Cosmopolitan Aging in Urban Zanzibar

Health, Gender and Transnational Care Spaces Related to Oman

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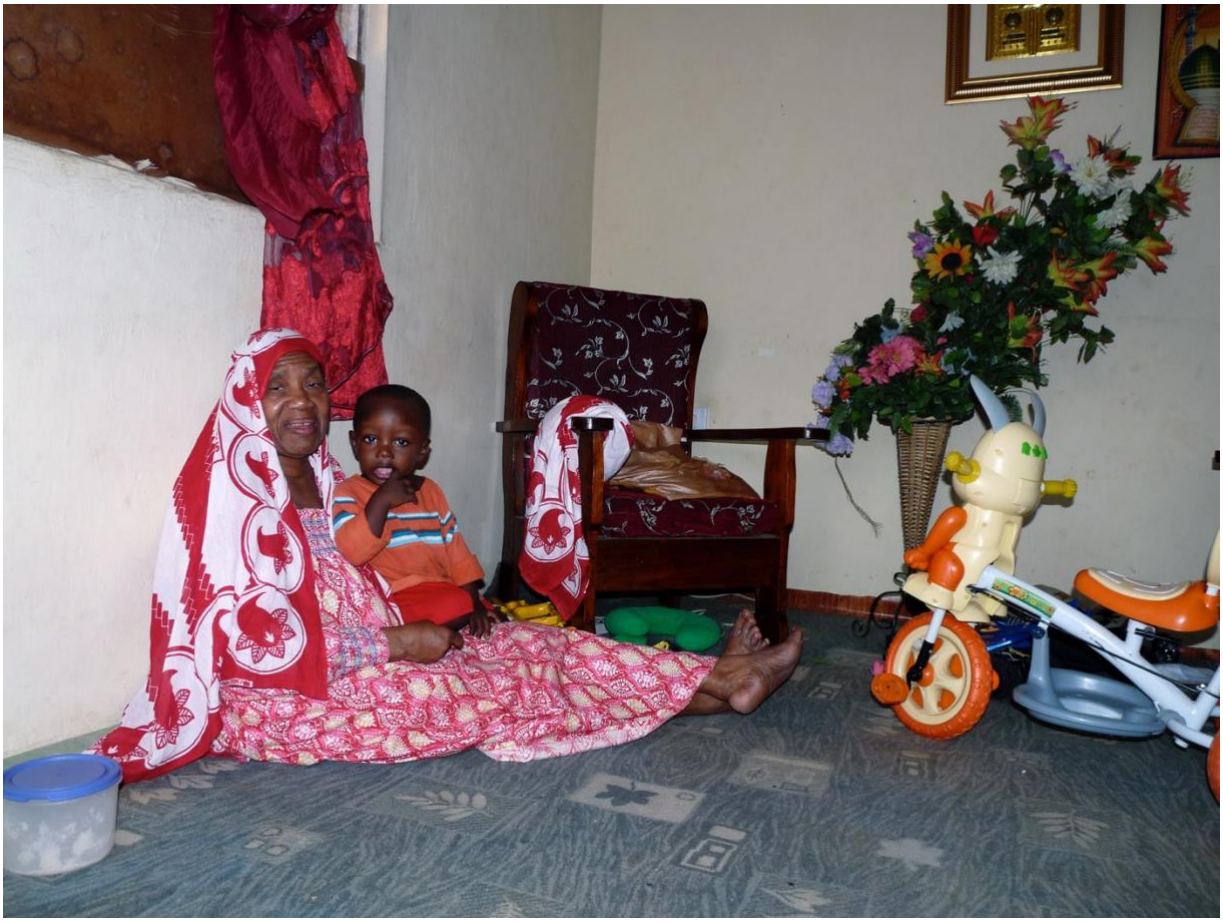

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Kuishi kwingi ni kuona mengi.

To live long is to see much. (Swahili proverb)

Uzoefu ndio mama wa maarifa

Experience is the mother of knowledge. (Swahili proverb)

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Nawashukuru sana wazee wa Zanzibar hasa mkoa wa Mjini Magharibi pamoja na jamaa zao wa Unguja na Maskati ambao wamenifahamisha juu ya maisha yao na wamenisaidia kuandika kitabu hiki. Ahsanteni sana! Nilichojifunza kwenu sio tu kinajaza kurasa za kitabu hichi lakini pia mmenifundisha mengi zaidi yahusuyo maisha, nawashkuru mno kwa hilo. Shukran!

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Chapter I:

Introduction

Picture 1 - Research Assistant Saleh Mohammed Saleh during an interview in Mpendae with a research participant having children abroad. In the background is a woman preaching on an Islamic Tanzanian TV channel.

I. Introduction

Aging, urbanization and transnationalization are three major developments shaping the 21st century all over the world. These broad transformations lead me to raise a number of questions around what they actually mean in everyday lives of older people in urban Sub-Saharan Africa: How do these developments translate for older urbanites, who may have an age, which their parents, having lived in rural areas, did never reach? How are elderhood, health and care practiced and experienced in a nation state like Tanzania, which declares caregiving for older people as a private affair, while older men and women may be engaging with relatives living in countries with elaborated social protection schemes?

On the way to finding some answers to these loose questions, this book's overall aim is to present an analytical understanding of older people's experiences and agency in relation to aging, health and care in the city of Zanzibar, one of the world's historically most cosmopolitan places. The city of Zanzibar is situated on the island Unguja[1], which constitutes together with its smaller neighboring island Pemba the from Tanzania semi-autonomous region Zanzibar. Based on a total of seventeen months of multi-sited ethnographic research in four areas *(shehia)*[2] of the city of Zanzibar and in the governorate of Muscat (Oman)[3], in this book I analyze norms and practices of aging and caring from the perspectives of fifty Zanzibari above sixty years of age, as well as their relatives and acquaintances in Zanzibar and Oman. I trace the transnational relations to Oman, as they are historically deeply grounded and are also constituent of Zanzibar's cosmopolitan flair. Accordingly, this notion of "cosmopolitan aging" is reflected in the title of this book. However, I can already reveal that I hope it provokes a reassessment. It should deliberately challenge those views who assume elderhood to be a uniform phenomenon of vulnerability exclusively tied to local places, as well as those who think of African societies as being monolithic and sealed off from other places and spaces.

To reach the above mentioned aim and to pay justice to the heterogenous and diverse experiences and agency around aging and elderhood in Zanzibar, two main research questions guide us throughout the book: 1) How do older Zanzibari experience aging and caring in different health situations and how do they agentically relate to diverse contexts of action like gender, kinship or religious norms? And 2) How do specific health situations and contexts allow certain older people to become involved in social spaces

[1] Officially, Zanzibar consists of the bigger island Unguja, the smaller island in the north, Pemba and several tiny islands but colloquially, Unguja is usually referred to as Zanzibar, because its territory constitutes the major part of the islands.

[2] I use the Swahili terms if there are no exact translations into English.

[3] The main body of data was collected between 2012 and 2015; in Zanzibar mainly in the four areas *(shehia)* Chumbuni, Kikwajuni, Mpendae and Shangani. In Oman, I conducted research in the governorate of Muscat which includes Al Amarat, Bawshar, Muscat (Old Town), Muttrah, Qurayyat and Al Seeb).

of aging and caring that transgress cultures and national borders while in other situations older people are rather involved in localized spaces?

This book thus makes a point for understanding elderhood not as a uniform and stable stage of life but for paying attention to diverse and ever changing health situations, as well as different structural environments and their consequences for older peoples' experiences of aging and caregiving. An analysis from this perspective sheds light on how older men and women's engagements in social spaces of aging and caring vary for example depending on their health situation, gendered orientations or ideas of piety. With this situational and spatial approach to aging, this study thus counters simplistic depictions of older men and women in Sub-Saharan Africa as solely tied to local places and spaces but it also argues against a newer trend of assuming aging and caring as a completely transnational phenomena. Moreover, and based on this book's actor centered approach, it provides insights into the many facets of everyday lives of older people who interact actively with others to provide and receive care.

The thesis out of which I developed this book grew out of the larger and comparative Swiss National Science Foundation (SNSF) project "Aging, Agency and Health in Urbanizing Tanzania" (AAH) led by Brigit Obrist and Peter van Eeuwijk, both from the University of Basel.[4] In the larger project my colleague Andrea Kaiser-Grolimund developed a second book based on comparable research in Dar es Salaam (Tanzania) and the East Coast of the USA (Kaiser-Grolimund 2018). I conducted the research of my PhD project with the support of a research team in Zanzibar consisting of Saada Omar Wahab and Saleh Mohammed Saleh and a research team in Muscat consisting of Nujaida Al Maskari and Saleh Mohammed Saleh.[5]

[4] The project was funded by the Swiss National Science Foundation (no. 140425 and no. 152694) and conducted in collaboration with the State University of Zanzibar and the University of Dar es Salaam in Tanzania. The Tanzanian National Institute for Medical Research (NIMR/HQ/R.8a/Vol.IX/1376 and NIMR/HQ/R.8a/Vol.II/266) and the Tanzania Commission for Science and Technology (COSTECH no. 2012-386-NA-2012-125 and no. 2013-305-NA-2013-81) as well as the Zanzibar Research Committee approved the project. Dr. Salem Said Al Touby, Dean of the Oman Nursing Institute of the Ministry of Health supervised the research in Muscat. For more information on the SNSF research project see (Kaiser-Grolimund and Staudacher 2013, 2015).

[5] Further reflections on the collaboration with the research assistants can be found in Kaiser-Grolimund, Ammann, and Staudacher (2016).

1. Changing Contexts of Elderhood in Urban Africa

The phenomenon of aging and elderhood in Zanzibar and Muscat must be understood in a context which shapes and mutually is shaped by older people and their social network. Even though by elderhood I mean a loose state of being an elder that is self-ascribed and a genuinely intimate and personal experience, obviously, in a constructivist approach, such a self-perception is always shaped by society and contextual fields to which people relate while they orient themselves to temporal experiences and imaginations (Emirbayer and Mische 1998, 970). Sokolovsky (2004, 218) wrote in the Encyclopedia of Medical Anthropology about elderhood the following:

> A notion of elderhood appears to exist in most non-Western societies and is largely based on combining social and functional definitions of one's place in the life cycle. It is used as a marker of social maturity for population cohorts in relation to others in the community. This is contrasted to boundaries of old age which can take some of the criteria of elderhood and combine them with how a person's individual physical being and behavior reflect the biological aging process.

Elderhood thus can be understood as going beyond "old age" as it combines the physical being (possible decline of the bodily capacity), with social changes (like generational or gendered issues) and as I will argue many other contextual aspects (like historical, political or religious), which construct a culturally defined sense of oldness. Accordingly, I understand elderhood not as a static age stage but rather as being constructed throughout the life-course and thus, as an agent position that is relational, contextual and situational. My understanding of elderhood, similar to Simon's (2015), comes thus close to how Johnson-Hanks argued about "motherhood" as *vital conjuncture*, bringing together demographic vital events and the conjuncture of structure and action (Johnson-Hanks 2002). In the analysis though, I look not only at specific events but broader at the lived experience of aging but thinking with an understanding of agency following Emirbayer and Mische (1998) I mean action and structure not only as conjuncture but as mutually constitutive.[6] As a result, institutional projects like pension schemes and the legal determination of a specific chronological age, thus the number of years from birth to a given date, is one among several aspects that can be constitutive for the self- or externally ascribed "entry" into elderhood. The Tanzanian Aging Policy (URT Ministry of Labour 2003) and WHO standards (WHO 2002b), for example define *older people* as being sixty years old or older. In the selection of the research participants the overall research team decided to choose older people in a first step according

[6] "We might therefore speak of the double constitution of agency and structure: temporal-relational contexts support particular agentic orientations, which in turn constitute different structuring relationships of actors toward their environments. It is the constitution of such orientations within particular structural contexts that gives form to effort and allows actors to assume greater or lesser degrees of transformative leverage in relation to the structuring contexts of action" (Emirbayer and Mische 1998, 1004).

to their chronological age. This fact though, should not reduce the constructivist perspective I am applying to better understand the phenomena of aging, health and caring in Zanzibar.

I will first describe the recent demographic changes in (urban) Africa and specifically in Zanzibar, using such a chronological definition to describe how older people usually become portrayed as a single group, how a generalizing discourse about vulnerability in elderhood is nurtured and how I suggest to include older people's perspectives back into research and practice, thinking with an agency approach (Emirbayer and Mische 1998). I aim at looking more precisely at the phenomena of aging and elderhood and the closely related issues of health and care from the perspective of older people and thus, aim at trying to understand their diverse lifeworlds (Schütz and Luckmann 2003; Husserl 1977). This approach will provide a basis to think further how to better differentiate if and what kind of social protection and long-term care might benefit older people in diverse situations and unequal access to different social spaces in Sub-Saharan cities.

1.1. About demographic changes, urbanization and social protection

Life expectancy increased drastically in many African countries and the number of older people on the continent is expected to more than triple by 2050 (from 46 to 165 million, (UN 2017).[7] In Tanzania life expectancy at birth rose from 49.33 years in 1996 to 65.46 years in 2019, whereby on average, women live almost four years longer than men (UN 2017, 39).[8] This development is commonly framed as leading to a higher "burden of disease" as a more advanced age increases a health transition causing a higher prevalence of chronic conditions and the probability of older people to become unable to perform everyday tasks on their own. Consequently, this raises the need for long-term care (WHO 2017; Eeuwijk and Obrist 2016; Eeuwijk 2014).

Not much is known about how this long-term challenge is taken care of in the face of a growing number of older urban Africans who live longer and with more health problems. Driven by the call of the WHO *Global strategy and action plan on ageing and health* to develop for every country a system of long-term care and being informed by researchers, service providers, private sector and government stakeholders from sub-Saharan Africa and beyond[9] the WHO document (2017) reported the growing need for long-term care of older people in Africa as a larger phenomenon, mainly because of HIV/Aids; especially public health specialists related their research on care-work predominantly to an HIV-

[7] In 1990-1995 life expectancy at birth rose from 51.7 years (Tanzania: 49.6 years), 2015-2020 it is estimated to reach over 62.4 years (Tanzania: 66.7 years) to amount in 2045-2050 around 70.9 years (Tanzania: 73.5 years) (UN 2017, 39). In comparison with Switzerland for example: from 77.9 years (1990-1995) over 83.6 years (2015-2020) to years 87.4 (2045-2050) (UN 2017, 41).

[8] See for more details: https://countryeconomy.com/demography/life-expectancy/tanzania

[9] The conference took place in 2016 in Kenya and was organized by the Africa Region of the International Association of Gerontology and Geriatrics in cooperation with the African Union Commission and the World Health Organization (WHO 2017, 2)

endemic context, in which often older people have lost their children, who were expected to take care of their parents, while they end up taking care of their grandchildren, instead of being provided with care (Schatz and Seeley 2015; Klerk 2011). This discourse emphasized the gaps of family carers in the care arrangements of older people due to the inverted mortality of two generations but did pay less attention to the general increase in the number of older people in Africa. How caregiving by and for older people and especially "family care" looks like in other contexts in Sub-Saharan Africa is hardly explored though (WHO 2017, 7).

I argue that caregiving goes far beyond the context of HIV/Aids but is relevant for a majority of families on the continent. Amongst others simply because more people reach a higher age in Sub-Saharan Africa and because especially younger people are mobile and aim at achieving higher education or making a living elsewhere and consequently, they move away from their aging parents (Grätz 2010). In the literature, the fact that in Zanzibar and elsewhere in Africa more people migrate to and age in urban spaces today leads to the assumption that a "weakening [of] what were previously imagined to be robust 'traditionally extended family structures' which used to cater to older people and the sick" is currently at stake (Makoni 2008, 200). The romantic picture of "African solidarity" is thus seen threatened by urbanization processes and demographic change that overburden families and as a consequence lead to neglected older people (Aboderin 2004). First research in remote rural areas in other regions of Tanzania revealed that many older people remained in villages on their own, while their children and relatives from a younger generation moved to urban areas, but many still stayed engaged in translocal care arrangements (Büsch 2014; Gerold 2017; Klerk 2011; Simon 2015). What these demographic changes and processes of urbanization in Sub-Saharan Africa mean for older people who grow old in the city or eventually migrated themselves to the city is hardly explored empirically.

Urbanization and a rising number of older city dwellers is also observable in Zanzibar. In the district *Zanzibar Magharibi* (Zanzibar Urban West), which consists of the city and its agglomeration, the UN numbers 569,000 inhabitants (UN 2015, 346). From 1988 to 2002 the population in the city of Zanzibar grew incredible by 1160 percent.[10] Even though the proportion of older people aged above sixty years[11] is with 6.2 percent (RGoZ 2013, 13) still relatively low, the actual number of older people in the city has raised considerably and has in 2012 reached around 60'000 people above sixty years (RGoZ President Office 2012, 10-1). Moreover, the percentage of older people is expected to rapidly grow in the next decades, as younger women and men who migrated to urban areas will come into old age (URT National Bureau of Statistics 2013; URT Ministry of Labour 2003). I did not find any official numbers

[10] Partially though through new demarcation of the borders of the city.

[11] Even though the numeric age is just one among several aspects defining old age, the research team decided to select people above 60 years as research participants, which is in line with the Tanzanian Aging Policy (URT Ministry of Labour 2003) and WHO standards (WHO 2002b).

about rural-urban migration in Zanzibar but clearly many older people were not born in the city and only came to the city once they became frail. For example, almost half of the 50 older research participants migrated from the neighboring island of Pemba or other rural areas to the city of Zanzibar.

Formal social protection schemes for older people in Zanzibar are scarce. The major part of support and caregiving for older people does not come from governmental or commercial institutions but is left to themselves, their relatives, neighbors and friends. In Zanzibar only around 4.9 percent of all older people above sixty receive a pension of the Zanzibar Social Security Fund (ZSSF), which is a contributory pension scheme (RGoZ President Office 2012, 10-1). Those older people, who do receive a pension, are mostly former state employees and only recently the pension scheme was opened for all employees who want to contribute. However, the option is hardly used. The Ministry of Regional Administration and Special Departments also runs a cash transfer program, for around 11'000 people, "mainly for vulnerable older persons".[12] The pension gap among those who receive a pension from the contributory scheme is large. Most people receive around 40'000 TZS[13] and only few could rely on a pension of up to 500'000 TZS per month (RGoZ President Office 2012, 7). Generally, the available statistical data of the national census was collected on a household level but social relations and support networks of older people are not tied to the household alone. Thus, for example that 23 percent of the households in Unguja Mjini Magharibi (the region in which the city of Zanzibar is located) have at least one member (at any age) in a social security fund does not tell us much about how older people profit from this in practice (URT National Bureau of Statistics 2015, 85).[14] This only allows a limited perspective on the phenomenon of caregiving by and for older people.

While I encountered almost no community initiatives working explicitly with older people in Zanzibar, the non-governmental organization *HelpAge International* had an impressive influence on the government in Zanzibar and successfully convinced the officials "to work seriously towards the realization of the Universal Pension in order to alleviate poverty among older people" (RGoZ President Office 2012, 10f.). Recently, Zanzibar was praised internationally for being the first low-income "country" in East Africa having introduced a universal pension in April 2016 (Gillam 2016; Seekings 2017). The government spends 0.5 percent of its GDP and is not using any foreign financial aid for the undertaking (Zanzibar 2016). The relatively small size of the semi-autonomous region, which has autonomy in health and social protection issues renders it especially interesting and feasible to introduce pioneering projects and thus also makes it an insightful place to conduct research on aging and caring.

[12] Informal talks with staff at the Department of Social Welfare based on a draft version of the Zanzibar Social Protection Policy.

[13] Its value deflated heavily and fell from around 25 USD in 2012 to around 17 USD in 2018.

[14] 18.9 percent of them are members of the ZSSF (URT National Bureau of Statistics 2015, 85).

In the absence of sufficient formal social protection schemes, the bigger fear than not receiving a pension, was not finding support among relatives, neighbors and other acquaintances. The "worst case scenario" for the older research participants and all people I was talking to informally in Zanzibar was accordingly, being left "alone" and needing to go to one of the two old age homes *(nyumba ya wazee)* in Zanzibar.

1.2. Thinking beyond older people as a vulnerable group

While older people usually are not in the focus neither in public efforts for formal social protection nor in research, if they get into the spotlight, they often are framed as a vulnerable group as for example seen in the reports by the World Health Organization or of the World Bank.[15] This tendency was criticized by a couple of researchers. Schröder-Butterfill and Marianti (2006, 9) for example argued: "To date, vulnerability in old age has mainly been approached by identifying high risk groups, like the poor, childless, frail or isolated. Yet vulnerability is the outcome of complex interactions of discrete risks, namely of being exposed to a threat, of a threat materializing, and of lacking the defenses or resources to deal with a threat". In her study on aging and famine in rural Zambia, Cliggett (2005, 49) welcomed the approach of defining specific groups of people, like "the elderly" as vulnerable to poverty. While Cliggett stressed the importance of analyzing historical and political contexts and differentiating between groups instead of understanding all in a village as exposed to certain threats, with the situational and spatial approach I suggest, one can additionally pay more attention to how things change for an individual over the lifecourse and within elderhood. Also anthropological studies contributed to an image of older people as passive, vulnerable and in need for care (Thelen and Coe 2017). Even though not directly writing about vulnerability, Thelen and Coe made out research gaps especially in medical anthropology which circle around old age and care as "posing 'problems' in the 'private' sphere of kinship, and less often explored as a feature of political organization. As a result, the importance of elder care for representations of community and claims for belonging based on long-term reciprocal relationships are easily over-looked" (Thelen and Coe 2017, 2). For example, studies on aspects of aging as dementia and menopause interpreted these as signs of decay (Lock 1993; Leibing and Cohen 2006). It is important to take up Thelen and Coe's argument that "representations of ageing, care arrangements and older persons shape political belonging locally and globally" (Thelen and Coe 2017, 3) as it reminds us again that aging is never just a medical issue about older people as subjugated objects in public health spheres but needs to be understood holistically as more complex phenomena (Aboderin and Beard 2015).

[15] Website of the World Bank: http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTSF/0,,contentMDK:20663797~menuPK:6344572~pagePK:148956~piPK:216618~theSitePK:396378,00.html (accessed 16.06.2018).
Website of the WHO:https://www.who.int/environmental_health_emergencies/vulnerable_groups/en/ (accessed 16.06.2018).

Also in Zanzibar, as in many other places, older people appear as a uniform vulnerable (age) group in official documents. The Zanzibar Social Protection Policy which was developed in 2013, differentiated between six "stages of life" in which people are especially vulnerable.[16] Even there, a discrepancy between formal (governmental) and informal (private, charitable) social protection is visible in the definition of who should be supported. In the Zanzibar Strategy for growth and reduction of poverty: 2010-2015 MKUZA[17] II as well as already in its predecessor MKUZA I (2006-2010), vulnerability was defined by age cohorts whereby beside for example children, also people above sixty years fell into this category (RGoZ 2010, 17). The aim of MKUZA I and II was among others to "improve safety nets and social protection for poor and vulnerable groups" (RGoZ 2010, 57). While on the one hand MKUZA II thus made out older people as vulnerable group referring to their age, on the other hand the authors admitted that especially informal protection, thus support from families and community was not related to chronological age: "Disaggregating vulnerabilities by age cohorts means that some interventions are not captured, notably those that generally support vulnerable or impoverished people – individuals or households – regardless of where they are in the life-cycle. Examples include redistributed *zakat* monies" (RGoZ 2010, 17). Such institutionalized forms of support from the Islamic community are widespread in Zanzibar (ILO 2010, 98), for this reason MKUZA II took up what was started with MKUZA I: "MKUZA I sought to expand welfare support to the most vulnerable groups and to exploit opportunities of *Zakat*, *Infaaq* and *Waqf* in caring for the needy and the destitute. The strategy also involved the strengthening of families and communities to effectively support the most vulnerable and to encourage insurance schemes. The problem of delayed payment of gratuity for retirees and the small coverage of social security schemes were also addressed" (RGoZ 2010, 57). Zakat constitutes the third pillar in Islam, and commands to pay a kind of mandatory tax in the form of alms to the poor, while Infaaq means any spending to please God. Waqf is the "withholding of property in order to use the revenue it generates for philanthropic purposes" (ILO 2010, 209) or what I had heard more often to let someone stay in a house without collecting rent. Also Sadaqat (Swahili sadaka), a voluntary charitable act to obtain protection from God in return, was mentioned as a kind of informal protection. Thus, while in such community initiatives sponsors most possibly differentiated more than just helping any older person, in the official approach, defined by their chronological age, older people were generally addressed as a vulnerable group.

1.3. Changing contexts of health care for older people in Zanzibar

Particularly often, older people in Zanzibar had and still have to adapt to and shaped the dynamic social, political and medical contexts which continuously altered within the past decades. The over sixty years

[16] I only received a draft version of the report but had additionally informal talks with the responsible staff at the Department of Social Welfare.

[17] MKUZA is the Swahili acronym of *Mkakati wa Kukuza Uchumi na Kupunguza Umasikini Zanzibar*.

old were born into a time of drastic changes on the island: They experienced the "Zanzibar Revolution" of 1964, during which the dominant Arab elite was discriminated, killed and displaced. Subsequently, they underwent the establishment of the union with mainland Tanganyika. Many of the people I spoke to considered this to be a forced and unbalanced union with Tanganyika which was the basis of the formation of Tanzania. In the 1970s they came to be dominated by a (mostly mainlander) socialist one party political system that pursued the object to Africanize the island, promoted villagization and self-reliance (*ujamaa na kujitegemea* from 1973 to 1976), aiming at building familial ties among all Tanzania nationals (cf. Myers 2000, 438; Myers 2011; Scott 1998, 223; Shivji 2008, 155). This socialist government heavily promoted biomedicine in Zanzibar and announced free and universal biomedical healthcare for all (Beckmann 2010, 204). Even though officially promoted, the promise to free healthcare proved impossible to fulfill, especially since biomedical, as well as traditional treatments were hardly accessible. In the 1970s the government banned private medical practices. This resulted in the beginning of the biomedical health system's deterioration (Beckmann 2010, 205). The results were days of waiting for patients to be admitted at a hospital or alternatively travels to Dar es Salaam for a treatment (Martin 1978, 60). Finally, since the late 1980s, when neo-liberalism found its way into Zanzibar, public services were gradually privatized and cost-sharing models for public health facilities have been introduced, including hospital admission fees, costs of surgery, tests and other procedures, as well as prescribed medicaments (Beckmann 2010, 205).

At present, it is not easy for an older person to receive accurate health care. At the time I conducted the field research, free health care was advertised by the government on TV and radio in Zanzibar with the unmistakable slogan *afya bure* (free health care). Nevertheless, all research participants complained that usually they indeed did not pay for an examination as long as no testing material or expendable products were involved, but that only a few medicaments were available such as pain killers, antibiotics and anti-malaria medication. This was not only a problem for older Zanzibari but for people of any age and was openly admitted by the Minister of Health in Zanzibar, who in a public speech[18] even in 2018 reminded the ministry's executives of the ministry to provide free healthcare.

Beckmann (2010, 205) described how problems in health care shifted from availability in socialist times to difficult accessibility in a neoliberal context. In addition, according to Parkin, in Zanzibar exists a growing discrepancy of what would be there in terms of medical care and what most people can afford:

> An early attempt at free public health provision has thus given way to a privatized and barely regulated system at the same time as the urban population is changing in composition through migration. There are, moreover, as elsewhere, signs of a more 'class-based' differentiation of provision, with the small, mobile

[18] Website Blog "Zanzibar ni kwetu": http://zanzibarnikwetu.blogspot.com/2018/08/zanzibar-waziri-wa-afya-awakumbusha.html

> elite turning to one or two well-equipped but expensive hospitals and doctors, and with the mass of the population coping with what they can afford. (Parkin 2006, 699)

What these developments mean for older people and their families in Zanzibar and what older patients do in the given situation is not yet well explored. This dissertation contributes to this strand of research by viewing these developments through the perspective of the older people and their social networks as social actors.

1.4. Actor centered perspective: Putting older people's agency back into research

Considering the current demographic changes, urbanization and developments in social protection, which foster the image of a homogenous group of vulnerable older people and in light of the changing context of the health care system in Zanzibar, we currently do not know much about the lived experience[19] of aging in these contexts, which shape and are shaped by older people's lives. In this research, I thus seek to foreground a perspective rarely found neither in academic research nor in policymaking processes, which understands the phenomena of aging and caregiving from the perspective of older people themselves, thus by following an agent-centered perspective.

To emphasize this agent-centered perspective and the active engagement of older persons with others, I draw on the definition of human agency by Emirbayer and Mische (1998, 970). I am interested in studying the agency of older persons as a "temporally embedded process of social engagement" (Emirbayer and Mische 1998, 962) with potentially changing structures. Emirbayer and Mische developed together with Goodwin their concept of agency in work on revolutions and collective action, as a reaction to causal statements and mechanisms explaining problems posed by changing historical situations (Emirbayer and Goodwin 1996). While Emirbayer and colleagues focus on collective action, I believe that their work on agency can also be extended to more individual aspects of agency. As well as historical situations change, we can draw parallels to situations of health, which often change throughout the process of aging. Their focus on changing situations, instead of rigid, unchanging classifications of persons in certain contexts can help us to investigate the interrelated processes of aging, getting healthier or frailer, self-care and care giving from a new theoretical perspective and gain a deeper understanding of how agentic orientations shape aging and health in contemporary urban Tanzania. Through the interplay of habit (eg. How was elder-care provided in the past?), imagination (eg. What kind of care could I receive?), and judgment (eg. What is my need (as an older person) right now? What can be done right now?), "temporal-relational" contexts of action (eg. cultural, socio-cultural and a socio-psychological contexts of action but also the physical environment or the body) both reproduce and transform structural environments in interactive response to their current situation by

[19] I am following the understanding of Burch that "*lived experience* is inherently the experience of meanings" (Burch 1990, 147).

recalling past personal experiences and imagining possible future trajectories (Emirbayer and Mische 1998, 970). In this logic, the ageing and caring of and for older urban residents in Zanzibar is not the same for everyone but depend on heterogeneous experiences, as well as individual situations and diverse contextual aspects. Emirbayer and Mische (1998) suggest that, based on the actors' experiences, three temporal dimensions of agency can be analyzed: namely, orientations towards the past, the future, and the present. Accordingly, if we look at how older people experience, live in, and work on the city, we should take into account their structural context, local social practices and norms, and their imagination of the future.

This book thus aims at enhancing the development of a new discourse by looking at agency of older urban dwellers in the making and unmaking of spaces of aging and caring in and beyond a city in the Global South. In this sense, I focus in this book on the social construction of elderhood, health and care (as well as related gender, kinship, faith and so on) rather than looking for rigid institutions. Having this focus, I draw on the work of Berger and Luckmann on the social construction of reality (Berger and Luckmann 2010) and Goffman's interactionist writings (Goffman 1973, 2008, 2011). They investigate how people position themselves towards other individuals and socially constructed norms and normalities and how they live and interpret them in actual practice. I build on these perspectives and I am interested in how people become socially engaged, for instance by demanding care from others. In line with this epistemological stance, not only aging is socially constructed but also health and illness are. As Kleinman (2010) has argued in his Lancet article on the "Four social theories for global health", social constructivism is one of the social science "theories" which is relevant for the study of global health issues because it helps to highlight the "tension between global policies and local reality". Such tensions are common in global health programs trying to solve a "global health problem" like afflictions of old age (US National Institute on Aging, US National Institute of Health, and WHO 2011), which often ignore culturally distinctive significance in different local contexts. Kleinman summarizes the consequences of a social constructivist approach as follows:

> A corollary of the social construction of reality is that each local world—a neighborhood, a village, a hospital, a network of practitioners/researchers— realizes values that amount to a local moral context that influences the behavior of its members. For global health, the implication is that those local moral worlds can affect everything from smoking cessation interventions to HIV/AIDS prevention and treatment programs (Kleinman 2010, 1518).

By applying an actor-centered perspective I thus do not want to omit the analysis of contextual developments (such as international or national political developments or social, cultural or economic contexts) but I want to deconstruct the interconnection of the lived experiences of aging and individual agency with broader societal developments. So far, one of the core motivations for studying local social constructions of health and illness have been "to better understand which symptom sets are accorded

cultural significance, identify illnesses perceived to be mundane versus those that are serious, and examine how illness categorization influences patterns of health care seeking and treatment delay" (Nichter 2008, 69). As Obrist showed in her research on health, vulnerability and resilience of women in Dar es Salaam, Tanzania, it is crucial to understand local constructions of health and not just on illness and health seeking (Obrist 2006). Building on this approach, van Eeuwijk (2006) conducted extensive research on old age vulnerability in three Indonesian cities and showed that older people's own ranking of health problems differed strikingly from those of gerontologists. What most mattered for them were impairments affecting their daily living activities, not non-communicable diseases like diabetes or cardio-vascular diseases. Accordingly, in this study, I want to put older people's perspective back into research on aging, health and care and look specifically at different situations older people are confronted with.

2. Towards a Situational Approach to Understanding Aging

Elderhood is not a uniform or static age stage but is constructed in specific situations in which action and structure mutually constitute each other. In specific situations for example, lives of older people can be punctuated by profound experiences of disablement and this brings with it a certain kind of responsibility for others. Such a perspective differs greatly from how other anthropologists have looked at aging. For example, Lock (2013) traced the intellectual debates of experts on dementia but did not analyze what dementia is about from the standpoint of the people affected or their social environment in specific situations. If Lock had analyzed different *situations* of people suffering from dementia, from the perspectives of those affected, she could have observed big differences between somebody who is in a situation of being slightly or severely impaired due to dementia. If serious dementia prevents a person from walking around, and if she or he is not able to do anything on her or his own anymore, then this has profound implications for society (Kleinman 2012). People in such situations need support since there is a decline in functioning. Older people who are in a situation in which they suffer from severe health problems often cannot perform tasks and actions that they used to be competent at. Habits have to be changed due to severe health problems, and older people in such situations thus become dependent. If this happens in a city like Zanzibar, where the state services for older people are scarce, family members largely fill in the gap. Familial relationships are, accordingly, crucial to caregiving. These aspects though, depend on the situation, agentic orientations towards certain contexts of action and social spaces older people can relate to, to obtain care or in Hannerz words: "Whether or not an individual will adopt a culturally suggested mode of action may be taken to depend to a great extend on its relevance to his situation" (Hannerz 1969, 193).

If we understand agency as a *temporally* constructed engagement of actors in different structural environments, I argue that it makes sense to look at *situations* to better understand agency. Emirbayer and Sheller (1998, 762) mention "situations" on a sidenote and only in relation to the element of practical

evaluation, thus the "the capacity of actors to make practical and normative judgments among alternative possible trajectories of action, in response to the emerging demands, dilemmas, and ambiguities of *presently evolving situations*" but they do not specify what they mean by situations. By situation, I mean, in the context of my fieldwork, circumstances, in which older people find themselves momentarily. Looking at eg. specific health situations, we can see that social relations are crucial to receiving care and that certain older inhabitants of the city are not only able to mobilize their social network on the island; they are also able to respond to a possible marginality with transnational and cosmopolitan agency. I thus focus not only on people's connections and engagements with others but also on how certain people are able to obtain access to unfamiliar ideas and goods coming from abroad. This allows them not only to know about certain things but also to alter their habits and make creative use of new, alternative, foreign, or re-invented possibilities. I especially focus on how certain older people and their social networks are able and ready to mix ideas and thus draw on a cosmopolitan worldview to move away from urban marginality at least in specific situations (Staudacher 2019a).

2.1. Politics of aging and elderhood

Since aging is not an individual phenomena but the experience of aging and elderhood are shaped by relational contexts and are thus socially constructed, ideas and practices around aging and eldercare are changing, multiple, contested and controversial: What does it meaning to being and becoming old? What makes people perceive themselves or others to having "entered" elderhood? These questions provide an entry point for an analysis of, what I call "the politics of aging and elderhood", the negotiation of what aging means and who becomes an older person. Anthropological research has shown how human maturity, aging and elderhood mean different things depending on the cultural context (Sokolovsky 2009). Following Meiu (2014, 4), old age and elderhood (Makoni and Stroeken 2002) can be defined in relation to bodily transformations, chronological measurements of time, wealth accumulation, ritual initiation, age grades, claims to generational belonging, membership in age cohorts, social position, and commodity consumption. What aging and elderhood mean for different people in different situations and how it is negotiated and contested that someone is now old or not, underlies political articulations between and within generational groups. The diverse health situations play an important role in this. So far very little research has been conducted on aging in an Islamic contexts in Africa, and research on aging in sub-Saharan Africa was often conducted in an Eurocentric mode (Makoni 2008, 203) and in addition not paying enough attention to the diversity and fluidity of what elderhood means in different contexts.

To talk about older people as one group – no matter on which continent - is of course a huge generalization and it can seem to be an arbitrary choice to put together a bunch of people just because of their chronological age. Easily one can be trapped in prejudicing or stereotyping based on age and thus contributing to ageism (cf. Nelson 2005). Rather, to perceive oneself as old entails situational, fluid

and changing aspects of identity (cf. Cruikshank 2009, 5). That aging and elderhood are socially constructed means, that we also need to explore the heterogynous and situational characters of aging and elderhood, which I argue, are heavily shaped by norms and practices around different health situations to which older people and the people around them respond to. As it is typical for ethnographic research, I thus aimed at being sensitive to local understandings of the phenomena I studied. I tried to approach the field not with predefined concepts of what elderhood entailed but used sensitizing concepts like "elderhood", "aging" but also for "health", "care" or "caregiving", as they are common in grounded theory approaches instead. In the sense of Charmaz (2006, 16) I used these broad research interests or sets of general concepts to have some ideas on how to ask particular kinds of questions about the phenomenon. I thus used these sensitizing concepts as "points of departure" (Charmaz 2006, 17).

The following example of how to greet (older) people in the city of Zanzibar shows how contested and fuzzy the boundaries of inclusion and exclusion of elderhood *(uzee)* were even in one place. It is not surprising, that mostly, typical bodily aspects like grey hair, wrinkles or a bent body were decisive how strangers greeted a(n) (older) person in the streets of the city. Nevertheless, in case of doubt about their age, younger city dwellers preferred to approach (older) people according to a younger age. At the beginning of the research I wanted to address older people in Zanzibar in the way I had learned it from the dictionary and according to how it is common on the mainland Tanzania and in official policies (RGoZ 2010, 58; URT Ministry of Labour 2003), as *wazee*, which is translated as elders, older people or even respected people and ancestors and is also used to talk about (older) parents.[20] I was surprised when I saw my research assistants, Saada and Saleh slightly embarrassed in front of older people, when I addressed them as wazee. They corrected me and explained that in the older people's presence, I should only talk about *watu wazima*, literally complete people, meaning adults and only use wazee once they had mentioned the term themselves, since otherwise this could have been perceived as rude. On the other hand, the term watu wazima created confusion among older people and their relatives for its double meaning, as it means generally adults but also older people. We ended up saying "watu wazima, wazee" as a single term, which was an attempt to reduce as much touchiness and vagueness as possible, while most older people immediately used the term wazee to talk about themselves. Words for very old people like *mkongwe* (extremely old person) were almost exclusively used by the research participants to describe third persons, who were supposed to be extremely old, feeble and sick.

Having randomly chosen people according to their numeric age (sixty years and older) it became obvious that being old was not a clear-cut state but rather a process and was situational in its nature. I was wondering, whether relatively healthy older people perceived themselves as old and having entered elderhood. In the course of the research, I realized that having a focus on elderhood, health and

[20] See Online Swahili – English Dictionary http://africanlanguages.com/swahili/ (accessed 25th August 2017).

(transnational) care the majority of them acknowledged even minor health limitations and disabilities as being part of their aging process.[21]

2.2. Caring: receiving and providing care as an older person

A situational approach to understanding aging makes especially sense if we think of caregiving for and by older people. Various practices and ideas about caregiving in elderhood are completely different in specific health situation. When older people are confronted with health problems they can - or are not supposed to - do the same things they did when they were healthy. They can expect to receive[22] or provide certain kinds of care, depending on the health situation, gender, class and kinship or other social relations. As we will see in the discussion bellow, most anthropological literature on aging deals with aspects of caregiving for and by older people but they rarely look at aspects of agency, thus how people depending on their experience, judgment and imagination act in different health situations.

In the multidisciplinary literature, a variety of definitions of care exist, which range from a narrow rather medical understanding in the sense of "health care", that distinguishes "cure" and "care" to a very inclusive use of the concept. I do agree with Mol (2008) who writes in her book "The logic of care" about the problematic distinction between cure and care:

> In scholarly discussions about health care, 'care' is often distinguished from 'cure'. If it is done, the first term, 'care', is used for activities such as washing, feeding, and dressing wounds that are done to make daily life more bearable. The second term, 'cure', resonates with the possibility of healing, and is applied to interventions in the course of a disease […] In practice […] the activities categorized as 'care' and 'cure' overlap. (Caring) food and (curing) drugs may have similar effects on a body. Caringly dressing a wound may help its cure (Mol 2008, 1).

I use the concept of care in a broad sense, not distinguishing cure from care (Mol 2008) and including its technical/practical and emotional elements as defined by Kleinman and van der Geest (2009b, 159). I thus understand all activities that make the daily life of older people more bearable (Mol 2008, 1) – such as washing, feeding, and visiting with someone as well as dressing wounds – as part of older care.

[21] Talking about being relatively healthy in old age, I started to understand the verbal closeness to the contested "Western" concept of healthy aging. Healthy ageing in this programmatic sense "is the process of optimizing opportunities for physical, social and mental health to enable older people to take an active part in society without discrimination and to enjoy an independent and good quality of life" (The Swedish National Institute of Public Health 2006, 8). Nevertheless, this normative concept has not much to do with what I will describe in this book. Website of the European Union on Healthy Aging: http://www.healthyageing.eu/steps-healthy-ageing (accessed June 2018). For a more comprehensive analysis on the uptake of aspects in relation to the concept of "healthy aging" in Dar es Salaam, Tanzania look into Kaiser-Grolimund (2017).

[22] It is common to speak of care giving and care receiving, nevertheless considering older people as having agency "care taking" would better describe their active involvement in this process.

The concept of care though is embracing much more than just practices and constitutes a vital element of social organization in its widest sense (Thelen 2014). Referring to the German philosopher Martin Heidegger Geest (2018a, 139) summarized the essence of caring aptly: “The act of caring for oneself and for others and the attitude of ‘care-fulness’ typifies being a ‘human being’; to ‘care’ is the essence, the structure of being”.

Research on aging, health and care in Africa has been spearheaded by the medical anthropologist van der Geest in rural Ghana, for instance in his famous article on respect and reciprocity as key elements of old age care (Geest 2002). In a comparative study of India and Burkina Faso, Roth, de Jong, Badini-Kinda and colleagues (Jong 2005) analyze care rather implicitly in the wider context of social security. Their ethnographic case studies showed that especially poorer parts of the population and women were aging in insecurity, as family support was limited. Care provided by others, mainly by kin, is always situated within a complex whole of responsibilities, obligations, norms and values that is also linked to being part of a specific generation (Alber and Drotbohm 2015; Klerk 2011; Alber and Häberlein 2010; Eeuwijk 2006; Geest 2002).

There is, thus no guarantee that older people will receive care. Caregiving relations are not innate but “continually evolving social processes formed and shaped through daily interactions” in which older peoples’ “experiences and expectations of receiving care were situated within a complex web of support networks, based on a principle, if not practice, of reciprocity” (Freeman 2018, 119). Not only Freeman doing her research in rural Malawi but also research in a Ghanaian and northern Tanzanian context, showed the changing character of caregiving (Geest 2018b; Klerk 2018). Based on his research in Indonesia, van Eeuwijk thus suggests that older people face a “triangle of uncertainty” with social, economic and health dimensions (Eeuwijk 2002, 25; 2004, 124).

The concept of everyday self-care (Kaiser-Grolimund 2017) brings in an interesting additional piece of what could be seen as a kind of the care puzzle. Not only “others” (family, health professionals) provide care but also a person alone can or in certain instances has to take care of herself, sometimes due to the absence of other caregivers. While in the 1980s self-care was rather understood in opposition to professional care (Kroeger 1983) in newer literature like in an article of Richters, Rutayisire, and Dekker (2010, 102) on care in sociotherapy in Rwanda, self-care is portrayed as a kind of “self-recognition” by which patients take care of themselves for example through bible reading.

Caregiving for and by older people in family and private settings in Sub-Saharan Africa is not only mostly performed by kin, a major aspect of creating kinship and thus belonging happens through caregiving. Kinship is thus an important context of action for older people as well as for their social network in caregiving. By kinship, I mean the mutuality of being as a symbolic notion of belonging not a biological connection by “blood” and thus, kinship as culture, symbols and meanings (Sahlins 2013;

Schneider 2004). Relatedness (Carsten 2000) as a basis of kinship, was already adumbrated in Meyer Fortes "Kinship and the Social Order" as "fictious kinship relations" which have the same implications as "natural offspring" (Fortes 1969, 251). Already over twenty years ago, Borneman (1997) wrote about the intertwined connection of caregiving and relatedness.

Accordingly, in Zanzibar, I first needed to understand the kinship vocabulary to better grasp how caregiving responsibilities were created and perceived. I hardly heard anyone using the term *familia* which is the translation of family. Instead, talking about close relatives, usually older people referred to *watoto* to describe close younger generations including their own children, nieces and nephews, grandchildren and other close younger people. Sometimes *wajukuu* (grandchildren) were again differentiated from *watoto.* All other relatives usually fell under the notion of *jamaa*. In this sense, looking at aging and caregiving amongst others through the lens of kinship, this book also fills the gaps identified by Aboderin and Hoffman who argued that not yet much is known concerning the "social construction and constellation of aging families". More precisely, "the very concept of the African family – and, specifically, the family of older people – remains poorly defined and under-scrutinized". Furthermore, little is known about the quality of older adults' family relationships (Aboderin and Hoffman 2015, 285-6).

As we will see in the course of this book, care and caregiving are by far not easy to tie to one definition alone. According to Nguyen, Zavoretti, and Tronto (2017, 200) so far, "little attention has been placed on the varied understandings of care that shift according to historical and cultural contexts". Interestingly, even within the research team the Swahili notions and local concepts of care varied heavily depending on the area in Tanzania the research was conducted in. The research participants in Zanzibar had also diverging understandings and used the diverse terms, which could be translated as caregiving, depending on the situation and context. For this reason, I used the sensitizing concepts of "care" and "caregiving" to cover the large semantic fields. During the research, I replaced the notion of *caregiving* largely with *caring* as I had realized that aspects of mutuality and reciprocity in caregiving in private settings is very important and giving and receiving care are usually intertwined, while caregiving suggests that someone *gives* care and another person *receives* care. Due to the more common use of caregiving though, I will still use these notions interchangeably. Ideas and practices of caregiving are not only heterogeneous but as Simon (2015) wrote, they are often also invisible (at least at first). Also, Mol, Moser and Pols (2015) in their edited volume showed many intangible facets of (good) care, which need to be taken into consideration when analyzing what (good) care might be. Additionally, caregiving happens not only between people but also between people and objects (building on theories of Deleuze and Guattari: Fox 2002). Finally, while some argued that caregiving essentially means presence on site

(Kleinman 2017)[23] for others care circulates transnationally (Baldassar and Merla 2014c). In this book, I argue that the combination and integration of these diverse perspectives allows a more holistic understanding of what aging and caring in a cosmopolitan city mean.

2.3. How gender matters: different meanings and experiences of aging

I will take up aspects of gender in the sense of a relational context, as a transversal theme and line of analysis of aging, health and caring in this dissertation in all chapters. I generally ask the question how the lived experiences of masculinities and femininities change and emerge during processes of aging in situations of relative health, as well as of illness and related aspects of caring. By masculinities (or femininities) I understand the positon of men (or women) in a gender order (Connell 2005 [1995]). Masculinities (or femininities) can be defined as the patterns of practice by which people engage that position. As Saltonstall already wrote "doing health is a form of doing gender" (Saltonstall 1993, 12). With Maihofer (1995) I understand health (and aging) related actions as both gendered (in German: *vergeschlechtlicht*) and at the same time constituting gender (*vergeschlechtlichend*). Actions in relation to health are therefore not explained one-sidedly in advance by masculinity or femininity. Rather, according to Wehner et al. (2015, 35) they are regarded as the result of the development of concepts of masculinity or femininity and thus as part of the normatively required creation and maintenance of intelligent "male" or "female" "modes of existence" (*Existenzweisen*) (Maihofer 1995). How masculinity and femininity are determined in terms of content in different social spaces is always subject to processes of change.

Social science literature on aging, health and care is rarely linked to gender that fact in turn points out research gaps. Backes (2010), a gerontologist working on gender in the European context, sees "blind spots" in relation to aging and gender and postulates that older women are highly underrepresented in research. Because of the lack of serious analysis of gender in elderhood, she criticized the undifferentiated discourse on a feminization of old age which claims among others, that men would adapt to more female forms of socialization once they become old (Backes 2010, 454). Arber, one of the most mentioned researchers working on the intersections of gender and aging in English speaking Europe, argued that there exist still huge knowledge gaps concerning the implications of widowhood and divorce for older women *and* men and how new and different forms of relationship statuses influence meanings and experiences of aging (Arber and Ginn 1991; Arber, Davidson, and Ginn 2003b, 2003a; Arber and Cooper 1999; Arber, Andersson, and Hoff 2007).

[23] In the context of an ideal clinical setting Kleinman defines presence as "the intensity of interacting with another human being that animates being there for, and with, that person. Presence is a calling forward or a stepping toward the other. It is active. It is looking into someone's eyes, placing your hand in solidarity on their arm, speaking to them directly and with authentic feeling" (Kleinman 2017, 2466).

