, friends should be helping to provide material things such as organizing someone to fetch water, offering water for free, fetching the firewood, sugar, salt, kerosene and lending money when there is a need. The rest of the care practices have to be provided through family or kin relations. Friends like other non-kin members are only temporarily involved in providing care. They come during an emergency and help to negotiate and come up with better ways of providing care through their experience and advice. The moment someone permanent is found, they keep their distance and only visit and ask about progress and if they can be of help again.

In summary, two things emerge from the relationship between older people and their friends, one being that the nature of the friendship determines the quality of care. Secondly, the social and cultural norms and values largely determine the nature and quality of care to be provided and received by friends. Similarly, principles concerning

gender shape the relationship and the kind of care provided. All these determine the degree of engagement when a friend is facing a critical moment. Generally, there seems to be a mutual sharing of skills by friends during critical moments. These moments bring friends together. In establishing the friendship, certain expectations are raised by the actors that have to be met immediately or later. Much of the care in terms of practice largely happens in the form of sharing the activity that is socially and culturally acceptable. This includes but is not limited to sweeping the compound, fetching water, shopping and lending money. However, the more intimate care is, such as disclosing sensitive information, remains contentious between older men and women. However, our observation and participation in some of the events that brought friends together revealed how older women would easily share everything with their female friends but men did not. This includes frustration about the lack of help from children. A closely related newly developing social relationship that becomes a resource during old age care in Ikwe Town is that of tenants.

Care by tenants

Especially since the Mkapa Bridge across the Rufiji River was opened, Ikwiriri has seen a boom in the construction of infrastructure and houses (see Chapter 2). This increases the demand for accommodation. Many houses are owned by the older people. Since most of these houses have several rooms under one roof that were initially occupied by the children, after the children have grown up and became independent, they have rooms to let. Especially those older persons whose *nyumba* have an iron roof, rent out rooms to tenants. Among our Age-Study participants, eight accommodated tenants.

This section examines what kinds of relationships have developed between the older people and their tenants, who are far younger, often aged between twenty and forty. They are the workforce of Ikwe Town. Some have moved out of their parent's *nyumba* in or near Ikwe Town and established their own families, others migrated from other parts of the region or the country. Many of these young people work in the police force, health facilities, schools, research centres, and religious institutions, or are business people and researchers like me. This means, as I write this section, I will also reflect on my own experience with my landlady who was 68 years old.

Like neighbours and friends, tenants are considered as different relations than kin. When they move in, they are complete strangers. As time goes by the two get to know each other better in a good or bad way, good in the sense of accepting the other's behaviour and attitude and bad in terms of not meeting the older people's expectations. Since these are two generations differing in age and many other things, the relationship easily becomes sour and the tenancy is terminated.

The relationship is thus special in the sense that the younger person moves in looking for a place to stay while the older person may have some expectations and needs of care. The fact that the older person rents the rooms in order to generate income for the fulfilment of basic needs shows that the tenant becomes part of the care network from the point of view of the older person. He or she needs money to remain healthy and to complement whatever help they get from other kin and non-kin relationships. This means they are proactive and explore all possible sources through which they can provide care on their own or add to what they receive from others. As I argue throughout this thesis, the older people are not passive but active social actors who explore all possible means to ensure that they contribute not only to their own care but also to that of those with whom they live.

The question then is what kind of care comes from tenants? Do they provide the same kind of care like kin members? Being of the same age as their children, can the tenants be treated as their own children and similarly can they treat the older people as their own parents? These are some of the questions that we will try to answer in this section.

These are particularly interesting questions to study because these are newly evolving forms of care. Tenants are a newly emerging social group in Ikwe Town and a phenomenon that comes with rapid changes. The older people seem to use relations with neighbours as a model these new relations. The engagement of tenants in providing care is limited; it becomes mainly visible during emergencies or in the initial stage of critical health moments. If they agree to become involved, however, it is their responsibility to help until an alternative care provider is secured through other relations. Although the tenants never replace kin relations, they become neighbours, who are the resource for the older people during these moments.

Many houses in Ikwiriri are built in a style called “Swahili house” which has several rooms off a narrow corridor (see Obrist 2006:99). Often, these rooms do not have a ceiling and so what happens in one room is heard in the other four to seven rooms depending on the size of the *nyumba*. This means that “when one has a bad night” (F-100yrs) or “didn’t sleep well” (M-92yrs) it is not a secret, as the rest of the *nyumba*-dwellers will hear it. Similarly, if one is sick or has problems, the tenants know immediately before even other neighbours, friends and relatives. This makes them “very important” people (M-76yrs). Indeed, this is often what happened between me and the owner of the house I lived in. Often, she had some difficulties at night, and when she was ill then we all knew about it. The next morning she explained that she had pains in her body or a headache which caused her to complain and moan. On a few occasions, I told her to use the money I gave her not just as rent but to buy medicine

and sometimes discussed with her whether she should go to the hospital. The other tenants, two families, helped her with other activities such as fetching water, cleaning the compound, and cleaning the bath and toilet room that we shared. None of the tenants had to do her laundry and provide more intimate care such as massaging.

What is also clear is the temporary engagement of the tenants during these critical health moments. As tenants we were not permanently responsible for the owner, but we had to ensure that the children and other relatives who often visited her were informed. This means that the primary responsibility is communicating with the kin members.

Sometimes, the boundaries between tenants and kin became blurred:

Mzee Rashid (72yrs) lived with his wife and son. In the *nyumba* were three tenants, two working in the local bar and one running a business in the town. When his wife travelled and/or moved to the *shamba* during the agricultural season he relied on the tenants. They fetched water for him, cleaned the compound and sometimes gave him food. For him they were not only tenants but they had become part of his family. They respected him first as house owner and secondly as a father or *mzee* who needs their attention and help.

As these examples show, older people may not only receive the monthly rent from tenants but also practical care. The house owners told us many stories of tenants “helping to clean the compound” and “immediately helping while simultaneously communicating with the relatives”. At times, being more connected, such as working in organizations and meeting people who have other connections, tenants sometimes refer the older people for better treatment or medicine. However, this is done in collaboration with family members. There was not a single case in which tenants took matters into their own hands and arranged care for the older people. Everything was decided by the

family. However, what is clear is the influence and effect that rents have on the quality of care the older people receive. The rents in the area usually range between 2-15 USD. This money, which does not seem much, has a great effect on the lives and care of the older people. Some older men like Mzee Athumaini (M-102), who lives with two tenants, rely on this monthly rent to eat, buy treatment and pay for someone to renovate the house, mend the toilet and clean the compound. This happened after his wife left him when he failed to care for herself. Living with a grandchild who is in school, Mzee Athumaini eats at the nearby kiosks, which sell bites and tea for breakfast and food for lunch and dinner. He has been doing this for over ten years. Like others who live with tenants, when his condition gets worse he asks them for extra money and he deducts it from their monthly rent.

This new arrangement serves the older house owners like Mzee Athumaini, Mzee Rashid and others in many ways. It shows that what they get from tenants is not only the monthly rent but also care in terms of having company. They feel less lonely or bored and have someone to talk to when they need it. When his wife was away, Mzee Rashid felt less anxiety because of the presence of tenants: “I know there is someone sleeping in the next room, and when I have an emergency, I can call them and they come and help” (M-72yrs). Similarly, the female tenants who accommodated couples in their *nyumba* have the company of the spouses of the tenants and importantly the children. Although the arrangement is not the same as living with one’s family, the presence of tenants not only reminds them of their former life with their own children but makes them feel they are with other people. Thus, these new arrangements do not only generate an income but also help to ease feelings of being lonely, left alone or lacking care.

Professional care

Only a small number of older people in this study consulted professional care providers. A few went to a health facility, some of them all the way to Mchukwi hospital (see Chapter 2.4, see also Map 2) to obtain a diagnosis or treatment for acute illness episodes or chronic disease, either for themselves or for one of their children or grandchildren. Several study participants complained about difficulties in accessing health facilities and services, due to geographical distance and cost but also because they were not treated well by the health workers and even other patients. If they had to queue for hours, waiting in a long line of mothers with small children, they got weak and tired. Sometimes, when they finally came to the end of the line and met the health workers, they were told that they suffered from old age rather than an illness or received a prescription without any investigation. Once they reached the drug dispensary, they might be scolded for “stealing” the scarce medicine for young children.

Case Study 5.5 Bibi Zainabu, 102 years old

An old woman reported the following experience:

I am always sick. I hardly take any action. Once I went [to a hospital]. That was before I moved here. After I reached the hospital, the doctor told me: “Bibi, your time is up, you will finish the medicine for nothing. This is a normal illness of old age.” (*Bibi wakati wako umekwisha, utamaliza vidonge bure haya ni magonjwa ya kawaida ya uzeeni.*) Now I am just waiting for my time to come, since he told me so. I learnt my lesson that day. Oh! At this age I am not wanted at the hospital anymore, and I have never turned back. I don’t want to be told by another doctor: “Grandmother, your time is over for the medicine and if I give you the medicine it won’t help you. The sufferings are part of old age.” These words I don’t want to

hear anymore. Imagine, by this time we were supposed to be treated freely, and still that doctor has the gut to tell me this! Everything is money, your own health is money, without money you are not treated, I don't want to grumble and I don't want to be ashamed of myself waiting for hours in the line only to be given these words. Perhaps the words have even changed, may be they are even more insulting than the ones I was told because the doctors are also new, and they are of the new generations that hardly respect us anymore. The late Nyerere went with his free society, and now came the new generation with their own ideas where everything is money. Money comes even before human dignity. They should be ashamed, and I don't want to suffer at the hands of these new doctors.

However, her relatives found a way to help her, as great-granddaughter explained. When Bibi Zainabu is sick, she herself goes to the health centre with her 4-year-old daughter (Bibi's great-great-granddaughter):

We pretend that the girl has the health problem from which the grandmother suffers, whether it is a headache, back pain, eyes or teeth. The health center does not have testing machines. They just assume and give you the medicine that they think will cure you. Then after obtaining the medicine, we give it to Bibi. Since the doctor will give the small dose because she is a child, we kind of double the medicine assuming that that this is what Bibi would get if she herself would go. In this way we save money since the small children are treated for free in the health center while if Bibi went there she would have to pay. We simply cannot afford it, but at the same time we cannot let her suffer under our eyes. This is an embarrassment and shame to the family, and especially to us young people in the family. We have to find a way to make her comfortable even if it means breaking the rules.

In the course of the fieldwork we heard several stories like this. According to the 2003 National Ageing Policy older people (aged 60+) should receive free health care. In Rufiji, but also in many other parts of the country, the policy is not yet implemented. But as this example shows, even an old lady in Ikwe Town had heard that older people should have free access to health care. She was disappointed by the services she received and felt insulted by the words of the doctor. We often heard older people use phrases like “feeling shame” or “being embarrassed” in such contexts. Older people do not feel respected by the new elite of educated younger people, and they question the new morality of commodity relations which have replaced social relations rooted in kinship, an argument which has been taken up by Mwami (1998-2001).

The comment Bibi Zainabu’s great-granddaughter is one of the few comments of caregivers we include here. It nicely documents a highly relevant aspect of agency in care: Seeing her Bibi suffer, she feels ashamed or embarrassed and this prompts her into action. In other words, it is Bibi’s embodied agency – her critical health condition - which makes the great-granddaughter act. Agency in this sense is not reflected – on the side of the Bibi – and still leads to an action by “the other”.

A simple and very common way of seeking relief from pain or to treat fever and/or malaria, was to send a child or a grand-child to one of the many private shops and kiosks which sell over-the-counter medicine. A few older people sought help from traditional healers, and two study participants actually were healers (see Bibi Jika, Case study 3.2).

During my fieldwork, the CCBRT-Hospital Dar es Salaam provided outreach services for ophthalmology (eye) in Ikwe Town. Several older people also from our study went

to have their eyes screened and were then invited to go to Dar for further investigation and perhaps even surgical services. As Mzee Harubu recounted:

I am sick, my eyes don't see properly and I am expecting to go to Dar es Salaam for checkup. My child came home and told me: "Father! I have read in an announcement that they are coming to treat eyes on that and that date." Then, when the date arrived, I also went, and they tested the eyes. I was told they will come and pick us on 29/04/2010 for further treatment in Dar. This treatment, we are told, will be covered by them. Otherwise we couldn't afford it.

None of the older people in our study participated in social groups organized by religious congregations or by NGOs. During the Household Study, we specifically asked about any help received from such organizations or groups, in the past or at present. The answers were negative. To double check we paid particular attention to this issue in our Age Group Study but we did not hear about or see any group activities by the older people, except for their participation in political rallies, weddings and burials.

Nevertheless, biomedical ideas and practices have made their inroads into intergenerational relations in which old age care had been rooted. As was briefly mentioned above, Warufiji daughters used to give birth in their mother's home. This was one of many practices which strengthened the bond between mother and daughter which later justified why daughters can and should give intimate and personal care to their mothers. As Bibi Fatuma told us:

Some of my daughters came and gave birth here and others at their *miji* [their home]. But the tradition of giving birth at home is an old fashion now, and not many young people will be happy delivering at home because it is also risky. They

now deliver in the hospital, and those living in Dar will not come here just for delivery because it is obvious where the best service is and coming here is risking lives. These changes were imposed by some Europeans who came and lived here. They were telling us not to deliver at home and to rather go to hospitals where there will be a service. We gave them local names Nyamketo because they became like the Ndengereko and they were always with mothers and children, walking in the streets and playing, talking and influencing us to see the importance of hospital service.

Today the older and younger generations have worked out different ways of adjusting to this change. Some older people agreed that their daughters and grand-daughters should give birth in hospital, and then come to stay with them so that the parents could bless the newborn and the grandmother can take care of the mother. Some old women went to stay with the young mother and her new child. Still others reported that older people who were uneducated and old-fashioned insisted that the grand- and great-grandchildren should be born in their homes. The controversies over the question of best birth practice underline how intertwined the generations have been and still are, although the form in which the relations are lived may change.

5.3 Conclusions

A number of interesting points have emerged from the presentation of my findings which I would like to highlight and discuss, also with reference to previous studies on old age vulnerability and on ageing, health and care in Africa. Following up on the last chapters, I used “critical health moments” as an entry point for studying care. The obvious assumption is that older people - positioned along a continuum from having to not having strength - face moments when the performance of routines and tasks gets so

difficult that they need help from others. My study is thus guided from a broad understanding of care as help in critical health moments.

The first section in this chapter asked: Who cares for older people in Ikwe Town? What I found is that older men and women continue relying on kin care. I was able to show that they do not simply make kinship structures come alive but they actively rub against and shape them and thus show agency as defined by van Binsbergen (2007). Such an approach draws on, but at the same time moves beyond, an actor perspective to study old age in Africa as, for instance, used by Apt (1996).

My analysis of care by older husbands has shown that they try to live up to their role as household head and breadwinner, much in the same way as described by Obrist (2006:178) for Dar es Salaam. If their older wife faces a critical health moment, they may temporarily step out of their husband role and take over some of the routines and tasks of their wife. If the problem persists, they restore order by searching for a female kin member to step in.

If the old husband realizes that his aged wife may no longer be capable of performing her tasks, or if he loses his wife by death or divorce, he may marry a younger wife with the intention of securing care. Sometimes the wife who faces health problems agrees with the new marriage, but often such a decision causes tensions, conflicts and even divorce. If the wife leaves, the old man risks losing the support of the children they had together. Old husbands thus often try to accommodate both wives.

On the Swahili coast, divorce is rather common, also in old age. As in many other communities with a matrilineal kinship system as a back drop, women have stronger ties with their own lineage than with their husband and his lineage; they are always

welcome to come back to their parents, brothers and sisters. Van der Geest (2002:21) reports similar findings from the matrilineal Kwahu Akan group in Ghana.

As van der Geest (2002:22) points out, men often mention the care burden as a reason for divorce, while women say that men just want a younger wife. The fact that women bear the biggest burden of everyday care is a common phenomenon, not only in Africa (see e.g. van Eeuwijk 2006:72-73). “Women do everything” as the saying goes in Ikwe Town. Women are responsible for food, from cultivation to feeding, for the provision of water and for doing the laundry, to mention only a few tasks. This division of labour concurs again with findings from Dar es Salaam (Obrist 2006:177-211). In addition to the usual female tasks, older women often have to nurse much older husbands. They have to boil water and even bathe them, prepare soft food and feed them and provide comfort and massage them if they are in pain. At some point this may become too much. As van der Geest (2002:21) has also noted for Ghana, it is not uncommon for old women to leave sick and dependent husbands, especially if they are poor and can no longer provide the basic necessities. The older women feel they have fulfilled their responsibility as mother, grandmother and wife. Moreover, they are aware of their own precarious status: If the old husband dies, they might be expelled from the house by the in-laws, unless they had children with this husband who stand up for her. Older wives – like older husbands – thus have to weigh their risks. Usually, old women do not remarry; and often a sibling or a daughter takes them in.

Although not cited as an ideal, the reunion of siblings is an accepted care arrangement. The decision to bring them together may be made by one of the siblings or by adult children, who may even live in distant Dar es Salaam. More generally, intra-generational care – whether between spouses or siblings – is a phenomenon that has

long been neglected in the literature on old age care and may become more frequent in the future, if inter-generational ties further weaken (van Eeuwijk 2006).

The most common care arrangement in Ikwe Town is for daughters to gradually replace the mother in “doing everything”. Most older parents and especially mothers (60 out of 92) had adult and often older daughters as main caregivers. This pattern can play out in many variations. Daughters may have returned to the house of the parents after divorce, sometimes long before one or both of the parents needed care. In other cases a daughter was called back from as far as Dar es Salaam to become a caregiver. However, norms and values prohibit daughters to provide intimate care for their fathers. Since daughters often move back with their own children, it is the latter who take over the personal care. The joking relationship between grandparents and grandchildren allows them to do so (see Chapter 4).

Adult or older children living in the same house with their parents are not the only ones providing care. Others may live nearby and participate in practical care activities. Increasingly important is also “remote control” care, as it was commonly called in Ikwe Town. While the migration of the younger generations to town is often seen as a threat for the security and care of the parents (Apt 1996; van der Geest 2002; Roth and de Jong 2005), my study shows that older people also recognize positive aspects of expanding kinship networks. Some of them used “care from a distance” as resource, for instance in terms of access to health care services in the city, for obtaining material goods or support and for receiving more informed advice. Some women who had lost their strength and could no longer take care of themselves were moved to the houses of children in Dar es Salaam, but not all of them felt comfortable there, and some returned back to the village. An important bond between parents in the village and children in town was landed property and the products it produced. Some of the older people used

houses as an asset or offered house-sitting services to attract care from adult children and grandchildren.

What my study clearly shows is that critical health moments activate members of the “changing webs of kinship” (Alber et al. 2010). Older persons engage with their close kin through intra- and intergenerational relations. As van der Geest (2002:18, with reference to Oppong 1974) has noted for the Kwahu Akan also applies for the matrilineal Warufiji: the shift in loyalty from lineage to conjugal family in the younger generations. Like in his study, it was not easy to sort out the great diversity of care arrangements but a similar pattern emerged: The wife cares for her husband (and vice versa) until one of them dies or they divorce. A daughter gradually takes over from the mother and looks after both parents, the widowed or divorced mother or – in very rare cases – a widowed or divorced father. More commonly, the latter married a younger wife.

Emphasizing agency I was able to show how older people draw on the experience and the resources they have accumulated during the life course to tackle critical health moments. They draw on their kin to help them and thus contribute to reshaping intra- and intergenerational ties to match the changing needs. Over the past decades, they have also learnt to include neighbours, friends and tenants into their care networks, although with a certain reservation. They keep them “outside” of their own home or at least their private rooms but appreciate their visits, attention and occasional support. To have them nearby gives them assurance, and they often carefully cultivate good relations with them, partly in anticipating emergencies. Non-kin however cannot be asked to provide basic necessities like food on a regular basis or perform personal and intimate care activities. To cross these social boundaries would be shameful, not only for the older person but also for the close kin who is expected to provide this kind of

care. The only exception is the *majosti*-relationship between older women, which allows a closeness otherwise reserved for kin.

This brings us to the second question addressed in this chapter: What kind of care is provided for older people? Since we used “critical health moments” as an entry point, our attention was directed at rather mundane “activities of daily living” (van Eeuwijk 2006:70-71) or “activities of care” (van der Geest 2002:9). The two most important kin care activities were the provision of shelter, the whole process of getting, preparing and cooking food, fetching water and fulfilling other basic needs. Everything which had to do with bodily care and hygiene was performed within spouse-, mother-child-, sibling- or father-son-relationships. Some activities clearly required physical presence, such as feeding a mother in the *sina nguvu*-category, but we also looked behind the scene, so to speak, and asked: Who contributed to the feeding of porridge to this mother? Such an approach drew our attention to activities like visits, phone calls, the sending of gifts and remittances, which are performed by the more distant kin. Similarly, participation in everyday life showed that the older people also highly value neighbours and friends who pass for a visit, bring kerosene for the lamp, sugar for porridge, or give advice about how to relieve aches and pain, in short, show that they care. In fact, emotional care and keeping company came up as a highly valued form of care, between neighbours and friends but of course also in close family relationships.

As this composite picture shows, older people in Ikwe Town were able to mobilize a wide range of people in times of need: kin relations by descent, such as (grand)mothers, (grand)fathers, (grand)children, brothers and sisters, as well as by marriage, wife or spouse and – to a lesser degree – in-laws, but also non-kin like neighbours, friends and tenants, and in a few cases, professional care providers and healers.

Compared to the field of HIV/AIDS-related caring and nursing in Tanzania (see Dilger 2010), old age care is hardly structured by broader forces of an internationalization and privatization of health care. As our findings have shown, most older people do not have access to – or refuse to use – available services which are too far away, too expensive, and geared towards under-five-year-old children and pregnant mothers. Even a very old woman in Ikwe Town was aware that older people should receive free health care, although she probably did not fully understand what a National Ageing Policy is. As her example illustrates, older people experience the lack of adequate professional health care services in old age care not just as a practical, technical or financial problem. They question the new morality of commodity relations which has replaced social relations rooted in kinship, an argument which has been taken up and further elaborated by Mwami (1998-2001).

This lack of help from the state contrasted with the help provided by kin. In the case of Bibi Zainabu we saw that the condition of the Bibi spurred her great-granddaughter into action. When this young woman saw her Bibi suffering, she felt ashamed and wanted to give her relief - and this prompted her into action. In the sense of agency defined by Emirbayer and Mische (1998) it is Bibi's critical health condition which makes the younger woman act. Even if Bibi's pain was embodied - not reflected or discussed - it can still lead to an action by "the other".