Especially, postcolonial studies have addressed and critically discussed questions around the social construction of gender in sub-Saharan Africa and rightly pointed to the fact that the analysis should more take into account the complexities and ambiguities of the diverse contexts and situations (Ammann and Staudacher 2020). Studies around the making and shaping of gender identities in Africa revealed the dangers of "superimposing monolithic version of 'gender relations' onto African realities" (Cornwall 2005, 7). Livingston (2003) conducted research on recent changes in the negotiation of female old age in Southeastern Botswana, which I believe are common in Zanzibar as well: namely, first, on a changing epidemiology, where women get older but frailer, which impacts on the local understanding of senescence, secondly on changes brought through old age pensions and thirdly a newer development that seniors become care-receivers *and* care-givers. Another ethnographic research study realized in rural Zambia by Cliggett (2005) explored what happened to kinship ties in times of famine and how older men and women use gendered approaches to get support from their family members. On the intersection of aging, health and gender in Sub-Sahara Africa the literature becomes almost non-existent and the social construction of gender is usually not in the focus of the research but gender was rather taken as a given. I for example agree with Simon who argued that it is crucial that older men and women could perform their gendered activities and responsibilities (Simon 2015). In my analysis though, I aimed at additionally grasping how older people related in diverse ways to (normative) ideas of what older men and women should do and what actions they took as social agents.

Understanding gender as relational context in agency of older people in Zanzibar, the analysis of aging and care-giving opens up a door to lived experiences of masculinities and femininities, as they change and emerge during processes of aging and phases of illness in elderhood. Major differences in living and care arrangements, as well as general norms and experiences relating to aging and elderhood are marked and constituted by a binary understanding of gender.[24] I will illustrate how changing bodies and health conditions, heavily influence men's and women's capacity to take care of themselves and others and how these impact on how they relate to aspects of hegemonic masculinity (Connell 2005 [1995]; Connell and Messerschmidt 2005) or feminity but also how plural masculinities and femininities co-exist.

2.4. Older agents in three health situations

Besides the earlier mentioned political, economic and social transformations older people in Zanzibar experienced throughout their lives, today especially, the changes in their bodies and related health situations play a decisive role in their everyday life. As Eeuwijk, Obrist, Gerold and Simon have shown in their research project "From 'Cure to Care' - Among the Elderly. Old-Age Vulnerability in Tanzania"

[24] Even though being aware of more diverse and complex gender identities, in this dissertation I follow the emic construction of gender among the older research participants in urban Zanzibar, which predominantly sticks to a binary understanding dividing people into heterosexual men and women.

(2009-2012), it is crucial to differentiate how much older people perceive themselves to having *nguvu*, energy. Obrist (2018); Gerold (2017); Eeuwijk and Obrist (2016); Simon (2015) distinguished olderly people who have energy (*nina nguvu*), who have sometimes energy (*nina nguvu baadhi ya wakati*) or who do not have energy (*sina nguvu*) to better understand the diverse experiences of aging, health and care-arrangements of older people. Additionally, they pointed out that the negotiation of care-arrangements and the agency of older people become particularly well visible in "critical health moments", which Obrist (2018, 96) described as events of "discomfort, unease, pain or inability to perform as usual" and show the fluidity of aging (Eeuwijk and Obrist 2016). Building up on research on peoples' everyday conception of health and health sustaining practices in an underprivileged area in Dar es Salaam (Obrist 2006), I was interested in experiences of good health, thus focusing on what older people's and their relatives' perception of and coping with their health situation was, but also interested in their illness experiences (Kleinman 1988, 3), which Kleinman defined as follows:

> Illness refers to how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability. Illness is the lived experience of monitoring bodily processes such as respiratory wheezes, abdominal cramps, stuffed sinuses, or painful joints. Illness involves the appraisal of those processes as expectable, serious, or requiring treatment. The illness experience includes categorizing and explaining, in common-sense ways accessible to all lay persons in the social group, the forms of distress caused by those pathophysiological processes.

The biomedical diagnosis of a specific disease was thus of secondary importance to the analysis of this study as I wanted to find out what was at stake for the older people and their social network.

Building on the reflections of Obrist (2018); Gerold (2017); Eeuwijk and Obrist (2016); Simon (2015) and mirroring them with data from Zanzibar, I have in an iterative process developed the analysis of three typical situations. These situations link health and aging experiences of the older research participants in Zanzibar with the related implications for the older people as well as for their social environment. This approach highlights what was most at stake for older people and their families,[25] in health situations, which first, were relatively similar to when they were younger, being relatively healthy and self-reliant, second, they suddenly had to adapt to (health crisis) or third, learned how to deal with (chronic conditions).

[25] By family I mean the emic understanding of the research participants of whomever they called to be a sister, daughter etcetera in the sense of social relatedness (Carsten 2000) no matter whether they were actually biologically related or not. This stands in contrast of how structure-functionalists such as Murdock (1949) have grasped family in a single definition of who belongs to the family and what the family's characteristics and functions are.

By thinking with these three situations, which certain people experience during specific moments in time and in relation to gender, I pay justice to the fragile nature of health in old age I found among the older people I interacted with in Zanzibar and to their embeddedness in social spaces, within which they constantly interact with other social actors. Such a situational approach allows a focus on transformation and continuity, and accordingly on embodied[26] or anticipated, as well as unexpected or new experiences of aging, pave the way to diverse processes of social engagement and as such, forms of agency in what I call *social spaces of aging and caring*. Analyzing different health situations allows to see how (embodied) everyday practices (Certeau 2002 [1988]) of aging and caring are transformed and adapted especially by new experiences of health emergencies and other sudden changes.

3. Thinking with Spaces: Elderhood in and beyond a Swahili Cosmopolis

So far, I have explained that I aim at having older people as social agents at the core of this analysis and that for this it is enriching to look at different (health) situations of these agents. Additionally and in order to pay justice to the diverse people, commodities, ideas and places, older people can relate to, I suggest in this dissertation to think with *spaces of aging and caring*. I developed this perspective based on what I encountered in the field and in an interactive way going back and forth between analyzing and interpreting data, reading and relating them to the literature and discussing first results with the research team. In the course of the study, I more and more saw that the contexts of action of older people in the four urban areas in the city of Zanzibar I did research in were unequal. Accordingly, a structuring element of my dissertation became that I understand that, the older people's engagements related to local, cosmopolitan and transnational social spaces opened up and closed dynamically for older people - depending on their health situation.

Zanzibar historically grew as the cosmopolitan center of Swahili people. In Arabic *sawahil* means coast, and even though the definition is contested people under the multi-ethnic umbrella of Swahili are usually defined as "people of the coast", the land strip and islands stretching from Somalia to Mozambique (Middleton 1992, 1). As a "mercantile civilization" (Middleton 2004), Swahili are said to have established spaces reaching from their urban communities on the East African coast to the Arab Peninsula and South Asia over centuries. During colonial times the Swahili incorporated European elements into their cultural repertoire, and since Kenya and Tanzania became independent in the 1960s, there has been a steady expansion of "Swahili-speaking peoples" (Topan 2006, 59). These social spaces are of transitory, shifting and plural character and display varying degrees of engagement and exchange with Islam, (Western) modernity, and globalization (Loimeier and Seesemann 2006b, 1). The multifaceted character of contemporary Swahili worlds has been documented for nearly every sphere of

[26] In line with Csordas, I understand embodiment through the relation of experience and the body, whereby the latter constitutes an "existential ground of culture and self" (Csordas 1994, 1990).

life (among others: Caplan and Topan 2004; Loimeier and Seesemann 2006a), including for health and healing (Bruchhausen 2006; Larsen 2008; Obrist 2006). The literature has thus praised the transculturality of people in Zanzibar but has not paid much attention to the question of how city dwellers in practice actually relate to these cosmopolitan and transnational processes. It was also neglected to differentiate these relations in terms of diversity in intensity and kinds of participation in transnational and cosmopolitan social spaces. Accordingly, I analyze how older people are involved in the creation and maintenance of such spaces and what this means for their elderhood, health and care.

3.1. Historically based transnationalism and cosmopolitanism

The cosmopolitan cultural heritage resulting from Zanzibar's history provides a rich variety of alternatives and a plurality in most areas of life, including such diverse domains as medicine and healing, law, cuisine, architecture, language or trade (Middleton 1992; Swartz 1991, 27-40). In the following I provide a snapshot of the diverse influences from all over the globe in Zanzibar.

Founded by Arab migrants in around the eight century, and in close exchange with Persian, Indonesian, Malaysian, Indian and Chinese merchants, as well as with Portuguese and British colonial powers, the urban Swahili communities developed a rich culture drawing on Arab, African and Asian traditions (Mazrui and Shariff 1994; Caplan and Topan 2004). In the seventeenth century Arabs were not united in Zanzibar and thus, shortly after a visit by Vasco de Gama in 1498, Zanzibar became part of the Portuguese empire for almost 200 years. Portuguese used the island as a trading base for their colonial empire in Mozambique. During the 16th century Portuguese ruled with the support of Arab sultans in Zanzibar. 1698 Zanzibar fell under the control of the Sultanate of Oman after Sultan Saif ibn Sultan defeated the Portuguese in Mombasa. During the height of Arab influence, and with this of the ivory, clove and slave trades, from the early 19th century until 1890 Said bin Sultan moved his capital from Muscat, Oman to Stonetown, today's historic center of the city of Zanzibar. From 1890 to 1963 Zanzibar became a British protectorate until it gained independence and one month later in 1964 in the so called Zanzibar revolution and the related killing and expulsion of Arabs and other "non-Africans" and the merging of Zanzibar and Tanganyika into Tanzania (Middleton 2004; Myers 2000, 433). Later on, especially transnational cooperation between Zanzibar (or Tanzania as a whole country) and other communist nations shaped the contexts in which the research participants made their lives. Today, besides the tourist industry, international trade is common especially between Zanzibar and the Arabian Peninsula. Besides these developments, China is one of the major investors in Zanzibar.

Having the history of the island in mind we can thus understand that Zanzibar was attracting people from diverse empires and world regions for centuries and that many people from Zanzibar also travelled abroad be it as merchants, displaced persons or for education. In other words; Zanzibar is historically grown as a place of mobility, mixture and cosmopolitanism. According to Saleh (2004), Zanzibar developed into an important melting pot, where migrants from the Arabian peninsula, the Persian Gulf

and Indian sub-continent, as well as people from other parts of the globe, were integrated into society (Saleh 2004, 146). Many authors' voices can be heard in Larsen's statement about Zanzibar: *"*Living within a cosmopolitan and socially stratified society, people have an awareness of different ways of life" (Larsen 2004, 123). When I speak of cosmopolitanism, I am relying on Fair's (2004, 13) definition, which describes the concept as "a discursive and performative practice" that reflects "a sophisticated appreciation for international mixing and appropriation of cultural styles and symbols from multiple, geographically dispersed sites". Writing about such cultural elements, I like Coe's definition of culture as "a tool kit", which "emphasizes the flexibility of culture while maintaining that it organizes people's actions and possibilities" (Coe 2014, 14). Especially, thinking of cosmopolitanism, this definition helps to focus on the flexible and adaptable character of culture, as well as it keeps people as agents who can guide their actions. Besides this cosmopolitanism of which we do not know enough about how older people relate to it and how this shapes aging and caring, we also do not know much about the lived experience of the widespread contemporary transnational relations between older people and their social network in relation to aging and caring.

According to the national census 2012 (URT National Bureau of Statistics 2014, 2018) there are twice as many urban households with a "diaspora" component in urban areas of Zanzibar compared to urban areas of the Tanzania mainland. Even though for example a huge number of literature exists on the historical relatedness of the two places Zanzibar and Oman, on shared trade, culture and religion, rarely the complex relationships, the lived experience and moral worlds (Kleinman 1992, 128-30) of these relationships have been examined (Verne and Müller-Mahn 2013, 77). Aiming to contribute to fill-in this gap, I thus looked at these aspects from the perspective of the older people in Zanzibar and their relatives abroad. In my case, thirty-seven out of fifty of the research participants have relatives who stay abroad. They are spread over the whole world, with a majority staying in Oman. Some of the research participants are not having any family members or acquaintances living outside of Tanzania or even Zanzibar. Others have ancestors from the Comoros, India or Oman and still cultivate relations to (extended) kin in these places. Only a few of the older, especially male research participants, also spent time abroad; usually for studies or work (including as football players and actors) or due to business travels. Especially, stays in communist or socialist countries like the Union of Soviet Socialist Republics, Cuba or China were supported by the Tanzanian government and the respective states. Other, better situated older people sent their children to study, find work or marry in the USA, UK or in other parts of Europe, where many settled permanently. Nowadays and because Western countries increasingly restricted immigration, more and more young people travel to the east to obtain their educational degrees from institutions in Indonesia, India, China or Turkey or to find jobs in the United Arab Emirates or in Oman. Not to forget are all those families, which trade and especially import goods from Dubai, India and China. Further changes brought the opening of Zanzibar towards overseas at the end of the 1980s, as well as the rapid developments of the media, means of communication and travel, especially to the Arabian Peninsula (Oman and the UAE), the UK and the USA. I thus could have

followed connections from Zanzibar to many places in the world but I decided to trace the transnational relations to Oman, as they are historically deeply grounded and especially often mentioned by Zanzibari.

3.2. Grasping transnational aging and caring

Recent research in anthropology has shown a newly emerging interest in aging and transnational care (Baldassar and Merla 2014c). Transnationalism has been defined "as a social process whereby migrants operate in social fields that transgress geographic, political and cultural borders" (Schiller, Basch, and Blanc-Szanton 1992, ix). Transnational aging and caregiving are more and more recognized as important intersections between aging and migration (Palmberger and Hromadžić 2018; Ammann and van Holten 2013; Baldassar, Baldock, and Wilding 2007b). While a number of studies are concerned with transnational care provided for children within global care chains (Skornia 2014; Hochschild 2001; Lutz 2018), only few studies looked at aging in connection to transnational care provision so far (among them, Dossa and Coe 2017b; Mazzucato 2008b; Lamb 2009; Torres and Karl 2016). The literature in this area of research focuses mostly on migration to the north (Europe or USA) and neglects other areas. Predominantly, the research is about the caregivers in the global north or immigrants who become old in the countries they migrated to. With this book, I aim at contributing to this literature adding a perspective of the global south and insights from direct links of older Zanzibari, their family members in Zanzibar and their relatives abroad.

A similar approach was applied in a study on elderly care among migrants from Ghana in the Netherlands, which placed equal emphasis on the institutions and contexts of both home and destination countries in order to understand, how care of older people is organized, what objectives migrants had with respect to care giving and the means they used to reach these objectives (Mazzucato 2008a, 94). New trends surrounding aging and family have been documented in India and its diasporas (Lamb 2009). Older persons live and shape new forms of aging as they face – both embracing and critiquing – processes of "modern", "Western", and "global" living, such as elder residences in Kolkata and transnational living of Indian American families in the United States (Lamb 2009, 419). The cultural dimension of globalization in the form of flows of people, ideas and resources (Appadurai 2003) encompasses changes in the local representations and everyday practice of aging, opening up transnational spaces (Pries 2010). These studies have shown that meanings of physical aging vary across societies and change over time, also influenced by transnational dynamics. Profound transformations have challenged the lived experience and cultural constructions of aging and health as well as the family as a key site of aging and elder care across the globe, and globalization continues to accelerate these transformations.

Compared to a *translocal* approach to analyze long-distance caregiving, a *transnational* perspective urges us to include the dimension of national borders and other interests of nation states. Verne and

Müller-Mahn suggested viewing Zanzibar as "translocality" and therefore to understand its "continuous (re)construction through the movements of people, material objects and ideas" through it (Verne and Müller-Mahn 2013, 77). Through this lens, they understand the links between the island and other places as a product of diverse forms of connections and relations. Rarely the complex relationships and connections themselves are examined. Verne and Müller-Mahn explored in this sense the multiple relations between Zanzibar and its diaspora on the Arabian Peninsula by focusing on contemporary "translocal" trading connections (Verne and Müller-Mahn 2013, 77), whereby they focused primarily on the perspective of the Zanzibari Omani living in Oman. By concentrating on older people in Zanzibar and relatives in Muscat, I want to foster another kind of relationships and connections, the transnational practices of long-distance caregiving and aging experiences related to transnational caregiving. Being aware of a potential methodological nationalism (Wimmer and Glick Schiller 2002), I decided, in contrast to Verne and Müller-Mahn, to bring the nation state back into the analysis.

While the concept of cosmopolitanism allows an openness towards any kind of mixing of diverse cultural elements and goes beyond a thinking of nation states as structural context (Beck and Sznaider 2010), the concept of transnationalism brings nation states thus back into focus. I found the combination of these two approaches analytically helpful, to describe to what kind of cultural, social and political contexts older people and their social network are relating to. To better grasp these dynamics, I thus argue to apply not only a situational but also a spatial approach in the analysis and I pose the following questions: How do older people in Zanzibar relate to local, transnational and cosmopolitan spaces and what does it mean for them to be included in or excluded from such spaces?

3.3. Spaces of elderhood: aging and caring between places

Spaces are always tightly interwoven with places, as locations full of meaning that constitute sites of everyday practice (Cresswell 2009, 177). I thus want first to clarify what I mean by places, which are constituent of local worlds (Kleinman and Kleinman 1991) of aging and caregiving. Obrist showed that place should be an important aspect in the analysis of old-age care, pointing especially to "home" as a key site (Obrist 2018). I understand place in the sense of Cresswell, as "[…] a meaningful site that combines location, locale, and sense of place" (Cresswell 2009, 169). Cresswell defines the element *location* as an "absolute point in space", which has a certain distance from other locations and defines where a place is. To think with the concept of location can thus be interesting when thinking for example how far older people live away from relatives or health facilities. *Locale* includes the material setting for social relations as the "[…] buildings, streets, parks, and other visible and tangible aspects of a place" (Cresswell 2009, 169). For older people for example it can be important whether an area has paved roads or if they are not passable by foot during rainy season, or if their house is surrounded by a big wall or if they can just sit in front of their house and chat with passersby. Being able to host visitors at one's place allows to exchange and engage extensively with relatives from abroad and not only to see them during

a short visit as for other older people, at who's places relatives did not want to stay. As a *sense of place* Cresswell understands the individual or shared "meanings associated with a place: the feelings and emotions a place evokes" (Cresswell 2009, 169). This aspect turned out to be important for some of the older research participants as well as relatives who moved out of Tanzania who had strong emotions and especially often nostalgic feelings in relation to the place they grew-up or their parents lived at. Relatives abroad for example raved about the fresh fruits in Zanzibar, the healthier life of moving around and chatting in their own language, about the pleasant climate, the family members and friends and memories they had there.

Caring or aging can be understood as processes of producing space. Having the concept of place in mind, I understand *space* in contrast to place as how people interact with and relate to people, commodities and ideas *between* diverse places. Space in this sense is a social product based on values, social production of meanings, which affects spatial practices and perceptions (Lefebvre 1974 [1996]). This production of social space happens in the city as well as beyond it; even over national borders. I understand space as the product of iterations between social practices and place and thus in a sense of *doing space* (Herzig and Thieme 2007, 1079). According to Massey (1999, 283) space is always a "product of relations, relations which are active practices, material and embedded, practices which have to be carried out, space is always in a process of becoming. It is always being made". Space in this sense is a social product, which provides both the condition for and the symbolic representation of different types of social interaction (Levine 1979, 21). Additionally, in the production of social space identities are articulated, shaped and remade (Keshodkar 2013, 7) through lived experience of everyday practices (Certeau 2002 [1988]).

While Lefebvre famously focused on materiality of space (Lefebvre 1974 [1996]), Bourdieu emphasized more the connection of physical and social space. More so than Bourdieu's concept of field, social space in his understanding expresses articulations between physical space, embodied habitus, and sociality. Also Emirbayer and Mische (1998, 970), who developed a theoretical perspective on agency in revolutions and collective action, described cultural, social-structural and social-psychological contextual fields to which they understand people relating while they orient themselves to temporal experiences and imaginations. Social space though, is a broader concept than field and it is only by understanding how the habitus is generated through its position in social space that one can grasp how it operates in and constitutes a field (Bourdieu 1998, 32). I thus aim at combining interactions with the place and wider context they happen in as being part of the structural environments guiding human agency.

A frequently used but hardly defined notion, which might come to mind when I write of social spaces of aging and caring are elderscapes (Danely 2015; Sokolovsky 2009, 371-5).[27] Sokolovsky's famous edited volume "the Cultural Context of Aging" leaves us with the definition of one of the contributors (Stephan Katz) who writes of elderscapes as "places with high proportion of elderly" (Sokolovsky 2009, xxiv). The Cambridge dictionary defines scapes as "referring to a wide view of a place, often one represented in a picture".[28] However, instead of elderscapes I argue to better think with social spaces as this helps to grasp the topics' relationality and dynamic processes. In other words, what I mean by social spaces of aging and caring goes beyond aspects of quantity of older people involved. While I think it is important to analyze specific situations, the concepts of space allows to include in the analysis historical, political and economic processes over time to which people relate.

Especially in research on transnationalism, it is not new to use fields or spaces as analytical lenses to study phenomenon that span over two or several nations (Levitt and Schiller 2004, 149; Pries 2010). Social spaces, however, can also be created on the micro level while at the same time span across several nations (transnational life worlds of families), or they can be built on the macro level but with limited geographic boundaries (for example national health systems). Levitt and Schiller who worked with the concept of transnational social fields, defined social field following Schiller, Basch, and Blanc-Szanton (1995) as "a set of multiple interlocking networks of social relationships through which ideas, practices, and resources are unequally exchanged, organized, and transformed" (…) "they are multidimensional, encompassing structured interactions of differing forms, depth, and breadth that are differentiated in social theory by the terms organization, institution, and social movement" (Levitt and Schiller 2004, 1009). As I have outlined above I prefer to work with a spatial approach, instead of field approach but I still want to include transnational relations. Such an approach allows me to investigate with whom older persons engage in social spaces when they formulate their health concerns or do something about these concerns. Paraphrasing Whyte (2012, 63) we can consider health concerns and practices of older persons within social fields of possibilities and constraints shaped by policies, health care systems and life conditions. Transnational families who live in different nations but organize the care of a parent through regular and intensive interactions using new communication and transport technologies create other social spaces. International NGOs but also local self-help groups create further social spaces of relevance to aging and health.

Having been confronted with the diverse lifeworlds of older people in the cosmopolitan city of Zanzibar I wanted to better understand what it then means for older people to be in diverse intensities included in or excluded from typical spaces I made out from the many observations, participation and conversations

[27] For example as in the open-access interactive documentary, of Roberta Mandoki, Annika Mayer and Jakob Gross, 2016: *Elderscapes. Ageing in Urban South Asia*: www.uni-heidelberg.de/elderscapes.
[28] Webpage of Cambridge Dictionary https://dictionary.cambridge.org/de/worterbuch/englisch/scape.

I had in Zanzibar and Oman. Even though a considerable number of urban older people in Zanzibar have relatives or acquaintances abroad this did not mean that first, everybody had a transnational network, and second, that the older people could automatically draw on care or support from them at all times. I found it useful to think with three spaces of aging and caring as an analytical lens to grasp the unequal social engagements of older people, bearing in mind their situational, transitory, shifting, and plural character of such spaces: first, in a localized; second, a cosmopolitan and third, in a transnational space of aging and caring. I briefly introduce the three spaces below, which will come up in all chapters. It is important to understand that the engagements in these spaces vary, and that in some situations older people can engage in certain spaces, while in other situations they may access other spaces.

If older urban residents engage in what I understand by *localized space of aging and caring*, their agency is limited to a narrow local field in their social and spatial surroundings. By this I mean that they do not have relatives abroad or are not in contact with them. In this specific urban space, access to what I call cosmopolitan living—the willingness and possibility to engage with cultural "others"—is hardly possible (Skrbis, Kendall, and Woodward 2004). Older people who can only engage in this space mostly do not have the means to maintain relationships with relatives who live elsewhere since many of these older people and their families live in socio-economically poor places where, for example, access to means of communication and transportation are limited. In a localized space of aging and caring, older people are often not able to overcome major health crises or live with untreated chronic conditions.

A second space of aging and caring points to a cosmopolitan orientation of some older people. I understand their cosmopolitanism as "a discursive and performative practice" that reflects "a sophisticated appreciation for international mixing and appropriation of cultural styles and symbols from multiple, geographically dispersed sites" (Fair 2004, 13). Cosmopolitanism even becomes a lifestyle and moral position (Kleinman 2012). Levitt and Schiller (2004, 1008) argue that the literature on cosmopolitanism neglects exploring social relations and positioning, and focuses on the intersection of the individual and the global. Thinking with this space thus, it is necessary to bring the contexts, structures, and practices of cosmopolitanism together. Most older people who are at times involved in such a cosmopolitan space of aging and caring have worked or studied abroad, live in social environments with transnational ties or have ancestors from other areas of the world. They thus orient their practices towards many different cultural spaces at once. Usually they are having a higher education and are financially capable of translating their ideas into practice.

The third space, to which older Tanzanians relate to, is a transnational space of aging and caring. Some people are only occasionally involved in this space. For example, some have acquaintances or relatives outside the country (*mtu au jamaa nje ya nchi*), but they are only sporadically in contact with them. They typically receive visitors from abroad for a short time, and they call each other on important

holidays, such as Eid al Fitr. They usually can expect help from relatives abroad in case of an emergency like a health crisis. Others have one or several relatives or acquaintances abroad and exchange a lot of care in a broad sense. It is a more or less mutual exchange, because the older people also provide their relatives abroad with small gifts, recommendations and so on. They may communicate with relatives abroad on a daily, weekly or monthly basis, receive regular remittances, and visit each other. Some older people can go abroad for medical treatments, exchange gifts, and receive medicaments and medical tools. Relatives abroad often support the older person through their networks in and outside of Zanzibar.

To analyze aging and caring in a specific place, such a spatial approach fits not only well in combination with a thinking in situations but it also complements the concept of agency I have introduced earlier. Human agency itself allows us thus, a thinking combined with spaces to go beyond cultural, socio-cultural and a socio-psychological contexts of action Emirbayer and Goodwin (1996, 371) and helps not to forget diverse other contextual aspects, including physical space.

4. Studying Aging, Health and Care in the City of Zanzibar

To find answers to the broad questions I have introduced at the very beginning of this introduction I conducted ethnographic research, which was especially suitable for the constructivist perspective I wanted to use to better understand discourse and practice around elderhood, health and care. According to Levitt and Schiller ethnography is also the best method to study the phenomenon of the "creation and durability of transnational social fields" (Levitt and Schiller 2004, 1013). Participant observation and ethnographic interviewing allow researchers "to document how persons simultaneously maintain and shed cultural repertoires and identities, interact within a location and across its boundaries, and act in ways that are in concert with or contradict their values over time. The effects of strong and weak indirect ties within a transnational social field can be observed, and those connections, whether they take the form of institutional or individual actors, can be studied" (Levitt and Schiller 2004, 1013). Additionally, I was inspired by Charmaz's (2006, 2014) interpretation of Grounded Theory (GT), which Glaser and Strauss (2010) developed in the 1960s. I did thus not work directly with Grounded Theory design but used it as "logics-in use" (Carter and Little 2007, 1324) allowing a certain flexibility in modifying and combining different methodologies in a hopefully meaningful way. In this regard, Atkinson (2015) voiced the relations between the two approaches:

> In point of fact, it [GT] describes what any sensible researcher would do, and Glaser and Strauss [founders of GT] transformed good practice into a normative framework. In keeping with their pragmatist inspiration, they stressed a cyclical relationship between ideas and data, in a way that introduced a sensible role for experience and craft knowledge in the logic of scientific discovery. The logic – as has been noted repeatedly – is essentially *abductive*. That is, on the basis of observation (in the most general sense), one draws out *possible* analytic ideas that speculatively answer the question: What might this be a case of? One considers what general pattern or configuration might give rise to the observed phenomena. That

> tentative identification then provides what Herbert Blumer (1954) called a 'sensitizing concept' that can inform further data collection. Hence sensitizing concepts are used in dialogue with data, in order to generate further elaborations of the guiding ideas, refinements or modifications to them. This mode of reasoning is so central and so pervasive to the tradition that I call it *ethnographic abduction*, recognizing that there are multiple levels of social institutions and processes that call for such inference (Atkinson 2015, 56-7).

I thus repeatedly, through a long iterative process went back and forth between literature review, data collection, analysis and writing. As it is typical for ethnographic research but again also in line with GT, I aimed at being sensitive to local understandings of the phenomena I studied. I tried to approach the field not with predefined concepts of what elderhood entailed but used sensitizing concepts like "elderhood", "aging", "care" or "caregiving", as they are common in grounded theory approaches instead. In the sense of Charmaz (2006, 16) I used these broad research interests or sets of general concepts to have ideas of how to ask particular kinds of questions about the phenomenon and worked with these sensitizing concepts as "points of departure" which I shaped during the research process (Charmaz 2006, 17).

I briefly describe here the research process but I will go more into detail throughout the chapters, where I provide concrete examples of methodological challenges. While conducting an intensive Swahili course in Zanzibar staying in a host family, in whose extended family I stayed up to the end of the research, I recruited and trained Saada Omar Wahab and Saleh Mohammed Saleh, both historians and at that time junior lecturers at the State University of Zanzibar SUZA as research assistants to jointly conduct the ethnographic fieldwork in Zanzibar. Together we prepared the data collection and chose with the help of one of their colleagues, a geographer, four heterogeneous *shehia* (areas) in the city of Zanzibar. Through transsect walks[29] we recruited fifty research participants (twenty-five men and twenty-five women) above sixty years of age in the four urban shehia.

The data collection has been divided into six phases to allow a long-term perspective of how aging, health and care is experienced over a period of three years.[30] At the beginning the AAH team was developing the first interview guidelines together to allow a continuation and "testing" the previous

[29] Within the AAH project team, we decided to use a random and convenient sample strategies when selecting the older study participants in the four shehia. By applying transsect walks together with my local research team, I sampled our study participants aged sixty years and above in their private households. By starting at the geographical center of the shehia, which was defined by the *sheha* (leader of the area) we always followed three streets leaving from this center, in three different directions. When walking down the streets we identified every tenth house at the right side. With the support of the local authority we then found out, if an older person was staying in the house. If there was no person above the age of sixty living in the appointed house, the next house in line neighboring the identified house was chosen. If more than one older person was staying in the appointed house, we decided on the study participant's gender in order to have the same number of men and women included.

[30] The formal interview and observation guides can all be found in the Appendix.

research project's findings. Later in the research I developed together with Kaiser-Grolimund, my colleague and second PhD student in the AAH project, the research tools and we constantly compared the findings of the field researches in Zanzibar and Dar es Salaam, which helped tremendously to challenge our findings and reflections (Staudacher and Kaiser-Grolimund 2020; Kaiser-Grolimund and Staudacher 2015, 2013). In the first six months of fieldwork (field research phase I), the research assistants and I visited all selected fifty older research participants in Zanzibar at least three times. Through guided interviews with demographic and open-ended questions, informal talks, and observations, we gathered an enormous quantity of information on their health, aging process, and care arrangements. At the same time, to become a better idea of the context of elderhood in Tanzania, I mapped and visited together with the AAH team various non-for-profit and governmental organizations supporting older people in Zanzibar and Dar es Salaam.

While analyzing the first interviews and observations, I identified many transnational links, which produced new insights into the lived experiences of aging and health and into associated care arrangements. The fact that many of the research participants in Zanzibar have children or other relatives living abroad, let me choose thirteen older research participants with transnational relations (theoretical sample) to follow up in more detail, what these links meant for the research participants' elderhood, health and care (field research phase II). While in Kikwajuni all research participants had relatives abroad, none of the research participants in Chumbuni mentioned to be in contact with a close relative or acquaintance in another country. I chose those older people who had relatives in Oman, as these relations were most common. I thus, on one side continued to visit all fifty research participants sporadically but at least twice to follow up on their health and care situations on the other side, I specifically focused on those with transnational relations, with whom I spent more time. Besides doing thematic interviews with them, the research assistants and I spent a lot of time joining the research participants in whatever activity they were doing, like cooking, walking to nearby places, sitting around, and going to the mosques or the farms. Additionally, we developed ideas of broad areas we did not want to miss in our observation and participation, like aspects related to health, food, daily activities, infrastructure, interactions etcetera. Moreover, of those thirteen people, we interviewed the two relatives whom the seniors mentioned to be the most important caregivers to add a piece of understanding aging, health and caregiving from a more holistic perspective. As it became obvious that biographical aspects played a huge role in how older people practiced and experienced aging, health and care, I decided to ask eight of the research participants I found to have a particular personal history and were talkative enough to do an unstructured biographic interview together. All of them agreed to tell me about their lives in conversations which sometimes lasted more than three hours. This allowed me not only to better understand their present situation but it also enabled insights into how care relations developed over a long time and were much more reciprocal over the life course then they seemed to be once people were ill or frail. The biographic interviews provided thus excellent data to analyze the three temporal

orientations (past, present and future) of agency according to Emirbayer and Mische (1998) During the time I was not in Zanzibar, the research assistants called the older research participants monthly to follow up on their health and care situation.

I used the following field research phase (III) to discuss my observations and intermediate analysis with the smaller group of research participants having transnational relations in comprehensive semi-structured interview and continued the informal visits and talks with all research participants. I also prepared during this phase the field research phase in Oman (IV) where I travelled together with the research assistant Saleh directly from Zanzibar to Muscat to spend two months with relatives of the older research participants. In Muscat, I conducted over twenty interviews with relatives of older Zanzibari together with Nujayda a third-generation Omani-Zanzibari, whose grandmother returned from Zanzibar to Oman and Saleh, who has cousins and uncles living in Muscat. The aim was to obtain insights into the transnational social spaces to which some older Zanzibari can relate to. Like in Zanzibar I have learned many things about the relations between Zanzibar and Oman not only through conducting interviews and observations but in having had the chance to staying in the relatives' houses as their guest. Directly after the stay in Muscat, I again, returned to Zanzibar (field research phase V) to meet with the older people, bringing gifts from their relatives in Oman, show them pictures of the visit and ask more specific questions about these transnational relations. Especially after the research phase in Oman I got the feeling that through the widespread use of mobile devices field research became borderless. The communication between the research participants in Oman and myself and thus the flow of data did not stop at the time when I left Muscat and went back to Zanzibar but continued transnationally even when I returned to Switzerland, in some cases until to date (Staudacher and Kaiser-Grolimund 2016). After this, especially during the last field research phase (VI), I challenged my preliminary findings with each older research participant personally. Additionally, the AAH team together with the research assistants discussed the findings with Tanzanian academics as well as state and NGO representatives during dissemination workshops at the State University of Zanzibar and the University of Dar es Salaam. Listening to their opinions and comments concerning the findings was a very fruitful process.

Through all the field research phases my major aim was not to follow a strict procedure but to be flexible enough to follow in whatever the older research participants and their social network wanted to show and tell me of their lives. I believe that this openness and readiness of my research assistants and myself to also endure phases of boredom or to listen to stories, which did not relate directly to my research topics were key to being invited or at least tolerated in their private spheres in their homes and therefore created trust to talk about intimate issues related to aging, health and care. Especially as a relatively young, European and non-Muslim woman, this was not self-evident. While I found it easy to establish pleasant and trustful situations of exchange with older women and female relatives, whom I usually

visited with Saada, it took me a long time with some men to feel at ease to talk. A few men dropped out, relatively early during the research, arguing that they had too much to do with their own affairs. While both research assistants did an excellent job in interacting with the research participants, I could not have conducted the interviews with the older men without Saleh. With those men, I felt they had difficulties talking directly to me, I made myself as "invisible" as I could, by just silently sitting next to Saleh and listening to their conversation. Towards the end of the research, I felt, the interactions became much more open with all the men.

As I have adumbrated, I conducted most of the visits and interviews together with the research assistants to be able to communicate in appropriate ways in Swahili, to learn from them about life, norms and everything else in Zanzibar but also to discuss and analyze the data together. I reflected in detail about the crucial cooperation with the research assistants elsewhere (Kaiser-Grolimund, Ammann, and Staudacher 2016). The research assistants also transcribed all interviews in Swahili and translated them into English. After this, I worked with the qualitative data analysis software MAXQDA. Using theoretical as well as emic categories (Charmaz 2006), I coded over 200 audio-recorded interviews between and after the field research phases. Using for example the categories of the previous research project within our research group "nina nguvu", "sina nguvu", "nina nguvu baadhi ya wakati" (Gerold 2017; Simon 2015; Eeuwijk and Obrist 2016), this helped me to better understand the health situations. Nevertheless, I also realized that these codes did not fit to persons but only to situations. Having data about the trajectories of the research participants from over three years, I found almost all older people in several health conditions and I realized how these changes in the health situation influenced the organization of the caregiving. I thus, started to analyze specific health situations together with the caregiving in that particular situation and found this approach most enriching. Applying such an analytic lens of situations, corresponded for example with what I already sensed in the field concerning different gendered experiences of aging. I did not apply a strict coding regime but used the coding to find commonalities and differences and to roughly cluster around sensitizing concepts like "masculinity" to develop them continuously inductively out of the research data. Like this, new codes came up as for example "Ninajiweza" – "I can do it myself", which helped me to specify a grounded aspect of masculinity.

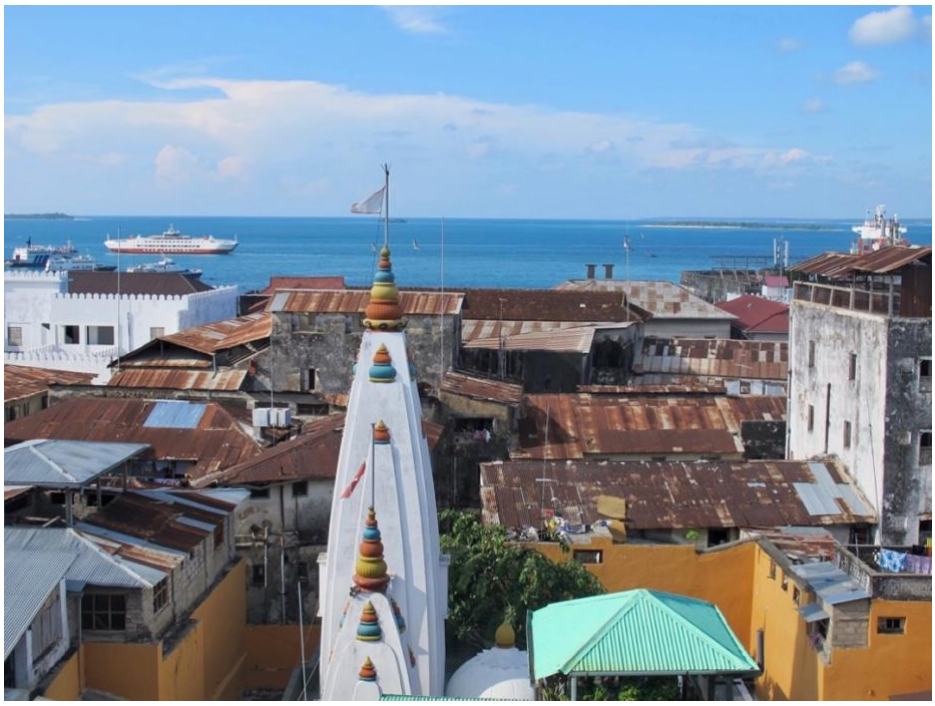
5. Overview of the book

To reflect the aforementioned research focus and the related questions, I organized this book in five ethnographic chapters, which are framed by this introduction *(chapter one)* and concluding reflection *(chapter seven)*. After providing theoretical reflections on how urban aging can be a fruitful lens to grasp how places and (social) spaces are created in the city, *chapter two* also situates elderhood in the four unequal urban areas in cosmopolitan Zanzibar and allows glimpses into local worlds of older people in these neighborhoods. *Chapter three* carves out typical aspects of situations in which older people are relatively healthy and self-reliant. It is followed by *chapter four*, in which I focus on situations of sudden

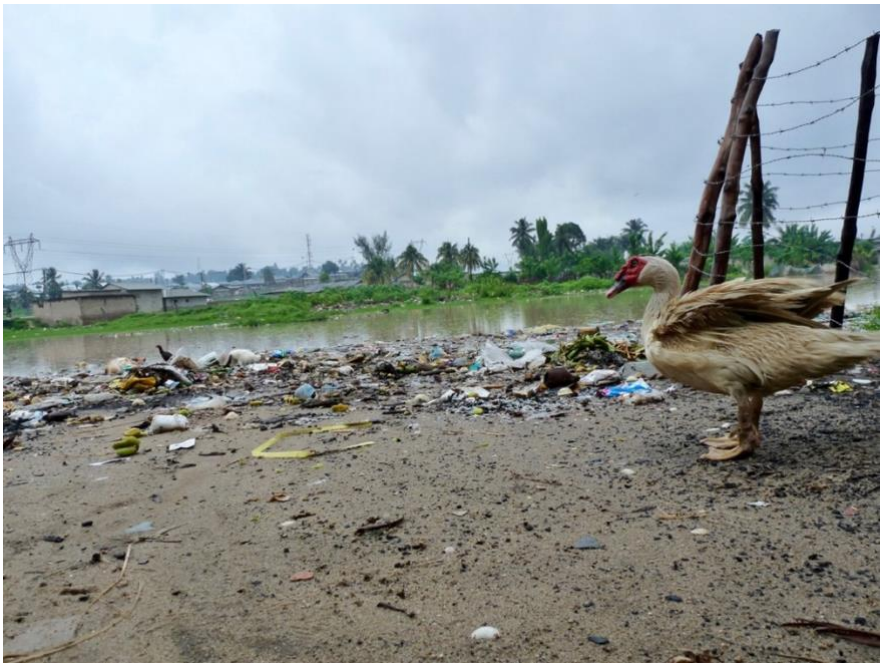
changes and health crisis. In *chapter five* I describe situations in which older people have become used to ups and downs of chronic conditions and how they shift between accepting and resisting these. *Chapter six* then outlines the entangled histories and relatedness of Zanzibar and Oman and illustrates how these provide a basis for the lived experiences of older Zanzibari and their relatives in Oman in relation to aging, health and transnational caregiving.

Chapter II:

Situating Elderhood in Cosmopolitan Zanzibar Town



Picture 2. Stonetown with view on the Shiv Shakti Hindu Temple (middle), Beit-el-Sahel (top left side) and the Indian Ocean.



Picture 3. Chumbuni during rainy season, when the football field turns into a lake mixed with waste.

II. Situating Elderhood in Cosmopolitan Zanzibar Town

1. Grasping Urban Aging and the City

The widespread disregard of older people in urban research and policy is surprising since they constitute a growing proportion of the urban population and can be encountered in all kinds of neighborhoods across cities, as we will see in the main part of this chapter. Both research on cities and the governance of cities primarily concentrate on their centers, whether they are spatial, social, political, or economic. In which (physical) places and (social) spaces in cities older people live and how they experience their life, their aging and their health is rarely looked at. In this chapter, I aim at presenting local worlds and everyday life, the contextual living environments, places and social spaces in which older Zanzibari are living in and are confronted with. Emanating from the presentation of the local worlds, everyday life and the living environments of four older persons living in different area (*shehia)* of the city of Zanzibar, I want to show the entanglement of places and spaces in which older people live, as well as their identification with and agency in this specific place. Through this, I am to situate elderhood all over the city when talking about different health situations in the next chapters. I will provide an overview of the four researched areas to show the diversity of places in which urban Zanzibari grow old and the consequences this can have for the inhabitants of the specific *shehia*.

In an environment like the city of Zanzibar where state institutions have a weak position and thus pension schemes and health insurances are not widespread, older people need to find other ways to cope with aging and receiving care. Private institutions or NGOs may fill gaps but mostly families and other social networks support older people. I argue that the place where a person is becoming old plays an important role, as it often has an impact on the accessibility of state services like hospitals and the availability of water, electricity, public transport, good streets and possibilities to continue working. Besides these aspects, social relations in the neighborhoods and the attractiveness of the place can influence if an older person can keep in contact with acquaintances living abroad, get access to a cosmopolitan lifestyle and can count on support in difficult situations. This chapter shows how some people can more easily profit from state and private services than others, as well as get access to resources from transnational networks. Among other aspects this depends on the place they are staying at.

1.1. Approaching Zanzibar town from its margins

Many of the older inhabitants in Zanzibar experience frailty, serious health problems, or even disablement. They often cannot work or make a living. The experience of such situations can push them towards the social margins and make them dependent on their social environment. The WHO report on *Global Age-Friendly Cities* (2007) analyses several aspects of urban living that can exclude older people from fully participating in a city. Examples include outdoor spaces and buildings; transportation;

housing; social participation; respect and social inclusion; civic participation and employment; communication and information; and community support and health services. To look at the city from the perspective of older people means understanding the city in a way that a possibly marginalized group of society experiences it. This approach hints at how typical characteristics of cities like infrastructure, mobility, or diversity are preconditions or the context of the city. The crucial point, though I argue, is investigating what the older inhabitants of Zanzibar actually do within this context: How do they make their way as actors through the places and spaces in and beyond the city? How do older city dwellers make use of the city's inherent possibilities and connectivity, and respond to and change structural aspects of the city through their everyday practices? How are their experiences of aging, health and care arrangements related to specific urban, local worlds or physical and bodily aspects? Answering these questions, we can see that urban seniors are also an important social group for studying how cities are experienced and constituted from their margins. This chapter shows that some older inhabitants are able to use their agency to create, what I call spaces of aging and caring not only in the city but also across national and continental borders. As the ethnographic examples will illustrate, other older inhabitants, though, are more bound to local places within the city or do not even go beyond the confines of the house they live in.

1.2. At the center: The right to the city and creativity in the city

Currently, we can observe two prevalent discourses on the urban in social anthropology, namely what can be called a right-to-the-city discourse and a creativity-in-the-city discourse.[31] The first sheds light on the impeded access to urban citizenship and problematizes inequalities and processes of inclusion and exclusion. Authors following this strand, point to the unequal distribution of resources, the limited access to urban infrastructure, the reduced participation in the urban economy, and the lack of social and political recognition for people on the urban margins (Lefebvre 1974 [1996]; Harvey 2012; Caldeira 2000). They describe African cities as places of informality, criminality, insecurity, and poverty (Myers 2011; Koechlin 2015, 16). In this line of research, authors often implicitly understand the center of a city as the point of reference for what a city is or should be. Most of the policy-oriented publications of international organizations and NGOs can be assigned to this perspective, especially when they focus on what some have called the "hard city" (Raban 1974), which refers to its material and physical aspects such as infrastructure and to its mobility networks such as means of communication and transportation (Freudendal-Pedersen and Cuzzocrea 2015, 4).[32]

[31] This analysis was developed together with Barbara Heer, Andrea Grolimund, and Carole Ammann in preparing two panels at the 2016 EASA conference in Milan, Italy.

[32] A refreshing counter example of this trend is Sion Eryl Jones's blog post of the NGO HelpAge International with the topic '10 ways Habitat III can protect and promote our rights in older age' .

The second discourse, which is more oriented towards the meanings, imaginations, and myths that constitute the "soft city" (Raban 1974), can be called the creativity-in-the-city discourse. It conceives the city as an enabling place. Authors following this strand bring the diversity of a city's inhabitants to the forefront and emphasize how the initiative of urban dwellers creates new, creative, and innovative spaces and practices (Obrist 2013; Förster 2013; Nuttall and Mbembe 2004). They have also investigated how networks of people become a city's infrastructure (Simone 2004).

There are thus four major deficiencies in current research that I address in this chapter. With that, I aim to better grasp the lived experience of urban spaces of aging and caring and to contribute to a broader understanding of what cities are. First, there are few studies with an actor-centered approach to cities in general, and to urban aging and older people care in particular (Koechlin 2015; Gerold 2013; Kleinman and Geest 2009b; Kleinman 2012). In the dichotomous discourses on older people care, scholars either argue that the social structures that support older people are falling apart, or they praise "African solidarity," how people help each other out (Makoni and Stroeken 2002). There are thus divergent discourses on cities as either hubs of exclusion, informalization, criminalization, insecurity, and poverty (Koechlin 2015, 16) or as spaces of diversity and creativity in which people connect and are its infrastructure.

This dissertation aims at enhancing the development of a new discourse by looking at the agency (Emirbayer and Mische 1998) of older urban dwellers in the production and contestation of urban spaces in a city in the Global South. On the basis of Emirbayer and Mische (1998), I see agency as a temporally constructed engagement of actors in different structural environments. Through the interplay of habit, imagination, and judgment, "temporal-relational" contexts of action both reproduce and transform structural environments in an interactive response to their current situation by recalling past personal experiences and imagining possible future trajectories (Emirbayer and Mische 1998, 970).

Second, the literature on cities has neglected the analysis of urban margins as central and important parts of cities. Instead, it tends to view the social, economic and spatial margins as undeveloped, deficient parts of the city. I start from the presumption that urban inhabitants living on the margins of a city do not at all represent negligible minorities of the urban whole. Rather, so I argue, those at the city's margins co-constitute the city, or in other words: a city is also defined by its margins. By focusing on the margins in this chapter, I do not seek to reproduce processes of marginalization that create those margins but rather to contest the assumption that the margins are marginal by moving the urban peripheries to the center of academic interest.