My main argument in this chapter thus is that we have to examine where and when older people's critical health moments do or do not lead to care action, and why. Most of the findings presented here explored when the older people themselves became active and evaluated their options by drawing on past experiences, considering pragmatic aspects and by anticipating potential outcomes – always taking other people in their care network into account. The data presented clearly show that they have

agency (as defined by Emirbayer and Mische 1998). Perhaps this point was even overemphasized because we did not systematically explore situations in which critical health moments of older people did NOT lead to any action by themselves or by others. Also, with a few exceptions, we did not pay attention to situations in which embodied old age prompted others to act. However, we do want to emphasize the general point: Underlying principles like reciprocity and respect (van der Geest 2002) or an “implicit intergenerational contract” (Roth 2005) provide guidelines, but it is the continuous – partly habitual, partly reflected effort older people and their significant others make which drives care as a lived experience.

Due to our primary interest in active older persons, the *sina nguvu*-category is under-represented in this chapter. Older husbands in this category can provide emotional care and company, as we have seen, but it will be difficult for them to find younger wives in case they lose the present wife due to death or divorce. Often women who were very old themselves, both wives and siblings, stayed with them and did their best to provide at least some basic care.

What I did not see in Ikwe Town is older people begging in the streets, as Spitzer and Mabeyo (2009:49) have reported for their two research sites: Kineng’ene village in Lindi District and Kingugi village in Temeke Municipality, Dar es Salaam.

The income earned by respondents from the rural area was generally too small to make a household of four or more people survive. As a consequence, such a little earning increased the vulnerability of older people to poverty and health risks. It is within this perspective that family members including older people were forced to go begging from their fellow community members. Some older people in Kineng’ene moved to Lindi town to beg for money and food in their attempt to

ensure their livelihood. In fact 20 older people in Kineng'ene and 11 in Kingugi admitted to resort to begging as a coping mechanism.

The authors state that they selected these two research sites with HelpAge Tanzania because the communities including older people were considered exceptionally poor.

In our case, we did not really find the cases where the older people were begging (*wanaomba*). However, the better-off older people commented on elderly being poor and finding it difficult to manage three meals. The older people themselves also narrated not being able to have enough to eat. It could also be that we approached them through a positive lens that prevented us from noting what others have seen in other places. Being relatively rural, it is also possible that begging is done in a way that is culturally acceptable thus does not take stand out as it does in urban areas.

Providing and receiving care does not always happen in a smooth way. Tensions and conflicts were not our primary focus, but a few older people's narratives suggest moments when conflicts emerged. Even though such moments can also be considered as critical, we did not investigate them. This may be partly due to the fact that conflicts and tensions are seen and handled as family affairs. Neglecting an older parent or relative causes shame and embarrassment, and such instances are kept from outsiders, including researchers.

Chapter 6 Care Practice in Bumba

We now turn to our findings on the practice of old age care in Bumba. Although this chapter addresses the same topic as the last one, it is structured a bit differently. One reason is the difficulty to distinguish between kin and non-kin in this remote village. Most people are related with one another through kinship and marriage or at least use the idiom of kinship. The second reason is that I would like to make even more explicit how care at home is embedded in kinship networks. The discussion thus begins with the unit where care takes place face-to-face, namely at home (*nyumbani*), and then gradually move outwards to those who are engaged in care but live in other parts of the same village, and finally to those who contribute from far. With this perspective I would like to emphasize how misleading it is to take survey data of living arrangements as a proxy for care arrangements. Some of the most important care arrangements become only visible as one follows the dynamics of care networks which expand and shrink over time. Moreover, and related to this point, I would like to demonstrate that temporality is a crucial aspect of old age care. The data presented here come from the Community Study, the Household Study (n=21), the Age Group Study (n=14) and my own stay in Bumba village (see Chapter 2.4).

As in Ikwe, kin relations are at the centre of old age care, but the kinship principles have been modified by the Islamic religion, the *ujamaa* ideology and new modes of production. In the course of this societal change, frames of reference other than kinship have also become important, for instance government structures and new regimes of transport and communication. In real life situations, the social relationships count more than any structural principles. As I will again try to show, it is the agency of the older people which matters most in activating and maintaining these relationships in critical

health moments. They adjust the social ties to suite their care needs. In other words, they turn these relationships into resources for care.

The older people in Bumba receive and provide care at home (*nyumbani*). Most of the *nyumba* in the village are small thatched huts, with a bathroom/toilet which is usually some 10-20 meters away from the house. Although the material structure of the home is of relevance for care, we use the term “home” mainly to refer to a social space. What we mean comes close to the concept of household but since we are primarily interested in care relations which are embedded in yet also distinct from economic relations, we prefer to use “home” as a “sensitizing concept” (Blumer 1954, in: Bowen 2006:7). With whom an older person in Bumba forms a home is an open empirical question I try to clarify in the subsequent sections. I further try to avoid the term “family” because – like “household” - it often hides more than it reveals. Family patterns in Tanzania are very diverse and rapidly changing (Bryceson 1995; Creighton and Omari 1995; Forster 1995; Tungaraza 1995) and what people actually mean by the Kiswahili term *familia* in a given situation has to be investigated not assumed.

6.1 Spouse care

As in Ikwe Town, older persons in Bumba receive care from the spouse. This rule applies of course regardless of age and gender, but it becomes even more meaningful in old age, when bouts of weakness or illness become a part of everyday life. Husband and wife are both involved in care, each of them having responsibilities assigned by kinship and gender. As the leader of the family, an older man is expected to make or at least influence most of the decisions, even when he is critically ill. His responsibility only diminishes if he cannot hear and talk. The wife, on the other hand, is expected to

provide the bulk of practical care and – even if she is too weak to do so - to offer advice about life in general and domestic matters in particular. In married couples, the spouse is expected to be the first to either provide or negotiate care.

When discussing care with couples in Bumba, it was common for the husband to say “my wife does everything”. But in contrast to Ikwe, many wives said the same of their husband: “He does everything”. At first it was not easy to make couples explain what the spouse actually does. Over the years of living together, the culturally prescribed household responsibilities and tasks have turned into gendered routines and were barely noticed. It was only during problematic situations, such as critical health moments, that the spouses began to reflect about shifting tasks, in order to help or simply to keep up the daily routine. But even then, living together had become a shared practice, often based on previous experience and communicated in deeds rather than words. Many of these interactions had become habitual.

Moreover, problematic situations have occurred before a couple became old. When a wife or a husband got sick, they also had ways of looking after each other, helping each other out or organizing somebody else to take over some of the tasks. The couple tacitly knew how to manage them with some help of others. In old age, however, helping became a topic, especially if two persons depended on each other. Temporary or longer-term adjustments had to be discussed, negotiated and tried out, especially with regard to food provision, bathing and personal hygiene.

Like their peers in Ikwe Town, older people in Bumba tried to work in their fields and gardens as long as possible. Especially during the agricultural season, when everyone was busy with *shamba* work, they had to make adjustments taking their own strength and the care needs of a weak or sick spouse into account. Young and old tried to catch

the rains and either plant or weed the *shamba*. During the day, hardly anyone stayed home, except for the weak and the sick persons. If, for instance, the husband could no longer join his wife in farming activities, she had to take over and arrange basic care for him. During the six months of field research in the village, I was able to observe and record many such small adjustments.

Wife cares for the husband

The wives are expected to be at the centre of care provision inside the house. This is their responsibility throughout their married life. Wives should cook for the husband, do his laundry, and boil and bring hot water to the washroom/toilet, regardless of their own health condition. As a woman commented during a group discussion: “As a good and caring wife you bring water to the washroom/toilet and call your husband to come and take a bath” (F-74yrs). The husband comes, takes a bath and either brings an empty bucket back or leaves it for the wife to fetch later. This kind of intimate care arrangement lasts into old age, as long as the couple has strength, and does not involve the younger generations at all. Even if they are living with their children, grand-and great-grandchildren, it is exclusively a husband-and-wife affair.

The routine becomes interrupted when the husband’s health condition becomes weaker. The wife then is expected to not only bring water to the bathroom/toilet but also to help him walk there. She should further help him with bathing. These rules are articulated but also practiced. Often the women went into detailed and even intimate descriptions. During the focus group discussions, for instance, women described how they tried to make their caring responsibility easier by bathing together with their husbands. This

practice saved time and water, a scarce resource in the village, and it reduced the burden of walking twice to the bathing place.

For the older husband who cannot walk anymore, the wife arranges a little toilet and bathing place inside the house and helps him. When I remarked that this arrangement may mean more work for them, some older women referred to Islamic faith and said that old age care “comes with blessings (*thawabu*)” (F-65yrs). If a wife ensures that her husband gets the best care, she will be blessed. Husbands who were confined to the room or even at times to the bed could not really take much influence other than complaining if he was not satisfied with the care he got. Together, the spouses had to find ways of accommodating the changing health conditions in their daily routines.

This process of adjustment was not always smooth. I noticed tensions, misunderstandings and even quarrels among spouses. This was particularly true when an older wife felt overwhelmed by the toil of providing care. Since this kind of old age care was expected of wives, she was not supposed to mention or openly express her frustration to her husband. Moreover, as some older women commented, too many complaints would make the old husband despair. In the worst case, expressing anger might lead to separation or divorce, something that was not expected to happen in old age. In fact, it would cause shame and embarrassment for the woman. As one older woman explained in a group discussion:

You run away from your husband because he doesn't have strength? You will be mocked and become a laughable object in the village! You will make people talk and you will not only embarrass yourself but the whole family including your clan. No one will understand you, and it is also against tolerance that is taught in our mosque. If you see an older woman divorcing her husband because

he needs her help then for sure she will suffer in this village. It is a small place where we know each other, and if such news come out, then the only option would be to run away from the village because whether you like or not, you will be laughed about by all people here. (F-84yrs.)

Older women's references to "blessings" and the social sanctions of "shame and embarrassment" indicate that old age care is seen and enacted with reference to religion, gender and kinship. Such values and norms continue to shape the local moral world in Bumba.

Old men did not only value practical but also emotional care, as the following statements from group discussions emphasize. "This is where the importance of having someone in the *nyumba* comes in" (M-83yrs). It is important to have someone "who asks what you want to eat" (M-83yrs); "someone who asks if you need anything special" (M-69yrs); "a person who asks how I slept" (M-87yrs) and "knowing that there is someone to send to Ramadhani's kiosk for medicine when the pains are unbearable" (M-93yrs). What mattered to these men were companionship and the assurance of having somebody to turn to in critical health moments.

The need for company and assurance makes even more sense if we consider the physical and social setting of the village. The houses and hamlets are quite dispersed, and nobody may hear it, if an older person cries for help. Moreover, distances become increasingly challenging as people grow older, weaker and perhaps even ill. Bumba is surrounded by bushland, and there are many snakes and other small animals, and since the village borders on the Selous Game Reserve, there is also a risk of coming across wild animals. It happens quite often that one meets animals during the daytime, and it becomes truly dangerous at night. As soon as it gets dark, the outside life almost stops.

Very few people move around at night. There is hardly any visiting except for cases of emergency even then only with great care and in a group of at least two people. At night, it is even more important for the older people to have someone around. It is thus not surprising that no older person lives alone in Bumba, according to our records. If an older person loses the spouse, she usually moves and joins somebody else, for instance a sibling or an adult child, as we shall see below.

Case study 6.1 A devoted wife, Mzee Ali, 97 years old

The case of Mzee Ali has already been introduced earlier (see Case study 4.3). His health was rapidly declining during my field research because he suffered from (diagnosed) Parkinson disease. It was touching to see how his wife tried her best to take care of him, and how he himself was eager to still make a contribution to their shared life.

In 2010, Mzee Ali was 97 years old, his wife 80 years old. In the morning, she asked what he wanted to eat and organized his meals and his days. When she went out to work in the fields, she prepared his food and put it near the place where he rested. She inquired how he felt and whether he needed anything special. She did his laundry, boiled water, brought it to the bathroom and helped him with bathing. She also gave him company and represented him in community events. They discussed what was going on in the village and shared future plans. His wife admitted that she often felt overwhelmed by work because the daughter could only help with the house work and the cultivation, but not with the intimate care work for her father.

Mzee Ali as the head of the house never wanted to just patiently rest inside and outside the house. He told me that his task was to guard the house. While he was

still able to do so, he slowly walked around the house to ward off thieves as well as monkeys and wild pigs that might come and destroy the crops in the kitchen garden.

As this case shows, the engagement of wives during critical moments also has its limits. Just like their husbands, the wives are getting old, and they are not spared from the health conditions that come with old age. They are often ill, tired and weak, and have a headache and pains. Therefore, despite doing a lot for their husbands, there are times when their care is limited.

Husband cares for the wife

When the reverse happens, and the wife's strength declines while the husband is still fairly strong, he first becomes more active within the household. He tries to do some of the work she has been doing. If she had been fetching water for him, he may go to the river or well himself and take his bath right there.

This practice is socially acceptable when an older wife is either ill or for some other reason cannot perform the task. If the husband would be doing the same while his wife is well, both would be treated differently. She would have to bear the consequences of being judged an unfit and rude wife, while he would be seen as being led by a wife. Both judgements are linked with the social sanctions of shame and embarrassment. However, if she gets sick and the husband cooks, fetches water, does the laundry and other household activities, the village does not regard that as shameful.

Another task the husband may take on if the wife is not well is to go to the kiosk which is located in the centre of the village near the school where I lived. This kiosk caters for

daily necessities. Every day I saw old men and women slowly walking to the kiosk. They left carrying small containers of cooking oil or kerosene, or small black plastic bags commonly known as “malboro” filled with maize flour, sugar, rice and other items. Only those older people who still had strength ventured all the way to Kibiti, the nearest small town with several shops and various services, about 20kilometres from Bumba (see Chapter 4.1). Few older people were able to ride a bicycle, and to hire a motorbike-taxi was too expensive.

Case Study 6.2: Taking over temporarily, Mzee Masoud, 71 years old

What it means for a man to temporarily take-over is illustrated in the following case.

Mzee Masoud (71 yrs.) lives with his wife who is 60 years old. His health condition is not very stable, and his wife does almost all the activities when he is weak, ill or tired. He falls into the category of the older people who sometimes have and sometimes do not have strength. When he feels up to it, he helps his wife with the *shamba* work, but she mostly does everything.

However, when his wife cannot work and care for him because she is ill or tired from work, he intervenes despite his health condition. This means he joins the other villagers to fetch water from the spring, almost 500 meters from their house. He also fetches firewood from the nearby bush land. In fact, their house is completely surrounded by a huge forest with plenty of firewood, and so this does not seem to be a big issue. He carries water to the bath and toilet for her. She cannot take a bath at the spring. It is a big taboo and a practice considered shameful for a woman to take a bath in a public area. This is not possible even with tall grasses and trees around. Women have to take the bath at home. For men, it is less restricted.

The most critical thing for Mzee Masoud is to walk the 3 kilometers from the house to the kiosk to buy medicine or things for the kitchen. When his wife is well she does all this but when she also has some critical health moments then it becomes an issue for him and he has to force himself to carry out these care activities for her.

This example shows that older men (have to) make a special effort in care provision, when the wife is temporarily unable to fulfil her responsibility. I actually observed many instances of husbands' temporary care engagements. If, however, the wife became frail and disabled for longer periods or even permanently, or if one of the spouses died, new care arrangements had to be worked out. One option was to move in with a sibling.

6.2 Sibling care

As in Ikwe Town, several older persons lived with siblings. Even if such an arrangement worked out well, it had often been rather difficult for the old person to leave the people, the place and the material belongings they had grown accustomed to. An older man used the words "painful and heart-breaking" (M-79yrs) when he talked about leaving his former home, although he had faced many challenges after his wife had moved out. An old lady, on the other hand, made the rather pragmatic remark: "One has to assess what is important: living alone, being lonely and also bored or being with a sibling whom you know and who cares for you." (F-98yrs)

The person who agreed to take up a sibling was old as well and also had to make adjustments.

Bibi Saada (86-yrs) and her husband Mzee Hassani (96-yrs) agreed to offer a new home to Bibi Halima, the older sister of Mzee Hassani. When Bibi Halima joined

them, the two women helped each other, but Bibi Saada notices that her sister-in-law, now about 100 years old, is rapidly losing her strength. She can hardly do any domestic work anymore. This means that Bibi Saada has to do everything for her husband and his sister: She cooks, fetches water, and cleans the compound, as best as she can [the homestead looked rather neglected in my view]. Although she is old and often feels overwhelmed providing care for the other two older persons, she enjoys the moments when they sit together and joke about the life and days gone by. Bibi Saada and her husband in fact gave Bibi Halima the main house to make her feel more comfortable. The two of them moved into a small thatched hut nearby.

If an old man or woman moves in with a couple, this not only means more care work for those who are still well enough to do so, it may also bring about changes in the actual living arrangement. Old couples pointed to their need of some privacy. In fact, sexuality in old age was an issue which cropped up now and then in my study and certainly deserves more attention in studies on ageing in Africa. The case of Bibi Zaria underlines this point and also nicely exemplifies sibling care.

Case study 6.3 Caring for a sister and a visiting husband, Bibi Zaria, 78 years old

We have already introduced Bibi Zaria (78yrs) in Case study 4.2.

I am married to Saidi (85yrs) who has two other wives. My sister and I live together, and I always have to make sure that she is fine. Before doing anything, I first ask about her condition especially how she has slept. I then prepare the water; wash myself and also help the sister, then we prepare for morning prayers. After the prayer we prepare porridge and cassava [for breakfast], and I finally go to the *shamba*. At 12pm I come back and wash myself, pray again with my sister and then

start preparing lunch and eat. I then take a rest, and at 3pm, I sit in the shadow with my sister and start making mats while exchanging stories and jokes. At 4pm we again prepare ourselves for prayer and continue resting and if we have a visitor we continue exchanging stories and different experience in life. If it is not a farming season we start preparing dinner.

My husband got married to another woman when I first saw that I am getting old. We discussed and agreed that it is becoming too much for me to satisfy him sexually. He comes when he wants and stays for a day or two maximum and goes back to the other wives. Last year he got married to a much younger wife (35yrs). The second co-wife also got tired as she is almost of my age. I sometimes wonder if he is really strong enough to satisfy all three women. When he comes, he isn't strong, but I guess he is showing off to his friends. He is still is my husband, provides for me and has all the rights. When he visits, we sleep in the kitchen house to have privacy, while the sister stays alone in the main house.

The older people were careful to make their adjustments in a culturally and socially accepted way in order to avoid gossip. Moreover, the way they told their stories and the way they interacted showed consideration for one-another. They tried to accommodate each other and to make each other as comfortable as possible. Again we see that care is not just about practical help but just as much about enjoying each other's company and looking out for the other.

However, even if they tried their level best, they sometimes reached their limits, especially if old age was complicated by an illness.

Case study 6.4 An old man with his wife and sister, Mzee Saidi, 95 years old

Mzee Saidi also used to be a member of the Bumba men's club, together with Mzee Salum (Case study 4.1) and Mzee Ali (Case studies 4.3 and 6.1).

I live with my wife Zainabu (84 yrs.) and my sister younger sister Binti Salma (92-yrs.). Since I became sick, my contributions to the household are very much limited. My main task is to look after the house and the *shamba* so that wild animals do not come and destroy the crops that my wife has planted. I can't farm anymore as my body is like broken into pieces. I am making mats and baskets, but even weaving has become a problem in recent years. As you can see, if I talk much, my whole body starts shaking, and even talking becomes a problem. I tell you, this disease [no biomedical diagnosis] is really a big challenge and you can hardly manage anything. You have to be looked after like a small baby.

My wife is the one attending the *shamba*. She still has some strength, and she is the one who feeds us, fetches water and does all the work that needs movement. As you can see, she is also becoming old. Sometimes she is not feeling well and we have to go without eating. With time she will completely fail like me and my sister.

My sister, Binti Salma came here after she was left alone. Nowadays she can hardly do anything because her condition has become like mine having this disease. God has given her a disease like me. Her condition is not yet as serious as mine, but one can see that she has already developed some signs. Sometimes we just look at each other in silence. We share the sorrow and pain that we can hardly do anything anymore to help my wife.

Even if these old people mobilize all their resources and stretch them as far as they can, they do reach the limit of their physical and emotional strength. Not only these three

older people I talked to felt overwhelmed by work, pain and worries about what will happen to them.

6.3 Children's care

Even if they were not visible in the accounts presented so far, the younger generation had been engaged in either initiating the present care arrangements or actively supported them. Also in the case of Mzee Saidi (see previous section), there is a daughter in the background who comes to stay with them during the agricultural season and looks after them. As he recounted: "She doesn't stay with us that long because she also has other commitments. When she is around, we are happy, otherwise it is a big challenge." Like most of the other older people in my study, he just stated the situation and did not complain, perhaps because admitting neglect to outsiders would bring shame on him and his family, or because he anticipated that this daughter or other children may become the main caregivers later on.



Plate 9 Daughter taking care of mother in Bumba (Photo by Jana Gerold, 2010)

Care arrangements often change during the agricultural season. Adult children who live in another village or in Dar es Salaam move back to Bumba to cultivate their fields, as we have just seen, and the older people who still have strength spend days or weeks in the fields (*shamba*). If new care arrangements have to be negotiated, the older person often has a say, as the example of Bibi Zainabu, the oldest woman in Bumba village, shows. She told me: “It is not anyone who can just come and stay with me. It has to be someone I like and someone whom I feel comfortable with. This is why the other daughter has to come from Jaribu [another village 40 kilometres away] when Zaina moves to the *shamba* or travels”.

During my field research, the main caregiver of Bibi Zainabu was her daughter Zaina, herself an older woman. But this has not always been so, as Bibi Zainabu told us:

Case study 6.5 Calling in an older daughter, Bibi Zainabu, 102 years old

Bibi Zainabu lives in a modern house by Bumba standards. The roof is covered with corrugated iron sheet. Her son built the house, but unfortunately he died and left children behind. After the funeral, the family decided to ask Bibi Zainabu who was already old and living alone to come and stay with the grandchildren. So she moved in with the grandchildren and raised them, until they got married and moved out. The family then decided to ask her daughter Zaina to move back to Bumba and take care of Bibi Zainabu. Zaina lived alone in Dar es Salaam, after her children had married and set up their own families. Since she still is in good health, Zaina cultivates the fields and carries out all the domestic tasks. They keep a garden near the house where they grow cassava, potatoes and beans. If she feels well enough, Bibi Zainabu still works in this garden or sweeps the compound. On the other days she rests in the shade under the mango tree or inside the house. The grand- and the

great-grandchildren often visit and give a helping hand, but they cannot (yet) be relied on as main caregivers. When Bibi Zainabu needs practical care around the house, it is Zaina who assists her. If Zaina herself is not feeling well, busy in the fields or wants to travel to Dar es Salaam to see her own children and grandchildren, she calls her sister Jaribu. This sister also has a plot in Bumba where she cultivates rice, and she is the preferred replacement of Zaina, as mentioned above.