A third deficiency in the research is that most studies on cities were conducted in Western metropolitan cities. There is an urgent need to include more cities of the Global South in the theorization of cities and

urban spaces (Robinson 2011, 2006). Since especially small (Bell and Jayne 2006) and mid-sized "secondary" cities are underrepresented in the literature, the city of Zanzibar constitutes a perfect case for enriching our understanding of what cities are and what they mean for older persons. Finally, there is also a lack of research on how transnational processes are connected to aging, health, and care, and how even city dwellers on the urban margins relate to transnational social spaces. Rapid transformations of urban spaces in Africa are not only produced by new actors and social formations, as Koechlin (2015, 16) argues, but also especially through a strengthened connectedness of translocal and transnational relations between people who live a significant distance from one another but may or may not live in the same city or country.

In this book, I focus not only on people's connections and engagements with others but also on how certain people are able to obtain access to unfamiliar ideas and goods coming from abroad – and others not - and to use their agency in the sense of Emirbayer and Mische (1998). This allows them not only to know about certain things but also to change their habits and make creative use of new, alternative, foreign, or re-invented possibilities. I especially focus on how certain older people and their social environments are able and ready to mix ideas and thus draw on a cosmopolitan worldview.

1.3. On the margins: urban aging, health, and (transnational) care

With the concept of urban margins, I mean less the geographical margins of cities but I principally refer to the social, cultural, economic, and political urban margins. Brand and Dávila (2011) look at municipal programs aimed at "upgrading informal settlements while integrating them both physically and socially into the fabric of the city." And the volume edited by Auyero, Bourgois, and Scheper-Hughes (2015) touches on social and economic margins in treating violence at the urban margins. Finally, a large number of studies analyze marginalization in a certain city but they leave open what this means for cities in general.

Even though the number of older people living in cities is constantly growing (WHO 2007), little attention has been paid to aging, the health situation of older people, and older care in cities (Gerold 2013). As the following chapters will show, agency of older persons in the city is intrinsically tied to their health situation. Also, urban places and spaces are accessed differently depending on the health situation. When older people are confronted with health problems, they cannot – or are not supposed to – do the same things they did when they were healthy, like earning an income, taking care of grandchildren, going to the market, or attending festivities. I argue that they can expect to receive certain kinds of care, depending on their health situation, gender, class, and family or other social relations. Based on his research in Indonesia, Van Eeuwijk (2002, 25; 2004, 124) suggests that older people face a "triangle of uncertainty" with social, economic, and health dimensions, and that there is no guarantee

that older people will receive care. I argue that such uncertainties as well as aging per se should be understood as embedded in particular spaces including specific neighborhoods.

Recent research on ageing and transnational care in medical anthropology was rarely connected to the analysis of cities, although such a perspective would allow to see to an increased degree how transnational care is dependent on certain preconditions like where in a city people live. As I have mentioned in the introduction of this book, I use the concept of care in a broad sense, not distinguishing cure from care (Mol 2008) and including its technical/practical and emotional elements as defined by Kleinman and Van der Geest (2009b, 159). I thus understand all activities that make the daily life of older people more bearable – such as washing, feeding, and visiting with someone as well as dressing wounds – as part of older people care which happens at home in the context of a specific neighborhood and for some over long distances to different areas in the city of Zanzibar, Tanzania or other countries.

On the other hand, studies on transnational urbanism have looked at globalization processes and transnational flows in cities, but they rarely touch on the transnational social spaces of ordinary city dwellers. Older people are completely absent in these discourses. Aspects of transnational urbanism have been discussed by, among others, (Guggenheim and Söderström 2010; Söderström, Dupuis, and Leu 2013; McCann and Ward 2011) who investigate the role of decentralized cooperation between cities in the recent strategies of municipal administrations and the "translocal" engagement of experts. Other studies have looked at marginalized groups engaged in urban art and sport projects (Celik 2013; Vierke and Siegert 2013) With the following ethnographic account, I am thus contributing to fill in this research gap.

2. Experiencing Elderhood in Urban Places

2.1. Everyday experiences of elderhood: glimpses into local worlds

In the following I will extensively, in thick description (Geertz 1973), describe four local worlds and the everyday life of older Zanzibari based on the areas. The aim of this approach is to invite the reader to delve into four local worlds and to get a feeling of the diversity of how older people in Zanzibar experience their later life and health conditions. I do this on the basis of Kleinman's concept of local worlds (Kleinman 1992, 128). I understand the *local* worlds as one side of what I call social spaces of aging and caring, which integrate additionally the experiences of translocal, transnational and generally cosmopolitan worlds. Focusing on micro-contexts of experiences in urban neighborhoods where everyday life is enacted and transacted, I wish to analyze particular forms of life compared to other local worlds and thus local ways of being human. Such local worlds can be very fragmented and contested, but they can also constitute the basis of local patterns of "what is most at stake" (Kleinman 1992:129). Kleinman conceptualized experience as a conceptual basis to describe and interpret local worlds of

illness and care. Kleinman and Kleinman *defined experience* as "an intersubjective medium of microcultural and infrapolitical processes in which something is at stake for participants in local worlds. Experience mediates (and transforms) the relationship between context and person, meaning and psychobiology in health and illness and in healing" (Kleinman and Kleinman 1991, 275). Experience can thus be understood as an intersubjective flow moving between and within persons, which is felt in "engagements, transactions, communications, and other social activities" (Kleinman 1992, 128). In order to better understand the local worlds in these diverse urban areas I focus on the everyday practices of the older people in the sense of Michel de Certeau (2002 [1988]), as depending "on a vast ensemble which is difficult to delimit but which we may originally designate as an ensemble of procedures" (Certeau 2002 [1988], 43) and as I argue happen in specific places and spaces, which constitute a structural background of agency.

Phenomenologically, the lifeworld (Schütz and Luckmann 2003; Husserl 1977) of a person, thus the lived world that subjects experience together, is understood by the individuals in its unity. Analytically, social scientists nevertheless try to grasp the structural contexts which guide human agency. Emirbayer and Mischer (Emirbayer and Mische 1998, 970) describe the cultural, social-structural and social-psychological contextual fields to which they understand people relating while they orient themselves to temporal experiences and imaginations (iterational, practical-evaluative, projective orientations) as human agency:

> As we conceive of it, the cultural context encompasses those symbolic patterns, structures, and formations (e.g., cultural discourses, narratives, and idioms) that constrain and enable action by structuring actors' normative commitments and their understandings of their world and their possibilities within it. The social-structural context encompasses those network patterns of social ties (see Emirbayer and Goodwin 1994) that comprise interpersonal, interorganizational, or transnational settings of action. Finally, the social-psychological context encompasses those psychical structures that constrain and enable action by channeling actors' flows and investments of emotional energy, including long-lasting durable structures of attachment and emotional solidarity. These interpenetrating (but analytically autonomous) categories crosscut the key institutional sectors of modern social life: the administrative-bureaucratic state, the capitalist economy, and civil society. (Emirbayer and Sheller 1996)

This understanding of a contextual background, which guides social actors in their agency but also is changed by the actors I argue, is relatively limited and does not include the many facets of the structural environments. Even though Emirbayer and Mischer agree that depending on time and place people may orient themselves differently towards one of their temporal orientations (iterational, practical evaluative and projective elements) (Emirbayer and Mische 1998, 1012) they omit to integrate place or *the physical context* more generally, including houses, built neighborhoods or bodies as a structural contexts of action in their concept. This should not at all be misunderstood as a structuralistic approach in which action

would be determined by these given physical or material aspects or a pure focus on "the hard city," as I described it above. Rather, I want to emphasize that when people act in specific situations based on experiences of past patterns (iterational orientation), judge practically among alternative possibilities (practical-evaluative orientation) and imagine possible future trajectories (projective orientation) they do this not only interactively in the context of certain culturally shaped discourses (cultural context), certain patterns of social relationships (social-structural context) and psychological structures (social-psychological context) but also in relation to how they evaluate the physical context.

To give an example of aging and care in the city of Zanzibar: An ill, bed ridden older woman in an area where no cars can pass through will remember how she went to see a doctor in the past and relate to culturally structured discursive formations like for example that women should not demand too much. She may evaluate her situation according to social-structural elements like who is around, who might actually help her and imagining recovery in the future. But she will also consider the physical context how she experiences her body, how seriously ill does she feel? In what kind of place is she? She will consider that the street is far away and that some people would need to carry her to the main street and hire a car to go to the hospital. According to her experience this needs a big effort but she might also imagine an alternative when considering this physical context. She might ask her neighbor to lend her a wheelchair or ask her son to let a doctor come by or she just decides that she will wait a bit longer to see if her health changes maybe without seeing a doctor. The actions of another woman in the same situation in the house of her child in a different area of the city with better roads and thus a different physical context, could look very differently. In short: According to my observations physical and bodily aspects and especially the environments in which older people lived, played an important role in their agentic orientations in their local worlds as well as generally in social spaces of aging and caring. I will thus consecutively describe the areas Shangani, Kikwajuni Bondeni, Mpendae and Chumbuni and delineate in each of the four local worlds everyday experiences of an older Zanzibari.

2.2. Shangani: Living in cosmopolitan Stonetown

Usually, when people in and outside of Zanzibar think of the city of Zanzibar the image of how the *shehia* (ward) *Shangani* looks like might come first to their mind. Shangani is prominently located on the archipelago and composes together with three other shehia the famous *Mji Mkongwe* (Stonetown), the old part of the city of Zanzibar. Until the 1920s Shangani was mostly inhabited by Europeans, *Goans* and *Khoja* (Sheriff, Jafferji, and Chomoko 1995).

The first time I was in Shangani in 2010 as a tourist coming for a weekend, I arrived in a group with other students by ferry from Dar es Salaam. We were fascinated by the seafront with its old buildings like the *Ngome Kongwe* (Old Fort), that was constructed in the late 17th century by the Omani to defend themselves against the Portuguese or the *Beit al Ajaib* (House of Wonders), which was built in 1883 for

Barghash bin Said, the second Sultan of Zanzibar and was at that time the first building with an elevator in East Africa. Our group was caught by one of the many so called *flycatchers*, people, usually male hustlers and especially often drunkards or drug addicts who try to sell aggressively unlicensed city tours, illegally copied CDs, old spices or paintings in the streets. He showed us around in Shangani and other parts of Stonetown and guided us to the many historical attractions (reflecting the Arab, Omani, Persian, Portuguese, British, and Indian influences in ruling dominance, religion, goods and slave trade), tourist shops and craft producers. Zanzibari with some visible shades of Indian, Arab, Persian and African descendent were passing by foot, bicycles or motorcycles, since cars cannot drive through in the small streets. Zanzibari men were wearing mostly Western clothes with long trousers. Only on Firdays I later found out, Muslims usually wear *kanzu* and *kofia;* the typical white long cloth and a white, brimless, cylindrical cap. Almost all Zanzibari women in Stonetown and other parts of the city wear *buibui*, a long dark veil often with glittery and colorful embroidery over their clothes to go out, as well as a *hijab* (hair scarf) and especially younger women sometimes a *niqab* (a black cloth to cover the face except the eyes). My first impression of the city of Zanizbar, which I got while walking through the small streets, but without entering any houses (yet) apart from stores, restaurants and hotels, was that this part of the city must live only from and for tourists. Of course, I was wrong with my perception: Once I started with the preparation for this research, I attended Swahili lessons and lived in a host family in Shangani for several months, I started to realize how much was happening parallel and next to the tourist world; and I learned that locals and tourists hardly interacted with each other except sometimes for business. The tourist industry is mostly in the hands of people from Tanzania *bara* (mainland), who sell tourist souvenirs (Maasai) or work for one of the many hotels or restaurants in the old town.

Houses with a souvenir shop in front on the ground floor provide space for two or more families on the back side on the ground floor and on the first floor. They normally share a common backyard, hidden from view to outsiders. Life in the backyards is different from what one might assume from the outside. My research assistants Saada Omar Wahab and Saleh Mohammed Saleh, two historians and lecturers at the State University of Zanzibar (SUZA), who live nowadays outside the city but spent a lot of time in Stonetown (visiting people, attending schools, teaching, doing shopping or participating in politics) showed their surprise. We were astonished to see how diverse the population of Shangani was, not only in terms of ethnic? backgrounds but also in terms of inequality: how politically and economically powerful families live next to extremely poor neighbors, who might live in similar buildings. Later, I learned that many of the economically poorer families do not pay rent in those houses; they are usually tolerated by the house owners, lived in *waqf* houses, that is an endowment made by a Muslim to or for a religious, educational, or charitable cause. Sometimes the buildings are owned by the state; many Arab and Indian families left the city shortly before or after the Zanzibar revolution in 1964 because of the ethnic cleansing. Additionally, many houses still belong to Arab or Indian families who had left the city and just return for holidays and therefore allow other people to stay in their houses and look after them.

Generally, in this area the high number of families with relatives abroad is high, as many moved out of the country either to the Arab Peninsula, Europe or the USA. When Zanzibari emigrants came back to the island to visit relatives, friends and their home place, they did not leave out the heart of the city. Accordingly, older people in Stonetown with social ties abroad usually were able to see them, once they travelled to Zanzibar.

In the national census of 2012 (URT National Bureau of Statistics 2013) Shangani was mentioned first out of 45 shehia (wards), which shows again its reputation as THE ward of Zanzibar City. According to the census 3886 people were living in Shangani in an average household consisting of 5.1 persons. The number of female inhabitants was compared to other areas just slightly higher (1976 women compared to 1910 men) (URT National Bureau of Statistics 2013, 236). This might be due to the fact that Shangani is a place where business, trade and tourism happens and typically men try to find work. Shangani is also a center of the liberal opposition party *Chama Cha Wananchi* (Civic United Front (CUF)). In the evenings men sit together at *Jaws Corner* a crossing and small square at the center of Shangani and drink coffee, play games and talk about politics. Sometimes a small TV transmits heated political debates. My research assistants Saada and Saleh both told me that besides being a place of heritage, Shangani is for them also a place where political riots usually start. This is similar to Chumbuni, a poorer shehia at the outskirts of the city, as I will show later in this chapter. On the walls of at *Jaws Corner* are many posters of political representatives and thus, in this very politicized ward, even small boys can give a political talk about CUF.

Shangani is a place where people come from all quarters to exchange, mingle, and where everything one needs, is close by. Even though the ward is frequented by people from all over the island, there is an atmosphere of familiarity, not anonymity: everyone seems to know each other. At night, when the streets become lined with cook shops and the heat becomes bearable, many older people sit in front of their houses on cemented benches, called *baraza* (Loimeier 2007) in order to watch the streets and chat with passersby. At this time of the day older people become most visible; and indeed, in almost every house we knocked on the door during the research we encountered an older person.

On Saturday and Sunday evenings many people from the city and beyond come to the neighboring *Forodhani* public garden where countless numbers of stands sell *mishkaki* (pieces of meat roasted on a skewer) and *chipsi* (French fries) as well as seafood, *Zanzibar pizza* (a kind of roti/crêpe typically stuffed with minced meet, egg and cheese and then fried) and *Urojo* (typical soup mix). People dress themselves nicely and children enjoy ice creams and the playground for which one must pay an entry fee. It is a place of leisure and self-portrayal. Older people are rather absent in the garden at night, except some older people who work as food sellers at the stalls, At the other end, just a little bit outside of the of the ward we can find the big market in *Darajani*, which is very well frequented by people of all ages.

Especially, older men are present there as sellers and buyers. I rarely met older women at the market but some outraged elderly research participants told me that nowadays even some older women could be seen at the market, which they interpreted as a sign that some older people were neglected. Besides the market and smaller food stores, banks, the main post office, stores of mobile phone companies, as well as many ministries (among others the "Ministry of Health" of Zanzibar) and departments (among others the "Department of Social Welfare" of Zanzibar), Shangani accommodates several pharmacies and private clinics. Close by, there are opticians, herbalists and different kinds of healers and most importantly the main public hospital *Mnazi Mmoja*. Shangani is also the place with the highest density of mosques) (*miskiti)*, the Roman Catholic Church, Hindu temples and other religious buildings and schools of every level, including a part of the Zanzibar State University and countless Islamic educational institutions) (*madrasa)*. Compared to other areas of the city, I would also argue that Shangani has the best access to tap water and electricity, and, most importantly, both are also accessible to very poor households.

Already in 2012, over 80 percent of the households in rural and urban regions of Zanzibar owned a mobile phone (Census 2012 Tanzania_Basic_Demographic_and_Socio-Economic_Profile: 39) but in Stonetown this number must be at almost 100 percent, since I rarely met somebody without any mobile device. Actually, most people possess even two or three phones with SIM-cards from different mobile telephone operators. This practice allows to have better access to at least one working network at a time and to communicate always through the cheapest channel depending on which provider the call receiver uses and so forth. My research assistant Saada drew my attention to the fact that many of the mobile phone numbers that people use in this area begin with a combination of numbers, which were the very first given out. So they were among the first in the city to buy a SIM card - a further indicator that people have the means to be very well connected in this ward and outside of it.

In brief, Shangani is a historical node which links people in the city and all over the world in diverse flows of goods, ideas and people. It is a place where people at least theoretically could access everything the island provides. Shangani facilitates cosmopolitan social spaces, since means of communication, transport, goods, access to various institutions and touristic places are available but this does not mean that everybody can access them. Especially, poorer and sick or frail older people who are bedridden or cannot leave their homes are sometimes not able to access these cosmopolitan possibilities anymore. After having provided a broad description of Shangani, I would like to focus now on an older woman, her everyday practices and experiences of this local world.

2.2.1. Bi Fatma – Comfort, habits and bad drugs (starehe, mazoea na madawa mabaya)

Bi[33] Fatma stays in a tourist attracting part of Stonetown, in Shangani. A small alley (*kichochoro*) leads away from one of the streets which is packed with small stores selling souvenirs to sparsely clothed tourists, who spend one or two nights in the historical city or do a day trip from one of the many beach hotels on the coasts of the island. The small side street ends just next to Bi Fatma's house. Sometimes tourist guides lead their clients to the stunning wooden door next to her house, for which Stonetown is famous. Behind those masterpieces of handicraft many houses in Stonetown are deteriorating slowly. Also Bi Fatma is living in one of those historical two story buildings, built by Arabs. It is surrounded by thick walls and has a typical Swahili backyard hidden from view. The ceilings are supported by black painted poles and the walls inside the house change their color every few months, since the old color flakes off due to the humid sea breeze. The research assistant Saada and I usually knocked at the heavy wooden door until one of the young women living with Bi Fatma opened the door. We took off our shoes and entered the building with the high ceilings and small windows. Normally, one of the young women led us to the living room, where we sat on the couch or on the floor and where Bi Fatma joined us, if she was not yet sitting there with other guests.

Bi Fatma presented herself to us as an incredibly charming widow in her early seventies. She grew up in Pemba, the neighboring island which forms together with the main island Unguja Zanzibar, a semi-autonomous part of Tanzania. In Pemba she was married as a second wife against her will to an older man and came after the Zanzibar Revolution 1964 to Unguja:

> I left Pemba around 1972, at first I was staying in another building, later the government brought me here (to the house she is staying now in Shanghani). There at the other place, my brother died, and my husband died as well. I started to live here with my children since they were still young, my younger sister was living here too she persuaded me to stay here. Everybody had their own life, but we helped each other until my children became adults."[34]

Bi Fatma says of her health that it is not static and it was going up and down, especially since she is suffering from high blood pressure. Even though she does not own the flat in the house she stays in, she considers it hers. She lives together with her brother's daughter, since her niece's father passed away and two children of her son. One of them, her granddaughter, who is around twenty years old, has a small son and spends the whole day at *bibi* (grandmother)'s home because she is divorced. Usually, at

[33] Abbreviation of *bibi*, which means grandmother but is also used for Ms., madam or housewife. All names are pseudonyms.

[34] "Mie nimetokea pemba kama mwaka wa 1972, ikaa hapa kwanza nilikuwa nakaa nyumba ile, alafu serikali ikanileta hapa, na kule kaka yangu kafa, na watoto wangu baba yao kafa, hawana baba, hasa nilikuwa na mwanangu mdogo na yeye anaishi hapa, akanivuta nikawa hapa, kila mmoja akawa na maisha yake, mpaka namie watoto wangu wakawa wakubwa ikawa tunanaisadiana."

night the niece leaves Bi Fatma to go to her place. She comes daily to help Bi Fatma. The other grandchild, a grandson, is jobless and causes a lot of problems to Bi Fatma. When we talked about the people with whom she stays she said:

> (…) the one who is troubling me is my grandson, because he is a drug user (literally: uses bad drugs to intoxicate). He breaks the doors; recently he wanted to destroy all of us in the house. His sister had golden rings. He stole them. I felt it is better to die. It is more than a year I didn't go to my home, even though my parents there passed away. I don't want to leave here because he may kill people here when I am not around. This thing is tormenting, but those who are fine/adults (hawa waliokuwa wazima) we are understanding each other well.[35]

Especially, in Stonetown, which is also the vibrant heart of the city, it is widespread that young men are involved in drug use and selling. For Bi Fatma the behavior of her grandson is extremely irksome. Because of its unpredictability she cannot only, not sleep well, and is living in constant fear but it implicates also that her children refuse to re-buy goods her grandson broke or stole and they reduced their material support for food. Almost every time we visited Bi Fatma, she told us about the issue. My research assistant Saada and I felt helpless as well, seeing this lovely and caring grandmother burst into tears. When we asked her how it came that she is living with her grandchildren she said:

> It is my faith, because for these children I am their mother. My sons got married while we were still living upstairs, but by that time they were still young, they gave birth to their children and dumped them here. I am an adult/older person (mtu mzima)), when I was told 'your grandchildren will stay here with you' I did not say no, because I knew they were still young, I could not send them away. I love them, it's ok if I starve but they must eat something.[36]

During the years we visited Bi Fatma she and the rest of her family undertook several attempts to organize relatively expensive stays in rehabilitation centers. Once, she accepted to participate in a rehabilitation program over several months, I could visibly observe, how Bi Fatma's mood and health situation improved. That grandparents live together with grandchildren of adult children who split up a

[35] "(…) mwenye tabu huyu mwanamme, manake unajua madawa mabaya haya ya kulevya. milango huvunja, juzi ilikua nusra atuvunje sote humu ndani, dada ake alikua na vipete vyake kavichukua unajua wizi. nkaona mie bora kufa, zaidi kuliko mwaka mie sendi nyumbani kwetu huko kuna wazee wangu kafa mzee wangu yule wa mwisho sitapi kuondoka mana nikiondoka naona huyu atauwa, sasa ile ndo inanila mie. lakini hawa waliokuwa wazima tunafahamiana."

[36] "Ni kwa imani yangu maana yake hawa watoto, mimi ndio mama yao, kwa hivyo wale watoto walioa wakati tuko juu huko, watoto ndio wadogo wadogo, washazaa ndio wakanitupia hapa. Sasa mie mtu mzima nikiambiwa basi fulani takaa hapa siwezi kukataa, yeye anazunguka ujana tu. Sasa mie siwezi kuwatupa, mie nina imani nao nikaa nao, nikikosa wakipata wao, ni sawa."

relationship is very common all over the city, because especially for divorced women it is difficult to bring children of an ex-husband into a new marriage, in which the husband should take care of the offspring of his antecessor. Nevertheless, Bi Fatma is still hoping that her son would come back once to take care of his children.

Mostly, Bi Fatma received financial support from her children who stayed close in the suburbs of the city. Besides this, she prepared sweet snacks (*visheti*), which were sold at a store where her children stayed: "I have my own child [son at Bububu], he is having his own family but he is helping me. And we ourselves, we are selling small things. You know it is not easy to depend fully on one person." Besides from her son and daughter in Bububu she sometimes receives small amounts of money (around TZS 10'000) from her sibling's children who stay in Dubai, once they come to visit her, but they did not support her regularly. She did neither have a pension nor a health care plan. Her children suggested that she could move out of the city to their homes around twenty minutes away by car but the older woman preferred to stay on her own with her younger relatives as long as she could. When we asked her if she still would like to stay in her house once she gets weaker she said:

> I know it will be difficult but I have children and grandchildren who will help me. But if it happens that I become too weak, I will come up with something else, but for now I am ok, I don't like to live in my children's houses, even moving to my daughter who lives alone with her son I don't want to. My son has his own family and he asks me to stay there with them but no, I don't want to. I told him that you can help me wherever I am, but it is not good to share the same house.

When we asked her about how she sees Shangani compared to other areas she told us:

> I mean, I have been here, since I left (Pemba), that's why I don't know the life situation of other places. I feel I could not live the same life as I experience here. A place where you have stayed and experienced its habits (mazoea). I cannot stay at another place. I do not like to go round and round (zungukazunguka). I can sleep three, four nights at another place if I like to do something there and then I come back.[37]

Bi Fatma explained to us that she married a husband in *Ng'ambo* (areas "on the other side," outside of Stonetown). She spent one year there but could not get used to the place. She decided to return to Shangani because of her habit *(mazoea*) to live there ("*kwa sababu mazoea, hapa nishazoea*"). Sometimes her children ask her to move out of the city to come and live with them but Bi Fatma could

[37] "Mie maana ake, mie toka nimekuja niko hapa, sasa nakuwa sijui maisha ya sehemu nyengine. Nahisi sitaweza kuishi maisha ya maeneo yangu, pale ale nilipozoea dasturi yangu siwezi kuwa sehemu nyengine, sipendi kuzunguka zunguka, nikalalae kwa mtu siku tatu au nne, mie kama shughulini napenda niende halafu nirudi."

not move away: "I want it for them but my heart says no, I cannot (move), I am already so used to live here."[38] She repeated several times, that the biggest issue was her being used to this particular area. She added that maybe others might say, that she was living in comfortable circumstances (*starehe*) but that she thinks that she is not living better than in any other area. Bi Fatma explicated:

> Here we live well, we have a good neighborhood, we understand each other, there is no problem. In this area, there is security (usalama), even if there is a difference between nowadays and the past. A long time ago we used to wash our clothes and spread them on the rope for a month, you could even travel and when you came back you would still have found your clothes on the rope. Nowadays, that security has gone, but there are no big problems.[39]

Since Bi Fatma found it hard to compare the shehia she lived in with other areas, we asked her to compare it with what she heard from her children about the place they stay at. They live outside the city in a small town, where plots of land were in high demand, and which is by car twenty minutes away from Zanzibar.

> Really, you can see there is unkindness (chukichuki), or some thieves. Really, I am very worried about that and that's why my children domesticate dogs. But I dislike that. Maybe if it must be, I go out but my daughter who lives alone, does not go out even to her neighbors like me (here). I go out and I wash my clothes, and I am very charming to them, because neighbors at Ng'ambo are jealous, it is different from how it is here where we joke with each other. There, it is a problem and she has bought a house there and done many and good renovations. I don't know what she can do about it. And that's why she is always silently inside the house. I cannot live in that situation and even if she asks me to live there I don't feel good to do so, unless I must (move).[40]

Bi Fatma concluded that for her Shangani is a place where good people *(watu wazuri*) are living who respect each other irrespective of their age, except for drunkards *(walevi*). She stressed that she never had a bad experience in this shehia.

[38] "Naitakia lakini moyoni nasema aaaa siwezi nishazoea hapa."

[39] "Hapa tunaishi vizuri, tuna ujirani mzuri, tunafahamiana hamna matatizo. Kwa sehemu hii uslama upo, ingwa siku za zamani na sasa mbali mbali. Zamani tunafua nguo, tunaweka mwezi mzima hamna unaweza ukasafiri ukarudi nguo zako zipo, sasa hamna usalama huo lakini hamna matatizo makubwa."

[40] "Kweli maana utaona kama kuna chukichuki fulani hivi, au pana wezi Fulani. Maana mie nina hofu inabidi wao wafuge mambwa sasa mie ile sichukui, labda ikiwa hamna budi nimetoka, lakini kama yule mwanangu mwanamke yuko peke yake kwenye nyumba hatoki popote hata kwa jirani ndani tu, kama mie, lakini mie natoka naanika nguo nachangamka, kwa sababu majirani wa Ng'ambo mara kam chuki, tofauti na masihara ya huku, kule ni tatizo na nyumba mwenyewe kanunua kaijenga vizuri, sijui afanye nini, ndo maana unamuona saa zote yeye kajikunja. Mie siwezi ndyio maana hata akinambia nikakae naona ziki labda iwe hamna budi."

2.3. Kikwajuni Bondeni: Living close to the city center

Kikwajuni Bondeni[41] ("valley of the small tamarind") lies just outside of Stonetown, by which it was originally separated by a river that passed as a natural border between *Ng'ambo* ("the other side") and *Stonetown*, the historical old town where Europeans, Goans, Arabs and other mostly "non-natives" lived until in the early twentieth century. On a historical map, which shows the distribution of different groups of people in the city before 1923; Kikwajuni on the other side was displayed as the place where "natives" lived. Even though it is outside of Stonetown it was a place where even before 1923 a radio station was installed. Kikwajuni was bordering onto the former government stables and the public works department stores (Sheriff, Jafferji, and Chomoko 1995, 9). Today, the shehia has around 2260 inhabitants (URT National Bureau of Statistics 2013, 236) who live according to the *sheha* (principal) in 246 houses. In the census on average 4.7 people indicated to live together in a household, which is one of the lowest numbers in the city (average household size in Mjini District 5.3) (URT National Bureau of Statistics 2013, 236). Compared to Shangani the houses are smaller; but the one-story buildings are often in good shape.

Before we started with our study in the four shehia, we met with all *masheha* in their shehia, to explain our research project and to receive their consent and advice. The sheha of Kikwajuni Bondeni was very welcoming. He had arrived in the shehia already in 1951 at the age of two years, so he could tell us a lot about the development of the shehia. He explained that at that time most residents were fishermen because Kikwajuni is close to the sea. The fishermen had often two jobs: On one hand, they did fishing, on the other hand engaged in agricultural activities. Many fishermen had some land at Kilimani, an area at the seaside, by foot ten minutes away from Kikwajuni. At that time, there was more space between the houses. Later on, more people came to Kikwajuni. Before the revolution in 1964 only one sheha was responsible for the nowadays divided Kikwajuni Bondeni and Kikwajuni Juu, since there were not many houses and most of the people knew each other. Compared to other wards Kikwajuni Bondeni is very small, which makes it easier governable for the sheha. The streets in the shehia are narrow, sandy, and muddy, because there are no tarmac roads. The sheha complained that the streets are *mbovu* (bad, defective, rotten, unhealthy, worthless and dilapidated) and not *salama* (secure, safe, in good condition). I also experienced that people live close together and that there is almost no passing by car, especially during raining season. The sheha also moaned about the limited access to water since sometimes four houses may have no water and only the fifth may have a water pump and get water. At least he could see an improvement concerning the access to electricity. It has been relatively stable since around the end of 2012 when the whole island was newly connected, and new cables were laid.

[41] *Kikwajuni* consists of two parts: the lower part *Bondeni* and the higher located part *Juu* ("up/high"). I will in the following abbreviate Kikwajuni Bondeni as Kikwajuni but am only referring to the lower side.

We asked the sheah, how he would advertise his shehia and he replied as many people in this shehia told us, by pointing out the good access to electricity and to the fact that people were "really kind." People would respect each other and many youths would to do sports and swimming. The sheha was even able to turn what others in the shehia saw as a threat', the unemployed youth into a positive aspect. Even his house looked like a center for youth of different ages. Young people came in the afternoon to play there. The sheha was convinced that providing spaces for the youth may protect them from using drugs, which is common in many other shehia. Additionally, because previously there were thieves in Kikwajuni Bondeni, they built up a *polisi jamii* (community police) to protect people. The image of the friendly neighbors and the bad strangers was possibly the most common way in all shehia, how people described their place of living.

Like Shangani, Kikwajuni is located close to the market *Darajani*, as well as in walking distance to the public *Mnazi Mmoja* Hospital and until 2014 it was just next to the *daladala* bus terminal. In nearly every house we encountered an older person. Older men became most visible in the shehia spaces during prayer times, when they moved to one of the many mosques or in the later afternoon at coffee places. Also in this shehia, the houses did not have a gate and all the houses had a *baraza* outside, on which people sat, when the sun was not too strong. Without any exception, all my thirteen informants in this shehia have relatives abroad.

2.3.1. Mzee Mohammed - Faith, pension and remittances

Mzee (polite way to address an older man) Mohammed, a relatively healthy and slim looking older man in his early 70s, was usually wearing thick glasses and a typical Zanzibari embroidered white, brimless, cylindrical cap (*kofia)*. He was born in the neighboring area (shehia) Vikokotoni, but since his youth he was living in Kikwajuni. At the time I was there, he stayed in a house his father bought and passed on to Mzee Mohammed's older brother. He told us that some of his forefathers have come from the Comoros islands. Mzee Mohammed has four children (yet unmarried) of two marriages. Since he divorced his first wife, he had been staying with his second wife, who is in her early fifties and a housewife, their children, the son of his late sister and his wife, as well as during the day with a household helper *(dada*) and sometimes with relatives they are taking care of. His wife was only half of the week in the house with him, as she was taking care of the children of her late sister in the close-by shehia Shangani. Many children of his brother and sister lived in the neighborhood in Kikwajuni. The children were still going to school or study, except the oldest one who was working at a hotel for some time but who was jobless at the time I was there. Their house is an average sized one-story building, in which one typically steps directly into the living room; with television and a sofa (even though one often sits on the linoleum floor on a plastic mat *(mkeka*), and normally as a guest does not go further to the areas that are hidden behind a curtain.

Usually, Mzee Mohammed's day starts with opening the neighboring mosque for the morning prayer *(Alfajiri)* around 5 a.m. After that he gets back home to prepare his youngest child for school and then he opens his small shop. He sells goods for everyday use like razor blades, tomato paste or superglue to the neighbors, as well as small snacks and sweets to the children who attend the *madrasa* lessons (Islamic school) at the mosque. When we were sitting with him at the store he knew all the people passing by, greeted them and had some conversations. As he is also selling snacks, which some women prepared, he normally waits until they are all sold around 10 or 11 a.m. and closes after that the store for some time if he wants, for example, to visit a patient at the close-by hospital. Compared to many other people in Kikwajuni he is not doing regular bodily exercises at the nearby beach or around the "Mnazi Mmoja" sports field. Nevertheless, he is still moving around by foot or bicycle while performing his duties.

During the hottest time of the day, at noon, Mzee Mohammed rests at home, sometimes watches DVDs with religious speeches and then opens his store again. He tries to never miss one of the five daily prayers and sometimes goes for an extra prayer *(dhikri*) at night. Mzee Mohammed aims at leading a life in which he does not only pray but also act according to his faith *(dini*). He tries thus to stay in good contact with other people, especially with religious people, hoping that they would help him if he needs their support: "If you do not care *(hujali)* about these religious messages *(habari ya dini),* even though it is your faith, another person will not care *(hajali)* about you as well. But a person who comes himself closer to them will be approached by them as well."[42] While talking about the role of religion in his life he mentioned: "I am already an older man/dignified person *(mzee),* thus it must be that I worship/do good deeds *(ibada[43]),* I am not able anymore /weak *(sijiweza),* even during the time of sleeping I have to worship/do good deeds."[44] On other days his store stays closed whenever he attends a funeral, a wedding or goes to another mosque to recite the Quran for those events (eg. burial prayers *(uradi)*. Normally, his day ends soon after the last prayer in the mosque at about 7.30 p.m. *(Isha).* Mzee Mohammed's health during the time we visited him regularly from 2012 to 2015 was fluctuating. When we asked him for the first time about health problems, he negated to have any but from time to time his legs and waist were hurting, when he was sitting or standing.

In general, Mzee Mohammed was avoiding to go to the hospital. He only brought himself to go there if he was seriously sick and if his wife insists that he should see a doctor there. He could walk to his

[42] "Wewe, ijapokua ni dini yako lakini umejikurubisha vipi na wale wenzako katika dini, sasa kama umejiweka hujali ile habari ya dini na nini na nini, japokua ni dini yake mtu hajali. Lakini binadamu unajikurubisha nao na vile vile nao watajikurubisha kwako."

[43] "'Ibādah (pl. ʿibādāt) refers to service, servitude, and by extension the very notion of religious worship in Islam." http://www.oxfordreference.com/view/10.1093/acref/9780195305135.001.0001/acref-9780195305135-e-1162

[44] "Nimeshakuwa mzee inabidi lazima nifanye ibada, sijiwezi, hata wakati wa kulala lazima nifanye ibada wakati wa kulala pia."

favorite hospital, the biggest and public health facility of Zanzibar, the Mnazi Mmoja Hospital. He was convinced that one can get good treatment there and even though patients normally must wait a long time before they can get free treatment, he considered it to be better than private hospitals which "just want to take out money from your pocket." But for ordinary health issues he just went to see his neighbor who is a doctor: "Ah, you know, if let's say, like this, I have leg/feet pains or any ordinary disease only, we have a neighbor here, he was a doctor, he is retired now. I tell him and he prescribes some drugs to me. That's it! I go to buy them and they help me."[45]

Mzee Mohammed had three main sources of income by which he tries to take care of his family: He received a pension, has the small shop and gets remittances from relatives abroad. His wife earned a small income by selling self-made snacks at a school; Mzee Mohammed did not consider this as part of the main sources of income. It is common in the city of Zanzibar that women are not expected to contribute to the household income, but could usually if they earned money rather use it for themselves.

Quite a few of the inhabitants of Kikwajuni have access to a pension as many were once state employees. Mzee Mohammed receives a pension from ZSSF of TZS 58'000 per month, which he hands over completely to his wife who buys school books and school uniforms for the children with it.
About the value of the pension to him he said: "You know the pension is very little and it can't help a person in any way. But it can be that there is a person to help him/her but because the person has inserted him/herself in thoughts like "Ah now I don't have a government job" this thought will pain him/her. I get a pension of TZS 58'000 how does it help me? But I get support from my people".[46]

While older inhabitants of other shehias were dreaming of such a pension, many older people in Kikwajuni complain that it does not help much and express their concerns about having given up their government job due to retirement, usually at around sixty years – a job which was connected to a good salary, prestige and security. Mzee Mohammed is in an ambivalent position in which he feels responsible for his family, especially since his children are not yet able to provide the family with an income, yet his pension does not get him far. He still sees it as his duty to take care of his children and of his wife, even in his old age.

[45] "Aa unajuaa kama, tusemee kama hivi naumwa na miguu, au maradhi tu ya kawaida.tunae jirani tu hapa Daktari alikua kashastaafu saivi, namuhadithia basi ananiandikia dawa nakwenda kununua na zinanisaidia."
[46] "Unajua pension yenyewe inakuwa ni ndogo na haiwezi kumsaidia chochote na vile anaweza kuwa ana mtu wa kumsaidia lakini kwa vile kajitia katika mawazo ya kwamba ah sasa hivi sina kazi ya kiserikali inamuumiza japo pension anapata, mimi ninapata pension sasa hivi 58000 inanisaidia nini lakini ninapata support na watu wangu."

When we met Mzee Mohammed for the first time in 2012, he had had a small store close to his late brother's house in which the family lives. Mzee Mohammed explained to us that his children opened the shop for him, since he was retired and needed an activity to earn an income. This business would keep him active. He stressed several times how important this store is to him but he also told us that even though he had a lot of sales, in the evening he could not find any profit in the cash box. Some weeks later we found him at home, selling his goods in front of his house on the veranda *(baraza*[47]*)*. He explained that he gave up the store but still wants to sell the leftovers:

> You have seen that shop there, that is the one I was earning a living with and now it is dead (…), they (nephews and nieces) bring money every month, we get lunch, and they pay for other expenditures but for dinner it has to be myself, there is bread in the morning, there is money for children for school, it is - I have to rely on myself. Since that shop collapsed I don't have anything that I can self-rely on. Lastly, I have talked to these (nephews and nieces) who are abroad the one here, has come to see the shop, he said, "we shall bring contributions to you so that you can make yourself a survival (…)".[48]

Even though I had the impression that Mzee Mohammed was quite happy to do his small business, sitting outside and chatting with others he told us at another occasion that he would prefer not to work anymore: "I just work because I have that small shop there, but if I would get money, I would prefer to only sit around (rest), but it is like that, I cannot just sit around because the family needs to eat."[49]

Mzee Mohammed has four nieces and nephews abroad. Three daughters of his late older sister *(dada)* support him monthly; they provided capital for his store and paid for the complete renovation of the house he lives in. Even the house itself, actually, was inherited by the children of his late brother, who let him stay there. The three nieces stay in the UK, in the USA and in Denmark. One of his nieces in the UK grew up in Mzee Mohammed's house because her mother re-married and could not take her into the new marriage. All of them put money together monthly and support him and his family, even though, as Mzee Mohammed stresses, they are having "their own families" where they are living now. Considering the fact that they have to support their children and partners Mzee Mohammad appreciates their contribution even more. He does not know who is contributing how much. His niece who stays in

[47] A place to sit in front of the house, common for all houses in Kikwajuni. More about the importance of *baraza* see (Loimeier 2012).

[48] "Umeliona duka lile lilioko pale, lile ndiyo nlokuwa linajiendesha na sasa hivi lishakufa kwa sababu haiwi pesa za duka zile zile hawa waliokodi, tunapata chakula cha mchana manake wanaleta pesa kila mmoja na familia yake ee wanaleta pesa kila mweisho wa mwezi tunapata chakula cha mchana cha matumizi na mengine lakini kula chakula cha usiku itabidi niitegeme mimi mwenyewe kuna mikate asubuhi kuna pesa za watoto skuli itabidi nijitegeme mimi mwenyewe mpaka lile duka limeanguka sina kitu cha kuweza kuniendesha mwisho nimewazungumza hawa walioko nje mwenyewe aliopo hapa wanakuja kaja kiliona lile duka kasema tutachangizana pesa tukulete ili tu ujiendesha lakini pesa ikiwa ni ya duka iwe ni ya duka iwe."

[49] "Ninajituma mana nina kile kiduka pale, lakini ningekua ninajipata basi ningekaa kitako tu lakini ni vile siwezi kukaa tu hivi mana familiya inahitaji kula."

Denmark told him to do exercises and helps him a lot concerning health issues. The older man told us that she already brought three measuring devices - unfortunately though all of them broke - and one to check the insulin level for diabetes. Besides that he also receives medicaments from them.

The fourth relative abroad lives in Turkey and brings gifts whenever he travels to Zanzibar. Mzee Mohammed appreciates the support he receives from his relatives abroad. Nevertheless, it also has implications for the range of choices he has in everyday life. For example, he does not get the money directly and can decide what he buys with it, but they send it to his neighboring nephew, who supplies the older man and his family with groceries and supports them financially in case of an emergency, for example for health treatments. Mzee Mohammed mentioned that he does not want to be picky and tell the nephew what to buy, but rather would accept anything he gets. This may imply for him, though, that he may not obtain the food he thinks would benefit most his health. When Mzee Mohammed and his family took his older sister into their house to take care of her, her children abroad employed a household help to do the cleaning and the washing up. Even though this sister has passed away several years ago, she is still working for the family. When we asked him about the most important source of income, he stated clearly:

> To say the truth, the money which helps me is the one I receive from outside (huko) but it is for the lunch for a month only. But for breakfast (chai ya asubuhi) and dinner (chai ya usiku) I relay on myself. And my small shop helps me as I use the money, which I get for that. It came a time I closed my shop and my children (vijana) sent the money again to rescue me and I reopened it again. But the money of the pension, it doesn't help me with anything, really, because I get only TZS 58, 000, so you should save it for buying school books for the children and things like this.[50]

This is quite typical for older people whose children are not yet grown up and cannot yet contribute financially to the household. As he still needs to support his own children, he depends strongly on help from other sources. Mzee Mohammed mingled during his life with people from all over the world: he worked for a Greek cigarette company, he weeded rice and harvested coconuts for Chinese employers and later he worked at a European-owned milk factory. Afterwards he was employed by the state to work in the agricultural sector.

[50] "Kinanchonsaidia sana,tuweze kusemaa,kwasababuu hizo zinazoletwa kutoka huko zinasaidia chakula cha mchana tu kwa mwezi,zinaweza kuletwa na kusaidia kwa chakula.lakini chai ya asubuhi na chai ya usiku najitegemea mwenyewe.na hicho kiduka kinanisaidia lakini pesa inayoingia ndo iyoiyo naitumia.kikaja kikaanguka ndo vijana wakasema waniletee pesa ili kunikomboa wakaniletea na nikakianzisha tena.lakini pesa za pensheni hazisaidii kitu kwakweli.mana napata shilingi hamsini na nane elfu,inabidi uziweke uje uwapatie mabuku ya skuli watoto ndo kama ivo."

He was outraged at the fact that caregiving for older people sometimes did not work out informally within families and the community and finally the state has to take care of older people. For Mzee Mohammed, clearly this would be the duty of the private social network and he points out that the state pays pensions to many and that for others old age homes were built:

> (…) The government takes elderly *(wazee)* as people of whom should be taken care of *(watu wa kuangaliwa)*, but now it is rather we, ourselves privately, who take elderly people as having already exceeded their time *(kushapitwa na wakati)*, he (a private person) cannot think "this elderly person, I take care of him *(ninamshugulikie)* in this or that way".[51]

Surprisingly, during fieldwork I never encountered anyone mentioning something negative about old age homes. Nevertheless, it is clearly seen as last option for those people who could not rely on a social network but was not at all considered as an option for those I spoke to. Most people in Kikwajuni compliment the state for doing something, which some families fail to do, even though it would be the responsibility of the private people. Most older research participants and their relatives did thus not consider the state to be responsible to take care of older people but instead clearly expected support from family members.

When prompted to compare Kikwajuni with other shehias in the city of Zanzibar Mzee Mohammed as many others stressed the peaceful living together in the neighborhood: "(…) the difference is that in Kikwajuni there is no hustle and bustle *(zogo zogo)*, annoyance *(tafrani)* or fighting between people as it is in Jang'ombe (the parts outside of Stonetown were originally called Jang'ombe "the other side"; today the term is used in Zanzibar for poorer areas of the city) but the people here are somehow having civilization *(wastaarabu)*."[52] When we asked him if he would like to change something in Kikwajuni when he compares with other shehias, he clearly negated and emphasized that such a thought had never come to his mind even a little bit. He was not the only one who showed his pride for Kikwajuni. On one hand, I found this especially interesting as other areas were better off and provided more planned infrastructure. On the other hand, as we will see in the next chapters, pride or sometimes also translated as honor *(heshima)* is a key aspect of what is argued to constitute "Swahili identity." Heshima can be understood as a "social status that a person earned from their community over time and through their behavior" (McMahon 2006, 197). The reluctance to complain outside the community and in front of me as a (European) researcher can be understood as reflecting this kind of pride in the historical shehia Kikwajuni. This is different in the shehia Chumbuni, an unplanned area, where usually newcomers from

[51] "(…) serikali inawachukulia wazee ni watu wa kuangaliwa, lakini sasa sisi wenyewe binafsi itawachukulia wazee hivi kushapitwa na wakati, hawezi kufikiria huyu mzee ninamshughulikie namna gani au vipi."

[52] "(…) tafauti yenyewe kikwajuni hakuna mambo ya zogo zogo (bustle) au tafrani (annoyance) za watu aah la au watu kupigana kama Jangombe lakini watu wa hapa kidogo wastaarabu."

rural areas settled when moving to the city. As we will see, the living conditions there are worse and the complaints much more explicit.

2.4. Mpendae: Living in a new part of the city

The rationale why my research assistants Saada, Saleh and the geographer, suggested Mpendae as one among the four areas we wanted to conduct research in, was that we intended to include a better off area. At the same time the contrast with the other shehias is not too strong either. There are other areas of the city with more affluent estates along the coast from Stonetown towards the airport, where a lot of expatriates and what colloquially is called "upper class" live. But this elite is so small, that we considered it to be more relevant to focus on the much larger kind of "middle class milieu" in Mpendae.

The young ward Mpendae is with 13,252 inhabitants (URT National Bureau of Statistics 2013, 236) one of the biggest shehia located at the eastern) border of the city.[53] The sheha (Mzee Hadji Seti Hadji), a convivial man in his mid-seventies, whom we met almost every time we went to visit the research participants, explained that the ward is divided into an "upper" (*juu),* a better situated and a "lower" (*chini)* side, where financially weaker families lived. Since we wanted to base our research on a variety of shehias, we decided to focus on the richer, upper side of Mpendae with its relatively big properties. This promised to give us a more diverse picture of the city. In the houses we mostly met larger families, an observation which was confirmed by the census which says that the average household size is 5.5 persons per household (URT National Bureau of Statistics 2013, 236). Geographically, Mpendae is part of *Ng'ambo* ("the other side"), thus the side, which was described as the "natives'" side of the city. Today, people do not refer to this area in this way, maybe because only relatively recently houses were built on it and also, because mostly poorer areas are declared to be Ng'ambo. The sheha explained that Mpendae was officially promoted and received its name after a hurricane (*kimbunga)* totally destroyed some areas around *Kwahani* in 1975:

> Since many people lost their homes, the government gave them plots in the - at that time - rural place where first small mango, guava, clove and coconut trees stood. The government announced that "Everybody who would like to (*anaependa*) should go to build a house and live here" (*"Yoyote ANAEPENDA kwenda kujenga ende akajenge na aishi hapo")*. This is how it became to be called *Mpendae*. From 1975-1990 there were only small houses. First, people came to do agriculture to plant rice and cassava in the area. On one side of Mpendae one can still see wet land which was used to produce rice. So, around 1975 the government gave those people a plot in a planned area and helped them to build mud houses with poles and robes from the countryside (*shamba)*. All people were required to go there and collect the material. At that time people started to move to Mpendae. Most people did not like to come here. The government had already planned the plots but people did

[53] Mpendae has an average sex ratio of 92 (male population: 6362; female population: 6890) and an average household size of 5.5 persons.

> not come. In that time a plot was not expensive. Other people came because of the big plots, large schools and so on. Only from 1990 onwards people started to build bigger houses there. It was a unique to plan streets so that also cars can pass inside the shehia. Electricity was well available. The access to water is difficult since ten years but it is the same like in other shehia because it is for whole Zanzibar a problem. But it is a secure place, planned, private schools even secondary are around and the houses themselves are in a good condition. People come and build whatever houses they want, from one to three storey buildings. There are medical services, even a hospital is opening, two private clinics and a sober house.

When I asked my research assistant and historian Saada Omar Wahab to describe how she sees the shehia she said:

> Mpendae belongs to the recently built parts of the city of Zanzibar. It is said to be modern and one expects to find new and nice houses and many rich people to live there. People who do not stay in Mpendae often only know the main street with its "modern things" like supermarkets, modern shops and restaurants, as well as it is famous for its good schools. Only if one goes a little bit inside you may realize that there are a variety of houses, different living standards, different lives and that it actually is a very diverse shehia. The sanitation is like anywhere else in the city: Nobody takes care of what is outside the gate. Typically, it is clean inside but not outside the houses. People are well educated but do still not believe that it is their business to clean outside.

She further observed that there is a lot of business compared to other areas in the city and the vegetable and fruit market called "Mombasa" is in walking distance. We saw more cars on the street and there were also cars for sale, which shows the financial capacity of some people living in Mpendae.

Saada's observations and statements show how Mpendae is having a reputation as being "modern," being home of many economic, educational and medical infrastructures and institutions but at the same time it gets forgotten that this shehia is also a place of diversity and inequality for those who can access these promise of "modernity" and others who cannot.

Historically, Shangani is most famous as being a place of mixture but Mpendae is keeping up. Many people who stay or work there are from the Tanzanian mainland. Several restaurants and pubs along the main street at the border of the shehia are managed by "mainlanders" (*wabara)*, as Zanzibari call them. Still though, I only met very few people in the inner area who are originally from the Tanzanian mainland *(bara)*.

2.4.1. Bi Khadija – I have no problems, only illness

As many times before, in the middle of our field research, Saada and I knocked on the huge iron gate outside the compound of a new, impressive pink house. The house was surrounded by a nicely cultivated garden. It was around ten o'clock in the morning. As usual in the house, around ten people, including visitors and members of the family, were in the compound either sitting on a big mat or busy in front of

the house. The housewife "Mama" (*ya nyumbani*), as our informant Bi Khadija called the daughter of her niece, had already prepared food on the charcoal oven. We were invited to enter the house.[54] Bi Khadija went in front of us very slowly. We sat down in the living room - on the carpet, and not on the velvety sofas which were mainly there for appearance, but not comfort. The living room was nicely decorated with artificial flowers, pictures, and curtains. It was well equipped with electronics like a hi-fi system and a big TV. *Bibi* (grandmother) insisted that we stay even though she had a low fever, was tired, and sometimes dozed off while we were there. Bi Khadija sat around most of the time because, she said, she did not feel like she could do anything anymore: "My health condition is that I am old, and I am not strong anymore, and my legs are not healthy. My child (the daughter of her niece) cooks for me, I just receive the food. I can bathe myself. But I can't do the laundry. (…) I can talk and sleep. But I can't do the laundry, grate coconut, collect firewood, fetch water because of my chest. Asthma is always bothering me. Until I get an injection, I am unable to sleep." During another visit, Bi Khadija said: "I don't have any hardship in life, I am only having a sickness in my body. I am sleeping, they are washing my clothes, I am eating on time, (…). I am sleeping in a nice bed, I am not sleeping on a mat nor on a poor bed made from rope (*Kamba)*. Like usually the accommodation is the same. Everything is just planned by God."[55]

Bi Khadija and some other research participants, especially in Mpendae but also in the two previously introduced shehias (Shangani and Kikwajuni Bondeni), are materially well situated and cared for in a manner they appreciate. But even though Bi Khadija lives in a wealthy family in Mpendae, she lives socially and physically on the urban margins:[56] She does not have the energy (*nguvu*) or capacity (*uwezo*) to participate in urban life. The fact that she lives in an area on the outskirts of the city constitutes an obstacle to moving around freely. She would need to walk around twenty minutes to reach public transportation to go, for example, to the city center or to the main hospital for a consultation. The mini bus (*daladala*) she would normally take is usually crowded and almost impossible to get on because the clearance of the door is very high, and the buses are always in a rush. Sometimes they do not even come to a complete stop to let people get in. During the rainy season, many of the streets in the area are not passable due to mud. If one can drive on them at all, one needs a car with four-wheel drive. Such road conditions are actually very common in all the areas of the city, and it poses an obstacle for older people who are no longer strong walkers. For them, falling down can mean a life-threatening fracture.

[54] As I have done in previous descriptions, all personal names are anonymised in order to protect the identity of the interlocutors.

[55] Bibi: "Mimi sina shida yoyote nina maradhi mwilini mwangu tu. Nalala, nafuliwa, nakula kwa time, (…). Kulala pazuri, silalii mkeka, silalii kamba. Kama kawaida malazi ndo yale yale. Yote ni mipango yake mungu tu."

[56] I write in more detail about "urban margins" in Staudacher (2019b).

It is not possible for Bi Kharifa to sit outside her home and chat with neighbors or people passing by because there is not a lot of foot traffic and her house is surrounded by a high wall, which is common in Mpendae. This means that she would have to be mobile to see people. Among my informants, both older women in general and especially older men and women with health issues hardly leave the compounds of their homes. If they become bedridden, they are likely to stay day and night in the same room with only very short visits, if any, from people other than those they live with. This means that older people especially in what people in Zanzibar city would call a "middleclass area" like Mpendae only encounter other members of the society on rare, spontaneous occasions, and they become invisible to urban society at large. This physical disconnection pushes the older more and more towards the social margins, especially due to the fact that they lack information about what is happening on the streets, such as the latest gossip, developments, and opinions, and they cannot contribute to current debates. In other parts of the city, spontaneous encounters are much easier since it is very common for older people to sit outside, as many of the houses even have an attached, cemented bench, called a *baraza* (Loimeier 2007).

The unreliable water supply is an issue that is problematic for all the inhabitants of Zanzibar, but it becomes especially dangerous for weakened older people since it makes storing food, sanitation, and maintaining a clean home more complicated. Bi Khadija belongs to the rather lucky ones because she can rely on the water tanks of her niece's family she lives with. Since Mpendae was built according to urban planning standards, the access to infrastructure is easier for those who can afford it, like Bi Khadija's family. Generally, Bi Khadija's case shows that the capacities and support of her family helps her in various ways. As many households in Mpendae can make up for the relative remoteness of the shehia from the city center by being able to do shopping, visits and medical consultations by car but for older residents in this area, who are not able to move around independently, this means leaving everything up to their social environment. This is quite a relevant point. There is mentioning in literature how such areas are hostile to domestic workers who have no cars, yet live there. But I never read about the effects on the older people. For immobile older inhabitants, this type of "middle class" housing does thus literally create walls between them and the outside world. Here we can already grasp the importance of place and space for the agency and everyday life of older urban dwellers as for example middle class housing can increase social marginality in terms of social isolation, although the economic marginality may be less a problem.

2.5. Chumbuni: Living on the Other Side

One day my two research assistants Saada, Saleh, the geographer, and I were discussing which four shehias we should choose to do research in. When one of them brought up Chumbuni, with almost 11'000 inhabitants one of the biggest shehia (URT National Bureau of Statistics 2013, 236) located in the West Urban District, they all started laughing and joking. I did not understand everything since my Swahili was rather poor at that time but I realized that it must be a very special place, a place somehow

too difficult to deal with for outsiders. I figured out that it was a crowded place, where people were supposed to be loud and everything a bit out of order – *Uswahilini,* the place where *Waswahili* (literally people who are Swahili speakers) live. I had read a lot of books about *Swahili* culture, which praised the openness, the cosmopolitanism and the civilized manner (*ustarabu)* of Waswahili and was surprised to meet such negative attributes.[57] Saada said in jest that she would not go there to do research and that Saleh could go to Chumbuni alone with me. They bantered with Saleh who grew up in Chumbuni and during the beginning of the research still lived there. Only later, during the course of the research, I realized that depending on whom we met, Saleh claimed that he lived in either a better off neighboring shehia or the area outside the city, where he was building his house as his home to avoid awkward situations of mocking and shame. Rarely, and merely to people he knew better, or more proudly to inhabitants of Chumbuni he admitted where he really lived. Even though he made jokes about the place he grew up, the bad reputation of the shehia could also rub off on his standing and as if the conditions of living were not already harsh enough, he also had for example to defend his person as being well educated, healthy and so on, as well as the place as being a suitable home for him, his wife and child towards his in-laws from a better off family.

Since Chumbuni stood representatively for the unplanned and poor situation in several shehias with little planned infrastructure in *Ng'ambo* (the other side),[58] we decided to start our research there after the rainy season. Considering the relatively small size of the city Zanzibar it took us quite a long time to reach Chumbuni by minibus *(daladala)* starting from the central minibus station in Darajani, which points to the spatial marginality of the area. When we reached the street which is the border of the shehia, it turned out to be the only place accessible by car and it was lined with small shops. Saada, Saleh and I entered the alley on the dried mud ground which was blended with rags and trash. Saleh guided us through the countless narrow streets along the modest mud and brick houses to the sheha's house to ask on the shehia administrative level for permission, advice and his blessing to do research. Children were playing in the streets and many people were sitting or working outside their houses. Many of them knew Saleh and called him "Saleh *manga* (Arab)" or shouted *wazungu* (white person/ European) to me, a habit which I was familiar with from children in other areas of the city, but I never had experienced in this intensity. Even though Saada too was a stranger in this area, I was obviously a foreign body. Contrary to the descriptions of my research assistants concerning the shehia, I felt positively surprised about the place. The small houses next to each other in this car free area were not just shaky, dirty or ugly but rather had something peaceful and almost idyllic in their small sizes, close to each other. Most houses

[57] Later I found the definition of Moyer (2003, 44) for *Uswahilini* areas as "characterized by an unplanned, almost willy-nilly arrangement of houses, limited access to electricity and clean water, and incredibly dense populations."

[58] For example, Mwembe Makumbi or Karakana.

were not neglected but maintained with whatever people could afford or found around them. The rather loud but friendly welcome, laughter and exchange among the shehia's inhabitants felt inviting and clearly everyone new everyone.

When I asked people in other areas how they see Chumbuni, some said they had never been there and could not describe it, while others imagined it as a source of agitation *(fitina fitina*) and crowding *(kikiri kikiri*). This might be due to the dense population in the shehia but also to the fact that it was a popular area for election propaganda of the former single political party CCM. CCM is more anchored on the mainland and the growing number of supporters of the in Zanzibar popular opposition party CUF, which clashed sometimes in tumults with CCM partisans in Chumbuni. Even though most houses have only two to three rooms, Chumbuni has with an average household size of 5.9 persons the highest number of people per household and with a sex ratio of 91 almost 10 percent more women in the shehia (URT National Bureau of Statistics 2013, 236). Compared to other areas, Chumbuni has with one primary and one secondary school few educational institutions. In contrast there are many *madarasa* (Islamic Schools). In former times Chumbuni accommodated radio antennas with a big tower to distribute it all over the city but nowadays it is no longer in use anymore.

According to my assistants the word Chumbuni stems from *chumbu* (field or countryside), which is the Pemba dialect for the Swahili word *shamba.* With the locative suffix *-ni* Chumbu*ni* it means "in the countryside." Chumbuni is one of the newly urbanized areas. It grew in the last thirty years without official city planning and no state-aided infrastructure like roads, an electricity network or water pipelines. That this settlement has a name in the Pemba dialect is not astonishing, since many migrated from the neighboring, poorer island Pemba or northern, rural parts of Unguja to Chumbuni. People gradually built their houses, whenever they had some money. Today there are few mud houses (*nyumba ya matope*) with wooden vertical poles and horizontal sticks, which hold the mud in place. These houses are usually covered with palm leaves. Some houses are mixed mud houses and brick houses (*nyumba ya matofali*). The majority of people lives in brick houses but were not able to complete them. After the construction of the foundation and the walls of the houses, they fixed corrugated iron roofs on top, without constructing a ceiling. Consequently, even the brick houses have often a mud ceiling. Most brick houses do also not have their walls plastered and if at all, only outside but not inside the houses.[59] These types of constructions are quite ok to live in during the dry seasons but expose its inhabitants extremely to the weather condition during rainy seasons. Around half of the older research participants in Chumbuni live in houses without electricity. Access to water is difficult and unreliable. Tap water is diverted in a bricolage from diverse other districts. Many households share a tap and may get no water

[59] With his skillful attention to details Saleh helped me a lot to better understand the housing types and living conditions in Chumbuni.

for two weeks and then only for a few hours. The unpredictable water supply means for the younger generations and mid-aged women that they need to walk regularly to fetch water wherever they find some. Few inhabitants of Chumbuni live close to wells where they can get water every day. The expensive option to buy clean water from the mosque, yet this is not affordable for most people in the shehia.[60] Not surprisingly, cholera breaks out regularly. Even though Chumbuni is a big shehia it has no own health service center and patients must go to a neighboring center in Karakana. That center has a special ward for pregnant women and if cholera breaks out, it is only open for these patients. Older people cannot expect treatment for age-related health issues there.

Saada and Saleh often discussed and criticized that children under the age of one year would play outside without any supervision, even though waste was laying around everywhere. Statistics showed that in Zanzibar generally around 63 percent of the waste is being dumped in the open space or bush, while the second most commonly used methods of refuse disposal by households was burying it or amassing it in a pit (36 percent) (URT National Bureau of Statistics 2014, 37). In Chumbuni I often observed how trash was thrown into a neighboring plot for example if nobody was staying there at the moment or a house was unfinished.

Chumbuni can be a tough place, especially also for older people. But when the rainy season starts, it becomes even more difficult. Many places are not reachable anymore because the streets turn into small streams. The mud and water mix became slippery traps for older and fragile pedestrians. The only positive aspect was concerning our research, since the older informants did not dare to go out anymore, we usually met them at home and did not have to search for them in the neighborhood. The image of the uncontrollable and harsh living conditions in Chumbuni was consolidated during these periods of the year. During every rainy season mobile phone videos circulated all over the city, displaying flooded areas in *Ng'ambo* of which Chumbuni is part. They showed pictures of desperate people, who were fighting against the flooding in their homes, standing in knee-high water in their living room or next to a house of which a part broke down. The central field on which children usually played football was completely flooded during the rainy seasons and looked like a pond attracting and accommodating many (malaria transmitting) mosquitoes. It is probably these impressions that come to peoples mind when we asked them about their image of Chumbuni. (oder so was)

[60] A family of four people needs around five tanks per month (each TZS 5'000 / US$3) and would thus have to spend TZS 25'000 / US$15, which can be half of a household's budget.

Mzee Hassan – A frail person does not eat fish (mnyonge hali samaki)

Usually, when Saleh and I went to visit Mzee Hassan in a small house in one of the narrow streets in Chumbuni, we met him sitting on a mat *(mkeka)* in the living room. Sometimes he was drinking tea and eating the typical affordable white tin loaf bread *(boflo)*. Mzee Hassan told us that he was born in 1921 and thus at the time of our visits in his early 90s. But listening to his lifestory and considering his appearance I would have guessed, he was 20 years younger. Like many of the older people we talked to in this shehia, he called himself as being poor and weak several times. Maybe out of shame or hoping to receive (financial) support from Saleh and me he said once while eating his bread: "Mnyonge hali samaki" – "A frail/neglected/poor person does not eat fish."

Two years before we met him for the first time he moved from his hut at another area of Ng'ambo to his son's house in Chumbuni, because he progressively lost his eyesight and was not able to stay alone anymore. He was born in Unguja but lived for almost 30 years on the island of Pemba where he worked as a cloves picker. After he came back to Unguja his tasks were to peel coconuts and to sell coffee. When we asked if he receives any pension he said: "My pension is sickness (laughing) that is what I got in my old age. I don't have a pension from anyone. I am tired of seeking a job, I never got one."[61] Mzee Hassan stressed that he was never employed. Even though he was frustrated that he cannot contribute in any way to providing food or support himself and his family, he explained his blindness was God's plan, which could not be changed. Already five years before he moved to his son, when he was probably around sixty years old, problems with his eyes came up. With the diminishing eye light, he also gradually lost the capacity to work.

Most of the older people I spoke to had multiple marriage experiences. Mzee Hassan was nevertheless rather exceptional as he married twelve times in his life. The first ten wives were pregnant but they all lost their pregnancies or children. After he had lost his hope he had one child with his eleventh wife and finally four children (of which one passed away), with his last wife, whom he met in Pemba. Once he lost his sight, he decided that he had to divorce his wife as he was not able to provide for her anymore. He explained his reasons:

> She is not my wife anymore and also; I don't want a wife anymore. A wife needs care (literally: to have things picked for her), do you hear?! It is two years now since I left my wife. Since I was blind my mind was from night to noon and from noon to night worried. So then I realized, you cannot care for her (literally: to have things picked for her), so stop, don't keep her, do not stay with her. Because this would be a sin *(dhambi)*, she

[61] "Pension yangu ni maradhi (anacheka). Ndiyo nilopata uzeeni, sina pension na mtu mie, hata mmoja. Nimechoka kuomba kazi, sikupata."

> needs to be helped with/served food, cloth and so forth. Today, you want her to look for *dagaa* (small fishes) and bring them to you to eat?! This is not right. I better thank God only.[62]

He and his wife did not want to be divorced but Mzee Hassan still decided to leave her "to struggle for herself" as he found himself not being able to care properly for her. Sometime after the divorce their ways crossed again unexpectedly. As they together had just one son who was capable of taking, providing a home to the parents, Mzee Hassan and his wife ended up living together in one house again even though as divorcees this time. While Mzee Hassan mostly needed support because of his visual impairment, his by then ex-wife was more providing care. She was looking after their grandchildren, while their daughter-in-law was away for work. At their son's place, his ex-wife thus continued to see Mzee Hassan, and helped him, by fetching water for him, washing his cloth, cleaning the room and so forth.

While many older people in the city of Zanzibar use mobile phones; this was not common in Chumbuni. Most older people in Chumbuni, like Mzee Hassan were not owning a mobile phone. He generally owned nothing, except his clothes. His children did not provide him with more than simple food and did not seem to have more than this anyways. The older man was disappointed about the fact that his children did not have jobs too, but compared to other parents he emphasized that he would never blame his children for this but that he would just pray to God that he may open their door to success. This reliance in God's power is a typical trait of people staying Chumbuni. Often fatalism is the only option they have to deal with problems they encounter. What could they claim from their children if they see that even these, even though still able to work, do not earn enough to feed themselves?

Mzee Hassan told us that few people come to visit him, but he did not want to reproach anyone, because everybody was busy with his/her own life. He often listens to the radio, which gave him company. He went out up to the shops one street further on and if he had money he bought something, which he asked his grandchildren to carry home. At the shops he sat and people who knew him, came to greet and chat. Sometimes he bought a coffee. During the rainy season he did not leave the house for several weeks. But also, generally he did not walk outside often and he did not attend meetings or go to the hospital. He was not able to see any improvement of his eyes' condition when he had gone there earlier on, even though he used medication. He explained that he is not doing anything anymore and he is just waiting for his last journey *(safari ya mwisho)*. Mzee Hassan passed away in August 2015.

[62] "Si mke wangu tena na wala sitaki mke. Mke anataka kuchumiwa. Unasikia?! Tangu niache mke ni miaka mbili hivi sasa. Tangu nilivyokuwa tena kabisa kabisa akili zangu usiku kwangu mchana, mchana kwangu usiku. Basi nikaona mtu huwezi kumchumia basi usimuweke, usikae nae. Kwa sababu utapata dhambi, atataka kuhudumiwa yule, kula, nguo, na nini na nini. Leo itakuwa yeye kaokote dagaa aje akugaie? Ata sivyo. Bora ushukuru mungu tu."

2.6. The place no one wants to end up: The nursing home

Besides the four shehia in the city of Zanziabar I have introduced there is a place all older research participants had heard of but none had been there: the *nyumba ya wazee*, the nursing home or literally the "house of the elders." Together with the research team and later also with the social work diploma students of SUZA I was teaching, I visited the two nursing homes in the city of Zanzibar several times. I want to introduce them here briefly as they often served as a point of reference for what could be said to be a worst case scenario for all older and younger research participants I was talking to in Zanzibar and Muscat. In our conversation nursing homes reflect the opposite of what was expected and wished by all I have met: care from relatives.

One of the nursing homes is led by three sisters of the Diocese of Zanzibar *(Sisters of the Precious Blood)* together with an employee of the Department of Social Welfare and is called *Welezo.* As long as residents can still do small tasks they stay at the entirely state governed nursing home *Sebleni Kwa Wazee* at Amaani. In 2014, in Welezo stayed 37 older people (29 men and 8 women), of whom are three-quarters Muslims and one-quarter Christians. The older people are on average around 82 years old. They cannot take care of themselves anymore. In Sebleni live 63 older people (22 men and 41 women). They come from Zanzibar, Tanzania Mainland, Pemba, Mozambique and Burundi. There are two "matrons," a woman and a man who are responsible for the nursing home. In Sebleni, all older persons are responsible for themselves; for example they need to cook and shower themselves. If they are not able to take care of themselves anymore, and need to go to the hospital, they should receive help from one of the "matrons." The nursing home consists of 5 buildings with 20 rooms in each building. There are showers and toilets in each building as well. The older people cook in their own rooms. Sixty persons are employed, including the guards. There are no nurses staying in the old age home, but the matron claimed to be able to provide some basic medical help. The older people are allowed to go out during daytime, from 7 a.m. to 12 a.m. (most of them return for lunch) and again until 6 p.m. Some of them spend their day working outside, many go to meet friends. According to the administration of the homes, none of the nursing home residents has a family; thus no one comes to visit them. The nursing home residents receive 40'000 TZS each month, and if there are donations from outside, they are shared by the older people, or they are used to buy food or other things needed at that particular moment. Some older people go out to buy their own food, others receive food that was bought by the matrons. Unlike Welezo, Sebleni is not supported by NGOs. Donations come from single donors only; some donate food for example.

If their condition gets worse they are transferred to Welezo. The old age home is partially financed by the Social Welfare Department, the Diocese and different small NGOs, as well as personal donations, *sadaka* (religious offering, alms) of community members. Besides the sisters have cows and chickens and they sell the milk and eggs to generate income but also the residents get these products from time

to time. In Welezo 48 staff members take care of them in two shifts per day. Two staff members and the three sisters stay also overnight in the compound. Some of the older do not hear or see anymore, some suffer from a mental disorder. Sister Teresa told the research team that traditionally, especially people who immigrated (for example from Mozambique, Congo, Burundi) and did/do not have their family in Zanzibar stay(ed) in the nursing home. Earlier the houses were used to accommodate Leper patients, after the Revolution in Zanzibar 1964 the Sisters of the Precious Blood were sent away. Bi Teresa, one of the sisters, told the research team, that the older people, who stayed there regularly, do not have children. If they have children, those children often are struggling even to take care of their children and that the older people are a burden for them. The nurses told us that, sometimes people are afraid that the older people have something to do with witchcraft and abandon them. Most of the older people who stay in the home come from the Tanzanian mainland and from rural places in Unguja and Pemba. Usually, a sheha (principal) of a village knows if there is an older person alone, who cannot take care of him- or herself. The sheha then contacts the district officer of the Social Welfare and the district officer informs through a report the director of the Department of Social Welfare, who then finds a place in one of the two homes.

These nursing homes do not only provide an example of care provided by others than the family but also illustrate an extremely localized space of aging and caring, which is especially in the case of Welezo retrained to the microcosms of the nursing home and often even only to the place of a resident's room.

2.7. How urban places matter

Obviously, the four areas and the nursing homes I have just described are different in many ways. Two shehias (Mpendae and Chumbuni) are spatially at the urban margins, yet their characteristics seem diametrically opposed. While older people in Mpendae may have access to infrastructure designed by urban planners and several health facilities, many inhabitants of Chumbuni are not only struggling with the poverty of their social network but can also not rely on state provided infrastructure or help from relatives abroad. Even though older people in Chumbuni are creative in finding ways to deal with some of these problems and can expect some support within the social space they can interact in relating to experiences they had made in their local world and thus relating to local ways of being human (Kleinman 1992:129), the physical context of the shehia clearly limits their agentic possibilities.

While poorer older people in Shangani or Kikwajuni Bondeni could easily and without high costs of transport go to the biggest public hospital *Mnazi Mmoja*, ill older people in Chumbuni often told us that they would not see any sense in going there anymore, since often they would need several consultations and they did not want to bother their relatives to pay and organize for the transport. In Chumbuni thus, many older people, especially those who are frail, ill or disabled, are not only at spatial margins, but also marginalized in physical and social ways. In Mpendae at least the streets were broad enough to

allow a car to enter and pick up an older person at home to drive her to a nearby health facility or the main hospital. Nevertheless, as the case of Bi Khadija has shown, for a frail older person in this shehia this still meant a higher dependency on family members, than older people in the two shehias close by the center of the city. She had thus less power to decide where she wants to go to and what she wants to do. These findings are in line with Obrist's analysis (2018) of research data from four studies on aging in Tanzania,[63] in which she describes how the place "home," as a "used and lived space" (Obrist 2018, 96) with its built structure and field of experience becomes more important the more people become old, ill or disabled.

Comparing Shangani in Stonetown and Kikwajuni Bondeni close by the city center we can see that Shangani is much more heterogeneous, socially and economically stratified with for example economically very poor to very rich households. It shows an exposure to diverse cultures, which is unique in comparison with other shehias and generally, is a good deal more busy area. Even though I met older people living in poverty in Shangani, I had the impression that they could still benefit from what was available for anybody in the shehia like running tap water, clinics, healers, mosques and stores just around the corner. Relatives of older people predominantly worked in the city center as well or did sell anything just outside the house, which normally insured that they stuck around the older person and could step in, if the older relatives needed anything. In this mixture of people, unskilled workers live next to highly specialized medical doctors and sometimes get a chance to be examined free of charge by a neighboring doctor at home or to receive a meal from better off neighbors, who could not be found in Chumbuni and who would be behind the walls in Mpendae. Most older people, even if they were very weak, sat on their baraza benches outside the house sometimes during the day and often without actively begging received some small financial support from neighbors and passersby.

In Kikwajuni though, the residents are a more homogenous social group of what might be called a middle class in its literal sense. As many older men worked sometime of their life as (lower) civil servants or at least with a contract for the state or a private company they are now accessing pensions and live in their own modest houses. The experience of the place is also important in Kikwajuni because most older people live there for a major part of their life already, went to school together, built alliances through marrying members of each other's families or had children at the same time, they are very well connected and can expect some support of their social environment in cases of emergencies. The good public schools in the close surroundings and the connections to public authorities allowed several men to study abroad and build further social networks. They paved the way for their children to go abroad as well. While some of this younger generation sends now money from their new countries of residence to

[63] The interview data of this study is also included.

the older generation as in the case of Mzee Mohammed to renovate a house, for daily support or in specific emergencies others completely broke the kinship ties.

All four urban neighborhoods as places are thus local worlds and as such locations full of meaning that constitute sites of everyday practice (Cresswell 2009, 177). The cases showed particular forms of life of older people, which relate to certain places, compared to other local worlds with different micro-contexts of experiences.

3. Conclusion: Entanglements of Staying in Places and Engaging in Spaces

The different places with their local worlds I have described in detail in this chapter can facilitate or complicate engagements in specific social spaces. The places where older people stay are thus tightly entangled with social spaces and are crucial to understand how flows of people, commodities and ideas between these local worlds and other places can happen. As we have seen in the description of the four shehia with their different local worlds, the contexts of aging and caring of older urban residents in Zanzibar can look very different depending on which places older city dwellers are living in.

The contexts of action of older people in these four areas are unequal. If we keep in mind that agency is a temporally constructed engagement of actors in different structural environments (Emirbayer and Mische 1998), these engagements are thus on the one hand depending on the given context but also change over time. As I have argued above, I understand physical places and in this study the differently built shehias as being part of the structural environment. Nevertheless, it is important to take more than the “hard city,” its material and physical aspects, and the “soft city,” its meanings, imaginations, and myths, into account (Raban 1974), when analyzing what lived experiences of aging in the city are. Local places constitute a contextual background for human agency but place is just one element besides other structural contexts which guide human agency. Emirbayer and Mischer (Emirbayer and Mische 1998, 970) describe the cultural, social-structural and social-psychological contextual fields to which they understand people relating while they orient themselves to temporal experiences and imaginations.

Understanding a city also requires integrating transnational and cosmopolitan experiences, relations, and possibilities for the analysis. In specific areas of the city, the chances are higher that an older person can keep up a cosmopolitan lifestyle or connect to relatives and maintain social networks that span beyond national borders. The transnational space of ageing and caring between older Zanzibari in the city and their social networks in Oman not only creates new practices of caring in which norms and values can be maintained and mutually reinforced. Long-distance care also overcomes some of the aspects of urban marginality that older people experience once they become seriously ill or frail.

By considering the African city as an ordinary city (Robinson 2006) and overcoming the North–South divide (Robinson 2011), I argue that these findings stimulate the discussion on how we can analyze the diversity of urban aging and what cities generally are: First, an actor-centered approach can help to understand how (older) people are living and working in a city since it follows their experience, imagination, and evaluation of a current situation. Second, the findings of this chapter call for a closer look at what specific places of residence and according local worlds mean for older people's engagement in local, cosmopolitan and transnational spaces of aging and caring.

In this chapter I have argued that urban aging is a useful perspective for studying urban life and social conviviality, especially when analyzing how cities are experienced, lived in, and worked in by inhabitants on the social margins. Looking at the older people of Zanzibar as an example of living on the urban margins can help us get a more differentiated picture of how places of residence and access to social spaces are entangled. At the same the stories of the older men and women in this chapter have illustrated that the place of residence is just one among many aspects shaping the experience of elderhood. We have also seen that urban older people, especially if they have a major health issue, are at risk of being excluded from the urban center no matter where they stay. The degree of health problems, impairments, or frailty thus fundamentally affects an older person's position in urban society and beyond. The next three chapters will discuss concrete health situations and their implications for older people's engagement in spaces of aging and caring in the city of Zanzibar with its generally cosmopolitan identity.

Chapter III:

Being in Good Health

Picture 4 – A relatively healthy research participant in his garden in Mpendae.

III. Being in Good Health: Gendered Efforts to Maintaining Respectful Social Spaces

At the very beginning of my research in the city of Zanzibar, I was advised that I should talk about older people as *watu wazima* (adults) and not as I have had previously learned on the Tanzania mainland as *wazee* (older persons or parents). This linguistic difference is interesting as at least I thought that *wazee* having its relational and generational meaning of being socially older was flattering, while preference was given to *watu wazima*, which literally translates as "people who are being complete, whole" or also "healthy, well, fine and physically fit." It is unlikely that people in Zanzibar are always consciously using this term and to refer to older people as *watu wazima* must happen very habitually. Still though, after having spent so many months talking about and observing aspects of elderhood in Zanzibar, I think that for "being a complete person" *kuwa na afya nzuri* "being in good health" is – as we will see, for men even more than for women - very important. This chapter thus, is devoted to finding answers to the question of how older people who are in a situation of relatively good health experience their elderhood and what kind of norms and practices of caring between themselves and others I could observe in such situations. It is necessary to clarify again that by "good health" I do not mean the absolute absence of disease, frailty or disability but rather emic perceptions and representations of older people and their social environment who articulate to feeling relatively healthy and as we will see in this chapter, to being well enough to do things on their own.

My ethnographic material suggests that having *nguvu* (energy, strength) and being *hodari* (clever, intelligent, experienced, knowledgeable, shrewd and powerful) were key for older people to perceive and represent themselves as *kujiweza*.[64] Kujiweza means being fit, being all right, being able to do without help or literally being able to do it themselves. Older research participants described "good health" to be the condition when illness was absent or minimal and in *uzee* (old age), only the "normal" weaknesses of the body like getting tired quicker, not seeing and hearing as well as previously or having light pains in the limbs were present. A further aspect how the research participants described themselves as being relatively healthy, was, if a person did not need to take many medicaments. Generally, the health definitions of good health the older research participants articulated do correspond with Obrist's (2006, 129) analysis of women's understandings of good health in a Swahili area in Dar es Salaam. These women usually differentiated the state of the body (physique, appearance, no sickness, functional ability) from the state of the mind (well-being, no problems).

[64] *Kujiweza* is the reflexive form of *kuweza* (to be able to/can) including the prefix *ji-* (oneself).

While people suffering from health problems often pronounced health deterioration as a major aspect of elderhood, relatively healthy research participants were more concerned about maintaining respectful social interactions. Articulations of what aging means for those in situations of relatively good health, were often expressed in an entangled way with understandings of "good aging" as such. *Kuwa na heshima,* "being respectful" was a central concern for many healthier older people. Being healthy but *(nime)shakuwa mtu mzima*, "(I am) being already an older person" older men and women argued that one should "respect, honor and esteem" *(kuheshimu)* oneself, as well as others. That *heshima* plays an important role in the gendered lives of Zanzibari of any age is well recognized in the literature (Keshodkar 2013, 139; McMahon 2006). According to Middleton, men typically acquire *heshima,* which he translates as "reputation or honor," through scholarship, religious piety and social integrity (Middleton 1992, 138), while it is argued that women traditionally would do the family's credit by staying under control of male relatives (McMahon 2006, 215) and by preserving their "physical purity" (Middleton 1992, 138).

Kuwa na heshima embraced for many older people an understanding of reciprocal social transactions, which was also expressed in their wish to contribute within their social space. Being able to care for others and to contribute physically or financially in the *jamaa* (extended family) was thus important for healthy men as well as women in all four shehia and from all social backgrounds. The range of contributions made by older city dwellers in their families and area was wide in scope and ranged from financial support, over helping in the household, letting family members stay in one's house, supervising grandchildren to giving advice by marital disputes and the like.

To better understand what it means to spending ones elderhood in good health in the city of Zanzibar, we need to look at articulations and practices of older men and women in their everyday lives and thus thinking through the intersubjective and relational dimensions of agency (Emirbayer and Mische 1998:973). In what follows, I investigate the gendered ways of how older people experience and frame being healthy, as a form of keeping a certain degree of self-reliance, not needing helping, while aiming at being socially integrated by at the same time providing and receiving care for and from others.

1. I Can Do it Myself (Ninajiweza)

It is not only for the sake of feeling well, that older people wish to stay healthy and having energy in their elderhood but also a good health condition is a precondition of being able to care for oneself and others. The case of Mzee Ali bellow, illustrates typical elements of being able to care for oneself in elderhood as many older people in the city of Zanzibar told and showed me.

1.1. Trying to do activities as usual

Mzee Ali grew up in Kikwajuni, just at the other side of the crack dividing Stonetown and the rest of the city (*N'gambo*). Nowadays, in his late 60s he lives in the newer and well established shehia Mpendae. His case provides us with telling insights into how he perceives the duality of being relatively healthy but still being confronted with afflictions of old age.

The situation of the widower is in many ways special as he is one of the few men who did not marry again after the loss or divorce of a wife. This was especially particular as he would have had the financial means and the capacity to take care of a new wife, in a way as it would have been expected by the urban Zanzibari society at large. Usually, men in his position and being in good health were not only expected to marry again but also to put this norm into practice. "Choosing" a (younger) wife would usually mean for men to be unburdened from household work. Instead, Mzee Ali lived together with his youngest daughter, who stayed during most of the week at a high school she studied at and only returned on some weekends. He invited his older brother to stay with him, since he was not as financially privileged as Mzee Ali who owned a house and as a former higher ranking member of the military and soccer player of the national team of Zanzibar received a comfortable pension. He is the only man I met who is living together with a sibling in his elderhood. The two shared the household tasks as much as possible but Mzee Ali was fitter than his brother and he took on more strenuous tasks like gardening, going to the market or sweeping. The older man thus, actively chose between different options he could picture being a fit widower, with a wealth of cosmopolitan experiences made in his past.

We had visited Mzee Ali already several times to participate in this everyday life, joining him in whatever he was doing like working in the garden, cooking, sitting on the mat outside his house in the relatively spacious garden and he told us a lot about his life and health before we had this following conversation. Saleh and I asked him about his health condition these days and he answered:

> Since we started there is no change at all in my health and I'm grateful that my condition is good and it did not worsen. It is still the same and it has also not improved like, I was not able to see far and then I would see far now, no, no, it is just the same. I still recognize a person when he/she is near, for example this is Salum (points at a man walking by) but if he is far, then it's still the same (and I do not recognize him/her). Because even when I did the treatment (of my visual impairment) they told me 'Mzee Ali, don't expect to be seeing as you did in the past, you won't see far anymore' but there is no problem in that. Even about the blood pressure, I thank God, when it increases I myself, move around (and decrease it) on my own.[65]

[65] "Afya tokea tulipoanzia pale hakuna changing yoyote iliyotokezea nashkuru kwamba hali imeendelea vizuri haikuteremka iko pale pale wala haikupanda kwamba nilikuwa sioni mbali na sasa ninaona mbali aah iko pale pale mtu awe karibu ndio namjua huyu Salum, lakini mbali itakuwa pale pale. Kwa sababu hata matibabu wa macho

Even though Mzee Ali, as most healthy older people, related aging with a deterioration of health, he pointed to the fact that good health in elderhood meant that one could still do the accustomed activities and enjoy life:

> A person in good health is the best thing because you can run, you can jump, you can be upright but if health starts to come down because of the age, the result is that now, I cannot go fast, I can't run. I was seeing far but now I can't. I had two eyes of which both were seeing well but now one I can see with one clearly and the other can't see, of course one will even go sideways. (…a healthy older person) you will see that he/she is doing all her activities as usual but if a person is not in good health, if someone is not in a good condition, you will feel he/she gets distress - this poor one - but if you are already an older person *(ukishakuwa mtu mzee)* but still in good condition *(hali nzuri)*, you will see that this person is enjoying, yes, like me. I am not in a very bad condition, yes, it is true I have a little problem with my eyes but if you compare me with someone whose health condition decreased a lot, that one will get a lot of distress – that poor one. I myself, while you came here, I was able to stand up, I went to wash the rice, I put it in a pot, I went to the rice cooker, I put in salt and I poured oil into it. But a person who is not in good health, you would meet this person in distress. Even to get up would be a problem.[66]

According to him, a person enters *uzee* (elderhood) or is already an older person *(anakwenda uzee au ni mzee)* because of his or her chronological age as such, but that *uzee* comes especially often earlier, even in younger years as a result of disease, by lacking "good income" or "good nutrition." He, on the contrary was never confronted with any of these problems.

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waliniambia Mzee MohammedAli, usitaraji kama utakuwa unaona kama hapo mwanzo, hutaona mbali lakini hakuna matatizo, hata hizo pressure nashukuru, kwa sababu inapopanda mimi mwenyewe ninakwenda peke yangu."

[66] "(…) mtu ukiwa na afya nzuri ni kitu pekee, kwa sababu unakwenda mbio, unaweza kuruka, unaweza kusimama, lakini tena afya ikianza kuanguka kutokana na age, kuchupa sasa hivi siwezi, ama kwenda mbio, *ku-run* siwezi, naona mbali zamani, sasa hivi sioni mbali, nilikuwa na macho mawili yote yanaona sawa sawa, sasa moja linaona vizuri lengine halioni, *of course* lazima utakwenda upande upande. (…mtu mzee lakini yupo katika afya nzuri) utamuona zile activities zake zile zote anazifanya kikawaida, lakini sasa akiwa hayupo katika good health, hayupo katika condition nzuri utahisi anapata tabu masikini, lakini ukishakuwa mtu mzee lakini yuko maana yake hali nzuri utakuta binafsi ana-enjoy, ndio kama mimi siko katika hali mbaya sana, kweli nina matatizo za macho kidogo lakini ukilinganisha na mtu aliyezidiwa sana yuko katika condition mbaya, anapata tabu, masikini. Mimi hapa umekuja nimenyanyuka, nimekwenda kukosha mchele, nimetiwa katika sufuria, nimekwenda katika rice cooker, nimetia chumvi, nimetia mafuta. Lakini unamkuta mtu hayupo katika good health, unamkuta mtu anapata tabu. Kule, kunyanyuka kwake tu atakuwa katika shida."

1.2. Planning, preventing and having self-respect

Distancing himself from people who would just "survive from one day to the next" Mzee Ali consistently emphasized that he and his late wife, who was a school principal, planned their lives, their children and their offspring's education carefully. According to their expectations, all four children could profit from top schooling in Zanzibar and the three older ones are living and working with their children in the UK and Canada after having gone there for studies more than ten years ago. In his eyes thus, their plan worked out. Additionally, to his pension, Mzee Ali also received monthly remittances from his children abroad, as well as medical gadgets, medicaments or fancy devices like electronic cigarettes.

Even today, Mzee Ali is planning and trying to influence his future aiming to prevent health problems. As a rather affluent and cosmopolitan elder urbanite he is aware of non-communicable disease in general and was most afraid of becoming affected by high blood pressure or diabetes, but not for example by cancer of which his wife died from. Accordingly, he invests into a healthy diet, goes around by bicycle and works in his garden to stay active. He is just unhappy with himself for not being able to manage his bad habit of being a chain smoker, which he tries to change using electronic cigarettes. Once he had a fever and went to a hospital to check if it was malaria, he was told, that he had a little higher blood pressure and received medication against it, which he took for some time. This changed when Mzee Ali learned from a friend of his that this medication contained a lot of chemicals whereupon he decided for the future to use only local herbal products.

Typically, older men and women in this situation of being relatively healthy, mentioned that they were following a special diet or taking care of what they eat because doctors informed them about the risks of hypertension and diabetes, both rampant diseases. In many households, all members received a special diet and had to adjust to the new recommendations, which were primarily issued by medical staff for the older family members. Accordingly, for example to decrease the salt consumption, a common recommendation to reduce high blood pressure, the sauce was not cooked with salt, only the rice with a little bit of salt.

Generally, the research participants agreed that *chakula kizuri*, "good food" was very important for older people. Already Obrist (2006, 141) describes in her research on health explanations among women in Dar es Salaam, how food came up as an essential part of what good health meant to them. What this *chakula kizuri* entailed was not the same for all. Mzee Omar Kombo for example told us that he aims at eating *ugali* (dish made of maize flour), rice, vegetables, fish, potatoes, little oil and coconut, so that he is not hungry anymore. So far, he is glad that he can still provide this kind of food to his family and even to his children who do not live in his house but come to eat there. He emphasized that if once this was

not possible anymore it would be time to move to one of his children. For others *chakula kizuri* was meat, fish and milk, which was praised as panacea to stay healthy and strong but also ice cream was among the favorites.

One aspect of having *heshima* for oneself, was the importance of being a responsible person and included diverse aspects of what could be called everyday self-care (cf. Kaiser-Grolimund 2017). Especially for more affluent members of the urban society, this responsibility meant to take care of one's body. Men often told us that they go for walks or ride a bicycle. Some do it because they have to follow up some businesses outside the house and others go purposively to do *mazoezi* (sports). As older women are expected by the family and the wider society not to stroll around outside, they spend much more time at home and do not go to do exercises outside. Inside the houses women take care of themselves as well by keeping themselves and the inside spheres *nadhifu* (neat, smart, tidy). Having self-respect is also closely interrelated with being faithful. Practicing their religion (in most cases Islam) and living according to these values seems to help older people to have peace of mind, which is an important aspect of being in good health as especially women told me about. Many older men emphasize that they take care of their health for a long time as they underline that they did not drink alcohol and did not go *nje, nje* – "outside, outside" - did not engage in adultery. On one hand this helps them to avoid problems with their wives, families and their religious conscience and on the other hand they also did not harm their body through substance abuse or sexually transmitted infections. Being not only afraid of infectious disease but more and more of chronic conditions as Mzee Ali mentioned them is widespread among the older population in the city of Zanzibar.

1.3. Wanting to be valued and aspiring acceptable (in-)dependence

In all three health situations I am describing in this book, the issues around how (in-)dependent an older person want and could be was complex. I found it especially interesting to observe in the situation of relatively health research participants how they mediate dependence and independence. On the one hand, in particular men articulate their wish to be independent from others. By having enough money to taking care of themselves, a household where they could be the "head" of and generally by keeping up a freedom of choice in whatever they want to do or eat etcetera. On the other hand, the cultural and religious norm of valued and respected older people also means that elders expect a reciprocal payback for what they did in their past. They thus need to give up some of their freedom to accept the care of others.

Mzee Ali does not know what the reason for his loss of sight of one of his eyes is but he suspects his service in the Tanzanian military in Russia and the connected exposures to radar rays to have had an impact. He nevertheless had to deal alone with this health issue and used his own money to pay for the

treatments (200'000 TZS).[67] His frustration that the state did not seriously take care of him and others after having "used" them in the military service has turned into a general bitterness of how people would be themselves nearest nowadays. This experience of being left alone by the state, as well as partially by relatives, was mirrored in many of his actions by which he wanted to make sure he could take care of himself whatever will happen to him. Most older people I met though, were painting a comparatively positive picture about how they felt treated and looked at by the state and the Zanzibari society at large. Mzee Ali, like the majority of the research participants, wanted to keep a certain independence also in elderhood but in comparison to others, he imagined that "abroad" older people would be treated with more respect by the state and the community than in his country. That impression he saw confirmed in my presence and research, which he understood to be supported by the Swiss government. I did not expect my presence as a foreign researcher to provoke such a reaction. Having been travelling in his past especially to socialist countries and being in regular contact with his children in Europe, he expressed his dissatisfaction in the contrasting juxtaposition on the one side, of the caring others, who do things for the older population, of which people in Zanzibar might not even know of, while on the other side, locally, older people would have lost their importance:

> In our place, the people treat you as unimportant. (…) For here when a person is aged is taken as not important but to our fellows (abroad, he was referring to the society I would come from) an old person is cared for/valued *(mzee anathaminiwa)* and it seems there are things which they get, which we don't know of.[68]

Mzee Ali thus drew on his cosmopolitan experience abroad and used it to explain how he imagined good aging. The theme of needing to be valued in the sense of reciprocity because of what older people did for their children and other younger relatives came up in virtually all conversations I had with the research participants. This reciprocity, usually was seen to be necessary within families but not many older people – even not former state employees - mentioned so directly the state to be responsible to show reciprocity. Even though Mzee Ali did not seem to be generally unhappy, he did use every opportunity to stress his loneliness and that older people would not be valued (*kuthaminiwa)* enough. Accordingly, for example, when we asked him if he has a mobile phone he said, there was no need to have one since he has nobody to call and his children abroad would contact him through the landline phone. He never directly criticized his children but still he mentioned several times that children

[67] As a reference may serve the universal pension introduced in 2016 in Zanzibar, which grants every citizen above the age of 70 years a pension of 20'000 TZS per month.

[68] "Kwa kwetu unachukuliwa mtu asiyekuwa na maana tu (…) kwetu mtu ukishazeeka unachukuliwa huna maana, lakini kwa wenzetu huko mtu akiwa mzee anathaminiwa sana na inaonekana lazima ana vitu tunaweza muhimu kuvipata ambapo sisi hatuvijui."

nowadays would not value that their parents educated and took care of them, they would also not ask for advice for example if they had marital disputes, which he remembered to be an important task of parents.

To some extent Mzee Ali had become a victim of his own success: By supporting his first three children financially, logistically and ideologically in going abroad to study he lost them being close to him. These children send monthly a *mchango* (payment, contribution) to him but he only sees them and his grandchildren every couple of years. His last born daughter is also not around during the week as she stays at school, thus he is mostly alone with his older brother for whom he cares. Mzee Ali thus planned and arranged for his children to profit from "good education," to study abroad and possibly to live there. Financially he is now in a relative stable situation. What he did not calculate was that apart from the price he paid for the education of his children, he is missing now their company in everyday life. In a context, where family members and especially children usually provide the closest support, including emotional exchange on a day to day basis, the physical absence of children seems to be especially bitter. Most older research participants did not have all of their children well educated and especially not all of them abroad. Comparing the cases, it seems to be crucial for older people to keep a good balance of having close relatives physically near-by and few relatives abroad who lived socially, financially and legally in save situations to being able to exchange regularly and support older people in Zanzibar from far. The case of Mzee Ali illustrates how older people who are relatively healthy might be able to take care of themselves and even others but that this does not mean that total independence is aspired but aspiring acceptable (in-)dependence. They wish to be contacted, cared for at least emotionally and like this being valued for what they did in the past.

Most older research participants mentioned that "good aging" also means to be able to contribute something to the household; this could be in the form of small household work or financial contributions to be able for example to buy things, which are missing in the household and not to need to ask their children for everything. On the other hand, "bad aging" would be if one "invested" in children and then would be left alone, if people do not take care of older people, if one needs help for everything and is sick or bed ridden. In general, the older Zanzibari research participants mentioned begging in the streets or ending up in an old age home as the worst case scenarios of "bad aging." In general, the research participants perceived that older people in Zanzibar were not discriminated in the society but respected, however they also lamented a reduction of respect and readiness to help older people if they are not family members, especially in the neighborhood and in the wider public compared to the past.