Daughters like Zaina fetch water, sweep the compound, clean the dishes, pound the grain and prepare the meals. Depending on the ageing and health condition of the mother, they provide additional care. When the mother is weak or ill, they help them carry water to the toilet or bathroom outside the house and later collect the empty bucket. For the mothers in the without strength category they provide more personal and intimate care. They massage them, help them when taking a bath and going to the toilet, even help them inside the toilet and clean them. Regardless of the age of the children, this seems to be the general arrangement between mothers and daughters, and very similar to the care patterns in Ikwe Town (Chapter 5). Some daughters become the main providers of food and cash for the family. They farm cassava, rice, mangoes and tomatoes that are sold to get cash for the everyday running of the family.

A few daughters brought their mothers to the home (*nyumba*) where they lived with their spouses. This care arrangement was not preferred by the older persons and only happened overcome very critical moments in the sense of emergencies. In such cases, the daughter had to negotiate with her husband concerning the best way to accommodate the “new arrival” (F-68yrs) or “the guest” (F-69yrs), as the older persons themselves put it. Clearly, they did not feel “at home” in such arrangements.

For married sons it is even more difficult to accommodate the interests of his wife and of his own parents. There are often tensions between the wife and the mother-in-law, and the relationship is even more strained if the wife and the father-in-law have to share a living space. Several of the older men considered it “difficult” (M-76yrs), “embarrassing” (M-86yrs) and as the “last option” (in group discussion). When an father or mother gets ill, the daughter-in-law cannot help her to have a bath or go to the toilet, because it is too shameful and embarrassing. It is “too intimate for her to get close to where her husband came from” (F-83yrs).

This puts the sons in an awkward position when it comes to providing care for their ageing parents. After marriage, it is nearly impossible for them to live with a father or mother in the same house. What they can do is to build a separate house for them.

Case study 6.6 An uncle moved close to his nephew, Mzee Hemedi, 79 years old

Mzee Hemedi used to live in another hamlet of Bumba, together with his family. When he grew older, he suffered from low vision and walking became difficult for him. His wife left him, and his older brother’s son decided to move him closer to the compound where he lived with his own family and the families of his two brothers. This nephew had already built a separate house nearby for his father. Mzee Hemedi was thus able to share a house with his older brother, and they enjoyed each other’s company. They talked about life in general and the challenges they now faced in old age, such as pain and weakness. They helped each other to make a fire to keep them warm during the night. The families of the three nephews took turns in providing the meals, fetching water and firewood. Mzee Hemedi was making an effort to sell tobacco in order to contribute to the living expenses.

By bringing the parents closer, the sons can organize with their spouses and children to provide care for them. They can arrange for the washing of clothes, cooking, cleaning, fetching water and when they are in pain to get medicine and massage them. They may also renovate the house which has to be done each year as the houses are very simple. For very intimate care they have to make special arrangements. In such cases, they may rely on relatives who live somewhere else and regularly come to provide help.

6.4 Invisible care providers:

Following the overall logic of this chapter, the more invisible and distant care providers in Bumba can be roughly divided into two groups. The first group includes people who are in close vicinity of the older persons. The second group comprises people who live either in another village, in a town such as Ikwe or in the city of Dar es Salaam. It also encompasses the institutions which have outreach health promotion or health service programmes.

The first group of care providers are the co-residents of Bumba. Some of them are close relatives who live in other hamlets. Others somehow related by kinship but not in a way which creates mutual obligations. Still, they may be asked for a favour. A typical case is that older couples and siblings who live alone ask village children to fetch water or firewood or to buy something at the kiosk in Bumba and the shops in Kibiti. However, the engagement of these children is limited; much of the care work still has to be done by someone else. A close relative has to come in and cook, help to carry water to the bath or toilet and do the laundry. This is because the village children do not have close kind ties with these older persons. They are temporarily engaged in providing care, and sometimes do it for a small payment.

The neighbours and friends can also be counted as invisible care providers. I became aware of their importance during the focus group discussions. It was always interesting to observe how much time the older persons spent asking about each other's condition before we could begin the discussion. They were not only happy to see each other but also eager to share news, exchange experiences about what they were go through and talked extensively about their health condition. At these and other events, they would also notice if one of their peers was absent and follow up with a visit. Those who could no longer participate in such events or go out to meet peers missed the comfort of such encounters, as Mzee Ali (M-97yrs) explained. At the end of my fieldwork, he could no longer attend such meetings and visit his friends due to lack of strength. He could barely walk 10 metres and was thus bound to stay at home. I often noticed the joy and happiness on his face when other older persons and neighbours passed or visited him.

If the main care provider was not around and a neighbour or friend made a visit, the older person might ask for help such as fetching water, pounding the grain, or shopping. It was then up to the goodwill of the visitor whether he or she responded positively to the request, but often they did.

Interestingly, sometimes even family members may act as care providers but remain hidden from the sight of the researcher. This happens, for instance, when a husband has more than one wife. Care by husbands with multiple wives is quite different from that of a man always living with his spouse. Often, those with multiple wives build each wife a house, which means that they have to spend an equal number of days at each wife's house. While the other wives expect him to observe this arrangement, they may accept a readjustment during critical moments. This means that the husband can spend most of his time with the wife who needs special care. Likewise, the children of the co-

wives sometimes come and provide care. How well such arrangements work out depends to a large extent on the negotiation skills of the husband.

Apart from the husband, co-wives and their children, the daughters who live in close vicinity may be there but hardly visible in the everyday life of the older person. Many daughters make regular visits but not necessarily spend a long time with their parents. They have to primarily fulfil their responsibilities for their own families. When the parents are ill and ask for special care, then adjustments have to be made. This includes the daughter temporarily moving in and helping her mother with the domestic chores and/or with intimate care, for instance, assisting her with taking a bath and going to the toilet, massaging her and even supervising her treatment regime. Similarly, when either the father or the mother has to be taken to hospital, the daughter – and sometimes also the son - takes responsibility for ensuring that the sick person is seen by medical staff, gets the medicine, and if the older person is admitted, that she has a suitable place to stay. It is also up to the relatives to provide a bed cloth, water and other necessities, including food. Usually, the daughter of the sick older person prepares food at home and asks the grandchildren to bring it, make sure the older person eats it and bring back the utensils. The daughters further have to fill the gap at the home of the older person. If, for instance, the mother has been admitted, the daughter has to fetch water, collect firewood and cook for the father or organize somebody else to do so.

The second category of hidden care providers includes those who provide care from afar. While the first category frequently visits the older persons, the second group does so only mainly triggered by a critical health moment. For me as a researcher, it was difficult to learn about them. Sometimes the older persons mentioned them in passing, at other times I happened to meet them when I passed by the house of a study

participant. At still other times I met them when they came to Bumba for rituals such as a birth, marriage or burial, a religious celebration or during the feasting season. These moments provided insights into the relations and the responsibility of each actor.

During critical moments, for instance when an older parent is ill, the children and other relatives who are not in the village respond in various ways. A typical way would be to send money that could be used to buy medicine or organize for the older person to be taken for treatment. The children may also come and help either the mother or father to care for the older person experiencing the critical health moment. In this way, the moment of care brings actors together and mostly those who are not always around. Those who come from far bring money, medicine and other gifts for the older person, who expect something from these visitors. Therefore, they not only visit, but they practically take over some of the caring responsibility.

Some of the older persons also travel to Dar es Salaam for a check-up. They usually only go if they have children or siblings there who can guide them and give free accommodation, treatment, food and other necessary care. While they do so, some also borrow money from friends and neighbours to make sure that they have some money for an emergency. This is particularly true as these “children in towns are not paid very much and cannot cater for our needs” (F- 100yrs). This means that it is not only one but a combination of social actors who provide care. For instance, sometimes one child provides accommodation, another child food and the siblings contribute to the treatment. This means that the person providing care is only one of many other social actors. This is particularly true when an older person is taken to hospital and admitted. Indeed, what surfaces here is the combination of otherwise visible and invisible care providers. Other relatives join in to support the main caregivers, and even at the home

place of the older person, neighbours and friends may collect some money or look after the house. Especially in emergencies, the care network becomes visible.

Sometimes, the health care institutions – in collaboration with the local governments - have a special programme in the villages to screen the older people and recommend that they have a thorough check-up at a major hospital. For instance, Comprehensive Community Based Rehabilitation in Tanzania (CCBRT), a locally registered non-governmental organisation first established in 1994, has a well-known hospital in the city of Dar es Salaam. Through their outreach programme they often visit rural villages and conduct screening for health problems. In the context of our study, some of the older people who were identified as having a serious eye condition benefited from the eye-screening programme. They were taken to Dar es Salaam for a major operation for free. The programme did not cover the transportation of accompanying relatives. However, the older people themselves made sure that a relative was present in the hospital to keep an eye on them before and after the operation. In other words, there a combination of care providers became engaged. While on one hand the hospital provides cure and care, the relatives also arrange for care. Therefore, all actors at the end of the day complement each other's care and this according to the hospital is agreed and accepted. This proves our point made at the beginning of the chapter that care for the older people in remote villages such as Bumba cannot be claimed to be provided by an individual, family or kin, but involves a combination of many social actors. Indeed this explains why we hardly encountered a situation where care had failed. The most important point however is that the older people are at the centre of all this.

6.5 Conclusions

Many of the care patterns I was able to identify for Ikwe Town also apply in Bumba: A very central part of old age care is the mutual care provided by spouses as long as they are capable of doing so. If one of them dies or if they separate or divorce, the remaining partner may become attached to a sibling (intra-generational care) or to a child (inter-generational care). In arrangements where an old couple, sister or brother takes in a sibling, they often face many practical challenges but suffer less from loneliness and boredom (see Case studies 6.3 and 6.4). The preferred arrangement of old women is to live with a daughter, if possible in one's own home (see Case study 6.5). Moving to the home of a married daughter with children often makes life difficult for all those involved. Also, it is difficult for old mothers and fathers to live in close proximity with a daughter-in-law because of culturally defined avoidance rules. Some sons have solved the problem by setting up a separate house for the parent and even inviting a sibling of the parent to move in (see Case study 6.6). Older persons regularly interact with the main caregivers, and in addition, they can usually call in favours from two groups of less visible care providers: The first group consists of relatives and neighbours who live in the vicinity and frequently visit or pass by. The second group provides care from a distance and comprises close kin who live in other villages, Ikwe Town or even Dar es Salaam as well as institutions which provide outreach care, as for instance the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT).

There are also some marked differences in old age care between Bumba and Ikwe Town. Perhaps because of the harsh living conditions, there were no older people who lived alone in Bumba. Since the residents of Bumba were all somehow related with one another, it may have been easier for older people to call in a favour from a "neighbour"

or “village child”. The category of “tenants” did not (yet) exist in Bumba, and this means that older people had one age care option less than their peers in Ikwe Town.