Mzee Ali explained that if at all the younger generation cared about their elders it only included related older people but not older people in general. When we asked the research participants explicitly if they feel that older people are discriminated (*kubaguliwa*) in the society they all negated. The processes of

social marginalization seemed to be much subtler and I was not sure whether Mzee Ali, even though he was healthy and energetic, sensed them more than others because of his confrontation with all kinds of moral worlds of his cosmopolitan lifestyle throughout his life, due to the physical absence of his closest family members or because he was just a very sensitive person. Thus, according to Mzee Ali, it had nothing to do with being discriminated as an older person but it had to do with being valued and loved and was more than just being greeted in a respectful way:

> It is only about being valued. This is enough, then if a person is valued, everything will come. If you are known as Mr. Ali who is my parent, first I was born by him, he brought me up, I have received his care *(matunzo)* and he educated me. If those things are present in your heart, then the rest, to value your parent will just come.[69]

While many of the older research participants in Chumbuni and other less privileged older people were glad to receive one or two simple meals per day from family members just not to be hungry, Mzee Ali who is having access to cosmopolitan spaces of aging and caring expressed aims for more than just covering the basic needs. For him being valued as *mzee* (older person, parent) did not just mean to have a house to live in and some food, as the old age home (*nyumba ya wazee)*, which the state provided to older people who did not have any relatives to take care of them. Some of my interlocutors interpreted *kuwa na heshima* simply as being friendly within their social environment. Mzee Omar for example said once: "If you respect others, and greet them with *Asalaam Aleykum*, they will respect you as well." For others, like mzee Mohammed being valued included much more: Children and other members of the community *(jamii)* around who care and ask for example, whether "their father" had eaten *good* food today, or ask, if maybe he is sick and cannot eat well today, people who are there until an older person goes to sleep, so that they would cover his bed well with the mosquito net to protect him. Accroding to many of the research participants such kind of respect *(heshima)* and good manners *(adabu)* should run through all levels of society starting from the family *(familia)*, over the community (*jamii)* to the whole country (*nchi nzima*). While some older people did not see a difference in how older people were treated in the past compared to the presence, Mzee Ali clearly sensed a loss of *heshima:*

> In the past time, when we were young, when I was in your age (around 30 years), all the houses around were my homes. You were respectful, you could be called and given a task in any house without even

[69] "Ni kuthaminiwa tu. Inatosha kwa sababu mtu ukeshakumthamini yote yanakuja. Ukishajuwa kwamba Mzee Ali ni mzee wangu kwanza kanizaa, kanilea, nimepata matunzo, kanisomesha. Vitu vile vikiwa ndani za moyo wako, halafu kikaja kitu kwamba huyu mzee nimthamini, basi mengine yote yangekuja."

> getting angry. So, the whole Unguja had respectful children and every family was competing with others in wanting their children to become the most respectful.[70]

Mzee Ali's understanding that a "child was not a property of only one person but a property of the area, the whole area" and his impression that "if you were sick, the whole area was troubled to treat you,"[71] is possibly related to the socialist spirit of the post-revolution era starting in the 1960s.

Most people became somehow humble during their elderhood. Usually, this became visible the more people felt they could not do it themselves anymore *(kujiweza)*. Referring to his age, Mzee Ali – even though being in good health – expressed to have only moderate aims *(malengo)*: "What aims could I have at this age? My personal aim is only to complete my end *(hatima)* well. I don't need a Boeing (model of aircraft) or anything like that. I just care about my eating; this is all."

These examples illustrate how some older cosmopolitans like Mzee Ali draw on different discourses, which are not easy to locate. Mzee Ali's example stands for those older people, mostly men, who made experiences abroad by travelling to socialist countries as well as later in their lives sent their children to Western countries or the Arabian Peninsula, and to hold up long standing relations to family members who emigrated to Oman and other countries after the Zanzibar revolution in 1964. These experiences influence present decisions for example how they want to prevent health problems but also future aims. As the examples show, do older people with such cosmopolitan experiences in situations when they are relatively health relate to a multitude of contexts of action. They refer to discourses from the "West / Global North," "the (Middle)East" or "the Global South," in their accounts and actions they show the entanglement of ideas about "tradition" and "modernity" as well as they mix socialist, Muslim and colonial moral concepts. This mixing and situational orientation to a broad spectrum of cosmopolitan spaces of aging and caring is what I mean by cosmopolitan aging in Zanzibar.

2. Lived Experiences of Gendered Aging

All three typical situations, which link health and aging experiences of the older research participants in Zanzibar with the related implications for the older people as well as for their social environment are experienced and lived in a heavily gendered way. I ask the question of how the lived experiences of

[70] "Zamani, tulipokuwa sisi wadogo mimi nilipokuwa na age kama nyinyni, nilikuwa najuwa nyumba zote zinazokuzunguka na nyumba yenu ni zenu. Unaziwekea heshima, unaitwa kutumika katika nyumba hizi hata uso usiukunje. Sasa Unguja nzima ilikuwa na heshima na kila familia inataka mtoto wake awe na heshima kumzidi mwenziwe."

[71] "(…) mtoto anakuwa si wa mtu mmoja mtoto anakuwa wa mtaa, mtaa mzima. Unaumwa, mtaa mzima unahangaika kukutibu wewe."

masculinities and femininities will change and emerge during processes of aging in situations of relative health.

2.1. Gendered lives in urban Zanzibar

In the Muslim community of urban Zanzibar, women and men have at least in the public discourse distinctly gendered everyday tasks which are tightly interwoven with other identities related to kinship and other social relations as being mothers, fathers, grandmothers, grandfathers, sons or a husbands, neighbors and so on. Contexts of action like access to formal education, religion, economic possibilities and social milieus further shape how older people relate to gendered norms and practices of aging and caring. Diverging identities through gendered social values based on complementary differences of Zanzibari men and women have developed historically and were further structured through the experience of discursive formations of Islamic norms, slavery, socio-economic mobility and urban migration (Keshodkar 2013; Fair 2001; Gower, Salm, and Falola 1996, 257). According to these so-called traditional models, women should stay at home and take care of the household and children (Gower, Salm, and Falola 1996, 257), while men are supposed to fill the house with what is missing from outside of it. In many ways the gender division of responsibilities *(majukumu)*[72] corresponded with what Obrist is describing in her study on health practices of mid-aged women of the Swahili community in Ilala Ilala an inner-city neighborhood of Dar es Salaam in the mid-nineties (Obrist 2006, 177). There, men were responsible for productive work, while women's responsibility referred to reproductive work (Obrist 2006, 177). Men in urban Zanzibar as well are generally expected to earn the major part of the income, do the shopping, have responsibilities in the wider family context and in the mosques. Using the household, which Obrist (2006, 46) defines as co-resident group of people sharing consumption, mutual obligations and social relations, as a socially structuring entity, Obrist (2006, 178) argued that women took over the majority of household responsibilities. In my study in urban Zanzibar many social responsibilities of men could not be grasped with the concept of a household. For example if a man went to buy glasses for his father who stays in his own house, or if a man overviewed the construction site of a house built in Zanzibar by a cousin staying in Oman or gave a lift with the motorcycle to a neighbor etcetera. I found the concept of household not particularly helpful whether to analyze gendered responsibilities nor for care-giving relations, as responsibilities and practices were not bound to entities as households but rather extended to diverse social actors, such as relatives, neighbors or faith groups in diverse places and spaces. That the responsibilities of men and women were constructed as divided was evident. Even though in the post-socialist era the historically high degree of sexual segregation was challenged by new ideals of individualism and imaginations of a "modern life" (Keshodkar 2013, 139),

[72] Some research participants differentiated between *mujibu* (duty, commitment, engagement) and *faradhi* (obligation, commitment, duty, responsibility).

I still found most of the respondents agreeing with what was framed as traditional models of complementary norms and practices for men and women.

2.2. Masculinities and femininities

By masculinities (or femininities) I understand the position of men (or women) in a gender order (Connell 2005 [1995]). Masculinities (or femininities) can be defined as the patterns of practice by which people engage that position. Bearing in mind Henrietta Moore's thoughts about the characteristics of femininities and masculinities, which I use here in the plural, I do not aim at framing fixed entities of male and female identities but to understand them as one of several aspects people can refer to in their articulations and practices:

> Femininity and masculinity cannot be taken as singular, fixed features which are exclusively located in women and men. We must agree to this if we recognize that subjectivity is non-unitary and multiple, and that it is the product, amongst other things, of the variable discourses and practices concerning gender and gender differences. (Moore 1994, 64)

Before I will go into the details of how these differences appear in the everyday lives of healthier older people, I introduce the relatively marginal field of gender and aging in anthropology and gender studies, especially in relation to older men and masculinity. Through this approach, I aim at contributing to a denaturalization of masculinity in research on aging, whereby gendered aging is usually looked at from the perspective of women, while aging of older men is depicted as natural and non-gendered.

Older men are typically not the first social group that comes to our mind if we think of gender and masculinity. The widespread oblivion of older men in gender research and policy, especially in Africa, is surprising since they constitute a growing section of the population. This book argues that masculinity is a fruitful, unusual lens to study aging and care, especially when one is interested in how gender in an urban and cosmopolitan African context is experienced, lived and worked on. This lens allows us to see, how throughout the life-course, but also in elderhood, how gendered sets of discourses and practices of power and resistance in the form of more or less dominant masculinities shape and structure the lived experience of aging and caring and thus also the relations they have to the world. Following Ratele's argumentation then, such relations "cover those arrangements males and females have to institutions, structures, laws and policies over and above males' relations to their own bodies, bodies of other males and female bodies" (Ratele 2016, 65) and are thus crucial to understand how men may relate to others.

Anthropologists and gender theorists like Beauvoir and Capisto-Borde (2011) Butler (1990), or Ortner and Whitehead (1981) have long argued that gender is not a natural essence but is relationally performed in response to an individual's particular cultural and structural situation. Many ethnographic studies

followed, which aimed at a better understanding of women's worldwide subordination by studying women but largely leaving out men for a long time (cf. Inhorn and Wentzell 2011). By studying men stereotypical as "men," individual men were buried in oblivion and their bodies, attitudes, and actions were represented as both "natural" and "essential" and not as being gendered like those of women (Gutmann 2007). Research on masculinities in Africa is apart from several studies from South Africa still almost non-existent. Most research on the rest of the continent is either historically (Miescher and Lindsay 2003; Miescher 2005; Miescher, Manuh, and Cole 2007) or psychologically orientated (Shefer, Stevens, and Clowes 2010). The scarce literature on maleness in the African contexts focuses predominantly on boys and young men struggling to become respected men (eg. Shefer, Stevens, and Clowes 2010; Mills and Ssewakiryanga 2005). A great part of the research on masculinities in Africa is related to HIV/AIDS research, sexuality and power inequalities between men and women (Shefer, Stevens, and Clowes 2010, 511). Men were presented as problematic and the complexities of the social construction of masculinities and contradictory experiences of boys and men were hardly shown (Shefer, Stevens, and Clowes 2010, 512). A handful of ethnographic research pointed at the entanglement of aging and male gender in Africa but did not look closer at the lived experiences of masculinities (Geest 2004; Cliggett 2005; Meiu 2014). Cliggett's study (2005) on aging, gender and famine among Gwembe Tonga people in Zambia, in which she analyses the deeply gendered ways of elder men and women to encourage aid from their children and fend off starvation, as well as Sjaak van der Geest's research (2004) on the relation between grandparents and older grandchildren in Ghana depict gendered care-giving practices.

Masculinities were widely understood as what men, say and do "*to be men,* and not simply (…) what men say and do" (Gutman 1996, 17). Criticizing former representations of masculinity as static and homogeneously bound to local social worlds and individual persons throughout their lives, Inhorn and Wentzell (2011) appealed for more research on how masculinities emerge. Emily Wentzell (2013) in her study on men with erectile dysfunctions in Mexico further encouraged to look deeper into the dynamics of masculinity and male subjectivity to find out more about how men continually rework their gendered selfhood in everyday interactions and throughout the course of their lives. Wentzell focused on what happened to masculinities of older men if a key signifier of manliness, namely "frequent sexual penetration" is at stake and the "ways that men link specific acts, experiences, and forms of embodiment into situation-specific ways of being men" in what she calls "composite masculinities" (Wentzell 2013:27).

To analyze how Zanzibari men's lived experiences of masculinities change during the aging process and depend on their health situations, I will lay out all three health situations. First, in this chapter, I will present the situation of relatively healthy older men and their "caring masculinities," and in the following chapters, look at situations of sudden health problems and breaks of continuity in which

masculinities are jeopardized and, situations of fluctuations of chronical illnesses and frailty where men got used to ups and downs and mostly came to terms with changing masculinities. These situations are not clear-cut and static, but men – like women obviously too - switch back and forth between these conditions of health.

I analyze how Zanzibari men's lived experiences of masculinities change during the aging process and depend on their health situations.[73] I follow the call of Inhorn and Wentzell (2011) and aim at analyzing how the lived experiences of masculinities changes during the processes of aging and phases of illness in old age in an urban and cosmopolitan East African context. I therefore understand care relations as social interactions, and the way older men position themselves to provide for themselves and others. Being able to care for oneself and one's family, I argue, is a key signifier of manliness in the predominantly Muslim city of Zanzibar. In this context I will illustrate how changing bodies and health conditions, heavily influence men's capacity to take care of themselves and others and how these impact on how they relate to popular discourses of masculinities. My aim is not to focus on gender hierarchies but to contribute to a broader discussion on masculinity and to open up the discourse of "hegemonic masculinity" (Connell and Messerschmidt 2005; Connell 2005 [1995]). There is generally a hegemonic form of masculinity, the most honored or desired in a particular context. The hegemonic form needs not to be the most common form of masculinity. Typically, many men live in a state of tension with, or distance from, hegemonic masculinity (Connell 1998, 5). The research data will show, how hegemonic masculinities can be much broader than they usually are portrayed as legitimizing patriarchy and gendered dominance.

3. Caring Masculinities: Seeking to Provide for a Family as Long as Possible

The first of these three situations is a snap-shot in which I observed older men being relatively healthy and self-reliant (*ninajiweza* – I can do it myself). In this situation, older men saw themselves - but were also seen by their social environment - as responsible members of society. Most men experiencing this situation cared for others and were able to react themselves to occasional health problems they suffered from.

It took me some time to realize how systematically such men were addressed respectfully as Mzee, also while my assistants and I were talking about them in their absence. In contradiction to older frail men, at least when people were referring to them in their absence, they were called *babu*, which means grandfather but has a slightly negative touch, referring to weakness and incapability. In contrast, I heard

[73] In this chapter I chose to focus theoretically on masculinities and will later in this dissertation go more into detail about how feminities shape experiences of elderhood.

several times how people said that they were only elders *(wazee)* but that they were still able to care for themselves (*wazee tu lakini wanajiweza)*.

If an older man described himself as being able *(ninajiweza*), it meant that he was in relatively good health, which allowed him to generate an income, or that he could organize money to support his family. Some men also emphasized their virility. A seventy-five years old man was relating to these typical aspects of caring masculinities when my assistant Saada mentioned that in spite of his age he was still able *(unajiweza)*, by agreeing and adding "Yes, I will work until tomorrow!"[74] Some men also emphasized that they were still in good shape as they had always taken care of themselves and their families. These older men proudly narrated how they were able to work hard, as they did not drink, stayed faithful to their wife(ves) and Allah, never went to prostitutes and wanted to do so in the future as well.

3.1. Manhood as fatherhood: Being able to care

Most men married younger women, which implicates that many older men still have young children at school age whom they feel responsible to care for as fathers. Urban Zanzibari commonly argue that based on habitual practices in relation to the religion of Islam, that a man can be as long with his wife, as he can care for her. I should mention at this point again, that while none of the twenty-five randomly selected women above sixty years of age stayed with a husband, the majority of men of the research participants lived with a younger wife. To have a wife and children are major aspects composing masculinities of adult men. For example Mzee Juma, a relatively healthy man in his late 60s living alone in Shangani, said when Saleh prompted him if he had a wife: "I don't have a wife, I am a divorcee but at the same time I am thinking of repairing my marriage status. Since I am an adult I need to have a wife."[75] To relate to this norm is nevertheless usually only possible in situations of good health, as also older men are expected to care for their children and wives, which is for most only possible if they are able to work and earn an income or have relatives abroad who support them.

Even though being or becoming a grandfather was a conversational topic, when I talked to younger generations, it rarely occurred in my conversations with older men. I caught myself in the act of relating to some of my research participants as grandfathers. Only very late I realized, that actually, the majority of them did not (yet) have any grandchildren, while almost all women had grandchildren. Most older men though were still busy with their duties as fathers. They often had married late and thus the age gap

[74] "Eeeh, nafanya kazi mpaka kesho!"

[75] Saleh: "Una mke?" Mzee: "mke sina nimemuacha lakini wakati huohuo nafanya repair ya kuoa kwasababu nishakua mtu mzima lazima nioe."

between them and their children was much larger than between mothers and their children. It was also common that they had children with several wives and thus had older and younger children but even if the older ones had children themselves, the grandfathers might still have had their own young children to take care as fathers.

3.1.1. Mzee Mohammed – Feeling responsible to care for the family

To illustrate how relatively healthy older men, habitually respond to ideas of "caring masculinities" I will present the case of Mzee Mohammed. Mzee Mohammed, a relatively healthy and slim looking older man in his early 70s, wearing thick glasses and a typical Zanzibari embroidered white, brimless, cylindrical cap (*kofia)*, lived since his youth in an older area of the town, which is relatively representative for the average living situation in the city. Mzee Mohammed has four unmarried children of two marriages. His children are still going to school or study, except the oldest one who was working at a hotel for some time but who is jobless now. Since he divorced his first wife, he stayed with his second wife, who was in her early fifties and a housewife, as well as with their children, the son of his late sister and his nephew's wife, and during the day with a household helper *(dada)*. His wife was only half of the week in the house with him, as she was taking care of the children of her late sister in the close-by shehia Shangani. Many children of Mzee Mohammed's brother and sister lived in the neighborhood in Kikwajuni.

Mzee Mohammed had three main sources of income through which he tried to take care of his family: He received a pension, had a small shop and got remittances from relatives abroad. His wife earned a small income by selling self-made snacks at a school but Mzee Mohammed did not mention it to be part of the main sources of income. It is common in the city of Zanzibar that women are not expected to contribute to the household income. Women could rather use everything they earn for themselves, unless their husbands are not able to finance the daily living, which in practice was often the case also among younger generations. Usually Mzee Mohammed's day started with opening the neighboring mosque for the morning prayer *(Alfajiri)* around 5a.m. After that he got back home to prepare his youngest child for school, he opened his small shop. He sold goods for everyday use like razor blades, tomato paste or superglue to neighbors, as well as small snacks and sweets to the children who attend the *madrasa* lessons (Islamic school) at the mosque. When we were sitting with him at the store he knew all the people passing by, greeted them and had some conversations. As he was also selling snacks, which some women prepared, he normally waited until they were all sold around 10 or 11a.m. and closed after that the store for some time if he wanted, for example, to visit a sick friend or relative at the close-by hospital or to go to a funeral. He was commonly moving around by foot or bicycle while performing his duties.

Mzee Mohammed explained that his children opened the shop for him, since he was retired and needed an activity to earn an income. This business should keep him active. He stressed several times how important this store was to him but he also told us that even though he had a lot of sales, in the evening

he could not find any profit in the cash box. I and eventually he, never found out what the reason for this loss was. Some weeks later we found him at home, selling his goods in front of his house on the veranda *(baraza[76])*. He explained that he gave up the store but still wants to sell the leftovers:

> You have seen that shop there, that is the one I was earning a living with and now it is dead (…), they (nephews and nieces) bring money every month, we get lunch, and they pay for other expenditures but for dinner it has to be myself, there is bread in the morning, there is money for children for school, it is - I have to rely on myself. Since that shop collapsed I don't have anything that I can self-rely on. Lastly, I have talked to these (nephews and nieces) who are abroad the one here, has come to see the shop, he said, "we shall bring contributions to you so that you can make yourself a survival" (…).[77]

Even though I had the impression that Mzee Mohammed liked to do his small business, sitting outside and chatting with others he told us at another occasion that he would prefer not to work anymore but that he must take care of his family: "I just work because I have that small shop there, but if I would get money, I would prefer to only sit around (rest), but it is like that, I cannot just sit around because the family needs to eat."[78] Mzee Mohammed's life situation thus constantly changed, which is typical for most Zanzibari urbanites. Especially for men it constitutes a constant struggle keeping the responsibility to provide for a family.

Mzee Mohammed's case shows representatively for many men at his age, how *being able to care* is very much at the center of how he relates to manhood and fatherhood. Even though he feels sometimes weak and would prefer to relax, he sees himself responsible to take care of his children and wife. In moments when he is not able to earn an income by himself, he tries to motivate his nieces and nephews abroad to support them. Nevertheless, he does not ask for direct help but that they would enable him to take care of himself by financing the shop. Through such remittances Mzee Mohammed and other men

[76] A place to sit in front of the house, common for all houses in Kikwajuni. For more about the importance of *baraza* see (Loimeier 2012).

[77] "Umeliona duka lile lilioko pale, lile ndiyo nlokuwa linajiendesha na sasa hivi lishakufa kwa sababu haiwi pesa za duka zile zile hawa waliokodi, tunapata chakula cha mchana manake wanaleta pesa kila mmoja na familia yake ee wanaleta pesa kila mweisho wa mwezi tunapata chakula cha mchana cha matumizi na mengine lakini kula chakula cha usiku itabidi niitegeme mimi mwenyewe kuna mikate asubuhi kuna pesa za watoto skuli itabidi nijitegeme mimi mwenyewe mpaka lile duka limeanguka sina kitu cha kuweza kuniendesha mwisho nimewazungumza hawa walioko nje mwenyewe aliopo hapa wanakuja kaja kiliona lile duka kasema tutachangizana pesa tukulete ili tu ujiendesha lakini pesa ikiwa ni ya duka iwe ni ya duka iwe."

[78] "Ninajituma maana nina kile kiduka pale, lakini ningekua ninajipata basi ningekaa kitako tu lakini ni vile siwezi kukaa tu hivi mana familiya inahitaji kula."

can remain respected and caring men who fulfill their duties, keep staying with their wives and maintain relations to relatives abroad.

3.1.2. Mzee Cheetah – Being a busy man to provide for the family

When I met Mzee Cheetah for the first time in June 2012, he was 70 years old and had two wives and six children. The first time, we met at his home in an older area of the city. He introduced himself as Mzee Cheetah because nobody knows his official name anymore and everybody just calls him "Cheetah" after the fastest land animal. The energetic man lived up to his name. Even though he was officially retired and was receiving a pension, he was still employed at a governmental institution, where my assistant Saleh and I met with him many times for talks and interviews. In the past, he had played traditional music *taraab* and he proudly told us about all the places in the world he had visited thanks to his employment in the cultural sector. For a long time, he was the coach of female netball and football teams. But above all, Cheetah was famous across the island as an actor in popular movies that were shown on local television. The case of Mzee Cheetah is an example of a very active older man. I was impressed by the note cards he always kept in the pockets of his trousers where he carefully wrote down all the things he wanted to do in a day. He was constantly busy trying to provide his first wife (who was also his cousin), their children, and his second wife, with whom he did not have any children, with everything they needed in life. Besides his work, he regularly went to the nearby market to buy food. He stayed mobile by bringing his son to school every day. As an active member of a diabetes self-help group, he was consciously concerned about his health, and, by building a new home outside the city, he was making financial plans for his retirement. Even though he considered himself strong, he told us in an interview in September 2012 that:

> I always have the same problem, but I try to keep it in a normal condition. I always suffer from diabetes and blood pressure. I try to exercise. I try to not eat food with sugar, except for seasonal fruits like bananas or a piece of mango. People say that fruits do not cause problems if you have diabetes, but I am very careful. I control myself so that I don't affect my health greatly and lose my capacity to do my work.

He told us about numbness in his legs and feet that was related to his diabetes, and after a small pause, he added that these health problems had also caused the loss of his virility (*nguvu ya kiume*, literally translated: "male power"), which worried him a lot. Half a year later, he felt much better and explained that he was not suffering from health problems anymore. He explained to us that it was necessary to be very active if he wanted to remain in a condition in which he would be able to do what he wants to do:

> I feel okay and strong because I can do what I want to do. But there are some at my age that are in a bad condition. But as for me, I am so well that I can run from here to K. (around 10 minutes) and now I am working at A. (governmental institution) under a contract. So, I think that I will be in the countryside gardening when my contract finishes. Therefore, I am trying to finish my house, to live in the *shamba* (countryside) because then I will be not working (under a contract anymore).

Before I returned to Switzerland in May 2013, I went to say goodbye to Mzee Cheetah at the Cultural Music Club where he was an active member. It was not without some pride that he showed me around, introduced me to his colleagues, and finally gave me a ride back home on his *pikipiki*, his motorcycle, before he went to pick up his son from school.

The ethnographic material illustrates how in Zanzibar being able to provide care is a main signifier of masculinity (*kujiweza* - being able to do it by oneself), whereby fatherhood and masculinity are overlapping. This "care-package" I argue, is composed of material aspects but also by protection, and by responsible behavior and sexuality. I came up with the notion of caring masculinities once I realized how important care-giving was for the men I met in Zanzibar. Only later on I realized that in the European context Elliott (2015) had developed a concept of caring masculinities. She defined caring masculinities as: "identities that reject domination and its associated traits and embrace values of care such as positive emotion, interdependence, and relationality. (She) suggest(s) that these caring masculinities constitute a critical form of men's engagement and involvement in gender equality and offer the potential of sustained social change for men and gender relations" (Elliott 2015, 2000). What I want to describe by caring masculinities does not mean that there is less gender inequality but rather that caring is a major aspect of masculinities in urban Zanzibar. In the three health situations presented in this dissertation, we will see how men relate in diverse ways to these masculinities.

4. Relaxed Femininities: Balancing Care-Giving and Care-Receiving

While also older women relate to ideas of being able to "do it themselves" and having a certain independence they imagined their elderhood much more as a time of having less duties then before and thus being more relaxed to provide care for others if they could but also usually giving themselves into the hands of their children. Even though *Bibi Bomba* a popular TV show in the whole of Tanzania, on *Clouds TV Tanzania*, a private channel, in which the public can vote for the best bibi, the "bibi bomba" portrayed and ridiculed in more than 40 episodes, suggested that older women should be active, play netball or sing the latest pop songs most older women and their relatives I met, preferred to lead a rather unspectacular everyday life. Compared to older men the norm is that older women can but do not need to work. The older women I spoke to, who all lived without a husband, were also not interested in marrying again but rather, when prompted asked back in amazement: "Why should I?" As long as they were healthy, they often profited from a new freedom based on reciprocity and Islamic values, being on the one side usually supported by children and at the same time not having to serve them. From the women's perspective, they had completed their duties, which included serving a husband and raising children. Nevertheless, usually, it was expected that an older woman in good health would help in the household, especially doing smaller cooking activities, or typically to do the prestigious job of serving

food, *kupakua,* if she was not able to cook anymore. Additionally, older women should wash their own clothes and eventually help generally in the household with sweeping and the like. Sometimes they would also take care of grandchildren, which usually rather meant being around the same time as grandchildren were and not so much providing the actual physical care. Typically, the oldest grandchild or a young girl, a *dada* (literally sister, meaning housekeeper or nanny) is doing the actual childcare like changing diapers, dress the children, cooking for them and feeding babies, carrying them around and so on. Rather, habitually, grandmothers relate to the role of the supervisor who intervenes, gives advice and orders, rebukes or comforts children.

Older women in a situation in which *wanajiweza* (they can do it by themselves) experience their aging relatively untroubled by *maradhi* (disease) and *fikra* (heavy thoughts). The ideal to live in a good health condition includes, especially for women, the importance of not having psychological stress (*fikra* - thoughts) because of family problems or difficulties at home. Relatively healthy older women often keep families together, even during quarrels. They were the last resort for abandoned children and divorced daughters who needed a home. In the conversations, the older women, especially the mothers, told me in detail about the problems that preoccupied them, such as marriage problems of their children or money and addiction problems in particular of sons and grandsons.

A substantial number of women narrated that although it is good to have many children, to give birth to sometimes more than ten children made their body very tired and weak. They portrayed a "good old age" as the possibility to do whatever they want to do and to be able to do everything independently by themselves, even though they did also see it as an ideal that children provide them with everything they would need *("kila kitu unafanyiwa, unaletewa, unafikiriwa"* - "everything is done for you, brought for you and you are thought of"). Others said explicitly that only "good care" (*matunzo* - care, attention, honor, protection) enables "good aging" and if you are not well "placed" you will not age well (*kama hujawekwa vizuri hutazeeka vizuri).* All research participants mentioned that an important aspect of "good aging" was to be together with relatives,[79] especially children. It did not make a big difference though, whether this offspring were biological or socially constructed children. Interestingly the spouse was rarely mentioned and as already mentioned, all twenty-five older women I accompanied over the years, were either widowed or divorced and did not want to stay with a husband anymore.

4.1.1. Bi Mwajuma – Working as there is no alternative

I was rare to hear from women compared to men, but I met a few in a situation of good health, who could still do whatever they did earlier on, even though they did it maybe in a slower pace like Bi

[79] Including relatives by kinning, thus not biologically related people who become related through a social process of making kinship (Howell 2006; Carsten 2000).

Mwajuma. She explained that she is not suffering from any health problem. For smaller health issues Bi Mwajuma does not want to go to the hospital even though she, as everybody else in Zanzibar, has theoretically not to pay for medical treatment. Once she went to see a doctor at the hospital because she had a fever but not all the needed medicaments were available. Bi Mwajuma did also not agree with the doctor who told her that she has high blood pressure, which she should treat but she insisted that she was not suffering neither from *pressure* nor was she having *maradhi ya safura* (anaemia), since she did not consider her being pale, as she told us. Because of this previous disappointing experiences she made as a patient at the hospital, she found the travel to the health facility not helpful but decided generally to just use *dawa za Kiswahili* (literally Swahili medicine), herbs which she picks around the houses in Chumbuni and if she had a flu, she would just use *Panadol.*

The way Bi Mwajuma deals with her health is quite typical for women in the city and generally for people living in Chumbuni. As long as possible, most relatively healthy older people did not want to go to see a doctor or go through check-ups, as they could reveal weaknesses they did not feel or did not want to know about (until now). To go to a health facility was perceived by many men and women as being cumbersome and not helpful. On the other hand, it was also a way to show a kind of independence and self-reliance. For others, it was just a waste of money to travel to the hospital, pay for check-ups like blood tests or x-rays (which are not included in the official free treatments) and medication. Others again, especially older people who lived in what could be framed as (often cosmopolitan) middle class communities in Kikwajuni and Mpendae went regularly for check-ups and appreciated the advice concerning diet and physical activities they received in private institutions, self-help groups as well as in the main public hospital. Compared to most people living in Chumbuni and other less privileged older people, older people being part of better off families having the relevant resources be it financial, social (people around who could help), cosmopolitan (their own and others' knowledge about a variety of possible solutions) to translate the diagnosis and recommended preventive measures or treatments into everyday practice. To practice such everyday self-care (Kaiser-Grolimund 2017) can be interpreted as a way of staying in control of one's life and health in the process of aging.[80] As we will see bellow again, in Chumbuni people could hardly orient themselves towards the future as in better-off areas, because they do not have many (cosmopolitan) options than to become habitually fatalistic and "give their destiny into the hands of God."

Bi Mwajuma is living in the middle of Chumbuni in a modest house with one unmarried and a married son, her daughter-in-law and grandchildren. Often when Saada or Saleh and I tried to visit her, she was not around and we were told that she was at the fish market selling *dagaa* (small dried fish). When we

[80] Kaiser-Grolimund (2017) explores everyday self-care in this sense in more detail in a middle class milieu in Dar es Salaam, which corresponds widely with my experiences in similar social environments in the city of Zanzibar.

met her at home the slender woman in her early sixties was always busy washing clothes, preparing food (if her daughter-in-law was away) or cleaning. She and her family did not have a lot to live on but she somehow always showed a good mood and made jokes that I was her daughter-in-law and that she finally wanted her son to marry me. Bi Mwajuma worked a lot but still knew her limits of her advanced age set. She once stated: "I do the amount of work my condition allows. I go (and do my things), on another day I am sent back/punished, on another day I decrease (the activities) because the body needs to rest."[81] The older woman is not only doing work for herself but also supports her family for example by washing the clothes of her grandchildren. Since she is living with her daughter in-law in the house, she expressed that she is not demanding as much as she would with her own daughters. She is always trying to share the housework with her in-laws, even though she sometimes would prefer to say that she is tired. Problematic in this living and care arrangement for Bi Mwajuma was that her son- and daughter-in-law in the house only provided her with breakfast and lunch but left it to her to find dinner on her own. Earlier on she prepared *maharagwe* (beans) and *mandazi* and sold them in the streets but she is not doing this activity anymore, which reduced her financial independence. Even though, she and her family referred to the ideal of an older mother who should be taken care of, who should relax and "earn the fruits of her life," in practice her everyday life looked different, similar to other older people who live with scarcity as a daily companion.

The case of Bi Mwajuma shows representatively for many women in her age who are relatively healthy but live in localized and less privileged spaces of aging and caring how the ideal of the relaxing older mother who should be rewarded reciprocally, cannot be completely translated into practice. They receive partial support and may only be able to reduce their activities a little bit. People in this situation need to do an effort to "do it themselves." I am not sure whether Bi Mwajuma would really have asked for more support from her daughters but it was a way to express, that she might have felt more comfortable sharing the household with a daughter, who would, according to Bi Mwajuma's imagination, see by herself what her mother was able to do. On the other side, many older women told me that living with a daughter and her husband made it difficult for them to ask for material support or small sums of cash from the son-in-law. Generally, to demand anything from their children compared to in-laws feels easier for these mothers and thus both living with a son or a daughter could thus cause difficulties either to receive financial or practical care.

While relatively healthy men seemed to be constantly busy to provide their families with whatever they needed, I had the impression women had at least theoretically more options in how to live their elderhood. The norms framing older women's agency had a more flexible touch and the expectations

[81] "Nafanya kwa kiasi ya hali yangu. Nakwenda siku nyengine narudishwa, siku nyengine napunguza kwasababu mwili unataka mapumziko."

about caring for others or being cared for were less strict. Compared to older men, it was by far more accepted for women to just be around and indifferent of their health situation, many also expressed it in this way: "*Nipo tu!*," "I am just here!" Even though families preferred their older female relatives not to walk alone in public, since this could give the impression that a family was not taking well care of their *bibi* (grandmother), they could do it without fearing consequences. For most women caring for others was just an optional plus, since they typically, were seen as having completed their duties as mothers by bearing and raring children.

4.2. Having children or developing intergenerational relations

A special case were women without their own biological offspring. Out of the eight older persons without their own children seven were women and only one was a man. Several men told me that after numerous marriages they finally were able to get a child. I did not ask them exactly where the child was coming from but it is obvious that for men it is easier to be declared as father in a marriage when their wife gets pregnant than for a woman who has to get pregnant through her own body. I conclude that men have other solutions than women to "get children" and with it care givers in the future. Many of the interviewed women married and were divorced by their husbands (as it is in an Islamic context) up to five times. It is difficult to say if they were divorced because they did not give birth to children but it shows that these women had struggles to "find children" outside a marriage. Thus, compared to men, women who were not able to have a child, could not just "outsource" their reproduction. In addition, many women were divorced from their husbands if they did not give birth to a child within the first few years of marriage. Most of them went through an odyssey of several marriages and then remained relatively young divorced. Older women without children start thus not only at old age to look for care givers but need to organize themselves while they are still young to create relationships in which they are seen as mothers or grandmothers. Having such "social children" and rely on the support of their "gained" children.

In all the cases of "childless" older people, children or grandchildren of siblings of the research participants take care of their family member. All these *mabibi* (grandmothers) without (biological) children stay in the house of a child or grandchild of a sibling, except two. One built her own house after getting a lump sum at the retirement. Another woman stays together with the grandchild of her late husband. The childless older man stays together with his wife and some children of his siblings. One woman gets a bigger amount of money every month from the granddaughter of her late sister. But this is rather exceptional. Some get a little support from a brother but as one woman put it: "What can they (the brothers) help me? They are helping their wives and children." Some older women get help from their neighbors, especially when they stay in their neighborhood for a long time and did even bring up neighbors' children. Neighboring boys may cut firewood or carry buckets of water, women in the

neighborhood may bring food or are around in case of emergencies or a temporal sickness (like a fever). One of these women has a neighbor who passes by every day to ask her, if she needs something from the market. If not for an emergency, all the research participants told me that friends in general do not play a big role in providing care and that only during Ramadan they may get some food from them.

It does not come out of nowhere, that especially older women, who are not having their own children, stay together with nieces, nephews or their children and get support of neighbors as they say almost as if they were their "own children." Throughout their life they developed "kin-like" ties with neighbors and "mother-child-like" ties with remote relatives. By bringing up foster children and establishing strong relationships to neighbors or distant relatives they become "social" mothers and grandmothers and can thus get support connected to this role. Five out of the six women without biological children we talked to raised even two generations. One woman who did not bring up any child at all is nowadays struggling to get support, even though she is staying together with her nephew.

Several older women told us how they "got a child." Bi Sikuroja for example told us the following story: "I just went there (to the countryside) for a visit, and they told me that she is my "somo" (someone who has the same name), then I said I want to raise her! They accepted and they give me a chance to raise her." When we asked her how she was feeling afterwards to stay with the child she answered: "I am feeling so happy! I got my own companion, who will take care of me in the future." This illustrates that for these women the habitual practice to have own children did not function and thus new modes had to be tried out to realize one's future aims of being cared for by someone if one is old. Bi Khadija instead raised her aunt's daughter once she became an orphan and later also stayed with her during the time she had her second child. Later she also took care of her "grandson" who actually is her nieces' child. She explained that his mother got pregnant again before she stopped breast feeding, so, she took the baby boy, as his mother had difficulties taking care of both babies. These women thus sometimes actively looked out to take care of a child but sometimes also just happened to become the *mlezi* (guardian) of a child. Another way of creating a "mother-daughter-bond" is that older women stayed with the younger women in a traditional period of care giving before and after the delivery of a baby. Through this act the "daughters" received previously care from the now older women.

That somebody else fosters children instead of their own parents is very common and is seen as proof of a good character of the foster parent. By fostering I mean that somebody takes over the partial or complete responsibility for a child whose parents are temporally or permanently unable to care for him or her. Adoption on the contrary is unpopular as according to Muslim faith "the creation of a fictive relationship of parent to child, by naming the child as one's own and by endowing him or her with rights and duties identical to those of a biological child is forbidden" (Mattson 2009). Accordingly, adoption was also not mentioned but instead the social mothers called themselves *mlezi* (guard).

The social children I spoke to told me that they are taking care of their female family member because "unfortunately" they are were not having their own children who help them, but that none the less they were like parents to them. The older women called their social children usually a "daughter" or a "son" and thus referred to norms and expectations connected with these titles. Normatively children are responsible for the care of their parents and consequently those who help older persons become like their children. It is a way to turn the care received in elderhood into something normal, into reciprocity where a mother who fulfilled her duties receives "a gift" back from her children. This could also be seen as a "cycle of care" (Tronto 1993, 107). Additionally, the children we talked to mentioned often three explanations why they take care of their older relatives: Because children should take care of their parents and older relatives out of respect *(heshima)*, out of love *(upendo)* and because as a good Muslim it is a duty to provide everything for the parents and older relatives but three times more for a mother than for a father. Only if one carries out these duties somebody would be able to reach paradise (see chapter six).

Child fostering by others than the biological parents is not only a practice which is reserved for childless women. Many families have one or several children staying with them of distant relatives who usually live in rural areas. This practice of child fostering is widespread and well-known throughout the continent. For childless women though, it is even more important to be able to raise such a child. Mzee Omar, a medical officer generalized (talking about his wife's niece, a small girl who lives with them in their household) how children often grow up with older family members who could be their parents or grandparents:

> Usually ladies would like to make sure that they have a young child in the house. Just to bring her up. For example, when she grows up then she also helps in domestic works. So, it is a matter of bringing her up, but at the same time expecting her to support the domestic works. So, that is done by almost all the ladies. They look for a small child like that (refers to the girl) to bring them up expecting that when they grow they have somebody in the house helping them. It is also a way of making sure that those small or young girls are being taught when they grow up. The sense is to give them responsibilities. When they grow up, they should look after their husband and family. So, they start teaching them from that young age.[82]

While obviously also men profit from this practice it is the domain of older women to choose, interact with and teach these children to stay with them, help and become responsible adults. These are typically reciprocal relationships. In their practices women thus relate to framing ideas of kinship, Islam and

[82] I conducted the interview in English.

reciprocity. This kind of fosterage shows how they imagine their future while taking care of them in the presence. The examples of childless women illustrates also that experiences of aging and care-giving are very situational and can constantly change not only depending on the health situation but also if a potential caregiver moves away, if there are personal quarrels or if older people or someone in their social space loses his or her job.

In many cases the older persons see the support of the social spaces they can interact in as something that is not self-evident. In case the older woman did not have raised these caring relatives and neighbors, they do more than their duty would be. Often the older women said about the support they get "Ninamshukuru, sihaba" - "I am thankful, it is not little." While parents have a lot of expectations towards their children, older persons without their own children often emphasized that they cannot expect much but that they are satisfied "ninaridhika" ("I am satisfied") with everything they get. In the words of Bi Khadija: "As unfortunately God did not give me children, I am glad they (her niece's daughter and her husband and their children) help me" and "I cannot ask for more."

Similarly, as mentioned by Alber, Geest, and Whyte (2008, 6) on the topic of reciprocity, many of these "socially constructed" children and parents share and transmit mutually not only their resources but also bound in honor their care and regard. Practically, these children might visit the older persons regularly for example to wash their cloth and help them in the household, stay with the parents since childhood in one house or ask their mothers to live at their place when they start to seeing a risk for them staying alone. Links between different generations develop and build intergenerational, reciprocal social spaces. As claimed by Alber and Häberlein (2010) I distinguish two types of generations: On the one hand genealogical relations of kinship and on the other hand also relations between historical/societal generations (gesellschaftliche Generationen) who generated certain things. In other words: The older generations relate in their actions to kinship norms establishing and maintaining parental links to the younger generations.

5. Conclusion: Establishing and Maintaining Social Spaces of Aging and Caring

In this chapter I sketched out how older people who are in a situation of relatively good health experience their elderhood and what kind of norms and practices of caring between themselves and others I could observe. Being in good health, keeping the ability of the aging body and mind in order to establish and maintain social spaces of aging and caring are central aspects of *kujiweza*. Older people try to keep up or regain this situation as long as possible as to leave this situation, usually entails major social consequences, especially for men. The finding that older people attempt to stay healthy as long as possible resonates with what Klerk has observed among older people in Northern Tanzania (Klerk 2011, 62).

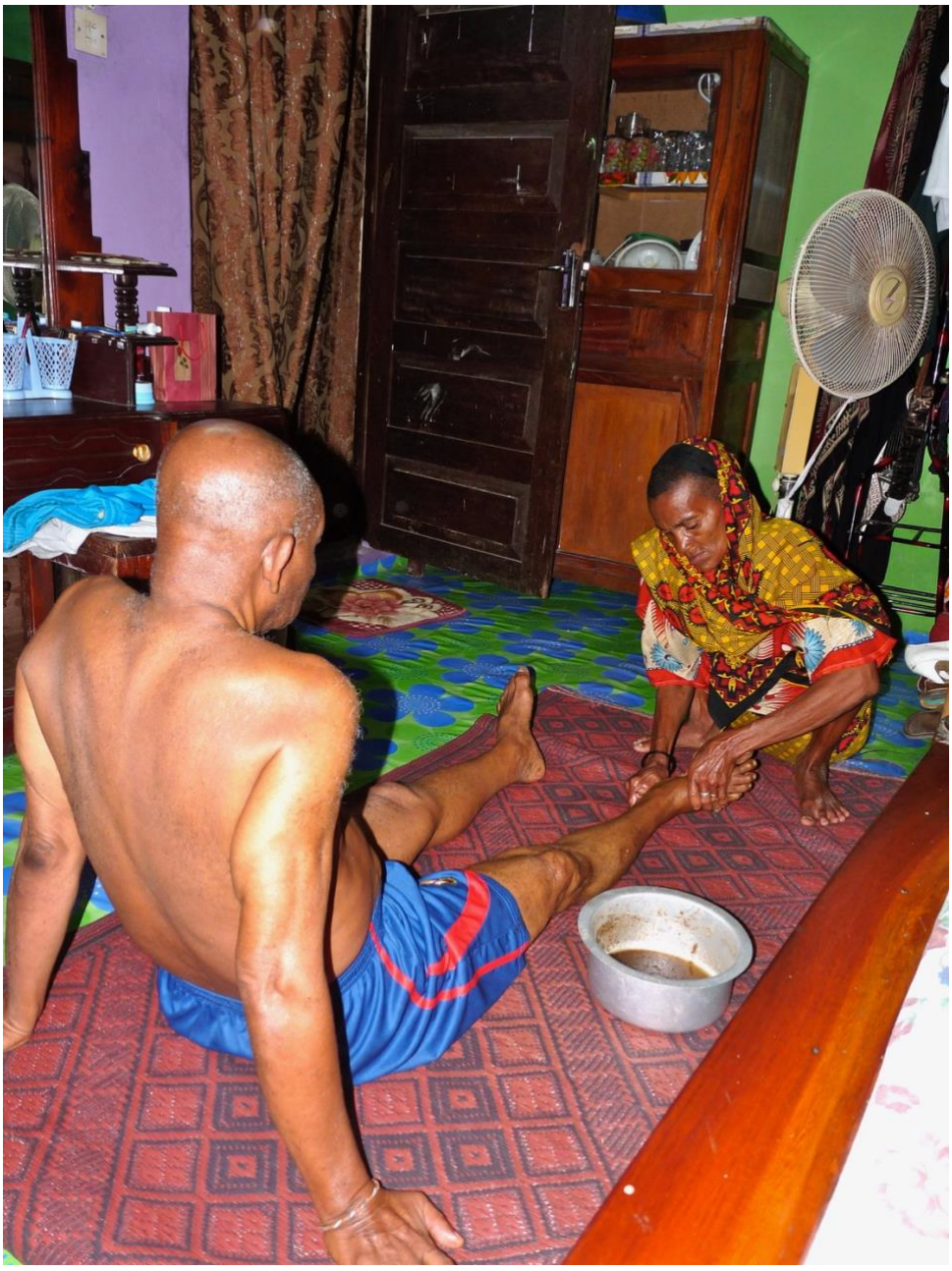
It is easy to imagine that staying healthy in old age was part of what people described as to be "good aging," when we asked the research participants to tell us how this would look like. For most older people my research assistants and I talked to, good aging was also to live close to family and to be cared for by relatives if no longer in good health anymore or frail. Nevertheless, as long as people were in relatively good health they wanted to do things on their own. The wish to dispose of a certain independence is not to be mistaken for the public normative North American and European ideologies of "active aging" (WHO 2002a) and "successful ageing," which came up with the new millennium and that offered a model of aging "emphasizing independence, productivity, self-maintenance, and the individual self as project" (Lamb 2014). Especially social anthropologists and critical gerontologists disclosed the ideologies' normative and singular understanding of how "good aging" should look like. They pointed out how this perspective did not only fit to how older people in the Western world wanted to become old but especially not how the majority of the world's population all over the globe understand what aging means to be for them (Lamb 2014; Torres 1999). Contrary to the normative understanding of the paradigm of active aging, the research participants – even in situations of relatively good health - did not wish to be completely independent from family but to be able to provide and receive care within diverse spaces of aging and caring. This can mean for example to have a certain freedom of choice to decide with whom of their relatives they wanted to stay or to have a say on what food they would like to eat. It could mean just to be involved in everyday decisions like living together with relatives or providing small financial contributions to the household.

As long as the research participants stayed healthy they could predominantly continue doing what they did earlier on. They could thus habitually, repeat earlier patterns of action as long as they faced the same or similar situations as in the past, also if they had to deal with relatively minor changes in their body or their responsibilities towards others. The analysis of how men and women relate to certain masculinities or femininities illustrate how gendered this situation is experienced and practiced. Contexts of action like access to formal education, religion, economic possibilities and social milieus further shape how older people relate to gendered norms and practices of aging and caring in good health.

In this situation, as long as the older people are healthy and can travel or attend ceremonies and other social events men and women usually can establish and maintain their position in social spaces of aging and caring particularly also with relatives and acquaintances abroad or in cosmopolitan social spaces. Relatives abroad can sometimes even prolong this situation of relative good health as they might help their older family members doing it themselves *(wanajiweza)* by sending them money, invest in providing them with a business or building houses and the like. The physical and sometimes complete absence especially of children though, can also make it more difficult for older people to deal with everyday life or cause mental stress. In situations less privileged men and women are not frail or ill, they may relate to the same norms like older people who have access to cosmopolitan or transnational spaces.

They also may expect care from their children, which these are not able to provide due to their own hardship. Without such generous support those older men and women are at risk of losing far quicker their status as complete people (watu wazima). Healthy older women have fewer problems to maintain their position as on the one hand mothers are in any situation assumed to be in need of support, as they are not expected to earn an income. Most women never were in such powerful positions as men anyways, and are not afraid of losing them either. As long as older men are able to care for others, they can stay with their wives and children who again help them as their husbands and fathers. We will see in the next chapter, how situations of health crisis not only mean changes in older peoples' health but also have social consequences: In the first moment, they lead to a rupture of habits, a new orientation of actions, and an opening up of diverse spaces of aging and caring, as often many people can be activated to help in the case of urgency.

Chapter IV:
Health Crises



Picture 5 – A *fundi* (skilled person) massaging a research participant recovering from a health crisis.

IV. Health Crises: Experiencing Sudden Changes

Life of older people can be punctuated by profound experiences of sudden changes to the habitual caused through what I define as a situation of health crises. Such a health crisis can be due to an illness of not more than a few days or an incident leading to temporary or permanent disablement. What I mean by situations of health crises has some overlap with what Obrist (2018, 96) called "critical health moments" and described as events of "discomfort, unease, pain or inability to perform as usual." With the notion of health crisis I nevertheless want to unite and stress the elements of emergency, the need for a sudden response and the experience of relatively sudden disruptions of and changes to the habitual. This is opposed to situations which still might be critical but have become situations of chronic conditions and related health fluctuations to which the older people within their social spaces get used to. How people experience elderhood and care in situations of a health crisis is the topic of this chapter, while I am discussing situations of chronic conditions in the next chapter.

This chapter will first set a focus on how older men and women experience health crises in a gendered way and how this challenges understandings and practices related to hegemonic concepts of masculinities and femininities. Older men and women who suffer from sudden and severe health problems often can no longer perform tasks and actions they used to be competent at. Habits have to be changed, and often a dependency on others is inevitable. People in situations of health crises need support since there is an immediate decline in functioning. The second focus explores the topic of care in times of a health crisis of older persons. I argue that health crises bring in a certain kind of responsibility for others and thus care-giving become a central issue. This responsibility can be differently understood by older persons who suffer from a health crisis and differently by their social network, but from both perspectives, it is heavily tight to gendered understandings of what is associated with expectations of being a man, a father, grandfather, husband or a woman, mother, grandmother and wife. Such a perspective differs greatly from how other anthropologists have looked at aging. For example, Lock (2013) traces the intellectual debates of experts on dementia but does not analyze what dementia is all about from the standpoint of the people affected or their social environment. Lock ignores the fact that it makes a big difference if somebody is slightly or severely impaired due to dementia, let alone the question how they experience sudden health crises. If serious dementia or more sudden health changes prevent people from walking around, and if they are not able to do anything on their own anymore, then this has profound implications for how they experience their aging and elderhood and how their social network and society at large perceives them. Social relationships are crucial to receiving care, and certain older city dwellers are not only able to mobilize their social networks on the island; but in addition – and this is the third focus of this chapter - they respond to their potential marginality (see chapter two) due to a health crisis, engaging in what I call transnational and cosmopolitan spaces of aging and care, while others must completely rely on localized social spaces. The stories of the older

men and women I am retelling in this chapter, show how the experiences and consequences of such situations are deeply gendered and how some older men and women are able to activate care, which span from local to transnational spaces.

1. Articulating Gendered Norms of Elderhood in Times of Health Crises

In this section, I look more closely at gendered aspects I found to be crucial to better understand what aging and elderhood mean for the Zanzibari research participants. The aim is to analyze older people's lived experience of aging in a health crisis and in this situation their orientation towards gendered norms and how specific masculinities and femininities emerge. In every-day life, the orientation in action (Emirbayer and Mische 1998, 963) towards gendered norms, like hegemonic masculinity (Connell 2005 [1995]; Connell and Messerschmidt 2005), usually happens very habitually and is thus not much reflected. This sub-chapter illustrates the gendered situation of older Zanzibari who suffer from sudden changes in their health experience and their aging, and how such situations provoke the articulation of gendered norms and explain different practices for men and women. I aim at looking at how masculinities and femininities emerge (Inhorn and Wentzell 2011) in situations of health crises in elderhood and thus go beyond the analysis of what men or women respectively, say and do *to be men or women*, and not simply what men and women say and do (Gutman 1996, 17).

In these particular situations, in which older people in the city of Zanzibar experience sudden health problems, usually habitual tacit gendered norms of what an older man or women should be able to do and represent, often become for a short moment explicitly articulated by themselves as well as within their spaces of aging and caring. While health crises imply especially for men abrupt breaks of continuity and loss of central aspects of their identities, they often mean for women to accept and to take on the role of honored mothers. Typically, older men who experience sudden health problems like strokes, bone fractions and became bed ridden were labeled as children by their social network, which I argue jeopardizes established masculine identities of (caring) aging men, as I have described them in the last chapter. Even though women also experiencing sudden health problems were compared with helpless children, their social network constructed these situations as providing new possibilities to finally let their mothers rest *(kupumzika)* after having completed their duties as caring parent a long time ago. It additionally provides a chance for the younger generation to frame the situation as being able to take care of a mother three times more than a father as it was highlighted in a frequently cited *hadith* in which Prophet Mohammad commanded believers to respect their mothers.[83]

[83] See chapter six for more details on how perspectives of Islamic piety shape agency related to aging and care.

1.1. Fathers Losing Control and Jeopardized Masculinities

In what follows, the stories of Mzee Cheetah, whom we got to know in the last chapter as a very energetic man in his early 70s providing care for his two wives and children, and of Mzee Maulid illustrate how sudden illness and disability can have an enormous impact on financial, political, social, and cultural aspects of the life of an older person. Especially for men, these situations did not only mean to be forced to react to health crises as such but it also meant not being able to live their life habitually (Emirbayer and Mische 1998). Suddenly, older men in such situations had to actively deal with their masculine identities and unmet expectations of themselves and others to fulfill norms of hegemonic masculinity (Connell 2005 [1995]; Connell and Messerschmidt 2005) of being good and caring husbands and fathers I have described in the last chapter. Their stories show again how health problems drive the older people in general but men particularly toward the urban margins, while older people in good health have more possibilities to agentically take up a central place in society and the city.

1.1.1. Mzee Cheetah – Becoming voiceless through a stroke

During the period I was away from Zanzibar, my assistant Saleh contacted the male research participants every month. He reported that he met Mzee Cheetah several times and he was in a splendid condition. Half a year after my departure from Zanzibar, Saleh tried to call Mzee Cheetah many times without him answering the phone. Finally, he went to visit him and learned from Mzee Cheetah's first wife that he had a stroke with drastic consequences. Suddenly he could not walk or talk anymore, and one side of his body was paralyzed. He tried to talk to Saleh but had to give up because not a single word was understandable. Two months later, when I was back on the island, we met Mzee Cheetah at his first wife's house. He was sitting in a chair in the living room. He had lost a lot of weight, but according to Saleh's observation he was in a better condition than the last time he had met him. The older man could walk slowly and move around, but he could not go more than the distance of a few houses away. He was not able to talk, but he could smile a little, and he seemed to understand everything we said. Mzee Cheetah, was nodding and trying to talk, but I could only guess what he was saying. During my visits, I showed him pictures of my life and told him about the latest developments, but in this kind of participation I had to admit to myself how this unidirectional "conversation" became very monotonous.

As we have seen in the last chapter, Mzee Cheetah was an extremely social person and he had countless friends and acquaintances, but after the stroke, many relationships faded. Several of his friends and neighbors told me that he was not the person he used to be, and one even made fun of his person by imitating him. Since he was not able to walk far and talk clearly anymore, he was just sitting in the living room or in his bed. Mzee Cheetah had to completely adjust his life. In front of him his first wife told us: "I am now the father and the mother" and thus referring to him as a child, having lost his function as a father. Without giving a reason, his second wife did not visit Mzee Cheetah anymore from the moment he had had the stroke.

The example of Mzee Cheetah shows us how quickly established living and care-giving patterns can change and in the case of his second wife even fall apart. From being a care provider, who was responsible for the family's income and for bringing his son to school every day, he became completely dependent on his first wife and daughter.

1.1.2. Mzee Maulid – Loosing health after an accident

Some days before we met him for the first time in 2012, Mzee Maulid, had just broken his leg while working on a construction site. He was around 75 years old and living in his house in Mpendae together with his wife and his children, who are still studying. Before the accident happened, he was working on construction sites for a long time. He explained how he already lost energy due to his age but that at this point he was totally failing to do his occupation:

> You know, my work is constructing houses, you understand well, yes?! Now, for our work you need a lot of strength (*nguvu*). Now, because of my age (*umri*), now even if I will work, I am not doing it the way I did. When I do the work, I need to reduce the workload. You understand! Now, it must be that my strength is little (small – *ndogo*). Now, I was forcing myself more and more and at the end you fail to work. You understand me already! (…) Health (*kiafya*) is not there anymore after the pain (referring to accident but using "pain" – *maumivu*) my health now went down.[84]

It is not only that he cannot work and earn an income anymore but also doing other daily activities (*pirika*). He can just do his personal things at home (shughuli zangu za nyumbani), like washing himself, sometimes going to the market. He tries to still do some *shuguli* for him and his family to survive (*kusukuma*) and even though it is very difficult for him he goes to *shamba* (countryside) to get some bananas and cassava.

1.1.3. Understanding Jeopardized Masculinities

Inevitably, such health crises as the two older men have experienced typically meant ruptures in the ways they related to their masculine identities before. Men like Mzee Cheetah and Mzee Maulid, as well as their social network were often at the first moment completely overwhelmed by this new experience and did not see any way of how they could still be men, fathers and husbands according to their previous experience of masculinities.

[84] Unajua mie kazi zangu ni za ujenzi unafaham sana ee?! Sasa kazi zetu hiz unatumia nguvu sana. Sasa kwa umri wangu nlio sasa hata kama nitafanya sifanyi kama nlivokua. Nikifanya lazima inapungua kasi. Unafaham sana ee! Sasa, inabidi lazima nguvu iwe ndogo sana. Sasa unakua unajilazimisha na ukijilazimisha, mwisho unakua unashindwa. Ushanifahamu ee! (...) Kiafya hamna tena baada ya kupata maumivu. Inakua sasa afya yangu inapungua kidogo.

While older men who felt more or less healthy and still had strength *(nguvu)* were often consulted if any kind of problem arose among their relatives, a serious health condition also implied losing the status of a social, cultural, and religious authority both within the family and beyond. Some relatives of older men told me that they could no longer take their frail father or grandfather seriously. They do not earn a living anymore, and, because these men suddenly only stay at home, they often are not able any longer to make well-informed decisions. In the city of Zanzibar, women largely practice their religion at home while most men regularly (up to and more than five times a day) go to pray at a mosque. Accordingly, a sudden health problem that does not allow men to leave the house alone or to perform the prayers outside the house means that they lose a major part of their daily routines and social contacts. I also met older men who divorced their wife because they were not able to support them anymore. Some of these men were telling me how they and their wives did not want to get a divorce but that the men decided to still do so, since they felt they would harass their wife.[85]

Such sudden health problems thus have enormous consequences on the life of a person and the position of these men in the social spaces they engage in and are obviously difficult to accept. Being in a situation of health crisis does not allow these men to conform with hegemonic forms of masculinities, being a caring husband and father, who provides for a family. Before I illustrate how new care arrangements need to be negotiated and implemented, I want to show how the experiences of women in such situations turned out to be different from those of most men.

1.2. Honored Mothers and Acceptable Dependency

In the following paragraphs, I present the stories of two women, who recently suffered from a health crisis. Compared to the older men I met, these women also became impaired through the incidents but were already used to being cared for (see chapter three). Because, they had already experienced over a longer time period a transition of social status, from being mothers, who are responsible for the whole household to becoming grandmothers and older mothers who did not have to work anymore.

1.2.1. Bi Nachum – Broken leg and without strength (sina nguvu)

Bi Nachum a widow, who was around 75 years old, when I met her for the first time in 2012, was living in Chumbuni in one of the poorest houses I have seen during my research. Bi Nachum, who feels frail and says of herself *sina nguvu* (I am without strength) for some years, grew up in a village in the north of Unguja, where she gave birth to thirteen children of whom four daughters and four sons survived. Like many women of her age, Bi Nachum was not sent to school or *madrasa* (Islamic educational institution) but she tried to learn on her own and was weaving mats, which she sold. She came to

[85] Mzee Hassan: "Nikaona aah hapana, nitamtesa" - "I have seen... no, I would harass her."

Chumbuni after she had lost her strength, as she said, when she was around forty or fifty years old. Her children bought the roofless house she is staying in now. This house is one of her biggest concerns, since the corrugated iron sheet, which only partially covers the living space, does not prevent the rain from entering.

Some weeks before we first met her, Bi Nachum broke her leg. Even before this incident happened, she was not able to do a lot anymore, because she was almost blind. She did not dare to go out anymore. People would laugh at her and call her a witch, she explained. Nevertheless, before she broke her leg, she was still able to do simple tasks like peeling potatoes or weaving mats. Since the incident happened we always met her in the same position on her bed in the tiny room, which was equipped with nothing more but her bed with a plastic bowl bellow and a water bucket for her to wash. In her immobile position, she could not do anything anymore. She told us: "I don't have any (things I can do), I am just here *(nipo tu)*. I don't have any matter."[86] She explained that the only "work" she can do was to sleep.

1.2.2. Bi Mchanga – Asthmatic attack and diabetic body (unajua, mwili wa sukari)

Bi Mchanga was one of the older women I met every other day, sometimes just to greet her, as I lived nearby and passed at her house almost daily. Usually, the door was standing open to allow a breeze and I found Bi Mchanga sitting on a sofa in the living room. Typically, she was surrounded by her small grandchildren running around or watching one of the many international TV channels for example from India or the United Arab Emirates. Bi Mchanga was suffering from Diabetes and high blood pressure and as a consequence of her obesity joint pains. The case of Bi Mchanga is particular in two ways: First, she was the only person among my informants who had a health insurance and second one of her daughters had the final say and responsibility in most issues concerning all aspects of care-giving and not her sons. Through her daughter who had a leading position in the public administration she received a health insurance card. This card allowed her to get free treatment and medication at one of the private clinics, where the waiting time to get a consultation was shorter.

Once, Saada and I went to see Bi Mchanga after I had not met her for some days. She told us how now she was fine again but that she had suffered two weeks earlier, from what she called *pumu* (Asthma). Bi Mchanga is used to deal with her chronic illnesses but did not expect to have such an intensive asthma attack: "Now my problem is diabetes and pressure, this asthma just came this time. I have it (asthma) but usually it does not do like this. This time, it came strongly / with energy *(kwa nguvu)*. I don't get it frequently unless I expose myself to dust."[87] During the asthma attack she was sitting during several

[86] "Sinaaaa (vitu ambavyo ninaweza kufanya), mie nipo tu. Sina langu jambo."

[87] "Hasa tatizo langu ni sukari na pressure. Hii pumu ilinijia mara hii tu. Ninayo lakini haifanyi kama hivi. Mara hii imekuja kwa nguvu, sipati mara kwa mara, mpka nichezee mavumbi."

hours on her bed just waiting until it would get better. Finally, she decided to take her mobile phone and to call her son Saleh to ask him to come to her. She explained further: "It took about a week and a half. During the first week I could not do anything, I was even washed like a child."[88] Usually, Bi Mchanga can help herself if it is a regular asthma attack. Through her experience, she knows what to do: "On other days, when asthma starts I get a flue, then I realize that asthma is nearly coming. But it only takes two to three days. I just buy medicine like *Minoflen.* But this time it did not listen / get cured *(haikusikia).*"[89]

When we asked her what she did to get relief she told us how her children arranged themselves to take care of her:

> I was brought to the hospital on Saturday, I mean, I started to be sick from Saturday. I did not sleep the whole night until four a.m. on Saturday, I then called the children that they should come, then they took me and brought me to the hospital. (There), I received an injection, medication, then I stayed at my son's, Saleh, (…). Nasra was in Dar. Then she came back and took me to her place in Bububu. We slept well on Sunday. On Monday, I was much sicker than the first time. Nasra took me again to hospital, where I again received an injection, I was given this here (points on her arm (probably a drip)). I went home with antibiotic medicine. Now, those medicines hurt me, I became again completely without strength *(sina nguvu)*. You know diabetic body *(mwili wa sukari)*. But, currently, it is better. My health is coming back.[90]

We asked her, why she went to her son Saleh, after she came back from the hospital and she answered: "I run away from the noise of the children, since that child of mine, Abedi, said: 'She will not rest, Mama, the children will disturb her, better you take her Saleh, so she will be able to rest!'."[91] Usually Bi Mchanga enjoys being around her grandchildren but during her health crisis one of her sons (Abedi) decided that it would be better for her to stay with another son (Saleh), to avoid the noise of the small children and recover well.

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[88] "Inapata wiki moja na nusu. Wiki moja nilikuwa siwezi chochote, nakogeshwa kama mtoto."

[89] "Siku nyengine nikitaka kufanya pumu, naona flue tena najua hapa pumu karibu. Lakini hata inanibana tu siku mbili, tatu. Nanunua dawa tu zile *Minoflen* lakini mara hii haikusikia."

[90] "Nilipelekwa hospitali, ilikuwa jumamos, maana nilianza kuumwa jumamos. Sikulala kucha, mpaka saa kumi ile ya jumamos, nikawaita watoto wakaja wakanichukua wakanipeleka hospitali nikapiwa shindano, nikapata dawa, halafu nikashinda kwa mtoto wangu, kwa Saleh, (…). Nasra alikuwa yuko Dar. Akarud akaja akanichukua tukaenda zetu bububu, tukalala vizuri jumapili. Jumatatu niliumwa kuliko mara ya mwanzo, tena akanipeleka hospital Nasra, nikapigwa tena shindani, nikaekewa ile ya hivi. Nikarudi na madawa ya antibiotic, sasa hayo madawa ndo yaliyoniumiza, nikawa tena sina nguvu, unajua mwili wa sukari, lakni sasa hivi afadhali, afya yangu inarudi."

[91] "Nilikimbia kelele za watoto, maana yae yule mtoto wangu Abedi akasema: 'Hatapumzika mama, watoto watamkera, bora mchukuwe wewe Saleh. Apate kupumzika'."

1.2.3. Understanding Honored Mothers and Acceptable Dependency

Bi Mchanga depicted these care arrangements as something that happened to her, in which she had no active role. In her narration, her children decided on the course of the actions concerning care-giving in this situation of health crisis. Thus, she frames her children as active provider and herself as passive receiver of care, as *mama,* for whom it is well cared for by her children. This framing itself shows her agency. In situations of health crises, it seemed for most women to be acceptable to be cared for and thus to be dependent on others; especially as a mother. She judged the paternalistic actions of her children as signs of love *(upendo)* and the Swahili concept of honor *(heshima)* towards her as their mother whom their want to reward for what she did. Kinship, Swahili and Islamic norms as well as reciprocity are thus all relevant contexts of actions.

While my data show how men in such situations were frustrated, struggled to "be able to do without help" *(kujiweza)*[92] and maintain their position as heads of the household or at least respected and responsible older men, aiming at providing care for their families as long as possible, women did less refer to these norms. On the one hand the majority of older women had gradually given up the responsibilities they had had as younger mothers and wives like raising their children, cooking for the whole household, doing major parts of the cleaning and washing for several members of their family. On the other hand, many older women of the random sample I met were in a chronologically older age than men and accordingly by comparison often anyway weaker. On the other hand, virtually all older female research participants were once married to older men and are by now in the majority widowed or divorced. Correspondingly, those older women were less normatively under pressure to provide and care for children or a husband and a wider range of contributions in terms of quantity and quality to their social environment felt to be acceptable. Though many older women wanted to contribute to and participate in their social environment even if it was just by helping to do small work in the kitchen, washing their own clothes or to buy matches for the household or soap for their grandchildren, they could do sometimes more and sometimes less which was fine for all who were involved.

1.3. Methodological Side Note: Grasping Health Crises

Health crises of research participants, as Mzee Cheetah's stroke or Bi Mchanga's asthmatic attack did not only open my eyes for the implications such health crisis could have for older people and their social network but it also challenged my methodological approach to understand people who could not verbally articulate and share their experience anymore. Being confronted with this methodological difficulty, I realized that in most cases of health crises I was not able to discuss this situation with older people themselves until their health situation was stabilized, became more routine and possibly new care

[92] See in more detail in chapter three.

arrangements were established. Often exactly during such situations of sudden health crises, I could not find my informants at their usual place anymore or they were too weak to talk. Thus, for me as a researcher this meant that I had to concentrate on observation, while verbal conversations had taken a back seat. Participating and empathizing in how bodily changes of aging felt like were anyway difficult and became almost impossible in those situations of pain, illness and disability. But even more so, I argue that my struggles to grasp the meaning of these new and not routinized situations in the research, exactly reflect these situations as such: These are mostly new situations of uncertainty for all involved parties which inevitably need to be interpreted and adjusted to. Methodologically, these cases thus also were difficult to follow up exactly on what happened during the health crises. Especially difficult was to find out how a person in a health crisis experiences this situation in the very moment it happened, as we usually could not be there on the spot.

2. Sudden Adjustments: Needing Care Here and Now

Some health crises were very serious and required immediate response relating to care. In this sub-chapter I will focus on the specific aspects of care during health crises, while I will talk about long-term care in the next chapter. I cannot stress enough that I understand care as an umbrella term, which includes a vast diversity of norms and practices (cp. Introduction). And additionally: Even though here I focus on care provided for older people in situations, when they are not able to care for others, especially in private settings care typically is practiced bidirectional. Older people do not just receive care, they also did or do provide care or might again take care of others later in their life.

Health crises of older people and related breaks of continuity and the habitual called for sudden adjustments in the care arrangements. In most cases participants tried to mobilize as many as possible of the social spaces they could access at once. This meant on the one hand for many to lead a cosmopolitan strategy making use of Zanzibar's typical medical pluralism (Leslie 1980; Penkala-Gawęcka and Rajtar 2016; Beckerleg 1994; Leslie 1976), relying on a variety of treatments and biomedical as well as spiritual support and on the other hand, to try to receive help from local social spaces as well as from those they stayed with. Neighbors, and the close by and reachable medical services as well as, if possible, from transnational social spaces such as organizational, financial or material support from relatives living in other countries.

2.1. Sharing Care-Giving Responsibilities: "We are Together" (*Tupo Pamoja)*

Care rarely happens inclusively between two people. Especially during health crises, usually, many people were involved to take care of an older person needing help. Two patterns were predominant: That either mostly female relatives came into a household of an older person for some time or the older person spent some days, weeks or months in the house of a relative and moved then to the next one. The following two cases of Bi Nachum and Bi Khamis will illustrate these two patterns.

2.1.1. Bi Nachum – Taking turns to provide care

Bi Nachum (I have introduced earlier in this chapter), who was in her mid- seventies, had broken her leg and was completely bed ridden. Even though she had had four sons and four daughters and five children who passed away already, despite all the relatives to receive all aspects of care was not easy. Those children, who were still alive, did not have any income. Prompted, with whom she was living, she told us, that she stayed with her son and her daughter in law, as well as with their children. In practice though, at the beginning of our research her son was rarely there. He was married in Dar es Salaam and once his mother became weak, asked in their village of origin if there was any woman willing to be married to him[93] as a second wife and move to the house of his mother in Chumbuni. The main intension of this marriage was to find a care-provider for his mother. Even though Bi Nachum's son managed to find someone to stay with his mother and help her with the basic everyday activities like cleaning the house or cooking, they lived with virtually nothing and can only afford one meal per day. Even though she knew, that she would need medication against her high blood pressure, she was not able to buy them anymore. Other children of Bi Nachum came by to wash her clothes. Bi Nachum's daughter in law, who suffers herself from asthma and could not do heavy work, managed thus hardly to take care of her before she had her leg broken.

After the accident Bi Nachum required even more help. First, because no money was available at the time Bi Nachum had broken her leg, the children had to ask relatives and everyone around such as neighbors to contribute a *mchango* (contribution) to bring her to a hospital and pay for the necessary material and treatment. Then, she also needed more physical support, because she could not get up herself anymore and needed to be carried to the bathroom. Her daughters made a plan by which, each one came for one week and slept next to her trying to help her at night, since she was completely immobile. They brought her the basin if she needed to go to the toilet and they carried it back to the toilet to clean it. The son with whom she stayed divorced his wife in Dar es Salaam and decided to stay with his mother in Zanzibar instead. In the morning, he and other sons came and carried her to the toilet or bathroom. The daughters washed her. Bi Nachum, explained how during the day her sons go out looking for money: "So, whenever they get something, they come and place it. If not, they continue to look for it." The sons give her some money for tea in the morning and also leave something if they have money. If they are not having anything, she has to wait until the evening. She explained that she lives with her family in such a secretive way, so that no outsider would find out if they had food or not. This was their family secret and an element of being together in this.

[93] The Swahili language points to the traditionally passive role of women in the marriage process as *being married* (kuolewa), while men are ascribed the active part of *marrying* (kuoa).

A son passed by every morning to carry her to the toilet, otherwise she helped herself with the bowl under her bed. Once we went to see Bi Nachum, we met the son with whom she was staying while doing walking exercises with her. Her elder son is paralyzed himself and cannot do any work or assist her in any way. Her children and daughter in law were the only ones who come to see her; even her grandchildren and neighbors were afraid of her being a witch and feared to be affected negatively by interacting with her. Bi Nachum was convinced that her children were tired to care for her but she asked them not to let her down, even though she felt sorry for them. Possibly, they did not have much of a choice either. This illustrates also how the rhetoric "honoring of mothers" is not just easily translated into practice, especially for less privileged families. Nevertheless, Bi Nachum referred to this norm to ask for help within the localized space of aging and caring she can interact in. Nevertheless, she is used to living in economic poverty, her context of action, knows the limited possibilities of her children and fears the realistic risk of being not cared for sufficiently.

During the time, she and her relatives were dealing with her health crisis the care-givers rotated among themselves daily to stay with her but the family was still struggling to find a convenient way of taking care of their *bibi* realizing that she needed intensive care for a longer time. Once the plaster around her leg was removed, she moved to her daughter, son in law and grandchildren in a neighboring shehia. As in many other cases, we followed the older person throughout the city, to see how their living and care situation changed. Previously, the daughter with whom she stayed now came to see Bi Nachum in her son's place and explained to us that her mother could no longer live there, because a son could not take care of her. She was referring to intimate care like washing the older woman's body, which she explained could not be done by a man. Implicitly she was not considering her daughter-in-law as an option to take care of her.

Even though Bi Nachum's leg was better, her situation got worse. The house of her son-in-law, where she stayed at that time, was in a very poor condition as well. While I was concentrated talking to her daughter, my research assistant Saleh, observed how the bed in which the older woman was laying was full of bedbugs. We could not really talk to her anymore since she seemed to have developed dementia, which according to her daughter had started recently. She remembered us just vaguely. Her daughter told us, how she had a stroke during Ramadan. They did not go to a hospital with her but the family called a doctor who came because she had inflamed eyes. From him she received medications for the eyes and he identified the stroke. At the time, we met her, she was paralyzed in the face and she could not walk anymore. After a year, she passed away. Bi Nachum experienced thus several health crises, one after another and constantly needed adjustments of how to be cared for. Her children tried to take care of her but even though they shared the care work among themselves and provided her with what they had; it was not enough to catch up with the diverse crises which came up.

The case of Bi Nachum showed us both typical patterns of how relatives typically share care-giving responsibilities during a health crisis by taking turns in staying with her and later, when her situation became more chronic moving her to someone else. Before I will more generally write about the sudden adjustments, older people and their families need to make, both being part of certain social spaces, I would like to contrast and complement the case of Bi Nachum with the situation of Bi Mwana who is living in Kikwajuni, the shehia relatively close to the city center. In her case, the two care-giving patterns (taking care of her at her place and then moving her to a relative) are also present but it shows how even though the practices can be similar the engagement in different social spaces can make a difference in how older people can receive care-giving.

2.1.2. Bi Mwana – Constant adjustments

Bi Mwana, who was 79 years old and widowed for more than ten years when we first met her in 2012. She was proud to have worked as a nurse for a long time and having lived a relatively independent life compared to many other women of her age. Having been born in a village in the north of the island, she came already as a newborn to the city of Zanzibar, where she was raised by her aunt and uncle, whom she related to as her parents. Bi Mwana married her husband in the city and raised his children from another marriage. At the time, she moved into his house his children were around five and ten years old. Bi Mwana never had her own (biological) children and thus, in her words did not raise children whom she has given birth herself (*watoto wa kumzaa mwenyewe* – children oneself has given birth to) but still brought up several children whom she calls each "my child" (*mwanangu*) today. In total, she raised two children of her husband, Khalisa, her older sister's daughter, since she was eight months old, a grandson since he was some weeks old and another grandson for some time in order to give his mother a rest. It was impressive to hear from her how what could be called the "social sharing of children" went further: During her workdays, each of the children was brought to or picked up by someone else again. This was not only the case of how Bi Mwana was raised herself but also in the child rearing of her children, one of her grandmothers and her father's aunt played an important role, while she was working. These days, this niece lives in Mwanza (a city in the north of the Tanzanian mainland), working for an international company. Bi Mwana can stay for free in her house in Kikwajuni together with, her late husband's grandson and her sister's grandson two young men of whom one moved out during the period of the research, because he got married.

Even though, Bi Mwana portrait herself as vital in her stories, she suffered from chronic health problems. Having experienced problems with her heart and respiration *(pumzi)* she was careful not to move too quickly, to stay away from heat, observing strict rules in her diet and to ask for help with tasks, which might be exhausting or agitate her. Nevertheless, she had several health crises, often rendering visible an additional health problem, while she was coping with others. She told us about the last one she experienced, whereby she explains how she encountered and countered several difficulties of everyday life to finally access the health system: First, she could not reach her (husband's) son Thabit, the first

person she usually contacts in such situations of health crises. She then called her daughter, who quickly came but who, has neither a car nor the financial means to take care of Bi Mwana. Luckily, having anticipated a situation of crisis, her (husband's) daughter could draw on the money her brother left her with. Bi Mwana also received help from a neighbor who passed by. This neighbor who happened to be a member of parliament suggested to drive her to the hospital with his car. The second major problem she encountered was to get a proper examination of her health problem at the main public hospital, which they solved by switching to a private hospital, where they did not only pay for the examination but also for the prescribed medicaments. Thus the third difficulty was the financial means to pay for the medicaments:

> Imagine, one day – those knees - when I came from the toilet… I was not able to walk anymore. I had problems to telephone Thabit (her husband's son). I would have been late (to go to the hospital). This member of parliament he loaded me and brought me to the hospital there (main public hospital), to my doctor. I went there, then, when I went there we were told that the x-ray was bad, not working. Halima (her husband's daughter) said: "Let's go to Al Rahma (Hospital)." We payed 14'000 (TZS). So, it was only a little problem. And it was also a little problem only, because he (Thabit) had left her (Halima) with that money (to use in case of an crisis).[94]

For her this was just a small problem *(hajambo kidogo)* as she was experienced in solving such problems and she had the possibility to engage with different people in an area, where people have cars and know each other, children who were prepared for such a situation and having the necessary financial means to help. For other older people in Zanzibar, for example from Chumbuni, each of these problems could have been the end of their journey to seek medical care.

Back home her relatives adjusted the care-giving arrangements. It became necessary, that Bi Mwana always had company who could help her, especially also at night: Besides the *dada,* the housekeeper who was hired by Khalisa, the niece in Mwanza, to do the housework from Monday to Saturday and was around from the morning until late afternoon, two other nieces and her daughter who live in the neighborhood started to take turns spending one night per week in the house together with Bi Mwana. This was necessary to help her going to the bathroom at night or to get dressed. Her late sister's grandson, who just got married and had moved out, still came to see her every morning and evening. He

[94] Bibi: "Fikiri, kama iyo siku moja - goti hili - natoka chooni (…) nikawa siwezi kutembea. Nliona tabu kumpigia simu Thabit. Nitachelewa. Huyu mbunge wetu akanipakia, akanipeleka spitali kule kule kwa daktari wangu. Nikenda kule sasa nilipokwenda kule tukaambiwa ex-ray ya pale mbovu haifanyi kazi. Halima akanambia 'twenzetu wapi hukuu Al Rahma'. Tukalipa kumi na nne. Ndiyo haijambo kidogo. Na haijambo vile kua kamuachia zile pesa."

sometimes also replaced her *dada*, except for the cooking. If he was there during the day, he brought food his mother (Bi Mwana' niece) had prepared. He also often spent entire Sundays together with his wife at Mwana' place. The grandmother raved about her and how she helped her with all kind of things like washing her curtains before Ramadan. Thabit, her son, came by usually in the evenings. They mostly were chatting. He was also always there to pay for medication and other things she needed. The grandson who still lived with Bi Mwana in the house had the role of a messenger and she often sent him out if she needed medication, thus he would go to get the necessary money from Thabit and then buy the medicaments at a pharmacy. Besides her relatives - and this did not change after her health crisis – she had a neighbor, whom she took care of when he was a child, as his mother fled to Oman, who passed by daily to ask her what she needed from the market.

This was thus the care arrangement we found her in and which became then a long-term care arrangement. One year later we went several times to her house without having been able to find her there. After some weeks, we finally could reach her grandson on his mobile phone. He told us that Bi Mwana just had had again a serious health crisis, a problem with her heart, and stayed since then with her son and his family in a small town, outside of the city of Zanzibar. Her grandson in a later phone conversation explained that she was doing "not bad" but that they could better take care of her there. She took her *dada* with her and stayed in her son's house until the end of our research.

2.1.3. Understanding Shared Care-Giving Responsibilities

In situations of health crises, many relatives from different spaces of aging and caring (see introduction) contributed within their framework of possibilities. This was not only true for the two cases I described but for all situations of health crises of the study participants I became a witness of during the research phase. Several times I heard relatives involved using the expression *tupo pamoja,* which translates as "we are together." *Tupo pamoja* means more than just literally being together. It usually was said smiling and always had a comforting touch of solidarity and (self-) encouragement. Even though care-giving during a crisis did not always just happened totally harmonically and the quality of care older people received was very diverse, this discursive formation tells us something about how care-giving should be practiced according to a common cultural imagination. Shared care-giving responsibilities were not only rhetoric but also in practice widespread and in the case of Bi Mwana as in many others, care-giving is not only shared during elderhood but the "care-sharing" started much earlier often during childhood of younger generations.

In all the cases I have analyzed, several relatives and acquaintances together felt responsible to take over either a certain aspect of care-giving or became care-givers for a specific period of time, until someone else took over again. The care-giving responsibilities were thus shared, sometimes explicitly and planned, in other cases the splitting up of care was implicit and grew out more organically. This was

true for practical aspects of care, such as helping to walk to the bathroom, financial support, as well as emotional assistance or hosting someone at home.

Even for families like that of Bi Mwana, who manage to take care financially of their *bibi* the family and the older woman need to be well organized and ready to put an effort into creatively finding (health) care solutions in cases of health crises. Bi Mwana had in this health crisis to imagine another way to come to her health treatment than what she usually did, as Thabit was not around. She and her daughter who was with her had to activate help from a cosmopolitan social space they could access and share with a member of parliament, a powerful man and owner of a car. Not all people in the city of Zanzibar have access to such kind of support. Having experienced other crises and imagining that such could occur, the family was partially prepared for the sudden need of financial support by having had crisis funds.

A typical practice to provide care during health crises but also in situations of chronic illnesses with long-term care circumstances was to take turns in providing care for an older person as the case of Bi Nachum is illustrating. Different in the two situations was in most cases the frequency of changes in people taking care of an older person. While during health crises the "care-shifts" were usually taking some hours, a day or a night, in long-term care arrangements one turn usually took weeks or months until someone else moved in to the older person's residence or the older person moved further to another relative. The case of Bi Mwana though shows us, that also in established long-term care-giving caregivers can rotate after a few hours. More important than the time shifts take is the fact that during health crises care-giving responsibilities needed to be distributed newly in the different aging and care spaces an older person was part of. Bi Nachum as well as all other research participants in Chumbuni had to organize herself very locally, while Bi Mwana had some more options by making use of cosmopolitan spaces of aging and caring, as she could draw on her own knowledge as a nurse and had the means to stay in touch translocally with her niece staying in the Tanzania mainland.

Almost all older people formulated their wish to be cared for by their children. Older women as Bi Nachum and Bi Mwana imagined in an ideal situation a daughter to take care of the physical and emotional care like preparing food for them, helping them in their everyday activities like washing or dressing themselves and being around to chat together. Sons were seen as financial care providers but also responsible to do heavy physical care for example to carry a mother to the bathroom, if she was not able to walk there on her own. As Beckmann (2010, 209) described, there is a common consensus among Zanzibaris that the extended family should serve as the primary network of support. In this research as well, care from others than the closer family, was mostly perceived as second choice and if possible was confined to household tasks and should not include very personal care such as washing the body of a sick older person. In practice though, the decisions are more pragmatic and *madada* (plural of dada) or

daughters-in-law care for older people, if this was the most practicable solution. Not everybody in the social network of an older person was responsible to decide about the next steps, which should be taken to deal with a health crisis. Mostly, those who could and would decide about care arrangements were well-established men, who were working and generally taking care of the family in terms of the financial aspects and what could be called patriarchal supervision. As we have seen in the case above of Bi Mchanga, we encountered exceptions though, where younger women were not only heads of a household but were in a powerful position within the larger family, especially if they had a higher professional position and the corresponding financial means. As we will see bellow, this orientation towards kinship and gender norms was generally in practice but especially in situations of health crises much more replaced by an orientation towards the available and practicable.

2.2. Relatedness in Care-Giving: Care Between the Desired and the Pragmatic

Despite the widely-accepted norm, that the extended family should take care of an older person, the practice happened to be more pragmatic. Even though this is sometimes also true for long-term care and non-kin like housekeepers or neighbors may take over certain aspects of care-giving, it is typical for health crises. The following situation of a health crisis of the wife of one of the research participants shows how neighbors and just everybody who is around become involved.

2.2.1. Bi Kauthar – Needing help of everyone around

One day in 2013, when I just came back to Zanzibar to continue the fieldwork, Saleh, my research assistant called me. He was in a hurry, telling me that I should quickly take a *daladala* to Chumbuni, where he was staying at that time and was well integrated in the social space there. Saleh informed me that his neighbor needs his assistance to drive his sick wife to the public hospital Mnazi Mmoja, as no one else around had had a car available. Interestingly, this neighbor, who still works as a tailor was also one of the research participants and I had already conducted two formal interviews with him in 2012 and have spent some time with him in his tailoring shop. He is married to two wives. The elder one, who was around 55 years old, now had a circulatory collapse. Of course, I wanted to join them to observe how they would deal with this situation. Once I reached there, Saleh picked me up at the main road and as usual he had to guide me through the – at least for me - labyrinth made of hundreds of footpaths of this shehia. He had left his car at the main road, as to get through would have been impossible. When we reached the house of the tailor and his family, many more people than usual were in the house of the older man. His wife was in a weak condition lying on a mat (*mkeka*) on the floor in her room. After some greetings and a warm welcome by my informant, around five young men, most of them neighbors, carried the woman on the small, dusty ways down to Saleh's car. To bring the women into the car was one thing, but to carry her further at the hospital to the right ward, was another one. Thus, the necessary manpower needed to be there too. To make the transport of all relevant persons possible they had to squeeze themselves together into the car: Two women (a daughter and a neighbor) sat on the backsides,

in their middle they seated the older patient, three of the men went into the cargo bay of the car, Saleh drove and I felt bad having occupied the passenger seat in the front. Even though I insisted that the patient's husband should take my seat and I would go by public transport, I could not convince him and he decided to come later by *daladala*. Saleh drove quickly to the hospital, where the men seated *bibi* into a rolling chair. After having found the responsible office in the right ward (female ward), *bibi* could quickly see the professional staff as she had already the required register book of the hospital.[95] The wife of my informant was admitted at the hospital and the helpers, brought her upstairs to the ward where she would stay for some time. There, officially, only two men and two women could accompany her. Thus, Saleh and I waited downstairs. The sick *bibi* upstairs was also told to wait for some hours until the responsible doctor would be back from her break and prayers. The help of her relatives and neighbors did not stop at the hospital. As it is usual at hospitals in Zanzibar, during her whole stay she always needed someone besides the professional staff to take care of her. It required thus again several people who brought her food, washed her, went to buy medicaments and additional medical material and so on. Not only in her case but generally, I observed many times how especially women went to visit relatives, neighbors or friends at the hospital, stayed there some time to talk or at least to be present with them and they often brought food.

2.2.2. Understanding Relatedness in Care-Giving: Care Between the Desired and the Pragmatic

If there was no wife or son around to wash an older man, the circle of acceptable people grew, because someone had to do it. If people were employed to support older people this was usually only done for housework. But even in these cases, when women were paid to help in the household and do for example the cleaning, helping to cook, washing dishes, the washing of clothes and everything else help was needed, they usually relied on a distant relative. These women, typically were unmarried, often bellow twenty years of age and coming from rural areas. All of them could stay and eat in the house for free and sometimes had the possibility to go to some evening lessons at a *madarasa* or attend sewing classes. The financial recompense for their work were tiny and the working hours long but it was a chance to get away from the rural life, to become exposed to other households and possibly to find a husband in the city. If biologically related or not household helpers are called *dada* (older sister), which points to relatedness in a social and cultural sense (Schneider 2004; Carsten 2000; Sahlins 2013; Alber 2003) and allows to frame this support of older people as a family matter. Older people also emphasized that this help was organized by their children, which again shows how parents desire to receive care from their children, even if this happens in an indirect way through a household help.

[95] Patients of the main hospital need to buy a small book at the hospital for 500 TZS (around 0.30 US$), in which the medical staff records treatments and medicaments needed.

2.3. Methodological Side Note: Ethical Dilemmas – Becoming Involved During Crises

Rarely, I was directly asked for financial support but it was clear, that especially during the first conversations and in times of crises some research participants expected financial support from the research team. I argue, that we can understand this positioning during crises as part of the strategy to trying to find help from all you can. Underlining their financial poverty and general misery, especially people in poorer areas like Chumbuni had a certain expectation not only towards the European researcher but also towards the well- educated and employed research assistants. This representation of being poor though often changed in the course of the research. It was fascinating to see how certain research participants – especially men – portrayed themselves during the first contact we had as poor and as not receiving any kind of financial support, while later during the research phase they more and more opened themselves up towards us and gave us a more nuanced picture of their financial income.

Being aware of the possibly negative implications such financial help from my side could have on the research[96] I was very skeptical about providing the research participants with anything more than the vague promise that this research might give insights into their experiences of aging and care not only to researchers but to public authorities, NGOs and the community. I had many discussions with my research assistants about providing financial support for the older people. Not only I was in an ethical dilemma but they were too. Being confronted with the poverty of certain older people and their condition especially during health crises it was sometimes unbearable to ignore their situation and not to help. On the one hand, this urge to help financially, had at least for my research assistants a religiously coined dimension, but to a greater extend it was simply sympathy. Not helping had a cruel and voyeuristic aftertaste.

We were in an ethical dilemma between on one side not wanting to influence the research findings more than necessary by provoking self-victimization of the research participants in order to receive our support and on the other side it felt not ok not to help them at least a little to buy medication, pay for a taxi to the hospital or just to bring along some fruits or other food. This was against all logic of sustainable help or societal change but felt right.

Parallel to how relatives and people around become involved during crises just as human beings – Saada, Saleh and I became as well. I had to give up my credo of not wanting to be involved personally by making (financial or material) contributions to the research participants. The naturalizing effect of our

[96] Such implications can for example be the provocation of statements, which the research participant thinks are desirable to the researcher (cp. Mead 1954 [1928]) or participation in the research under constraint due to financial hardship instead of conviction but it could also lead to problems of discrimination among the research participants. Finally, the research project could not cover such expenses anyways.

long-term research, had on the one hand the positive implication that people told us with every conversation more about their experience of aging, health and care but on the other hand we also were not only researchers anymore but deeper social relations, kinds of friendship (becoming a *shoga* (a woman's female friend) or a *rafiki* (generally friend)) or even relatedness developed, when we started calling the research participants *bibi* (grandmother) or *babu* (grandfather) or they related to us as *mwanangu* (my child) or *mjukuu* (grandchild) or in my case even as *mkwe* (in-law, in my case as daughter-in-law).

We thus eventually influenced our data by becoming involved in health crises in emotional, practical and financial ways. I argue though that this influence was a responsible and human way to conduct this kind of research and thus, allowed us a deeper insight into the experience of aging and made it possible for us to actually participate in their lives and thus apply an established method of ethnographies.

3. Entering Cosmopolitan and Transnational Spaces of Care

In health crises, profound experiences of sudden changes to the habitual let older men and women as well as their close relatives in their local proximity ask the question: "What should we do now?" The answer they found, in order to deal with situations of health crises did not only lay in the proximate local social space but when suddenly older people were confronted with new conditions of their health and the established care patterns needed to be adapted, some could intensify or (re-)activate additional care by engaging in cosmopolitan and transnational spaces of aging and caring (cp. Introduction). As we will see, these two spaces can overlap as typically in both, people engage who went through (higher) education in and outside of Zanzibar, who can raise the necessary financial means, are in good relations with relatives and other (powerful) people outside the family in the city and abroad and live in a locale which allows them to do so. In Bourdieu (1986) terms these are older people who have access to the necessary economic, cultural and social capital to become involved in cosmopolitan and transnational spaces of aging and caring. While it was often easier for older men than women to engage in cosmopolitan spaces (due to their education, past travelling experience, public interactions, etcetera), it turned out that some older women skillfully draw on transnational spaces by positioning themselves as mothers towards relatives abroad, what I will elaborate on in more detail in chapter six.

3.1. Remembering a Wide Range of Possibilities: Making use of Cosmopolitan Spaces

I argue, that in times of crisis and uncertainty older Zanzibari, typically could build on experiences and engagements they had made of cosmopolitan living in the past. Skrbis et al. defined such a cosmopolitan living as "the willingness and possibility to engage with cultural 'others'" (Skrbis, Kendall, and Woodward 2004). Fair, even though in the context of fashion, puts the core of cosmopolitanism in Zanzibar in a nutshell: "a discursive and performative practice" that reflects "a sophisticated

appreciation for international mixing and appropriation of cultural styles and symbols from multiple, geographically dispersed sites" (Fair 2004, 13). Even though not all older people can engage in cosmopolitan spaces of aging and caring I would still bring forward the argument that cosmopolitan aging and care-giving in Zanzibar can be understood as a lifestyle and what Kleinman (2012) called a moral experience. Even though this cosmopolitan position is habitual and slumbering in many older people and their relatives in everyday life, it comes to the fore in practices and discourses of health crises.

A typical aspect of the cosmopolitan space of aging and caring is the use and interaction with ideas of what is in the literature usually called medical pluralism (Leslie 1980, 1976). Already Beckerleg (1994, 308-9) and Parkin (2013, 29) have described the wide range of similar textbooks and medical preparations made of plants in different Swahili Muslim towns along the East African coast. Coming mainly from South Asia, especially India, by ship, Zanzibari know them by Urdu, Hindi, Arabic or Swahili names and regard them as belonging to the wider Islamic medical corpus. Some Arabic books on humoral medicine (humorism) are available from different regions of the Middle East.

While I agree with Parkin (2013, 33) on his conclusion that most people would regard biomedicine as good for acute conditions but secondary to customary therapies for chronic complaints, as Swahili on the East African coast would feel more loyal to (Islamic) healers, I did not observe this loyalty in urban Zanzibar. This can be due to my person interacting with the older people and their families, who might possibly have seen me as representative of the biomedical world. But having spent a lot of time with the research participants, I had the impression most did not coin their narratives to please Saada, Saleh and me. During the interviews, when talking about possible treatments in cases of health problems many of the older research participants criticized all kinds of approaches deviating from the biomedical treatments. In practice, in cases of crises they were pragmatic and most tried everything they could imagine and had access to, in order to get relief. In fact, the research participants and their relatives mostly began to seek first aid in biomedicine. After that, however it is true that, some of the realization of the biomedical pathway (Parkin 2013) was difficult. Sometimes, a clear diagnosis could not be made or they stopped the examinations and treatment after a while because they did not improve the situation. After a diagnosis, older people and their relatives often bought only part of the prescribed drugs because not all were available or too expensive. For some, this was the moment to try out other treatment methods. Especially because traditional healers could respond more flexibly to the financial situation of older people and this strategy seemed more feasible. Some though, were concerned that the way to traditional healers could be more expensive in the long run and thought the healers would take the money out of their pockets.

In the literature there is a consensus that "Swahili medicine is pluralistic, offering sufferers a choice of therapies based on competing theories and religious ideologies" (Beckerleg 1994, 311). In her research on coastal Kenya Beckerleg depicts the quest for therapy as an "individual choice." Even though I think it is crucial to understand the older people as agents having certain options in what they do and how they and their families react to health crises, some are having more possibilities to invest into plural forms of therapy, while others may lack the energy, knowledge, financial means, contacts and experience to engage in such cosmopolitan spaces of aging and caring and do thus not have such a choice.

The following exemplary case of Mzee Cheetah, who suffered from a severe stroke (we got to know him earlier in this chapter) shows us how health crisis can require immediate action and how thus, older people and their social network try to activate a multitude of care options at once. This example illustrates how during a health crisis cosmopolitan spaces of aging and care can open-up, as every available contact and treatment is activated. The willingness and possibility to engage with cultural other treatments for example is one way to deal with the new and uncertain aspects of health crises.

3.1.1. Mzee Cheetah – Diversification of care

After his stroke, Mzee Cheetah could count on a large part of his social network and received a wide range of (medical) care. His wife coordinated his medical treatment at the hospital and at home with an herbalist. He went to the hospital together with his daughter, who had been living in Oman. She did not return to work in Oman because of the condition of her father. She was sleeping at her father's place even though she is married. Her husband stayed somewhere else. After the stroke, Mzee Cheetah was in the hospital for one week, and then his wife decided that he should leave, even though the medical staff asked Mzee Cheetah to stay another week. Cheetah's wife complained that the medical staff did not explain the sickness to them, and she also did not see any improvement after one week. The doctor told them that he should do exercises, move, and try to talk. When relatives talked to him, he grimaced and became angry, perhaps because he felt they were making fun of him. This older research participant made use of a wide range of treatments, which his first wife also organized. Cheetah's wife invited us to attend a session with the herbalist (*fundi*, literally meaning "skilled person"), a 66-year-old skinny but strong woman. We entered the bedroom where Mzee Cheetah was laying on a mat (*mkeka*) on the floor in short sport trousers. Bi Wanu, the herbalist, massaged him with an oil with five ingredients. She started with the legs and continued to every other part of his body. Sometimes he made noises that showed he was in pain. The *fundi* told us that there are different kinds of arm rings of the ethnic group of *Maasai* for different kinds of *wanyama* (animals/beasts) – bad spirits. She told the family to buy such a ring. After he took the ring off for the massage, Mzee Cheetah did not want to put it on again, but his wife insisted that it was a medicine (*dawa*) and he should wear it. Besides the treatments by the *fundi*, they also use *madawa ya kisunna* (supererogatory Islamic medicine) and went to a spiritual healer who

does *kikombe*, which is part of Islamic healing. He writes Koran verses with saffron on paper, which he then puts into water. Then, after a while, the patient drinks this water. Mzee Cheetah himself did small exercises and walked around to get better.