Moving from the older person to their spouse, siblings, children and other caregivers has made the whole care networks visible. Within this network, the older persons play an active role, not only as holders of a particular kinship position created by descent and marriage, but also as individuals with a certain action space. This resonates with recent writings on generations in Africa. “Members of a generation are not surrendered to their cultural and societal position, but are able to use that position to bring about new ideas and practices and pursue their own interests within the historical circumstances in which they live” (Whyte et al. 2008: 3). My study contributes to this new trend in anthropological studies in Africa, that of trying to envisage the “active voice of generation” (ibid.) replacing approaches which give the main emphasis to the social structure that determines everything and leaves little to the actors. In old age, (great)grandfathers and (great)grandmothers have certain rights and obligations – which exist in Bumba society independent of the current generation – but my main interest is on how a *mzee* engages with these rights and obligations in everyday life to activate and sometimes create social relations and connect them in a care network for critical health moments. The agency of the older persons of course rubs against the agency of potential and real caregivers. However, with all their life experience and the social status that can be achieved in old age, it is rare for older persons to completely miss all the possible opportunities. It is unusual for an older person not to have a spouse, siblings, children, neighbours or friends. Even if some holders of these positions are not available or willing, the web of kinship allows for flexible replacements of holders of the positions.

Approaching the older people in this way helps us, on the one hand, to avoid the trap of over-romanticized old age care as, for instance, Ireogbu (2008) seems to do for Nigeria and, on the other hand, to refrain from over-dramatizing the lack of old age care as, for instance, Spitzer and colleagues (2009, 2011) have done for Tanzania. Older people make an effort to ensure their own care, and they do so in active negotiation with a number of social actors.

Part 4 Conclusions



Plate 10 A way of saying thank you to the Bumba community (Photo by Jana Gerold, 2011)

Chapter 7 Ageing, Health and Care in Rufiji

As outlined in Part 1 of my PhD thesis, this study set out to explore how older people in the Rufiji District, a predominantly rural area in coastal Tanzania, conceptualize ageing and the links between ageing and health, and how they negotiate social relations in order to ensure old age care. It responds to a call for medical anthropology to shift the research focus from cure to care (van Eeuwijk 2003b; 2006; 2007) and contributes to a small but growing body of ethnographic literature on ageing in Africa, for instance by Apt (1996) and van der Geest (2001, 2002, 2009, 2012; van der Geest and Sadler 2010) in Ghana, Badini-Kinda (2005; Badini-Kinda and Roth 2007) and Roth (2005; Roth and de Jong 2005; Roth 2008, 2012) in Burkina Faso, Catell (1989, 1996, 1997a, 1997b, 2002a, 2002b, 2008, 2009) on Kenya, Mwami (1998-2001), Mesaki (2009) and de Klerk (2011) in Tanzania and Livingston (2003) in Botswana.

For a long time, researchers – including sociologists and anthropologists - did not pay much attention to ageing in Africa. The sociologist Nana Apt who lived and worked in Ghana was an exception. Already in the 1970s, she became engaged in a nine-country-study of the United Nations Social Development section. Looking back she writes (2005:4):

This was my first ever study on ageing and like many African scholars at the time, I myself was skeptical about the need for such an inquiry: after all ageing was not ‘an issue’ for Africa. Families were responsible for their ageing members and, in any case, aged people were few, embedded, and adequately cared for in the day-to-day life of their extended family.

Many of her African colleagues shared this view. They considered ageing an issue for developed countries and not Africa and suggested she would do well to examine issues that impacted on the growing numbers of children and youth in the country. The insights of the United Nations survey convinced her otherwise (Apt 2005:4), and together with her colleague Monica Ferreira in South Africa (see Ferreira 2005), she started to build up African research on ageing.

I made a similar journey of discovery in my PhD project. At the start, I was not aware of ageing as a societal issue in Africa and as a field of anthropological research. Up to now I face similar criticism among many colleagues in Tanzania as Nana Apt did 30 years ago in Ghana. My theoretical and empirical research have convinced me that the study of ageing, as a biological process and even more so a cultural and social phenomenon is of high relevance to my own country and to Africa more generally.

The common neglect of the topic in Africa is deeply rooted in the scholarly and popular notions about modernization. The work of such scholars as Donald Cowgill (sociologist) and Lowell Holmes (anthropologist) has articulated these notions and became highly influential (Cowgill and Holmes 1972). Looking at historical developments in Europe and the United States, they came to the conclusion that the older people's influence and authority was decreasing due to changes related to the industrial revolution and associated changes in intergenerational relations: The younger people were no longer willing to support the older people and thus put pressure on the state to develop institutions for old age protection. Their work spurred heated debates and more research on the topic (see Street and Parham 2002).

African researchers like Aboderin (2004) and Makoni (2008) called for more scientific inquiry into the understanding and experience of ageing by the older people in Africa (i.e. an “emic” perspective). While I concur with their suggestions, I claim that such research requires more than a simple recording of “older people’s voices”. We have to go deeper and study the cultural construction of ageing in particular historical and geographical contexts, as suggested by Jay Sokolovsky (2009c), a pioneer and leading scholar in the anthropology of ageing.

Following the lead of these and other scholars, the principal aim of my PhD thesis is to study the social construction of ageing from the perspective of older people in a specific rural context of Tanzania. What is important to note is that my study formed part of a larger research project with a rural and urban component (see Chapter 2.2). For my study I concentrated on the Rufiji District, about 150 kilometres south of Dar es Salaam, more precisely on the small but rapidly growing town of Ikwiriri and the remote village Bumba (see Map 3).

In my theoretical approach, I aimed at refining the social constructivist perspective (see Chapter 1.3). As Burr has rightly criticized, human agency has received little attention in the social constructionist perspective (Burr 1995, in Andrews 2012). I therefore drew on the conceptualizations of agency by Emirbayer and Mische (1998) and van Binsbergen (2007). Both of them draw attention to the question of the actors’ freedom in engaging with other actors and with pre-existing structures and to the fact that social structures shaped, for instance, by gender and kinship, are themselves subject to change.

Moreover, I have contended that ageing as a biological and a social phenomenon is flexible and complex and not a fixed state. In this understanding I have been inspired by

many studies on ageing from a life course perspective (Chivers 2003; Cattell and Albert 2009; Sokolovsky 2009d). More particularly, I referred to the concept of “vital conjuncture” proposed by Johnson-Hanks (2002, 2006) in her study of motherhood in Cameroon from a life course perspective. I have suggested that the concept of vital conjuncture is useful to examine ageing as a concept and practice along different trajectories, such as “social status” and “health. Ageing becomes contentious when its construction recalls the experience and social environment of the actors involved.

To sharpen my mind with regard to changes in the social environment of the older people and to capture the views of key actors in the emerging field of ageing and health in Tanzania, I drew on the notion of cultural flows (Appadurai 1996). What are the implications of the fact that the older people in both research sites are connected to the outside world through media like the radio, through institutions like religious congregations, health services, the government, non-governmental organizations as well as through infrastructure such as roads?

The three concepts “agency”, “vital conjuncture” and “cultural flows” provided a loose conceptual framework for my PhD. My more specific interest was in the social experience of ageing, health and care from the perspective of the older people themselves (see Chapter 1.3). I thus situated my research with reference to anthropological studies on each of these notions.

With regard to “ageing” I found the idea of “social clocks” (Fry 2007) particularly intriguing. Building on comparative anthropological research on ageing, Christine Fry has suggested that “social clocks” related to work, education and leisure, but also to marriage, family and kinship or to community affairs and spiritual affairs organize how

people move along their life course in a given society. One of the questions I have investigated in my PhD thus asks which temporal structuring of ageing is relevant in my study sites.

Concerning “health” I started from the premise that health assumes a special meaning in old age when people become more aware of their vulnerability (Schröder-Butterfill and Marianti 2006; van Eeuwijk 2006). I was particularly interested in how older people in Rufiji experience vulnerability and health in their everyday lives. Using a broad interpretation of health I followed Obrist’s example (2006:30) and focused on how the older people explain their health condition (*hali ya afya* in Kiswahili), and what it takes to produce, maintain or even lose health from their point of view.

The notion of “care” assumes different meanings in different social and cultural contexts (Tronto 1993; Kleinman and van der Geest 2009). Following Pols (2004) I have adopted a relational approach and explored the social relationships through which care is provided and received. In line with my approach to ageing and health as a social engagement in everyday life, I have tried to figure out what care means in my study area “by listening to those who are directly involved in it and by observing their actions” (van der Geest 2002:9).

My methodological approach was firmly rooted in ethnography (see Chapter 2.4). From 2009 to 2011, I conducted extensive fieldwork in two sites within the Rufiji District, namely in a small town called Ikwiriri (9 months) and a remote village called Bumba (6 months). Following the comparative qualitative design of the overall research project of which this PhD forms part, I carried out four complementary and partly overlapping sub-studies, moving from a stakeholder study, to a community study, a household study

and finally an age group study. This approach allowed me to first gain an overview of the broader contexts in which ageing, health and care is embedded on the national and the district level and to then gradually narrow the focus on the older persons themselves (defined as 60+ following the National Ageing Policy of Tanzania), first in a larger household sample (Ikwiriri: n=92; Bumba: n=21) and then on a smaller sub-sample (Ikwiriri: n=43; Bumba: n=14). Although my study was guided by the design of the overall project, the particular context in which I worked and the ethnographic approach I used turned it into an original piece of research.

The Swiss-Tanzanian leaders of the overall research project selected the Rufiji District as the rural research site because it had a particularly high proportion of older persons (see Chapter 2.3), probably due to the out-migration which began already in colonial times. Located in the floodplains of the Rufiji River and its wide delta, the area is known for its fertility but also for its devastating floods. The Warufiji (people of the Rufiji River) consist of several ethnic groups, including the Ndengereko who form the largest group, the Matumbi, Nyagatwa, Ngindo, Pogoro, Makonde, Zaramo and Hehe (Hoag 2003:23-24). Still, they commonly refer to a shared identity based on making a livelihood in a riverine environment (Hoag 2003:24). Most Warufiji are Muslims and are conversant with Kiswahili and the loosely defined coastal Swahili culture.

In response to heavy floods in the 1960s and 1970s, the then socialist government under the late President Julius Nyerere carried out a large resettlement scheme in Rufiji which heavily affected the subsistence economy, especially those farmers who had to move their fields from the rich soils of the floodplain to the poorer soils of the higher elevations. Both Ikwiriri and Bumba are resettlement villages, but while farmers from Ikwiriri can still cultivate on the fertile farms in the floodplain, the residents of Bumba

have to rely on poorer soils. In both settlements, the Warufiji grow cassava, maize, rice, millet, coconut and fruits. From the planting season to the harvest, many farmers in both settlements prefer to stay in the fields (*shamba*), living in small thatched huts for days and weeks. Another transformation which leads to different dynamics in the settlements has to do with infrastructure, transport and communication. While Ikwiriri has grown into a bustling small town, especially since Mkapa Bridge has been built across the Rufiji River, connecting the main road from Dar es Salaam with Lindi and Mtwara further south, Bumba remains isolated, about 20 kilometres away from the main road and the next bigger settlement. By selecting these two settlements, I wanted to explore whether differences in the types and location of the villages affected the older people's experience of ageing, health and care.

Part 2 of my PhD thesis examined what it means to grow old in Ikwe Town - an administrative division of Ikwiriri - (see Chapter 3) and in Bumba village (Chapter 4). To allow for a comparison, I followed a similar outline in both chapters. I first presented and discussed my findings on the social dimensions of ageing and then paid particular attention to how people experience health in old age.