Mzee Cheetah and his relatives had not only to deal with his medical care but generally with changes in how to care for each other. His daughter, who did not go back to Oman took care of her father during the day while Cheetah's first wife was working. She thus had to wash and dress him, cook, clean, be there for visitors who came by and just be around and help him with anything that occurred. His second wife only came to see her husband once in all the months since his stroke and she did not contribute financially to the medical treatment. Mzee Cheetah and his family lost the main part of their financial income but he still received a pension of 60,000 TZS (30 US$) per month and they lived on that and his wife's salary (around 150,000 TZS / 75 US$). The pension became more important to the financial livelihood of the family than it had been before, even though it did not cover their expenses. They rented out the house that Mzee Cheetah built for retirement to supplement their income. Neighbors came around and brought small amounts of money, but they mostly stayed only for a very short time since Mzee Cheetah was not able to talk anymore.

Even though Mzee Cheetah could not know that he would end up having a stroke with such life-changing consequences he still sometimes before the incident happened, had ideas about possible future care arrangements in the case of a health crisis. After Mzee Cheetah had had his stroke, I went back into the transcripts we had of talks with him when he was still feeling strong and able to deal with his chronic condition of Diabetes. In the course of a conversation we touched on the topic of what would happen if he would need more care. He told us, that usually he and the child of his older sister helped each other but that just recently she had invested to get into politics and lost all her fortune. He was not sure at all, who would take care of him but he said several times, that it must be his wife and children, even though he knew it would be (financially) difficult for them. As if to reassure himself he then added several minutes talking about what I would interpret as a combination of discursive practice on reciprocity and piety. On one hand, he stressed that everything is in the hands of *Allah* and that we would reward those who had cared for others. He added that his house at that time was a nodal point for his relatives who lived on the country side (*shamba*) and came to the city for medical treatments. During their stay in Cheetah's house they would be served with everything they need. He did not expect directly care from them in return but believing in God that this would happen to him as well, since he took care of his relatives, when they needed it.

3.1.2. Wide Range of Possibilities: Making use of Cosmopolitan Space

Even though Mzee Cheetah was in this situation literally paralyzed and needing help with everything, he was still an agent with a past of experiences of interactions with culturally others as he, due to his

work, had to travel through many regions of Tanzania and on the African continent but also - and maybe more importantly - interacted with a wide range of people from all over the world in the city of Zanzibar. Mzee Cheetah carefully planned his day-to-day life and his future retirement, but he could not foresee that he would suffer a stroke, which would prevent him from working in the big garden of the house he built outside the city.

It was through imagining potential future situations that Mzee Cheetah created strategies to change his prospects. Before Mzee Cheetah had his stroke, he built on his past experiences and habits. He not only constructed an additional house; he also paid into a pension scheme and established a large family of which he took care. After the stroke, Mzee Cheetah had to reorient himself as much as he could. He was not able to become the healthy man working in the garden he had imagined. His experience gained a new dimension. Nevertheless, he could still partially rely on what he had imagined before: the pension and, especially, his first wife and children.

The case of Mzee Cheetah illustrates how older urban inhabitants in a cosmopolitan space of ageing and care might draw their agency from a range of experiences in diverse social and cultural spaces. At the same time, what I also would like to show with the situation of Mzee Cheetah, is that access to cosmopolitan spaces of aging and care does not necessarily have an equal standing compared with finding solutions for a health crisis. Even though people tried to activate as many networks as possible in crisis situations, these efforts did not always pay off in the form of multiplied support. As we have seen in the case of Mzee Cheetah and his second wife's disappearance from the care arrangement, the new situation could also lead to a discontinuation of certain forms of support.

What I have observed though in many cases is a general openness to try out everything available to get possible relief and to come to terms with the situation in terms of health and care-giving. Accordingly, he and his family decided, for example, to try out all kinds of treatments at the same time. The difference in what I call here cosmopolitan compared to others in the city, who are only engaging in localized spaces is the openness and possibility to access a multitude of health treatments and broad range of care-giving models stemming from diverse cultural contexts.

Concluding, the case of Mzee Cheetah is representative for what I mean by engaging in cosmopolitan spaces of aging and caring in situations of crises, as it illustrates the widespread openness towards a range of approaches, originating from all over the world and which maybe combined at once. But it also shows that a large part in (medical) care seeking in situations of health crises was based rather on pragmatism than ideology to try out everything, hoping that one of the approaches might eventually help. Last but not least, the example also depicts that this "choice of options" was limited to access only for some people and in specific situations, such as health crises.

3.2. Caring over Borders: Making Use of Transnational Spaces

For those older people and their family in Zanzibar with relatives abroad one answer to the openly or tacitly posed question in situations of health crises of "What should we do now?" was to get them involved, even if it was just to inform them about a health crisis. While geographically close care arrangements enabled, for example, care for older people in health crises when family brought them food to the hospital or came by with incense (*udi*) and an imam to pray, relatives abroad not being able to help by being physically close, organized goods, money, and treatments. Their help was often not at all coordinated but sometimes incompatible with the circumstances in Zanzibar. For example, even though well intended, most of the material equipment (from crutches to blood-pressure gauges) remained untouched or could not be repaired once it was broken. On the other hand, operations, physiotherapy, a housekeeper and the like that relatives abroad organized and paid for were very welcome and a great relief. Older people especially valued their relatives' support in treating cardiovascular diseases, tumors, back and limb pains, and physical limitations like cataracts and other vision impairments. For example, relatives living abroad paid for the research participants to have surgery for back pains, heart disease, and cataracts. The surgeries the older people told me about were performed in Tanzania, Kenya, India, and Oman.

Mzee Makame's rather exceptional portray will show us, that often engagements in cosmopolitan spaces and transnational spaces of aging and caring overlap but at the same time the transnational relations are more built on personal relations compared to cosmopolitan lifestyles. It also depicts how especially in a situation of a health crisis he was involved in all three spaces, which is typical for people belonging to what might be called the elite or middle class. To illustrate the lifeworld of people who can engage in transnational spaces of aging and caring in situations of health crises, I claim that it is necessary not only to look at the interactions during a health crisis but to understand the contextual biographical and social background of an older person over the long-term.

3.2.1. Mzee Makame –Medical travels to India

Mzee Makame was an officially retired medical officer, who was at the time we met him for the first time 63 years old. Considering his high position in the administration, his little house in Mpendae, which was originally an exhibition model for houses, which could be bought by state employees, seemed relatively modest with no surrounding wall or fence and thus open for neighbors and people who just wanted to pass by. He seemed to be quite fit but told us that in the past two years his health seriously deteriorated, that he suffered from blood pressure, diabetes, and back pains.

On the first day, we met him in his house in Mpendae, where he stayed with one of his two wives, five of seven children and his wife's niece. The reason to find him at home was, that he just came back from

an operation of his back in India. Usually though, whenever we went spontaneously to visit him, he was not at home. Like Mzee Cheetah he was one of those men who were constantly busy with their many duties, contacts and tasks. However, this did not mean that they did not take time for us. On the contrary. We just had to learn, early enough, to make an appointment with them, which we weren't used to with many other older people whom we could meet at home at anytime (apart from the prayer and rest periods).

When Saleh asked Mzee Makame during one of our visits to narrate a short life history, he told us first about all the places where he studied and worked. His education and work biography shows us how he was involved throughout his life with culturally others: Coming from a rural area of the island, he moved to the city of Zanzibar where he stayed during the time of the revolution and attended secondary school. In 1966 he completed the school with the *Cambridge Exam,* a certificate which entitled him to study at universities in Great Britain and in other countries. After the exam, he was employed by the government as a teacher working in different parts of the island and was then employed in two ministries. In the late 1960s and early 1970s, during a period the new government in Zanzibar sought developmental help from socialist allies, Mzee Makame received a scholarship to study medicine in the Soviet Union USSR. At that time, it was almost impossible to leave the island legally, except for governmental employees. When he came back, he worked for five years in different hospitals on Pemba and Unguja before he received again a scholarship to specialize further; this time for two years in Japan. Back in Zanzibar in 1982 he climbed the career ladder up to the top of the Ministry of Health. From 1995 on, the moment the multi-party system was introduced in Zanzibar he navigated between the Ministry of Health and unpaid leaves during which he cooperated with two large international humanitarian organizations working in Zanzibar and Dar es Salaam, in which he also moved into powerful positions and was enabled to do a Master of Public Health in the USA. At one point, he came back from Dar es Salaam to live in Zanzibar, because his father was sick and he was the one taking care of him.

During this time, Mzee Makame also started feeling weaker and found out that he had Diabetes. Additionally, already for a longer period he suffered from back pains. I will describe in detail the situation of his chronic health problems in the next chapter but want to focus now on the moment his chronic health condition culminated in a health crisis and turned as a result into a really bad chronic condition.

Saleh: Concerning your health. Is it that you have the usual strength?

Mzee: No, I don't have the usual strength because of the problem with my back. The problem of my back is increasing, since last year. Last year in January I got like a stroke. I got (severe pain) “an attack” on my neck and numbness on my right hand.

Saleh: Ok.

Mzee: Numbness *(ganzi)*. Especially on my right hand, which is not yet ok.

Saleh: It's not yet recovered.

Mzee: But now, it's decreasing. But the day I got that stroke, I went to the hospital and I found out that also my blood pressure was 190/150 and it was very high. So, that was the first time I did realize that I had blood pressure because all the time my blood pressure was 140, not above. So that day, it rose to that amount. So, I was sent to the hospital and my blood sugar was very high (18). From that day, the pain in my back increased. So, I got pain on my neck, my lower back, I did a *CT-scan* (computed tomography scan) and went to experts from Spain and they advised me to do the operation on the *lumbar* (lower segment of spinal cord). They did it but it was not successful. I got released only one month ago. After that the problem increased, I went to the Ministry of Health to explain my problem, and at that time the strength of my legs became less. And the numbness in the legs is increasing (*ganzi*), so they told me that there is a need to be sent to India. So, therefore, in January this year, I was sent to India. In India, they found out that I have problems at my neck. And they found out also that I have a problem down here (pointing) with my hip. So, they asked me, where to start and I told them they should start up, because I got severe pain in my hands. It is the numbness. They started from top, they operated me and they told me to go home and to return after three months. So, I returned home, I got relieve and in May this year I went back to India. I went there, and they did the operation on the *lumbar spine*. I went on 5th of May they operated me on 9th and I came back on 18th. Now I am on medication. I am not yet fit. But I am much better.[97]

[97] Saleh: "Sasa kutokana na afya yako unajihi bado una nguvu zako kama kawaida? Au some time unapata."

Mzee: "Nguvu sasa hivi sina kikawaida zakawaida kwa sababu matatizo ya mgongo yameeendlea na yamezidi kuwa makubwa kuanzia mwaka jana. Mwaka jana mwezi wa januari nilipataa kama a stroke. Nilipata a stroke yaaa maumivu ya shingo pamoja na nna numbness katika mkono wa kulia."

Saleh: "Okay."

Mzee: "Ganzi. Hassa mkono huu wa kulia ambao bado."

Saleh: "Bado hauja poa bara bara."

Mzee: "Lakini nn inapunguwa sasa ivi naa siku hiyo nliyopata hiyo a take nikaenda nikapima nikagundu pia blood pressure ilkuwa juu ilikuwaa around 190/150 something like that ilikuwa very high na kwa mara ya kwanza ndio notice kwamba kuna blood pressure kwa sababu miaka yote ilikuwa blood pressure yangu 140 ee note above. Lakini siku hiyo ilipanda kiasi hicho itabidi nikapelekwa hospitali na sugar nilipopima wakati huo siku ile ilikuwa around 18 ilikuwa very high ilikuwa very high kwa hivyooo kuanzia hapo sasa maumivu ya mgongo yaa yakaendelea kuzidi. Nikapata mgo maumivu ya shingo na maumivu yaa lower back sasa wakaja wataalamu kutoka Spain wanakuja siku hizi, bahati nikapiga CT scanning hapa walipokuja wale wataalamu nikenda wakanambia kwamba kuna problem spine lazima kufanya operation kwenye lamba wakafanya operation lakini inaonekana ile operation haikuwa succsessfull kwa sababu ilinipa relief kama mwezi mmoja miwili baada baadae maumivu yakaendelea sasa kwa bahati serikali nikaenda serikalini wizara ya afya nikawaeleza matatizo wakati ule ilikuwa miguu nguvu zinapunguwa nambness inaongezeka na nn kwa hivyo mwaka mwakani wakanambia kwamba ee pengine labda kuna haja ya kupelekwa India. Kwa hivyo wakanifanyia usafiri nikaenda india mwezi waa january mwaka huu. Nikaenda India waka kufika India wakaona kweli kuna matatizo kwenye shingo. Wakaona kuna matatizo kwenye chini hapa."

When he had the stroke, his family quickly called their neighbors to ask for help. The news of his health crisis spread like wildfire. His neighbors usually called him to seek advice in cases of health problems but this time it was the other way around. Mzee Makame praised the solidarity in Zanzibar and explained how a medical assistant from the neighborhood came quickly to check on him. This man later went to buy some medicaments for him. When Mzee Makame's condition became worse his neighbors drove him to the hospital where he could rely on his experience and connections as a medical doctor and high ranking civil servant to receive quickly the necessary examination with a CT-scan and access to experts.

Besides the help from neighbors and the medical institutions, he mainly received care from his family. Also in his family, he was a major care-giver for his wives, children (of whom two studied abroad but none worked yet and three children live with severe disabilities), his mother-in-law living in Pemba and his sisters in Zanzibar, for whom he organized and paid for example medical travels to India. He was clear though, that this support was reciprocal: For example, his wives took care of the children and the household not only when he was in Zanzibar but also during the years he studied and worked outside of Zanzibar. One of his sisters in Zanzibar was very close to him. They consulted and advised each other and she for example took care of his house and children during one year when he and one of his wives stayed in the USA.

While most older research participants did only mention relatively close relatives, when we were talking about receiving help, he instead also referred to friends and extended family, which shows how he was habitually engaging with a broad range of people in Zanzibar and abroad:

Sandra: Is there now - apart from the things we already discussed - anything else you are glad to get help for or anything that you may not do and you get help for?

Mzee: Yeah, in fact, whenever I have any problem I share it with my friends and my family. Yeah, I do get help from my friends. I get help also from my uncles who are outside Zanzibar. I have three uncles: One is in London and two are in Washington. So, if sometimes I need support they send it to me.

Sandra: Financial help or other help?

Saleh: "Chini,"

Mzee: "Kwenye kiuno na wale wakanishauri wakaniuliza tuanze wapi? Mie nikawambia anzeni huku juu kwa sababu juu nilikuwa napata matatizo hassa kwenye mkono huu. Ganzi ilikuwa ganzi la kweli kweli. Kwa ivyo wakaanza huku juu wakanifanyia operation waknambia sasa hivi nenda nyumbani ukapumzike baada ya miezi mitatu urudi tena. Kwa hivyo nikarudi nikapumzika nikapata nafuu kwenye Mei nikarudi tena India Mei hii ya juzi. Kwa hivyo nilikwenda kulee wakanifanyia tena operation ya Lumbar. Naaa nikarudi kwenyee Mei nilikwenda tarehe nilikwenda tarehe tano May. Operation wakafanya tarehe tisa nikarudi hapa tarehe 18 Mei. Kwa hivyo sasa ivi nipo katika kujiuguza. Bado sijaka sawa lakinii lakini afadhali."

Mzee: Yeah, financial help. When I have a very big problem for example travelling outside (Zanzibar), for example when I went to India, they sent me some money just to make sure that I have enough pocket money.

Sandra: And from the friends you mentioned?

Mzee: From friends, also I get some help. They are here in Zanzibar.

Sandra: What kind of help?

Mzee: Financial, even some material support, it depends upon what I ask for. For example, when I had my daughter's wedding, I did receive financial support. Because sometimes it is a custom. When somebody has such a big event we just support each other. I did get such support. There are so many friends, there are friends with whom I studied together and have different posts at the Government. So we help each other. [98]

Mzee Makame did not only have his uncles in the USA but also two daughters of his late older sister and a nephew who lives in the UK. While he communicated with all of them – especially when any problems occurred, he was not in contact with one of his younger brothers who stays in the UK. About him he said: "That one is (....) communication is not that good, sometimes we stay over two years without any communication. Sometimes he comes here and then he leaves without even seeing me. That one I do not know, we are not very close."

In the third and fourth year of our research, when we wanted to visit Mzee Makame we only met his wife or children at home. He went several times again for operations and treatments to India. We could not find out more than that he was not doing well. Some months after my last field stay in Zanzibar I found an article in a Zanzibari online newspaper briefly reporting about his demise and the burial. The big pictures showing all the men attending his funeral, people such as the first vice president of Zanzibar and the secretary-general of the opposition party Civic United Front (CUF), Maalim Seif Sharif Hamad figured among the attendees.

3.2.2. Understanding Caring over Borders: Making Use of Transnational Spaces

Mzee Makame's situation depicts how transnational care is one among many aspects shaping his care arrangement. In his case relatives abroad play rather a subordinate role. For others, only the engagement in a transnational space made medical journeys abroad possible. But even for them, those people nearby were crucial in care-giving and especially in cases of frail older people often facilitated staying in contact with relatives abroad as Kaiser-Grolimund (Kaiser-Grolimund 2018, 2017) emphasized by defining this relations as a *triangle of care.* In this triangle the older person, an "observing eye" in Tanzania, usually a family member staying physically close by the older person and a relative abroad engage together in the long-distance care-giving.

[98] This conversation was one of the very few in this research I conducted not in Swahili but in English.

To be able to draw on transnational spaces an older person needs to have established these relations long before. The case of Mzee Makame is an extreme example as he had privileges and the experience to draw on ideas and relations as a medical doctor and a member of the elite of public authorities and international organizations. Even though he told us about his health crisis in retro-perspective, it provided us with insights into how his relatives, neighbors and government institutions were involved in caring for him in the situation of his health crisis. Locally, even in his close by neighborhood he was very well connected and could rely on relationships he had established earlier when he was in good health and could care for others too. While this case is not representing a typical case in how older people are able to profit from the government it still is common that especially men who have spent time in Socialist countries to study or work for some period.

The fact that even he as a high ranking civil servant did not have any official health insurance, is crucial to understand how care-giving and receiving is a personal affair, even if the government is involved. Mzee Makame told us that at the time he was a state employee to have a health insurance was not yet common and he only was covered during the time he worked for the international organizations. Realistically, he could have organized health insurance coverage for himself and his family but it looks like they were not having any relevance to him. He preferred to reciprocally help each other within the family and to rely on personal benefits he could receive from the government in Zanzibar also in the situation of a health crisis.

The research participants commonly assumed that operations and major medical interventions abroad and in Dar es Salaam were better than those in Zanzibar. Accordingly, also Mzee Makame and his sisters travelled for operations to India. While I met several older Zanzibari who went for medical treatments to the Tanzania mainland, Kenya, India or Oman for them their travels were not financed by the government but by relatives abroad. Mzee Makame, who thus received the intervention sponsored by the state, was the only one who defined the aid of his relatives abroad as pocket money. Nevertheless, his example shows that in a crisis, relatives abroad were open to help and contacted him, although he once mentioned that they normally only talk on the phone about once a year.

In general, older people in Zanzibar expect their children and younger relatives to take care of them no matter where they are. Even though many younger people abroad support their parents not all offspring do so. The expectation that family members abroad should help especially in situations of health crises, when a larger amount of money was needed, was nevertheless fulfilled by many relatives of the research participants. The different circumstances abroad sometimes though caused a mixing-up of how the care-giving usually should take place in elderhood. While normally, the younger adult generation should care for the older relatives, the circumstances in other countries enabled older relatives abroad to help their

generation (for example siblings or cousins) or even a younger generation of older people (for example children, nieces and nephews above 60 years) in Zanzibar. Eeuwijk (2014) observed the phenomenon of elder to elder care in other (local) contexts and whilst this goes beyond the scope of this book, a focus on elder to elder care in transnational context might be illuminating.

4. Conclusion: Opening-up of Spaces of Aging and Caring in Health Crises

In this chapter I have shown diverse aspects of the lived experiences of elderhood by people being in a situation of a health crisis. I also argued that their orientation towards gendered norms of aging and caring becomes explicit in this situation. Working in a gendered way on the city and interacting with their social environment within and beyond national borders older people make the best of their situation by using their agency to receive care. This opening-up of spaces of aging and caring helps to overcome, at least to some extent, positions of marginality due to health crises.

In cases of health crises older people's agency in the sense of (Emirbayer and Mische 1998) becomes observable when care is arranged or performed. This means that agency can be observed in the present bargaining processes (Emirbayer and Mische 1998) of negotiation for or activation of care arrangements (Kleinman and Geest 2009b, 159). If an older person is confronted with a health crisis in a city like Zanzibar, where state services for older people are scarce, family members largely fill in the gap. Familial relationships and generally gendered kinship ties are, accordingly, crucial to care giving. In such a situation, the agency of an older person is essential to obtaining care.

Depending on their habitual backgrounds, older inhabitants of the city draw on their experiences of responsibilities, obligations, norms, and values to deal with specific situations, demand care, and imagine the future. As we have seen in this chapter, this happens remarkably often in a gendered way. While for many men, situations of health crises rather means moments of rupture and uncertainty, in which they had to reorient themselves and change the imagination of their future, typically, women could rely more on their past and future orientations in order to deal with the present situation. For older men and women common was the opening-up of spaces of aging and care, since in this particular situation they activate their social network in and outside Zanzibar to care for them, as well as they use their cosmopolitan experience to deal with the given health problems. Since these transnational spaces are complexly built on historical aspects, I will devote the whole of chapter six on transnational care with the example of Oman.

For example Mzee Cheetah carefully planned his day-to-day life and his future retirement, but he could not foresee that he would suffer a stroke, which would prevent him from working in the big garden of the house he built outside the city. It was through imagining potential future situations that Mzee Cheetah created strategies to change his prospects. Before Mzee Cheetah had his stroke, he built on his

past experiences and habits. He not only constructed an additional house; he also paid into a pension scheme and established a large family. After the stroke, Mzee Cheetah had to reorient himself as much as he could. He was not able to become the healthy man working in the garden he had imagined. His experience gained a new dimension, as he suddenly could not relate to aspects of hegemonic masculinity as he did before. But he could still partially rely on what he had imagined could help him: the pension and, especially, his family.

Mzee Cheetah's situation also shows that it makes a big difference if somebody has a long-term chronic condition like diabetes or experiences a loss of energy, which might hinder him or her in certain situations from doing what he or she would like to do on their own (kujiweza), compared to somebody who suffers a life-changing health condition like the consequences of a severe stroke. Such impairments require responses to aging and become urgent. The degree of health problems, impairments, or frailty thus fundamentally affects an older person's position in urban society.

We have seen in the cases above that receiving care in situations of crises it not as simple as that. Many anthropologists have argued that care provided by others, mainly by family, is always situated within a complex net of responsibilities, obligations, norms, and values that are also linked to being part of a specific generation (Alber and Häberlein 2010; Eeuwijk 2006; Geest 2002; Klerk 2011). Old-age care is often specifically connected to respect and reciprocity (Geest 2002). Also my research resonates with Freeman's analysis (2018, 119), which showed how the experiences and expectations of receiving care of older people were situated "within a complex web of support networks, based on a principle, if not practice, of reciprocity." This reciprocal understanding of care though, I argue is more bound to long-term care than to short term care during specific health crises. During health crises which required short term care on a local level, everybody who was around could become involved. In transnational care relations though, reciprocity played an important role in providing (often expensive) support in health crises.

It was not always possible for the older research participants to be immediately provided with what would have been desirable during a health crisis, as for example the necessary financial means needed to be collected among relatives and acquaintance first. Other health crises were difficult to overcome without the intervention of powerful family members, who were having enough authority to take decisions, could organize treatments and also pay for them. Thus, not everybody staying with an older person could initiate the necessary steps to receive the necessary institutional (medical) care services *(huduma za kiafya).* Often the person who could take the lead in decisions and actions was spatially at another place, either due to different locations of residence, work or travels. On the other hand, some people who lived locally with or close by the older person, as neighbors or housekeepers *(dada)* became

suddenly and rather unexpectedly involved in care-giving in health crises, even though this would not have been the favorite choice of the older people but they were the only ones around to help.

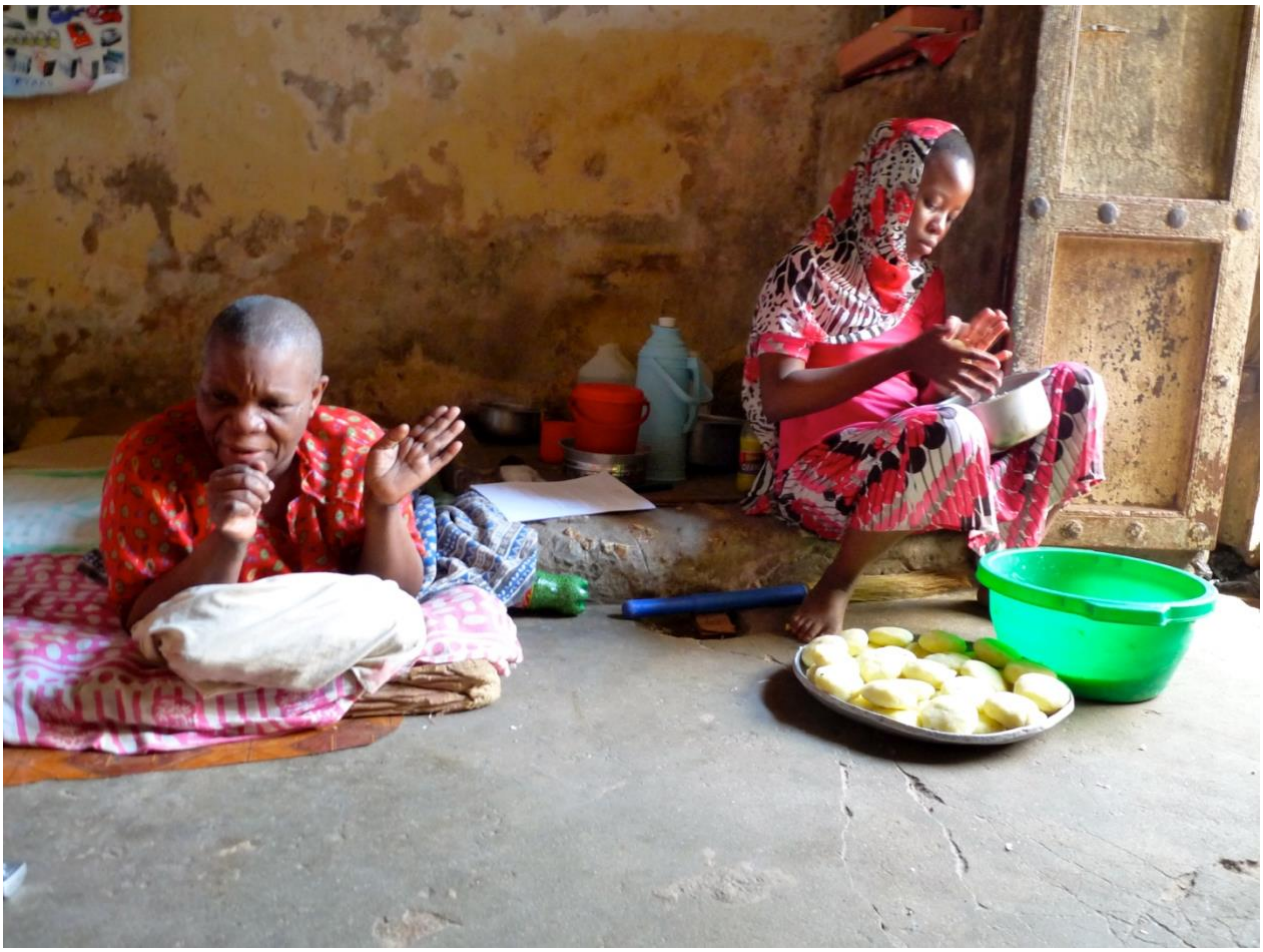
The case of Bi Nachum showed, how besides the long-term care arrangement, which was already in place, in the situation of a health crisis typically additional care-giving was organized by taking turns in staying with the older person. Bi Nachum's case also illustrates how difficult it is for families to take care of an older person in a situation of an crisis in the context of a poor area like Chumbuni, and how older people are grateful for the care they receive, but need to take additional efforts to hide towards the world outside their family, if they are missing anything. Even though Bi Nachum's relatives tried to help her, this story also depicts what is not accessible for her: the interaction in cosmopolitan and transnational spaces of aging and caring and the access to effective health treatments and (medical) care beyond her relatives. While many things in the health system in Zanzibar have theoretically changed over the last fifty years with the opening of the island to the rest of the world, practically, older people often lack the knowledge, connections, and financial means to profit from new (medical) possibilities within and outside of Zanzibar.

As we have seen in chapter two, residential areas and formal social protection provide an important context to the processes of ageing, health, and receiving care. This background affects the accessibility of state services like hospitals and the availability of water, electricity, public transportation and reliable infrastructure in situations of a crisis. Besides these aspects, the social networks attractiveness of a neighborhood can influence whether an older person maintains contact with acquaintances living abroad, or can access a cosmopolitan lifestyle (Fair 2004) and thus find possible solutions for urgent problems.

Thus, this chapter showed us how for most older people in situations of health crises, spaces of aging and caring open-up, as this relatively short moment of breaks in the everyday lives allows many people to become engaged. For some older Zanzibari these sudden engagements happen with nearby family members and neighbors in localized spaces of aging and caring. Others can build on experiences they made in culturally different contexts or knowledge they have acquired through interactions with people from all over the world, imaginations gained from what they have seen on international TV channels, have learned from their social network and are able to translate ideas from these cosmopolitan spaces into practice. Lastly, a relatively privileged group of older urban dwellers with relatives or acquaintances abroad could draw on transnational aging and care spaces to come to terms with health crises. These relationships, which were established before there was a health crisis and therefore sometimes made it possible to organize, finance and provide practical support for medical interventions in Zanzibar and abroad.

We will see in the next chapter that although there may be similar dynamics operating with regard to chronic diseases, in the longer term older people and their social network must find a normality in order to endure health problems over an extended period of time. It also takes a much longer breath and is rather unspectacular to care for people with chronic diseases over a prolonged period of time. As we will see, this can lead to social spaces that have opened up at short notice during health crises, closing again and fewer options being available there after.

Chapter V:
Living with Chronic Conditions



Picture 6 – An older woman with paralyzed legs, staying in one room together with two daughters and grandchildren in Shangani.

V. Living with Chronic Conditions: Acceptance, Control and Unspectacular Care

While in the last chapter I have been describing situations of health crises, which can be seen as sudden disruptions of and changes to the habitual in the lives of older people, in this chapter, I want to depict a further situation, which in the analysis turned out to be constitutive for a different kind of experience of aging and caring: This chapter is about older Zanzibari living in situations of chronic conditions and coping with related health fluctuations. As in the previous two chapters the first aim is to grasp the lived experience of aging in this specific situation, which is widespread among very old people, and generally especially among older women. This also entails to analyze how differently situated people live with, and try to control, chronic conditions in a context of health care more orientated to acute health problems (Whyte 2012, 71). The characteristic of this health situation is that people have been chronically ill, severely frail, or disabled mostly for an extended period of time. The element of time though, is less important for the analysis than the fact that people become used to this situation and can draw on past experiences. Thinking with the three component elements of agentic processes I have introduced earlier (Emirbayer and Mische 1998, 963), especially the habitual element comes to the fore in this situation. Habitual practice is given when actors, in our case the older research participants and their relatives, reactivate earlier patterns of action if they face the same or similar situations as in the past (Förster 2018), which as I will depict, is typical for recurring difficulties related to chronic conditions.

The umbrella term "chronic disease" is even within professional communities (i.e. medical, public health, academic or policy) very inconsistently used (Bernell and Howard 2016). What I want to emphasize by invoking the term "chronic" is less relating to a fixed definition or number of diseases, which are included or excluded by it, than rather the transition from diseases or functional disabilities from being acute or fatal (as presented in the last chapter) to chronic. The biomedical binary divide of acute sickness and chronic diseases was criticized in the anthropological literature for not representing the actual lived experience of people suffering continuously from chronic conditions, which are marked by ups and downs (Manderson and Smith-Morris 2010a; Whyte 2012). I do not aim at contributing to such a chronic – acute dichotomy but I think it is worthwhile to distinguish between health situations, which are understood by older people and their relatives as needing immediate action and other situations they judge as not necessarily requiring (prompt) action. With this understanding, older people being confronted with a situation of chronic conditions can thus not only suffer from chronic illnesses but also from chronic conditions that are not indicators of disease, but long-standing functional disabilities, such as visual impairment.

As I was interested in the illness experience (Kleinman 1988, 3), and thus focusing on what the older people's and their relatives' perception of and coping with their health situation was, the biomedical

diagnosis of a specific disease was of secondary importance to this analysis. I rather explored what Kleinman famously defined as illness:

> Illness refers to how the sick person and the members of the family or wider social network perceive, live with, and respond to symptoms and disability. Illness is the lived experience of monitoring bodily processes such as respiratory wheezes, abdominal cramps, stuffed sinuses, or painful joints. Illness involves the appraisal of those processes as expectable, serious, or requiring treatment. The illness experience includes categorizing and explaining, in common-sense ways accessible to all lay persons in the social group, the forms of distress caused by those pathophysiological processes. (Kleinman 1988, 3)

I do thus explicitly not refer to a biomedical definition of chronic disease or non-communicable disease (NCD) as used for example by the World Health Organization (WHO), even though many of the research participants are diagnosed having chronic diseases such as cardiovascular diseases (CVD), cancer, chronic obstructive pulmonary disease or type 2 diabetes. Additionally, the illness experiences of the older research participants shed light on what in the biomedical world is referred to as co- or multi- morbidity, the presence of more than one distinct condition in an individual (Valderas et al. 2009) and illustrates the interrelatedness of different disease being experienced at the same time in one body.

This chapter provides a window into situations of older people living with chronic illnesses and long-term care in private settings at home and with their social network in a context of scarce institutionally offered alternatives. This perspective will highlight aspects of gender and piety in relation to care-giving and the often reduced engagements of older people as agents in localized, cosmopolitan and transnational spaces of aging and caring I have introduced in the previous chapters.

1. Structural Ignorance of Chronic Conditions in Elderhood

Already Manderson and Smith-Morris (2010b, 1) suggested in their edited volume on "chronic conditions as fluid states" to "draw on the idea of chronicity to heighten sensitivity to the structural factors that create, maintain, and produce fluidity and flux in these disease patterns, their management, and outcomes." To contextualize and contrast the experiences of chronic situations by older people within specific social spaces, I do here first in this chapter, by focus on the local public health perspective, and by taking up how the international community and the government bodies in Zanzibar assess (and partly ignore) issues related to chronic diseases.

1.1. Putting NCDs and long-term care on the agendas of African countries

Only recently, the growing need for long-term care of older people in Africa has reached modest public awareness through the publication of a report of the WHO on long-term care systems in sub-Saharan Africa (WHO 2017). Even generally, it is not long ago, that NCDs as an object of political concern in

and for countries of the global South emerged at all and so far, social scientist's analysis on the topic is hardly available (Reubi, Herrick, and Brown 2016).

So far, especially public health specialists related their research on care-work predominantly to an HIV-endemic context, in which often older people have lost their children, who were expected to take care of their parents, while they end up taking care themselves of their grandchildren, instead of being provided with care themselves (Schatz and Seeley 2015; Klerk 2011). This discourse emphasized the gaps of family carers in the care arrangements of older people due to the inverted mortality of two generations but did pay less attention to the general increase in the number of older people in Africa and their own experience of long-term chronic conditions and their consequences.

As mentioned earlier, life expectancy increases drastically in many sub-Saharan African countries (from 51.7 (Tanzania: 49.6) years (1990-1995) over to 62.4 (Tanzania: 66.7) years (2015-2020) to 70.9 (Tanzania: 73.5) years (2045-2050) (UN 2017, 39),[99] so that the number of older people on the continent is expected to more than triple (from 46 to 165 million) by 2050.[100] This demographic transition in Africa is accompanied by a health transition leading to an increase in chronic conditions, which is commonly framed as an increased "(double) burden of disease" and often renders older people unable to perform everyday tasks on their own and consequently increases the need for long-term care (WHO 2017; Aboderin and Beard 2015; Eeuwijk and Obrist 2016; Eeuwijk 2014).

Driven by the call of the WHO *Global strategy and action plan on ageing and health* to develop for every country a system of long-term care and being informed by researchers, service providers, private sector and government stakeholders from sub-Saharan Africa and beyond[101] the WHO report (2017) acknowledges the growing need for long-term care of older people in Africa as a larger phenomenon, which goes far beyond the care-giving in the context of HIV/Aids, and therefore becoming relevant for a majority of families on the continent. The report though also points out the lack of information and evidence on family care for older people in sub-Saharan Africa (WHO 2017, 7). In other words, what is going on in most African countries concerning chronic illnesses and long-term care-giving in family settings is a big black box to the national and international authorities as well as the research community.

[99] In comparison with Switzerland for example: from 77.9 years (1990-1995) over to 83.6 years (2015-2020) to years 87.4 (2045-2050) (UN 2017, 41).

[100] https://population.un.org/wpp/Download/Probabilistic/Population/ (accessed 2018/11/06).

[101] The conference took place in 2016 in Kenya and was organized by the Africa Region of the International Association of Gerontology and Geriatrics in cooperation with the African Union Commission and the World Health Organization (WHO 2017, 2).

1.2. A nation starting to deal with non-communicable diseases

The public health system in Zanzibar[102] is geared to acute health problems and not to chronic illnesses. Especially on the most accessible level of primary health care units, which should according to the Zanzibari Government be reachable for 95 percent of the population within five kilometers the focus lays on different aspects, especially health facilities at this level provide "preventive, treatment and care services for diseases and health conditions including malaria, upper respiratory infections, injuries, water and food borne diseases" (RGoZ Ministry of Health Zanzibar 2013, v). Even though the number of people suffering from chronic illnesses on the island is growing, structurally, the changes from acute and communicable disease to an integration of more health services for people suffering from chronic and non-communicable diseases are taking place at a slow pace.

In mid 2012, shortly after I had started conducting my field research in Zanzibar, the Ministry of Health (MoH) in Zanzibar established a NCD Unit after having conducted its first "National Non-Communicable Disease Risk Factor Survey" in 2011 (RGoZ Ministry of Health Zanzibar 2012). The Ministry of Health undertook the survey with the help of the Danish International Development Agency (DANIDA) and the World Health Organization (WHO). In the report, the authors showed that half of the admissions to medical wards in Zanzibar could be related to diabetes, cardio vascular diseases and chronic lung disease (RGoZ Ministry of Health Zanzibar 2012, 2). Not only the numbers show an increase in the reporting of chronic illnesses but also among my research participants chronic conditions were very common. Astonishingly, even though older people are typically confronted with (often multiple) chronic diseases only people up to the age of 64 years were included into the survey (RGoZ Ministry of Health Zanzibar 2012, 4), which might be interpreted as that from a public health perspective in Zanzibar there is not a major focus on chronic conditions in older people.

In the beginning of 2015 I finally managed to visit this relatively new NCD Unit. Having arrived at Mwanakwerekwe, close by the biggest fruits and vegetable market on the island, I was looking for the building with the NCD Unit. I knew, it was next to the huge and impressive Malaria Office, I thus asked the guard there, about the entrance to the NCD Unit. Prompted in Swahili and English, he did not know where the unit was. After a short period of wandering around and unsuccessfully asking people passing by whether they could help me find the office, I called the NCD Unit head on his mobile phone. I had met him before during several occasions, among others at a workshop of the Zanzibar Association for Retirees and Older People (JUWAZA - Jumuiya ya Wastaafu na Wazee Zanzibar -),[103] where he trained

[102] As a semi-autonomous region, Zanzibar has its own national competencies, while relatively few areas are union matters (such as foreign affair or defense and security). The public health system is in the competence of Zanzibar and different from the rest of Tanzania.

[103] Homepage of JUWAZA: https://juwaza.wordpress.com/

health workers. He came out of an unimposing door of the neighboring house of the Malaria office and excused himself, that there was no sign at the entrance showing me that this was the place I was looking for. I met a small but highly motivated team, consisting of a handful of public employees working on issues especially related to the prevention of chronic illnesses.

My perception of the official role of chronic illnesses as well as the NCD unit as marginalized in the Ministry of Health was confirmed when the unit head told me how he and his team wanted to conduct a workshop at the Ministry, but not a single employee showed up. Nevertheless, the engaged team did not give up: They explained how their aim is to "strengthen the primary health care units," which they did by providing trainings to doctors and prescribing nurses and with the help of an illustrated catalogue, the "Desk Guide for Chronic Non-Communicable Disease and Risk Factors." "Awareness-building" related to NCDs is one of their aims. They told me how they traveled throughout the country and met influential people, how they went to schools and talked about risk factors, about what are healthy foods and they integrated district commissioners and shehas into their projects.

For public health specialists as well as researchers and NGOs it is not easy to find funding for projects related to non-communicable disease, especially in African countries. Besides the missing awareness of problems related to NCDs, it is difficult to show the impact that a specific project had, given the complexity of chronic illnesses. A major part of the work done by the Ministry of Health though is funded by international donors, who set the agenda differently, is putting a focus on Malaria or HIV/Aids and other infectious disease. The head of the unit explained that the financial support is almost exclusively coming from the World Diabetes Foundation[104] and from time to time from the WHO for reports. The scarce funding might be one of the reasons why the NCD unit is kept small and is not interesting for many employees of the Ministry of Health. The staff of the Unit though, see it as multisectoral issue going beyond the Ministry of Health. They do what they can and cooperate with whom they can, for example with the Zanzibar Non-Communicable Disease Alliance (Z-NCDA - Jumuiya ya maradhi yasiyo ambukiza),[105] a tiny group, which was established in 2014 and especially with the Diabetic Association of Zanzibar (DAZ). One success for them was that, in the governmental strategic plan (RGoZ Ministry of Health Zanzibar 2013) they could integrate the NCD strategy. They also achieved that hospitals and traditional healers have now a NCD register book, where they can fill in NCD cases and which the unit wants to use to monitor and evaluate the developments related to chronic diseases. The NCD unit with its modest resources thus tailored their interventions mostly for health professionals but did not involve the wider population and older people with their specific

[104] Homepage of the World Diabetes Foundation: https://www.worlddiabetesfoundation.org/

[105] Homepage of the Z-NCDA: https://zncda.wordpress.com/

problems often living with multiple chronic illnesses and family caregivers, who might be the most common cases of care-givers for people living with chronic illnesses but unfortunately were not targeted.

This background of the national developments in public health provides a basis to better grasp the contexts of action (Emirbayer and Goodwin 1996, 371) in which older people and their families engage, reproduce and transform these structures. There is thus a disinterest of most state agencies as well as many international donors, in a serious attempt to address the problems arising for the growing number of people suffering from chronic illnesses. This shows how difficult it must be for older people experiencing one or several chronic illnesses to receive adequate medical care, because it is not available. On top of these difficulties come of course the problems related to accessing the health system as with other health problems, like for example having someone who assists in the travel to the health facility personally and financially. In the case of chronic illnesses, a major problem concerning the medical treatment is that even though free health care is advertised by the government on TV and radio in Zanzibar with the unmistakable slogan *afya bure* (free health) in reality, most research participants face at the health facilities is, that they had to pay for testing material (for example for blood glucose test stripes) or if expendable materials were involved and that due to the fact that only few medicaments were available for free such as pain killers, antibiotics and anti-malaria medicaments, the only medication they take over an expanded period of time were pain killers. Many older people thus, take the necessary medication related to their chronic illnesses only for few days or weeks or just sporadically, once they feel not well, as they were often not available or simply not affordable for them, especially over a longer period.

The following examples of older research participants' experiences of chronic illnesses in the broadest sense will illustrate how the older urbanites and their social network got used to taking (or renouncing) action in a context in which chronic illnesses, frailty and other long-term conditions were framed as a private affair.

2. Coping with Chronic Conditions

In the anthropological literature it is well established, that the situation of living with chronic conditions is by far not a uniform one (Manderson and Smith-Morris 2010a; Becker and Kaufman 1995; Smith-Morris 2010; Strahl 2006) Whyte nicely described what it means to live with a chronic condition from an anthropological point of view:

> To live with a chronic condition does not imply stasis. There may be what feels at the time like a biographical disruption, a dramatic turning point, although this itself is an empirical question. Thereafter, chronicity has a course just as acute illness does. People learn to adjust their lives to restrictions of their bodies and (sometimes) of their treatment regimens. The condition becomes, if not normal, at least

> familiar. Yet even then, the course is not necessarily flat, straight, and consistent as the term chronicity might suggest. Flare-ups, acute episodes, improvements and deteriorations characterize chronic illness. (Whyte 2012, 69)

In the following I will describe different vignettes of older research participants in such situations experiencing fluctuations in their health while suffering from chronic conditions like diabetes, hypertension, chronic pains, or eye problems. Most of them had several chronic conditions at once. A typical trait of this situation is that people – and I mean here older people and their social network - were largely used to these ups and downs. It is well known that older men and women living with chronic conditions do experience these differently depending on their gendered orientation towards norms of hegemonic masculinity or femininity (Hurd Clarke and Bennett 2013). I have decided to present the experiences of women and men bellow separately. I was hesitating to further such a binary approach to gender but even though certain experiences and practices of men and women living with chronic conditions might have been similar, the articulation and interpretation of norms were strikingly different. In this situation of fluctuating ups and downs was for both genders common first, that they could rely on their previous experiences of how to deal with chronic conditions, and second that for most of them the access to social spaces closed.

2.1. "I am just here": Constructing femininity by accepting ups and downs

Drawing on gendered norms and responsibilities, as I have described them in chapter three, women usually judge their situation living with chronic conditions differently than man do. Most older women depict themselves as relatively passive accepting ups and downs as part of their elderhood. In practice though, most women were only on first sight passive. Many did carefully observe their bodies, anticipate possible difficulties, and weigh up when to ask relatives for help and when to endure their situation. To grasp these "quiet actions" was more challenging than to talk about and observe the fulfillment of more obvious responsibilities like doing the laundry or going shopping, which became often less in situations of chronic conditions. To spend extendedly time with the research participants helped to become aware of how even physically very weak older women were shaping their aging and care-giving.

2.1.1. Bi Fatma – Weighing up when to do something about chronic conditions

Bi Fatma whom we met in chapter two, where I introduced the shehia Shangani, explained, that her health is not something static, and that on some days she has fevers, some days she is fine. Even though her health goes up and down and she feels strong only sometimes ("*nina nguvu baadhi ya wakati*"), she is one of the more active research participants. Bi Fatma told us that she has problems with her blood pressure *(pressa)* and with her chest. She is often coughing. Once again, as she had experienced before, she felt her heart was beating too quickly; she went to the hospital and told us afterwards:

> It happened at once, I had to go for a check-up, and they gave me some medicine to use. But I don't like to go there regularly, you know everything needs money, sometimes I think it is best if I leave everything as it is, but if it becomes serious I am buying medicine from the pharmacy. I don't like to go to the hospital often for check-ups because I feel like it will be too much for my children.

The case of Bi Fatma speaks for many older people I have met, and especially for older women, as Bi Fatma is used to her chronic condition and usually reacts on her own. Generally, she knew what to do, when she felt one of the reoccurring health problems. She often took painkillers "like panadol, anti-cold, you know panadol is like a food, because when you feel a headache you just swallow it."

Being constantly confronted with fluctuations of the health condition most research participants, but especially older women in situations of chronic conditions only went to see a doctor if a health crisis was coming up, towards which they could not react on their own. For several reasons, older people in such situations hesitated to go to a health facility. One reason was that, especially in the case of women, even though none of them mentioned that children would complain to accompany them seeing a doctor, they articulated limited capacity of their children to support them. A related reason was that the treatment of chronic conditions was expensive and could become a major expenditure if they had to take a medicament like anthihypertenives uninterruptedly. Others again, having chronic conditions did not go to the hospital anymore as they did not find it helpful. I will explore this more in detail later in this chapter. Older women were careful to only ask for help, once they absolutely needed it and like in the case of Bi Fatma for them it was normal, that the health condition was going up and down. The fluctuation alone was no cause for concern but habitual.

2.1.2. Bi Mwana – Being cautious not to provoke problems

Like Bi Fatma, Bi Mwana knows her chronic conditions well. Her case illustrates exemplarily as well, how some older women being in a situation of having a chronic condition try to prevent suffering by being cautious about what they do; limit themselves in their actions and how they feel to keep their situation under control. Even though, Bi Mwana, the retired nurse living in Kikwajuni we got to know in the last chapter, portrait herself as vital in her stories, she made no secret of her chronic health problems:

> My health condition is fine enough *(sihaba* - it is not little*)* like that. Another hour (when it is getting worst) I am afraid of being buried. Another time I feel better *(nakua afadhali).* And besides, yes, my heart is troubling me. This pressure is not going up a lot or going down but more the heart is the problem.[106]

[106] "Afya yangu ndiyo sihaba ivyoivyo. Saanyengine nacha fukiwa. Wakati mwengine nakua afadhali. Na moyo zaidi ndiyo unanifanyia matatizo. Ile presha haipandi sana wala haishuki sana lakini zaidi moyo."