Although the older people in Ikwe Town and Bumba did not always bring up the same points in the conversations and discussions, there are many commonalities in what they said and did. I discovered a shared multi-dimensional concept of aging which is rooted in a similar way of life, dominated by the physically demanding tasks of farm work. At the same time it soon became obvious, that my image of Bumba as an isolated village was only partly true. People in Rufiji were highly mobile, and even older people living in Bumba continued to be socially connected to the outside world and were not confined to the village. Even if they were physically disabled, they remained connected with

ideas, people and institutions through their minds, through social relations and with the help of new technologies like the mobile phone.

In both settlements I found that growing into old age can be considered both literally and figuratively as a vital conjuncture (Johnson-Hanks 2002 and 2006). Older people spoke of old age as *ngoma* (a special event with dancing). They explained that once you are on the dancing floor (growing older), you just have to dance, whether you get the rhythm or not is something else. Every time a new song is played (a new challenge emerges) you dance, but you cannot claim to be an expert on the dancing floor. Signs of ageing just come up, at different times for different people, you cannot foresee what you will experience. Every day brings a new challenge, you just try to play along, while one day is different from the next. What in my view the notion of *ngoma* further implies is that one sign alone does not qualify somebody to claim the status of an older person. In this sense, the notion of *ngoma* shows parallels with the concept of “vital conjuncture” (Johnson-Hanks 2002 and 2006). Many signs have to come together for somebody to “become old”. All the social dimensions of old age including the conceptual links between ageing and health seem converge in this vital conjuncture of old age which the older people in my study referred to as *ngoma*.

From their descriptions of the signs of ageing (*dalili za uzee*) I have abstracted several social dimensions of ageing, which in many ways conform to studies in other settings (Fry 2007). First, age is conceptualized as a person’s relative position within the life course from birth to death. In the small town of Ikwe and even more so in Bumba, many older people had known each other for a long time or they used well-known events to assess whether somebody was older or younger. A person who was older along the life course dimension was called *mzee* in the sense of seniority.

A second social dimension of ageing is social status. What I found remarkable is that older people affirmed that one cannot simply claim to be *mzee*. It was a title given by others to designate social status. “You have to earn it and strive to get there,” as one man in Ikwe Town put it. Similarly, the polite address *shikamoo* referred to status. Both terms, *mzee* and *shikamoo*, implied respect, seniority and authority. Moreover, especially younger people in Bumba insisted that the ascription of the *mzee* status by others depended to a considerable extent on appropriate appearance and behavior. An older person should not dress and act like a young one, as this would be shameful. The status of *mzee* can thus be thought of as a dimension of norms and values linked to positions along the life course, in other words to status. But seniority and authority is not only defined in relation to age, they also come with positions in economic, political and religious fields. In this sense, even a young school teacher or politician can be addressed as “*shikamoo mzee!*” This is a clear indication of the changing “politics of age” (Aguilar 1998) in which older people influence is contested by younger people who claim economic, political and religious leadership. During my fieldwork this became most obvious during political rallies (see Chapter 3.2).

A third important social dimension of age plays out along kinship. Whatever a person’s status of seniority or authority, he or she could not just be called or call himself or herself *babu* (grandfather) or *bibi* (grandmother). This term was reserved for those with at least a grand-child. However, since people have children at a young age in this area, even being a grandfather or grandmother was not necessarily a sign of *uzee* (old age). As older people pointed out, somebody’s status as *babu* or *bibi* becomes evident when many voices call him or her by these terms (i.e. when there are many grand- and great-grandchildren). Especially in Bumba, the older persons emphasized the joking

relationship between themselves and their grandchildren. Grandchildren might say things to their grandparents which would be considered as an insult if they were mentioned by somebody in a different relationship with them. Another aspect of kinship was the idea that grandparents are like the trunk of a tree through which life forces pass on to the branches (children) and leaves (grandchildren). In this metaphorical sense, grandparents would eventually become firewood and then turn into ashes. What was only mentioned in passing was the power which used to be attributed to older people in transition to becoming ancestors, an idea which was common across Africa (see Cattell and Albert 2009). The idea still lingers and came up a few times with regard to the power of older people to curse younger generations, the importance of getting their blessing and the witchcraft accusations in some parts of the country (see Mesaki 2009). All in all, it seems that the reverence for older people as future ancestors has been attenuated by influences of religious and other forms of education.

Forth, within kinship, the idea of generation is particularly important, empirically and analytically. In her study on “The Nivaquine Children” in urban Burkina Faso, Roth (2012:282) has pointed out:

Intergenerational relations taken as an analytical concept allow us to understand old age-as well as childhood and youth- as a product of the relations between young and old, and not as an isolated, bounded period of time (Roth 2012:282).

Although Roth’s interest was to look into transfer of knowledge between the generations, in our context it was particularly interesting to see how these social categories and relations provided frames that were referred by one another. Roth has also emphasized that these social categories or realities are the product of social

relations. Indeed, what we have seen in Ikwe and Bumba is how old age was constructed through generational relations. When the younger generation interacted and communicated with the older generation and vice versa, they made those differences visible.

A fifth social dimension of ageing is organized along the health status. Inspired by the approach Obrist (2006) developed in her study on Swahili conceptions of health as encompassing both the state of the body (physique, appearance, functional ability) and the state of the mind, I have examined the intersection between ageing and health. My findings show that in Ikwe Town and in Bumba village, these states of the body and the state of the mind were also much discussed in everyday life, and they were important in constructing and defining signs of old age and ageing. This is less surprising if we consider that Obrist's study was conducted in a predominantly coastal community of Dar es Salaam. There have been long historical links and there is much mobility and interaction today between the Warufiji in Rufiji and those communities in Dar es Salaam.

Since the older people in Ikwe Town emphasized "strength" as a key health concern, a finding which has also been reported from other parts of Africa (Fry 2007), the north of Tanzania (de Klerk 2011) and the complementary urban study of the overall research project (see Chapter 2.2), we grouped the older persons according to how they position themselves along a continuum from "having strength" to "not having strength".

Underlying these strength-categories is a notion which the team of the overall research project decided to call "critical health moments". These are moments when older people felt weak or painful and thus unable to carry out their gendered routines or tasks, such

as attending to the farm, sweeping the compound, cleaning the house, cooking, doing the laundry and taking a shower. The term “moment” may be slightly misleading. We did not just think of a fleeting moment but rather of an interruption of common routines and activities. Such an interruption may be of short or long duration.

In all three strength-categories the older persons referred to physique, in this case the “thin body” which was considered as “normal” for older people, and other bodily signs, such as white hair, loose skin, visible veins, no teeth, impaired eyesight and hearing, and of course menopause for women. Appearance was mentioned more by women and referred to ways of taking care of oneself, for instance in terms of hygiene and dressing. Both men and women made remarks about the unattractiveness of old bodies. The state of the mind (*hali ya kifikra*) was mentioned by old persons in all “strength categories”, although in various terms. Some older persons mentioned worries, others – in Bumba - confusion and forgetfulness. Not surprisingly, stiffness, pain, illness and even death were much discussed in the “not having strength”- category.

What I did not expect was that one of the most common non-communicable diseases in Europe - Parkinson – would affect people in this remote village. The old man suffering from this disease had made great efforts to obtain a biomedical diagnosis, going all the way to Dar es Salaam after a long process of health seeking. Other old men and women suffered from uncontrollable shaking without having a biomedical diagnosis. These few unfortunate cases have shown how difficult it is to then live with a chronic and degenerative illness in such a harsh environment.

For older people in Ikwe town, access to the health facilities, communication and transportation was easier than for their peers in Bumba. Most of them used medicine,

food and other goods they bought from small shops in the town. In Bumba, there was only a kiosk; for all other goods and services older people had to travel far or find somebody who was willing to help them.

Closely linked with health was a sixth dimension of ageing organized by work and leisure. The key criterion of their assessment was whether or not they were able to perform gendered routine activities or responsibilities. The first group (n=18) thus considered themselves as still capable of performing these activities and tasks. The second and largest group (n=62) noticed an up and down in their capability to perform; in Bumba they described how they adjust to a loss of strength either by resting more, reducing the weight of what they carried, the distance they walked or the hours of work. The third group (n=34) was no longer able of performing routines or tasks; they were confined to the house, some of them even to the bed. But as some of them emphasized they could still supervise and give advice.

A surprising finding was that a blind man in Ikwe Town considered himself as belonging to the “having strength” category because his social position and wealth enabled him to still perform many activities (see Chapter 3, Case study 3.1). This finding resonates with statements of older men in Bumba who considered the capability of findings solutions as a sign of strength.

It was further striking to see that only 18 older persons (Ikwe: 8 men and 6 women out of 92; Bumba: 4 men and no women out of 14) described their health condition as strong. The small number of older persons in the “having strength” category may be partly explained by the physically demanding work and harsh environment; few men and women above 60 still believed that they could continue with their everyday life

activities. Those who did talk about critical health moments as temporary, the pains came and went, they did not completely stop them from carrying on with their everyday activities. Interestingly, the men assessed their strength not only in terms of work but also in terms of their participation in community events and activities, such as funerals or meetings. By engaging in these activities they could feel how the body responded and reacted.

While Part 3 of my thesis explored what it meant to grow into old age in Ikwe Town and in Bumba, presenting and discussing the notion of *ngoma* as a vital conjuncture and elaborating on the multi-dimensional concept of ageing, Part 4 has examined older people's care negotiations, concentrating on the meaning of care as it could be elucidated from everyday practice. As van der Geest's (2002) in Ghana, I found that older persons commonly talked about care in terms of "help". I thus decided to use the Swahili term *kusaidia* (to help), often in combination with another word for care, for instance in questions like: *Nani alisaidia kukuhudumia?* (Who helped serving or attending you?) *Nani alisaidia kukuangalia ...?* (Who helped looking after you ...?) *Nani alisaidia kukusindikiza hospitali?* (Who helped or accompanied you to hospital?) *Nani alisaidia kukutunza?* (Who helped providing practical care for you?)

Being aware of the "modernization trap" as well as of romantic views of the "African extended family" outlined above, I further made an effort to explore with an open mind "who actually cares" in critical health moments, again favouring the view of the older people themselves. When older men or women felt weak or painful and thus unable to carry out their gendered routines or tasks, such as attending to the farm, sweeping the compound, cleaning the house, cooking, doing the laundry and taking a shower, someone else might or might not intervene to help. In accordance with the approach of

the overall research project, I thus set out to capture what happens in these moments. This approach allowed us to follow care practice in action, from its inception, through concrete activities of helping to the restoration of the routine or an adjustment.

As in the previous part, I have separated the presentation of my findings from Ikwe Town (Chapter 5) and from Bumba (Chapter 6) to allow for a comparison. In both chapters, I have examined who actually cares for older people and what kind of care they provided. I will summarize and interpret answers to each of these questions in the subsequent paragraphs.

In both research sites I found older people to rely on a care network. At the center of this network were spouses, siblings, and children, whether they lived nearby or at a distance. When these relatives were not present or for certain, more narrowly defined care activities, neighbours, friends and tenants as well as professional health care providers also played a role.

With regard to care provided by spouses, I often heard the expression that wives “do everything” for their husbands. As defined by their gender role, they carried out all the domestic tasks, such as preparing food, cleaning or fetching water, and contribute to the household economy. If the husband faced a critical health moment, they provided practical and emotional care and took over some of his responsibilities, for instance in farm work (see Case study 6.2 for Bumba). That women bear the biggest burden of everyday care is a common phenomenon, not only in Africa (see e.g. Finch and Groves 1984; Finch and Mason 1993; van Eeuwijk 2006:72-73)

In Rufiji, divorce was rather common, also in old age. At some point, care became too much for older women. As van der Geest (2002:21) has also noted for Ghana, it was not

uncommon for old women to leave sick and dependent husbands, especially if they were poor and could no longer provide the basic necessities. The older women felt they had fulfilled their responsibility as mother, grandmother and wife. Moreover, they were aware of their own precarious status: If the old husband died, they might be expelled from the house by the in-laws, unless they had children with this husband who stood up for her. Older wives – like older husbands – thus had to weigh their risks.

As in other communities with a matrilineal kinship system as a back drop, women in Rufiji had stronger ties with their own lineage than with their husband and his lineage. They could always return to their parents or to brothers and sisters. Van der Geest (2002:21) has reported similar findings from the matrilineal Kwahu Akan group in Ghana.

When the wife was unable to carry out her tasks, the husband usually got engaged in care work (see Case study 6.1 for Bumba). He temporarily took over and organized help if the critical situation lasted longer or became permanent. If the wife remained ill and/or the couple separated or divorced, old men commonly married a much younger wife. In some cases, the older wife agreed with the husband's decision, in others remarriage led to tension and conflicts. There was a real danger that the old men lost the support of the children they had with the older wife (see Case study 5.1 for Ikwe Town).

I did not come across remarriage among older women. For them it was more common to link up with siblings or daughters. The reunion of siblings was an accepted care arrangement, although not stated as a norm. The arrangement was made by the older people themselves or by adult children, some of whom lived in distant Dar es Salaam. Frail older couples who took in a sibling and had to manage primarily on their own, as

in the case of Mzee Saidi and his wife, faced many practical challenges, but still they asserted to suffer less from loneliness and boredom (see Case study 6.3 for Bumba). More generally speaking, intra-generational care – whether between spouses or siblings – is a phenomenon that has long been neglected in the literature on old age care and may become more frequent in the future, if inter-generational ties further weaken (van Eeuwijk 2006).

The most common care arrangement in Rufiji was for daughters to gradually replace the mother in “doing everything”, if possible in the parents’ home (see Case study 6.4 for Bumba). Most older people and especially mothers had adult and often older daughters as main caregivers. Several developments led to such an arrangement. Daughters returned to the house of the parents after divorce, sometimes long before one or both of the parents needed care (Case study 5.3 for Ikwe Town). In other cases a daughter was called back from as far as Dar es Salaam to become a caregiver. However, norms and values prohibited daughters to provide intimate care for their fathers. Since daughters often moved back with their own children, it was the latter who took over the personal care. The joking relationship between grandparents and grandchildren allowed them to do so (see Chapter 4).

Moving to the home of a married daughter with children was usually not the preferred option because it made life difficult for all those involved. For old mothers and fathers to life in close proximity with a daughter-in-law was also not a preferred option because of culturally defined avoidance rules. Some sons solved the problem by setting up a separate house for the parent and even inviting a sibling of the parent to move in (see Case study 6.5 for Bumba).

Older people not only negotiated care with the adult and older children who lived in the same house but also with those who live nearby and others with whom they engage through “remote control”, as they called it in Ikwe Town. In the literature, migration of the younger generations to town is often seen as a threat for the security and care of the parents (Apt 1996; van der Geest 2002; Roth and de Jong 2005), but my study showed that older people saw also positive aspects of expanding kinship networks. In their stories they recounted how they used “care from a distance” as resource, for instance in terms of access to health care services in the city, for obtaining material goods or support and for receiving more informed advice. Some women who had lost their strength and could no longer take care of themselves moved to the houses of children in Dar es Salaam. Not all of them felt comfortable in the city, and some returned back to Ikwe town or Bumba village. An important bond between parents in the rural area and children in town was landed property and the products it produced. Some of the older people used houses as an asset or offered house-sitting services to attract care from adult children and grandchildren.

Emphasizing agency I was able to show how older people draw on the experience and the resources they have accumulated during the life course to tackle critical health moments. They prompted and induced selected kin to help them and thus contributed to modifying intra- and intergenerational ties to match their changing needs. By shaping these relations, older people were showing their agency as defined by Binsbergen (2007). Older people in Rufiji took some freedom in engaging with other actors and with pre-existing structures which were themselves subject to change.

Older people in Ikwe Town also included neighbours, friends and tenants into their care networks, as opposed to strangers with whom they had no closer relations. In this

bustling rural town, there was a high demand for housing. Older people who owned a house and had empty rooms because children had moved out or migrated to other towns often took in tenants. This was different in Bumba where there was no demand for houses as there was hardly anyone from the outside who wanted to go and settle there. The school had six teachers' buildings and only two were occupied. Moreover, most people in Bumba were related with each other. The categories "friend" and "tenant" were thus not relevant, but more distant relatives were often referred to as neighbours. In both settlements, older people kept neighbours "outside" of their home or at least their private rooms but appreciated their visits, attention and occasional support. To have them nearby gave them assurance, and they often carefully cultivated good relations with them, partly in anticipating emergencies. Non-kin however could not be asked to provide basic necessities like food on a regular basis or perform personal and intimate care activities. To cross these social boundaries would have been shameful, not only for the older person but also for the close kin who was expected to provide this kind of care. A notable exception is the *majosti*-relationship between older women in Ikwe which allowed a closeness otherwise reserved for kin. Also in Ikwe I met an older woman who was a successful healer and was close enough with her neighbours to ask them for a loan (see Case study 5.4)

This brings us to the second question addressed in this chapter: What kind of care was provided for older people in Ikwe Town and Bumba? Since we used "critical health moments" as an entry point, our attention was directed at rather mundane "activities of daily living" (van Eeuwijk 2006:70-71) or "activities of care" (van der Geest 2002:9). The two most important kin care activities were the provision of shelter, the whole process of getting, preparing and cooking food, fetching water and fulfilling other basic

needs. Everything which had to do with bodily care and hygiene was performed within spouse-, mother-child-, sibling- or father-son-relationships. Some activities clearly required physical presence, such as feeding a mother in the *sina nguvu*-category, but we also looked behind the scene, so to speak, and asked: Who contributed to the feeding of porridge to this mother? Such an approach drew our attention to activities like visits, phone calls, the sending of gifts and remittances, which are performed by the more distant kin. Similarly, participation in everyday life showed that the older people also highly value neighbours and friends who pass for a visit, bring kerosene for the lamp, sugar for porridge, or give advice about how to relieve aches and pain, in short, show that they care. In fact, emotional care and keeping company came up as a highly valued form of care, between neighbours and friends but of course also in close family relationships.

My first impression may have been of an older couple living by themselves in a ramshackle hut, but during my repeated visits I gradually became aware of what I call the “invisible care network”. Older people in Rufiji were able to mobilize a wide range of people in times of need: kin relations by descent, such as (grand)mothers, (grand)fathers, (grand)children, brothers and sisters, as well as by marriage, wife or spouse and – to a lesser degree – in-laws, but also non-kin like neighbours, friends and tenants, and in a few cases, professional care providers and healers.

Compared to the field of HIV/AIDS-related caring and nursing in Tanzania (see Dilger 2010), old age care in Rufiji was hardly structured by broader forces of an internationalization and privatization of health care. As our findings have shown, most older people did not have access to – or refuse to use – available services which were too far away, too expensive, and geared towards under-five-year-old children and

pregnant mothers. A positive exception was the outreach programme for eye care by the Comprehensive Community Based Rehabilitation in Tanzania (CCBRT). During my fieldwork older people from Ikwe Town and from Bumba were able to enrol in this program and get free eye scans and treatment in Dar es Salaam. Even if contact with prevention and health care services was restricted, most older people in Rufiji had heard through the media that they should receive free health care. As the example of Bibi Zainabu (see Case study 5.5) has shown, older people experienced the lack of adequate professional health care services in old age care not just as a practical, technical or financial problem. They questioned the new morality of commodity relations which has replaced social relations rooted in kinship, an argument which was put forth and elaborated by Mwami (1998-2001).

This lack of help from the state contrasted with the help provided by kin. In the case of Bibi Zainabu we saw that the condition of the Bibi spurred her great-granddaughter into action. When this young woman saw her Bibi suffering, she felt ashamed and wanted to give her relief - and this prompted her into action. In the sense of agency defined by Emirbayer and Mische (1998) it is Bibi's critical health condition which makes the younger woman act. Even if Bibi's pain was embodied - not reflected or discussed - it can still lead to an action by "the other".

My main argument in this chapter thus is that we have to examine where and when older people's critical health moments do or do not lead to care action, and why. Most of the findings presented here explored when the older people themselves became active and evaluated their options by drawing on past experiences, considering pragmatic aspects and anticipating potential outcomes – always taking other people in their care network into account. The data presented clearly show that they have agency (in the

general sense of Emirbayer and Mische 1998 and van Binsbergen 2007). Perhaps this point was overemphasized because we did not systematically explore situations in which critical health moments of older people did NOT lead to any action by themselves or by others. Also, with a few exceptions, we did not pay specific attention to situations in which embodied old age prompted others to act. However, we do want to emphasize the more general point: Underlying principles like reciprocity and respect (van der Geest 2002) or an “implicit intergenerational contract” (Roth 2005) provide guidelines, but it is the continuous – partly habitual, partly reflected effort older people and their significant others make which drives care as a lived experience.

What I did not see in Ikwe Town and Bumba is older people begging in the streets, as Spitzer and Mabeyo (2009:49) have reported for their two research sites: Kineng’ene village in Lindi District and Kingugi village in Temeke Municipality, Dar es Salaam.

The income earned by respondents from the rural area was generally too small to make a household of four or more people survive. As a consequence, such a little earning increased the vulnerability of older people to poverty and health risks. It is within this perspective that family members including older people were forced to go begging from their fellow community members. Some older people in Kineng’ene moved to Lindi town to beg for money and food in their attempt to ensure their livelihood. In fact 20 older people in Kineng’ene and 11 in Kingugi admitted to resort to begging as a coping mechanism.

The authors state that they selected these two research sites with HelpAge Tanzania because the communities including older people were considered exceptionally poor.

In our research sites we did not come across cases where the older people were begging (*wanaomba*). However, the better-off older people commented on elderly being poor and finding it difficult to manage three meals. The older people themselves also narrated not being able to have enough to eat. It could also be that we approached them through a positive lens that prevented us from noting what others have seen in other places. Being relatively rural, it is also possible that begging is done in a way that is culturally acceptable and thus does not stand out as it does in urban areas.

The situation of older people we encountered in Rufiji was also different from the problems faced by older people in the Kagera Region which was particularly hard hit by the AIDS epidemic (De Klerk 2011). In Kagera, *sina nguvu*, 'I have no strength', was also a common expression used by older people when talking about experiences of old age, but these older people – and especially the older women – carried the additional burden of caring for their sick children or grandchildren. In Rufiji, we noted only a few such cases. Moreover, due to the epidemic, the kin networks in Kagera were disrupted, and this caused much tension and conflict within families and within the wider webs of kinship. Also in Rufiji, providing and receiving care did not always happen in a smooth way. A few older people's narratives suggested moments when conflicts emerged. Perhaps I did not give them enough attention, but all in all, the older people's accounts were more about how they tried to go on, in spite of the hardships they faced.

Many of the older persons we presented in the case studies belong to the *sina nguvu*-category. I often became concerned when I saw them struggle but I also learnt to respect their pride and dignity. Older husbands were proud that they could still provide emotional care and company, and the wives and sisters who stayed with them did their best to provide at least some basic care. Their dwellings and material belongings were

often modest, also by local standards, but they did not complain and emphasized that they were used to a harsh life since childhood.

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