She knows how to cope with her illness. Having experienced problems with her heart and respiration *(pumzi)* she is careful not to move too quickly, to stay away from heat, observing strict rules in her diet and to ask for help with tasks, which might be exhausting or agitate her. Bi Mwana thus, is not able to do her small tasks *(kazi ndogo ndogo)* any longer and she told us that generally she is not having *nguvu* (energy) anymore.

If not for medical treatments, she is not leaving her house anymore. She stopped going to the next street to sit there early in the morning. She explained that this was partially due to her health condition but in particular, she did not go there any longer since her *mwenzi* (companion) passed away. Before the death of her companion, Bi Mwana loved to go there together with her, but these days alone, she is afraid the people passing by there might mistake her as a beggar and give her money. This makes her uncomfortable going there anymore. She also stopped going to a *dua* (prayer) reciting group of women in the *shehia* even though she is still formally part of it. Since she is the oldest member of the group, she usually had to recite the prayers, as this is a cultural convention. But she told us that she does not want to do so anymore, as she felt too weak, thus she completely stopped going, even though she would have liked to just attend the meetings. In this situation, her life was bounded by her house. Her daily rhythm was getting up at 5a.m., bathing, praying and then she was sitting close to the open door. Like this people who passed by came to greet her and asked how she was doing.

Even though almost all older people told us that they would prefer to be cared for by their children or other relatives, older women like Bi Mwana who have a paid housekeeper, had the advantage that they more easily asked for help. Maybe this is also related to their social position in what could be framed as middle class in a socio-economic sense, often having access to cosmopolitan social spaces and in which they were used to have some delegating competencies throughout their lives. I had the impression that women who could not draw on external help were more cautious not to be a strain on their relatives and especially those who took care of them.

The case of Bi Mwana though, shows another aspect of (self-) limitation, which I found to be widespread among women with chronic conditions. Because of her fluctuating health situation, she is afraid of going out. On one hand, she feels too weak, thus the physical condition hinders her but on the other hand she is struggling with what is expected from her as an older woman. Being perceived as a respected elder by her prayer group, she is offered respect *(heshima)* by asking her to recite the prayers. This is a common practice and honor for older and expectedly wiser people. On the other hand, she is afraid to be perceived as a beggar in the streets; and I heard this fear from many older women. Besides ending up in an old age home, to be a beggar in elderhood was one of the worst-case scenarios for virtually all the people I spoke to in urban Zanzibar. The dominant cultural norm is that older frail women, suffering

from chronic conditions, who cannot take care of themselves anymore, should be helped. Partially this is also true for older men but particularly, for older women, this comes together with the piously colored idea in Islam that mothers should be generally honored more than fathers and especially after having completed their reproductive responsibilities (see more in chapter six). According to this cultural norm, the first group of people who should help are own children. What women were afraid of was the following: If such an older woman suffering from frailty, illness or disability, is seen by strangers passing time in the streets this could be interpreted as if the children or other relatives would not take care of her. What would she be doing on the street, if she was provided with everything she needed? Even though it was also contested whether healthy older women should walk around alone this was commonly perceived as less problematic, as there could be good reasons such as going to visit a patient. Older women thus often oriented themselves towards these norms, being afraid of casting a damning light on their children and relatives. Even though I had the impression many of them would have liked to go out more into the public spheres, they judged the negative connotation as more important than their own desires. I only met a few women like Bi Msimu, who lives in Kikwajuni but always underlined that her father was *mbara* (mainlander), and that she was different from Zanzibari because of that. Bi Msimu was one of the few women I had met who defied all social conventions and did not care much about others. Besides sitting around with men in the coffee corners, only occasionally wearing a scarf although she was Muslim, she smoked cigarettes and told everyone her opinion, all of which was rather exceptional in the given context.

2.1.3. Bi Mchanga – Being tired because of diabetes and too many births

A woman who also compromised on the spaces she accessed was Bi Mchanga. In the last chapter I have been writing about how she and her family managed an unusual asthmatic attack. Bi Mchanga who was living in Kikwajuni and the only research participant having a health insurance, suffered from diabetes and high blood pressure and the consequences of her obesity. Once we had the following conversation about what she understood to being healthy and in which she explained what she thought were the causes of her own health situation:

> Saada: Now, generally, how do you identify a healthy person?
> Bibi: A healthy person is quick/agile *(mwepesi)*, he/she does his/her work/tasks, but I again, I think to me this diabetes has already destroyed/damaged me, I cannot do any work/tasks anymore, now, everything is done for me.
> Sandra: And in elderhood, an older person, what is a healthy person?
> Bibi: Good health, as I have told you, you do your work, you go and you return. Now, I am an older person, only sickness *(maradhi)* has increased in me. You know when a person has given birth many

> times, she gets very tired. I had delivered fourteen pregnancies, twelve are alive. That is why my body is tired.[107]

Thus, at that time, without having asked Bi Mchanga directly, how she explained her health situation, she gave us two reasons: on one side her diabetes and on the other side her reproductive activities. Compared to other older men and women she differentiated illness and general elderhood relatively clearly but she also links them by saying that sickness increased as she is an older person. Most of the older female research participants had given birth multiple times except the six women who did not have any biological children. High numbers of pregnancies and deliveries manifested as typical pattern how these women explained their weakness of the body and health condition.

In the course of the above conversation, I wanted to understand more about how Bi Mchanga explained her health condition and I asked Saada to insist again. This question again opened the conversation regarding psychological aspects, which she considered to cause her pain:

> Sandra/ Saada: What do you think are the reasons for these problems?
> Bibi: Aaah, no, my child. They told me, maybe you are thinking/pondering. But I don't have thoughts/worries *(fikira)*. Ok, I have a little thoughts/worries. I have one son, the father of these (children) here (pointing to small children playing in the living room), jales (he has been to jail), Now, that one is causing me problems. I mean, he is not giving me happiness/comfort/rest *(raha)*, I mean when he is causing his problems, I get worries. Mama, normally, he has work, he is working with Indians, he got a good car, but now, he goes to bars until early in the morning, he comes back. At the time he comes back, he goes to work. I see problems, now I believe, this makes me ill, I cannot see
> this.[108]

[107] Saada: "Sasa kwa jumla, kwa mtu mwenye afya nzuri ni yupi au yukoje?"
Bibi: "Mtu kwenye afya nzuri anakuwa mwepesi, anfanya kazi zake, lakini mie tena, nafikiri hii sukari hapa mie imeshanivunja, siwezi kufanya kazi tena, mie sasa kila kitu nifanyiwe."
Sandra: "Na katika umri wa uzee, mtu mzima yupi ambaye anakuwa na afya nzuri?"
Bibi: "Afya nzri, kama nilivyokwambia, kama mwenyewe unafanya kazi zako, unakwenda, unarudi. Sasa, mie japo mtu mzima, maradhi tu ndo yamenizidi. Unajua mtu akizaa sana anakuwa anachoka sana, mie nimezaa mimba 14, 12 wapo hai, basi tena mwili ndio umechoka."

[108] Sandra/Saada: "unadhani matatizo haya chanzo chake nini?"
Bibi: "Aaaa. mwanangu wewee, wananambia labda unafikiri, lakini mie sina fikra. Fikra haijambo kidogo, nina mtoto wangu mmoja, baba yao yule magereza. Sasa huyo ndio ananipa tabu, maana hanipi raha, maana akifanya yeye matatizo yake, mie napata shida kifikra. Mama, hivi anakazi anakwed vizuri kazini kwa wahindi, ana gari nzuri kapewa, sasa, yeye atakwenda mabaa mpaka saa alfajiri ndio anarudi, akirudi muda huo ndio atakwenda kazini, sasa mie naona tabu, sasa nadhani mie huwa naumia siwezi kuona hivyo."

As we have seen in chapter three *kujiweza* is closely interwoven with the absence of worries *(fikra)* but as I had mentioned, unexpectedly many older frail or chronically ill women told me about their worries concerning family matters, which seemed to have a dominant impact in their health and well-being, especially in the long-term or served at least as explanation for illness.

Bi Mchanga is one of the research participants who regularly went to do check-ups about her chronic conditions. Probably this was fostered through the fact that she had a health insurance (being covered through her daughter's employment at a ministry) but also as she was staying close to the main hospital, had a daughter who had diabetes as well and also regularly went to the hospital and because the family generally had the financial and cosmopolitan capital to pay a lot of attention to her chronic conditions. Normally, she goes to check her *pressure* (hypertension) and *sukari* (diabetes) values at the hospital every two weeks. I did not hear of any other woman going that often for check-ups. When the results were not good enough, she received medication accordingly. She also took regular medication against *pressure* and knew from her doctor that as long as she would take these pills without missing any, she could keep the situation under control. She did not like *dawa za Kiswahili* (traditional Swahili medicine) but was convinced that the medicine from the hospital helped her a lot. Having learned from the first time she was taken by her children sick from diabetes and high blood pressure to the hospital, she got used to the rhythm of going to the hospital and getting advice from the doctor how to proceed and supplies once the medicament was used up. At the hospital as well, the doctor told her what she should consider in her diet and advised her to go for walks regularly. Clearly, Bi Mchanga tried to take care of her health problems and to do as she was advised at the hospital and by her children. At the same time she found it difficult to follow some of them, for example to go walking as an exercise to reduce her overweight and impact her diabetes seemed difficult to her. This was due to similar reasons as above for Bi Mwana. She thought that it was culturally not appropriate for an older woman to walk around, especially not on her own. Maybe the argument was prefaced but in any case, she was by far not the only one who argued like that. Another piece of advice came from her children: Because of her hypertension Bi Mchanga should not cook anymore. This was a very common advice for older frail women living with their relatives I had heard many times. I had the impression for Bi Mchanga like for most older women this rather felt like a ban than advice as most of the relatives were relatively strict with the implementation. This means for Bi Mchanga and Bi Mwana like for many older women that they have to restrict or are restricted to engage not only in fewer spaces outside of the house but also inside their home.

2.2. "I am already old now": Coming to terms with changing masculinities

Men who were confronted with fluctuations of chronic conditions like diabetes, hypertension, chronic pains, eye problems or frailty or sudden health problems turned into situations of chronicity in the long term, got differently used to the ups and downs of their health compared to women. In the following, I

will give examples of men in the field of tension between expectation, respectively acceptance of decline and the habitual practice to control and change their health situation.

2.2.1. Mzee Mohammed – Expecting and accepting decline

I have introduced Mzee Mohammed (in chapter three) being relatively fit and having a small store, where he was selling goods for everyday use. Two years after our first conversation, Mzee Mohammed's health was marked by ups and downs and he felt much weaker then when I met him at the beginning of our research. He said: "(My health) is not good since my age is increasing and I am not like a fish that becomes stronger as it grows. The more human beings grow the more they become weaker."[109] A year later he was complaining about several health issues: "The more I go ahead (become older) my health goes down, ah, I mean my health itself is not good anymore. My back and my feet increasingly bring about problems."[110] Later in the year, he felt better but finally in 2015 he complained again about the "deterioration" of his health, especially his feet.

The more I have seen him struggling with himself being fit, being able to do without help or literally being able to do it himself (see about *kujiweza* in chapter 2), I observed how he started to relate differently to ideas of masculinities. He dissociated himself from hegemonic masculinity, where he should have been the main provider of the family and take care of them financially and rather oriented himself towards alternative masculinities and attributes like being a spiritual man. Even though he was a faithful person throughout his life, I never heard him speaking so passionately about worshiping.
Mzee Mohammed rested more often at home, sometimes watched DVDs with religious speeches. He tried to never miss any of the five daily prayers and sometimes went for an extra prayer *(dhikri)* at night. Mzee Mohammed aimed at leading a life in which he does not only pray but also act according to his faith *(dini)*. Apart from praying, he tried to cultivate relations with other religious people, hoping that they would help him if he needed their support. He claimed, "if you do not care *(hujali)* about these religious messages *(habari ya dini)*, even though it is your faith, another person will not care *(hajali)* about you as well. But a human being who comes himself closer to them will be approached by them as well."[111] While talking about the role of religion in his life he mentioned: "I am already an older man/dignified person *(mzee)*, thus it must be that I worship/do good deeds *(ibada[112])*, I am not able

[109]"(Afya yangu,) ah si nzuri kwa sababu age inazidi kua kubwa na sio kama samaki kila akikua nguvu zinazidi, binaadamu akikua nguvu zinapungua."

[110] "Kila tukiendelea na afya inazidi kua chini kidogo, mh manake inakua afya yenyewe si nzuri sahivi tena. mara mgongo na miguu tena inazidi kuleta matatizo."

[111] Mzee: "Wewe, ijapokua ni dini yako lakini umejikurubisha vipi na wale wenzako katika dini, sasa kama umejiweka hujali ile habari ya dini na nini na nini, japokua ni dini yake mtu hajali. Lakini binadamu unajikurubisha nao na vile vile nao watajikurubisha kwako."

[112] Ibādah refers to service, servitude, and by extension the very notion of religious worship in Islam.

anymore /weak *(sijiweza),* even during the time of sleeping I have to worship/do good deeds."[113] This shift towards religious values and being a faithful person was widespread among older men, especially, once they started to frame themselves as being old but it was not exclusively a masculine trait. Older women as well became more careful to be "good Muslims."

While Mzee Mohammed as many older men in his situation prioritized religiosity as part of relating to masculinities, others stressed how they gave more responsibilities like the financial management, to their wives. Many men told us that they were not able to be sexually active anymore, which they usually attributed to their old age and not to chronic conditions. For example, Mzee Tajir, said openly without being prompted that he and his wife would not have a sexual relation anymore and explained: "Aaa, at this age we don't make love anymore, I am sixty-seven years of age, I can't make love anymore."[114] He also added that nowadays he just gives the pension to his wife, and she does everything else. He eventually helps cleaning copper materials in the sitting room and he advices her but otherwise she cares for him and this seemed to be completely fine with him. He usually appeared relaxed and in a good mood. Those men who were able to still find some aspects they could relate to ideas of caring masculinities, like Mzee Mohammed, who begun to care more about religious duties or Mzee Tajir who could not have a sexual relation with his wife but cared financially for her, seemed usually quite relaxed and in peace with themselves. Other men though struggled until their death with the fact that they could not be the caring men they were before.

2.2.2. Mzee Omar - Multimorbidity and controlling the body

The case of Mzee Omar, the former medical officer, whom we got to know in the previous chapter shows us how he was convinced that he was responsible for and could influence his health condition. Not only did he blame himself for his back pain, but he was also constantly controlling his blood sugar level.

> Saleh: Because it seems that you are strong. So, do you have any problem with your health?
> Mzee: Yes, I have. My health started to go down since 2005. That is the time I felt that I have a problem. So, I went to check my blood sugar. And the diagnosis was that I have diabetes.
> Saleh: Do you have it? Yes. Therefore, that is the first change the mid-diabetes.
> Mzee: The second problem that I have for a long time, is the problem of my back. The spinal cord, this happens because of my office work, and perhaps because I was farming on the shamba.
> Saleh: Do you cultivate or do you do farming?
> Mzee: Yes, I have my own field, my own *shamba*. I used to go there to cultivate. You know the cultivation on rocky areas. You must have this tool (mentions special tool).

[113] Mzee: "Nimeshakuwa mzee inabidi lazima nifanye ibada, sijiwezi, hata wakati wa kulala lazima nifanye ibada wakati wa kulala pia."

[114] Mzee: "Aa age hii sisi hatufanyi tena mapenzi, miaka 67 siwezi kufanya mapenzi."

Saleh: Where?

Mzee: B.

Saleh: B.?

Mzee: On the rocks. But the pain started even when I was in Japan. I accumulated my pain with the cold, when I was in Russia. At that time, I was young, and I did not want to protect myself carefully, I just put on simple clothes. I did not care. Therefore, I think that cold affected me. So, I think the problem of the back started at that time. Because of that reason.[115]

Mzee Omar did thus relate his back pain to his own neglect. He further explained that he could fast during the whole month of Ramadan and that he was able to control his blood sugar level. He could keep it in a normal range. But, after Ramadan he felt that it had risen again. Since Mzee Omar was used to rebalancing his bodily problems, he was convinced that this problem was due to fake medication. He thus changed the medicament and could straighten out his blood sugar level again. As a medical doctor, it is not surprising that he was convinced of the neoliberal ideas of being responsible as an individual for your own health problems. Interestingly though, this neoliberal understanding was relatively widespread, especially among older men who could access cosmopolitan spaces of aging and caring and thus actively engaged with these ideas from western biomedical sources. This understanding of being able to manage the body was though even in the case of Mzee Omar combined with ideas of Islamic humoral medicine of cold and warm bodies.

[115] Saleh: "Kwa sababu unaonekana bado unajiweza, sasa kunaa afya yako una tatizo lolote la kiafya."

Mzee: "Tatizo nnalo. Na afya yangu imeanza kuzorota kuanzia mwaka 2005, ndio nlipoanz kujihisi hassa kwamba nna matatizo na baada ya kuona matatizo yale nkaenda nkachek Sugar niakuta kwamba midmetics."

Saleh: "Unayoo."

Mzee: "Eeehe kwa ivyo hilo ndio tatizo la kwanza midabetics. Lakini tatizo la pili ambalo nilikuwa nalo muda mrefu ni matatizo yaa maumivu ya mgongo. Uti wa mgongo na hili zaidi lilitoka labda na kazi ambazo nnlikuwa nafanya baada yaaa hizi kazi za za ofisi na mengineyo kwa sababu nliku na nalima shamba."

Saleh: "Unalima."

Mzee: "Eeee shamba ya shambani kwangu. Nilikuwa nnakwenda nnalima eee naunajuwa tena kilimo cha maweni. Lazma uwe na mtaimbo ukae kitako."

Saleh: "Wapi?"

Mzee: "Apo B."

Saleh: "Aaa B. ee."

Mzee: "Maweni, sasa lakini maumivu yalinianza zamani kwa sababu hata nlipo wakati nlipo niko japani nlianza kuhisi maumivu ya nyonga. Sasa nnayahusisha maumivu haya labda na baridi ambayo nnliichezea wakati nlipokuwa urusi kwa sababu urusi kulikuwa na baridi sana. Na mie wakati ule kijana nnlikuwa si sipendi yale mambo ya yakuvaa kuji kujihami na baridi ile nlikuwa na vaa nakwenda simple as possible. I did not care (Anacheka). Kwa hivyo nadhani ile baridi ilin ilin ilin iliniumiza kidogo. Kwa hivyo nkawahi nkasema kwamba labda maumivu yale ya mgongo yalianza wakati ee naamini kutokana na sababu ile. Kutokana na sababu ile."

2.3. Getting used to and anticipating problems

Many of the older men and women had somehow accepted their chronic situation. I often heard older people, older men and women, saying of themselves: "*Nimeshakuwa mtu mzima*" ("I am already an older person") when giving an explanation about how they could not do certain things anymore. It usually was said with a sigh and had a slightly unpleasant touch. Older women – I really never heard a man saying this - had again a distinct way to express their experience of being in a situation of chronic conditions. Typically, women who were not able to work or help in the household anymore due to chronic illnesses or frailty said raising their hands and voice a little: "*Nipo tu!*" ("I am just here!"). I do not often quantify aspects in this study but in this case I have counted how many older women stated once during an interview that they were just here ("Nipo tu!"): These were thirteen out of the twenty-six, thus exactly half of all female research participants. This expression seemed to be much more positive and even though bodily suffering was inherent, it sounded almost pleasant. It had a touch of being relieved from duties and responsibilities. I understand it as a way of saying that it was kind of fine to sit in the living room and watch the grandchildren play and not having to be active.

These expressions and cases above of older women illustrate the ambivalence of this health situation. On one hand women present themselves as passively just being there, having or wanting little responsibilities to bear, even though they are more active agents then they seem to be on first sight. Women with chronic health conditions are generally expected to accept ups and downs passively and this is also how they represent themselves as women, referring to hegemonic ideas of femininity of "just being there."

We have seen in the examples that in addition to the physical limitations, older women are socially and culturally expected to restrict themselves to engage in certain (social) spaces. This restriction of social spaces is perceived ambivalently as well. On one side, the women described it as limiting but on the other side they also depicted it as showing care of their children and other relatives towards them as it is not just a restriction but that this kind of "work" or whatever they should not do anymore, is now normally done by others for the older women.

This (self-) limitation of women accessing social spaces also had consequences for their health. Even though usually older women tried to change their habits or practices in their everyday life as they were advised at the hospital or from relatives in order to improve or maintain their health situation, sometimes they were not able to do so. On one hand this neoliberal idea of only having to change your behavior to stay healthy could not work out if the living conditions were too poor to do so. On the other hand, especially older women often seem reluctant to follow the doctors' advices to change their health behavior. Medical staff in Zanzibar's urban hospitals gave "gender-neutral" health advice to older

patients but older men and women translate them differently into their everyday health practices. While for example men often adhered to recommendations of doing walking exercises to mitigate NCDs and their consequences, older women frequently disregarded the advice. Older women mostly agreed with the doctors that it was important to stay physically active but did not feel comfortable to go for a walk outside as it was recommended – since many of them were not used to leave their house to walk alone in the streets as I have discussed above.[116]

Pronouncing their emerging identity as older people by saying for example "*Nimeshakuwa mtu mzima"* ("I am now already an older person") provides men in chronic health situations an opportunity to lower the set pressures to be in control. The acceptance or embodiment of the chronic situation as part of one's identity as an older person could be understood as what is usually called chronicity, a continuum of disruption (Smith-Morris 2010, 25).

While they are socially expected to address their health problems, aging is inevitable. Most men were though still finding new ways to define themselves as active agents. This idea of staying in charge as a man is well compatible with a neoliberal understanding of being responsible for one's own health. To be passive as a man and not to participate in social spaces seemed to be at any age culturally hardly acceptable. Even though many men still wish to be able to provide for their families, they had to find new ways of being respected older men and to relate to different aspects of masculinities like being a more faithful person or controlling their health problems.

One relevant context of action in situations of chronic conditions was thus religion. Virtually all informants emphasized the importance of practicing religion (mostly Islam) or *kuwa na imani* (having faith) during the whole life but especially in old age. This was not only relevant in relation to chronic conditions but fits well to this situation as it illustrates how the phenomenon was aggravated. Older men and women recited prayers and the Qur'an, most men went several times a day to a mosque and many women attend classes at *madarasa/chuo* (Islamic school). From an outside perspective, the five prayers a day give a clear day structure and a life rhythm to the older people. They ask for blessings and guidance from Allah. Often older men and women payed *sadaka* (religious offering, alms) to the mosque and then someone of the mosque pray *dua* for them. Difficult life situations and sicknesses are often seen and accepted, especially by older women as *mitihani* (examinations) from God. While some older people perceive these *mitihani* as a demand to change something in their life, others take them rather fatalistic,

[116] An easy solution to this culturally inappropriate suggestion to do sports outside the private space would have been to propose exercises that the women were able to do at home or together in groups with other older women in a more shielded place (Staudacher 2015).

and see the challenge in accepting their fate. Several men and women were talking about *majaliwa* (endowment, destiny; God's will) or *majaliwa ya Mwenyezi Mungu* (Almighy God's will), and that the book of life was already written by Allah to express how little they could do in this and simply had to accept it as destiny.

Very popular at the time I conducted the field research were DVDs and *YouTube* videos sent around on mobile phone with *mawaidha*, (Islamic) religious sermons and advice usually given in hour-long speeches of a *Sheikh/Shehe* (Muslim teacher / patriarch / respectable wise man). The Sheiks usually are from different coastal cities in Kenya as well as from Tanzania and touch on all aspects of life such as how to be a good husband or wife, take care of the family or how to respect oneself and with this Allah.

3. Long-Term Care-Giving

As we have seen, the characteristics of chronic diseases and conditions are thus that they mostly last unlimitedly or a very long time, healing is unlikely, the causes of chronic diseases are not yet clear and typically the course of a disease is itinerating between stable phases and phases of unstable health crisis and thus oscillating up and down (Haslbeck et al. 2015; Hughes and Heycox 2010; Schaeffer and Moers 2011). This means that people living with chronic conditions might at times be able to deal with their situation independently but at other times need support from their social network. In most cases though, to receive care over a long-term was an essential aspect of experience of elderhood for people in situations of chronic conditions. Long-term care-giving or rather -receiving was tightly intertwined with the experience of chronic conditions. Already in the 1970s Strauss and Glaser (1975) argued that the social network of a chronically ill person is heavily included in dealing with chronic conditions of the patient but that at the same time a chronically ill person often takes an active role in his or her health care seeking.

As the other chapters have already illustrated, "care" is not a given concept as such in Swahili language and societies. As introduced earlier in this dissertation, I rather use the English term "care" as a sensitizing concept to bundle many responsibilities and practices of help and support, which are sometimes based on social norms of kinship, faith, reciprocity and compassion and often just done habitually and out of missing alternatives. Long-term care-giving thus turned out to be an unspectacular but essential necessity, which was not always self-evident but needed to be upheld and sustained by at first glance inconspicuous actions of the older people who were suffering from chronic conditions.

In what follows, I will present only one case of a man. On one side this has to do with the fact that I did not have many men among the research participants who received long-term care. I got the impression that many of the older men who needed intensive care passed away very quickly and it did often not even come to a long-term care arrangement. Maybe this is the reason why I have much more data on

frail and chronically ill older women than men. On the other side, long-term care-giving was not very different for men and women. For both, men and women, it became more difficult to access aging and care spaces. I decided thus to focus here more on women and femininity in elderhood, while in other chapters I did go more into details regarding aspects related to men and masculinity.

3.1. Building on experience: Being able to influence care-giving

Obviously, all older people made different experiences throughout their lives including in elderhood. All have learnt how they in their specific life situation can best treat certain health problems or whom they could ask for help in a certain situation. They also know their context of action fairly well. If not explicitly, at least implicitly they all adhere to certain norms and expectations and they all refer in their actions to the past, presence or the future. I am referring here again to agency as Emirbayer and Mische's (1998, 962) had defined it:

> (agency is a) temporally embedded process of social engagement, informed by the past (in its "iterational" or habitual aspect) but also oriented toward the future (as a "projective" capacity to imagine alternative possibilities) and toward the present (as a "practical-evaluative" capacity to contextualize past habits and future projects within the contingencies of the moment).

However, this interplay varies depending on the structural contexts of action (Emirbayer and Mische 1998, 963). Agents "may increase or decrease their capacity for invention, choice, and transformative impact in relation to the situational contexts within which they act" (Emirbayer and Mische 1998, 1003). The following examples show how these older people could at least partially transform the care-giving they received by acting in enabling contexts of action. In these contexts, they could for example habitually rely or explicitly invoke norms of reciprocity or kinship and often their expectation how care should be practiced was fulfilled. I do thus again, analytically separate agency and the structural context of action but still aim at understanding them as mutually constitutive.

3.1.1. Bi Mwana – Feeling well cared for by a dada and (social) kin

Bi Mwana, the nurse staying in Kikwajuni, we now met several times in the course of this dissertation, provides one of the examples in which the long-term care-giving seemed to be very satisfying for the chronically ill person. Her case is also interesting because she did not have blood related children but raised the children of her husband and others. In chapter 3 I have already described in detail how she and her relatives constantly had to adjust the care-giving in situations of a health crisis. Even in the course of her longstanding chronic condition she could rely on several people at once. As we will see, living in a relatively affluent and cosmopolitan context facilitated her care standard undoubtedly. A major part of the care-giving activities was carried out by her housekeeper *(dada)*, whom her niece living in Mwanza, a city in the North of mainland Tanzania, had organized and financed for her. Bi

Mwana had raised her niece like her own child and thus established a mother-daughter kinship relation and expectations of reciprocal care-giving, which the niece fulfils even staying far away. Bi Mwana elucidated how the housekeeper *(dada)* whom her relative had organized for her helped her:

> I mean, as my task/job *(kazi)* like that for example in the kitchen, I was given someone to cook, wash dishes, sweep, wash my clothes, everything! I am telling you, I don't have any kind of a problem. Now, myself, I can put a chair there, sit like this we're talking, enough, but I can't do any kind of work.[117]

On another day, she told us again, how she used to cook and how these days her *dada* would do the work in the kitchen. Bi Mwana nicely describes her relation to the young woman, as on one side a helping hand and companion with whom she likes to spend time but also, as a young inexperienced person needing guidance and supervision, which she could and needed to provide:

> To cook, I am not cooking by myself anymore. I put my stool there to her, the one who is helping me. I mean, I talk to her. In the morning when she is here - she is not sleeping here – thus, when she has arrived here, I am telling her to put the charcoal stove for me. I put in the charcoal and start the fire and then, I watch the way she is cooking. And you know, the ancient *(ya zamani)* cookery is not the one of today. They can disarrange the dishes and then you are left with a sauce *(mchuzi)* which is tasteless. And although we are supposed not to use salt, sometimes you missed it. Therefore, I am sitting on my stool and watch. But I cannot move close to the heat, I am afraid. We were told to stay away from fire, because our problem has no time, anytime it can appear.[118]

Bi Mwana not only needed help with household activities but also for her personal care. Even though she could go alone to the bathroom and wash herself, she was afraid that her heart or respiration could trouble her while she was bathing. She could not bath alone anymore and needs assistance in pouring water and scrubbing her back, massage her with Vaseline and then prepare a warm tea for her. Mostly her dada was helping her with these activities, since she was the one who was always around except on Sundays. Once her husband's grandson was home in the later afternoon or evening on Sundays her older "grandson," who was staying with her before he got married, the dada left the house. At night her late

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[117] "Maana, kazi yangu kama hivyo, ukiambiwa huko jikoni nimetiliwa mtu wa kupika, kuosha vyombo, kufyagia, kufua nguo zangu, kila kitu! Nakwambia sina tatizo la aina yoyote ile. Sasa tena mwenyewe kuweka kistuli hapo jiani, nakaa kama hivi tunazungumza, basi, lakini siwezi kufanya kazi ya namna yoyote."

[118] "Kupika, sipiki, lakini huwa mwenyewe. Naweka kistuli pale na yule ananisaidia yule. Manake ndyo nazungumza nae. Asubuhi vile akishakuja hapa - halali hapa - akishakuja hapa, namwambia aniwekee seredani. Natia na makaa ndani ya seredani, nawasha halafu, natizama vile namna gani anavyopika. Na unajua mapishi ya kizamani si ya sasa. Vuruga vuruga halafu mtu anakuachia mchuzi haujakolea mchuzi. Ingawa tunaambiwa tusile chunvi lakini unatamani siku nyengin. Ndyo maana mwenyewe nakaa kwenye kistuli changu. Lakini kusogea kwenye moto siwezi naogopa. Manake, tunaambiwa sisi maradhi yetu hayana muda wakati wowote yanatokea."

brother's grandson was staying with her in the house. Normally, he did not do a lot of activities for her but was just around in case something would happen and to give the alarm to her (social) children in case of an upcoming health crisis.

The small luxury in Bi Mwana's house like shining furniture, a cable TV that worked well or a landline phone (the only one I had seen among the research participants) made her appear just a little bit better off than others. Having worked 32 years at the main hospital in Zanzibar, she was receiving a monthly state pension of 35'000 TZS[119] (around 15 US$), which she usually decided to directly hand over to her late brother's grandson, with whom she stays in the house, for whatever he needed it. She herself usually received financial help *(msaada wa fedha)* from the boy's *mjomba* (maternal uncle) and from her niece in Mwanza. When we asked her if she receives financial help, she explained, how well she felt cared for:

> It's this one's (points to teenager watching TV) maternal uncle (mjomba), he gives me money, and that one, my older sister's child who is in Mwanza she works for (a big international company). Those are the ones who help (kusaidia) me more, they also give me money. For my life, I don't have problems. I can't tell you a lie. I mean, even just now, if I phone him, telling him, "Father (baba), listen! I want this amount of money!" he is ready, anything that I want. The book/file (medical prescription), when I come back from hospital, I give it to this man (her brothers grandson) he goes to his uncle, takes money, goes to buy me medicine.[120]

Even though the consultation at the main public hospital is free the medicaments are only partially covered. Concerning the costs of medicaments her story is representative for most of the research participants.

> And you do not get them (medicaments) for free, ah! Like this time, I went (to the hospital), I was prescribed six medicaments. Three I have received, three I did not get. I got them bought (at a pharmacy in the city). Now yes, that one (pointing to her grandson) when he came back told me: 'Bibi, this medicament is expensive, one of them alone costs 30'000 (TZS)!'[121]

[119] This amount might have been enough to cover her *chai* (literally tea but meaning breakfast) for a month.

[120] "Mjomba wake huyu, ananipa pesa, na huyo mtoto wa dada yangu aliyeko Mwanza anafanya kazi kwenye (big international company). Wao ndyo wananisadi zaidi sana, wananipa pesa pia. Kwa maisha yangu sina matatizo. Siwezi kukwambia uongo. Maanayake hivi sasa hivi, nikimpigia simu nikimwambia "baba we! Nataka kiasi fulani!" Yuko tayari, chochote kile ninachokitaa. Buku nikirudi hospital ninampa huyu bwana, anakwenda kwa mjomba wake, anachukua pesa, anakwedna kuninunulia dawa."

[121] "Na hupati bure aaa! Kama safari hii zimeandikwa dawa sita. Tatu nimepata, tatu sikupata. Nimekwenda kununuliwa. Sasa ndiyo yule akaja akanambia: 'Bibi, dawa hizo ni khali, hiyo moja tu peke yake thelasini'."

One dose of the medicament she mentioned lasts only for three weeks. Thus, she would need more than her pension to only pay for this particular medicine. It does not come as a surprise that older people without any income or relatives who could defray the cost of these drugs were not adhering to long-term medication often necessary to treat chronic conditions. While for a health crisis fundraising *(kufanya mchango* – make a contribution/donation*)* is very popular and a widespread practice to finance the quick access to (sometimes also expensive) treatments, it is a difficult and often not a realistic endeavor to find funding for the treatment of long-term / chronic condition.

In Bi Mwana's case though, I had the impression she and her relatives managed to continuously support her in a way she appreciated. Bi Mwana was proud of how people took care of her, even though she was mostly helped by her *dada*. This is even the more astonishing as commonly relatives and the older people underlined the importance of care being provided by own children. Possibly, the fact that her niece had organized and paid for the housekeeper made up for the non-compliance with this norm. Bi Mwana felt she had everything she needed, as she could take the necessary medication, had someone who was around and could help with everyday needs in the household and her body care, in a way she could determine it but she also received guests with whom she could chat and exchange or could sit at the entrance of her house to observe and talk to people passing by. It is difficult to determine how it came about that she felt so well cared for but it seemed to be a combination of being able to decide about how the care-giving was performed, her relative affluent living standard including her pension and the financial support she received from relatives, but also the fact that she was honored by her relatives, the children whom she had made her own, a practice that made her now "harvest the fruits" of reciprocity and intergenerational obligations.

3.1.2. Bi Fatma – Balancing independence and caring

Even though Bi Fatma[122], who stays in Shangani, is suffering from high blood pressure *(pressa)* and asthma, she still does a lot of the household activities or at least advices the two young female relatives who stay with her what to do. Her granddaughter, who helps her in the house, normally went to buy food at the market, washed dishes and swept the floor, before she went to school. During our research, she dropped out of school because she was often late for school due to the work she did in her grandmother's household and was not able to follow the classes as *bibi* said. Bi Fatma still tried to cook by herself as she did not like the "children" to prepare the food for her but found it difficult because of her problem with her blood pressure, as she could not sit close to the fire.

The following episode illustrates the close interconnection between care-giving and care-receiving:

[122] I have introduced her case in chapter 1 and write about her health situation above in this chapter.

Once, while we spent a morning at Bi Fatma's place, she went to the kitchen and after some time I decided to follow her. Saada said she preferred to stay in the living room, as the kitchen usually is a private space so that I could go as a not knowing Mzungu (white person/European). So, I joined Bi Fatma and her niece in the kitchen, while sitting on a mat. The kitchen was simple, a little bit messy and what was pretty unusual, neither the kitchen was outside in the backyard, nor having any window, and thus, as bibi mentioned several times, was quite dark and she could hardly see anything. A cockroach went her way without disturbance. Her brother's daughter, a seventeen years old shy girl rasped coconut and told me that they will prepare rice and *mchuzi* (sauce). Bibi did smaller works like taking out the fish of the freezer, washing small things, placing the pan on the gas cooker on the floor and from time to time she gave the girls small tasks in the kitchen. She excused herself for not sitting on the mat with me, since she felt *ganzi* (numbness) in her legs and sat next to me on a small stool. She started chatting about a variety of topics like characteristics of men and women, styles of cooking in Europe and Zanzibar, about one of her daughters who unfortunately, could not have more than one child after a difficult childbirth and she told me that what concerns her, she never wanted five children, it just happened. During our chat her four years old great-grandchild came back from playing in the street. A reprehensive discussion between him and Bi Fatma followed: He had received a *mandazi* from his father. He wanted to keep it for himself, which made his fellow with whom he was playing outside crying whereon bibi told him to bring his friend a part of the mandazi. A bit later her grandson Saidi, who lived outside of the city came to greet and disappeared two minutes later as quick as he had appeared.

On one side Bi Fatma was taking care of the younger generations of relatives by supervising them and giving advice or comfort on the other side she also needed their help, as she could not do certain tasks anymore as staying close by the heat or lifting heavy things. The house she stayed in was very centrally located in Shangani and I always met relatives, friends or neighbors at her place. It seemed like e meeting point not only to see Bi Fatma but also to get together.

To sustain her life, Bi Fatma received financial support from her children who stayed close by in the suburbs of the city. Besides this, she prepared sweet snacks (*visheti*), which were sold at a store where her children stayed: "I have my own child (son at Bububu), he is having his own family but he is helping me. And we ourselves, we are selling small things. You know it is not easy to depend fully on one person." Besides from her son and daughter in Bububu she sometimes received small amounts of money (around TZS 10'000) from her sibling's children who stay in Dubai, once they came to visit her, or if she had an emergency but they did not support her regularly. She did neither have a pension nor a health care plan. Her children suggested that she could move out of the city to their homes around twenty minutes away by car but the older woman preferred to stay on her own with her younger relatives as

long as she could. When we asked her if she still would like to stay in her house once she gets weaker she said:

> I know it will be difficult but I have children and grandchildren who will help me. But if it happens that I become too weak, I will come up with something else, but for now I am ok, I don't like to live in my children's houses, even moving to my daughter who lives alone with her son I don't want to. My son has his own family and he asks me to stay there with them but no, I don't want to. I told him that you can help me wherever I am, but it is not good to share the same house.[123]

Bi Fatma's case shows thus how long-term care-giving can have a range of shades from very intensive long-term care of an older person or as in her case, more subtle ways of care-giving. Bi Fatma as many other older people had to balance independence and the indispensable care they needed. These observations follow also the logic of not becoming a burden to relatives, which I have introduced earlier in this chapter, by dividing the "care burden" in order not to become too much dependent from one person.

3.1.3. Bi Safi – Moving to children to avoid gossip

To add here another piece of this phenomenon of compromising on interacting in public spaces by women suffering from chronic conditions to avoid negative gossip about care-givers, I would like to allow a glimpse into an interview with Bi Safi. The frail older woman suffered from *pressure*, pains in her legs and she was almost not able to walk anymore or to carry anything heavy like a teapot. Additionally, she had problems to see well as she had an eye bulge. She stayed in a room in a big multi-family house in Shangani. I remember when I have seen her for the first time in the crowded backyard of this typical Swahili house, where many children were running around, waste was piled up and pigeons were searching for delicacies. Bi Safi was standing at the wooden railing of the balcony on the first floor and looked at the bustle in the backyard. At that time, she felt well cared for by her granddaughter who came to see her daily from another area of the city and brought along food for her, cleaned her place and washed her clothes. She also was helped a lot with household chores by a neighbor living on the ground floor of the house and was chatting with many people in the house. She describes exemplarily how she agreed to move away from Shangani, where we met her first while living alone, to a grandson in another

[123] Saada: "Ulishawahi kufikiri kitu kimoja, ukifika uzee wako, na huwezi kufanya kazi zako tena, itakuwaje maisha?"

Bibi : "Najua itakuwa tabu, lakini watoto na wajukuu nilokuwa nao watanisaidia, lakini ikitokea sijiwezi kabisa huwenda nikapata fikra nyengine, lakini kwa sasa hivi, najiweza sipendi kwenda kumkalia hata yule aliyekuwa mwanamke peke yake, yeye kajenga kule lakini sitaki, na yule mwenye mke wake, na watoto anasema bora ukae hapa, namwambia bora nitakapokaa popote unisaidie, lakini sio uzuri kukaa katika nyumba moja."

area of the city, where we visited her in the further course of the research. During this chat, her grandson's wife was sitting next to us and was following the conversation carefully:

> Sandra/Saada: How was it or how did it happen, that you moved away from Shangani to move over here?
> Bibi: It was, I am not able to take care of myself (sijiwezi) alone anymore. I can fall over there and the children are far away, I have no one who could take care of me (literally: could be concerned with me - *kunishughulikia*). I have seen, if I did not go, I would have provoked gossip against my children: "They have left their mama all alone, she has not even someone to take care of her (literally: observe her – *kumwangalia*)!" I have seen, better I'd come over here, to be here, people are here who take care of me, this is how I came over there.[124]

Bi Safi thus decided to move to her grandson, where his two wives took care of her. Even though she had established a well working care environment in Shangani, she was in her action referring to norms of kinship and possibly Islam according to which care-giving and the supervision of an older person should primarily happen between children or grandchildren and mothers or grandmothers. It should even not seem like she had been left on her own, which was not at all the case in practice. It was difficult to discuss her perspective in detail, considering the usual presence of grand-daughters-in-law, when we came to visit her. Bi Safi was anyway clever enough to frame her statement as a kind of compliment to her relatives. Even though, she could expect now that she will be cared for and concerned with her (*shugulikia*), moving to her grandson and leaving her neighbors and friends in Shanghani behind, also meant for her having a smaller circle of people who took care of her. Additionally, her sister and her children, who were living in Oman only supported her in situations of crisis and were more absent then they could have been.[125]

3.2. The limits of agency: If context complicates care-giving

While we have seen now examples of how some older people could at least partially transform the care-giving they received by acting in enabling contexts of action, others have to cope with more restraining and adverse contexts of action. Even though I want to stress that also in these cases the older people had (like all human beings) agency, the structural contexts they were acting in, were more difficult to be influenced in a way that would have been beneficial to the older research participants.

[124] Saada: "Ilikuaje au ilitokea vipi mpaka ukaamua kuhama Shangani ukaja kuhamia huku?"
Bibi: "Ilikua sijiwezi pekeyangu. Naweza kuanguka pale na watoto wako mbali, sina wakunishughulikia. Nikaona nisije, nikawapa wanangu kusemwa vibaya na walimwengu: "Wamemacha mama yao peke yake, hana hata wa kumwangalia!" Nikaona, bora sasa nije huku, kwakua huku watu wapo wakunishughulikia wapo ndio nikaja huku."

[125] See methodological side note at the end of this chapter.

3.2.1. Bi Sikuroja – "It's not little": Being thankful for care if not having children

Bi Sikuroja who is just a bit over sixty years old and living in Chumbuni, is one of the six women out of the twenty-five female research participants who did not have any biological children anymore. Additionally, to our routine visits and interviews we conducted a biographic interview with her, which proofed to better understand how her situation came about. Her case illustrates how older people without children often had just to take whatever was offered to them in terms of care-giving and how important a pension and social kinning, thus not biologically akin people who become related through a social process of making kinship (Howell 2006; Carsten 2000) could become.

Bi Sikuroja was suffering from asthma and described to us that sometimes she is feeling very heavy, not being able to do anything, while on other days she takes care of all the household chores. Like Bi Mwana she was sent from the country side to the city of Zanzibar and was raised by a *mlezi* (guardian). When she got married she moved again to the countryside with her husband. She gave birth to two children. One died at birth and the other one when he/she was five years old. Bi Sikuroja was around twenty-five years old, when she got a divorce. After her divorce, she returned to the city and did never marry again even though she would have liked to do so. As a divorced, childless woman she went back to her *mlezi's* place. For a long time, she stayed together with the man and woman who raised her up until her *mlezi's* husband married another wife who said that she could not live with a divorced woman and that Bi Sikuroja should take care of herself. Not having had any formal education, back in the city the older woman worked as a state employed sweeper and compound cleaner until she was physically not able to work anymore. As a part of her pension, she had obtained a lump sum with which she built her own modest house in Chumbuni, where she lives now alone. This was seven years before we had met her first in 2012. She had started to receive a pension in the same year.

Usually she coped on her own with her everyday life. She told us that there were only two children related to her, her brother's son and his daughter, who helped her occasionally (*kuletea msaada* – to bring help to someone). The nephew took her to his house sometimes, when she was not feeling well. But his own condition was not very good as he was not working but "just carrying fish." When we asked her, who was helping her in the household she said that she was endeavoring by herself *(najitahidi mwenyewe ivyo ivo)* and doing everything like sweeping, washing dishes, cooking by herself. Sometimes her brother's granddaughter, whom Bi Sikuroja called *mwanangu* (my child), comes to wash Bi Sikuroja's clothes. Once we visited Bi Sikuroja, the young woman was staying there for a week to help the older woman with all the daily chores. She was married but she asked permission from her husband to come and stay with Bi Sikuroja, which she appreciated, especially knowing that because of her visit her grandniece had to neglect her own household with her husband.

Bi Sikuroja was in good relations with her neighbors who went to fetch water for her and passed by daily to greet her. Like most people in Chumbuni she had no relatives staying in another country[126] but one living on the Tanzanian mainland who called her regularly to ask about her condition. Bi Sikuroja told us that she is satisfied *(ninaridhika* – I am satisfied) with the care that she is receiving and added "it is not insignificant" is *(si haba).* After a pause, she concluded that she cannot ask for more because she knew people sacrifice themselves a lot.

The limiting structural context of action in her case is for example that Bi Sikuroja was living in the poor neighborhood of Chumbuni and that she was divorced without having raised any children of her own, which she could rely on now. Even though she called her brother's granddaughter *mwanangu*, and thus pronounced their social kinning, she still knew, that she could not ask as much as if she had raised the young women or if she had been her own offspring. She had thus not many options but to accept whatever she received.

3.2.2. Bi Nachum –Health crises becoming chronic and care lagging behind

In the last chapter I have introduced the story of Bi Nachum, who lived in Chumbuni as well as in very poor circumstances and had her leg broken. During the time she and her relatives were dealing with her health crisis the care-givers rotated among themselves to stay with her. Some months later, when they became more used to the new situation, her care situation changed again: Once the plaster around her leg was removed, she moved to her daughter, to her son in law and grandchildren in a neighboring shehia. Similarly to many other cases, we followed the older person throughout the city, to see how their living and care situation developed. Previously, this daughter came to see Bi Nachum in her son's place and explained that her mother could no longer stay there, because a son could not take care of her. She was referring to intimate care like washing the older woman's body, which she explained could not be done by a man. Implicitly she was not considering her daughter-in-law as an option to take care of her.

Even though Bi Nachum's leg was better, her situation got worse. The house of her son-in-law, where she stayed at that time, was in a very poor condition as well. While I was concentrated talking to her daughter, my research assistant Saleh, observed how the bed in which the older woman was laying was full of bedbugs. We could not really talk to her anymore since she seemed to have developed dementia, which according to her daughter had started recently. She remembered us just vaguely. Her daughter

[126] It was typical though, that when we asked her if she had relatives abroad (*nje ya nchi* – outside of the country), she affirmed and told us about a relative on mainland Tanzania. I mention this to show how deeply anchored the idea of Zanzibar being a country and culturally distinct was, even though officially it is only semi-autonomous. I was thus sometimes skeptical whether even these relations between Zanzibar and the Tanzanian mainland had some transnational quality.

told us, how she had a stroke during Ramadan. They did not go to a hospital with her but the family called a doctor who came because she had inflamed eyes. From him she received medications for the eyes and he identified the stroke. At the time, we met her, she was paralyzed in the face and she could not walk anymore. After a year, she passed away. Bi Nachum experienced thus several health crises, one after another and constantly needed adjustments of how to be cared for. Her crisis became chronic. Her children tried to take care of her but even though they shared the care work among themselves and provided her with what they had; it was not enough to catch up with the diverse health crises which came up.

Like Bi Sikuroja, Bi Nachum had to deal with a clearly limiting structural context of action. She could have asked hundred times for better care, her children as well had not much space to do more for her. The children themselves were disadvantaged in several aspects for example in relation to economic (not having the financial means), social (they lacked having befriended health care workers or doctors or financially powerful relatives abroad), cultural (knowledge how to treat her health problems) or symbolic capitals (Bourdieu 1986) and could only to a limited degree change the situation of Bi Sikuroja, for example maybe washing her bed sheets more often or spending more time chatting with her whereby they possibly could have realized that what turned out to be a stroke was something that needed a medical follow up.

3.2.3. Mzee Cheetah – Care stabilizing at a low level

I have introduced Mzee Cheetah in the last two chapters already. His case illustrates an ideal typical course of his health situations which string together a relatively fit situation (he defined himself like that even though he was suffering from diabetes) that was followed by a stroke and ended in a situation of chronic conditions. I want to stress again that this sequence is just one of many health trajectories.

During the months after his stroke, I often went to visit Mzee Cheetah at home. He made slow progress. He gradually recovered enough strength to go for a walk close by his house, and he regained his smile. He seemed to understand everything I said, which he showed by nodding and making basic facial expressions, but he never managed to talk again, and I was left to imagine what he wanted to tell me.

The care arrangement stabilized. But while Mzee Cheetah seemed to receive a lot of attention during the first months following his stroke, the support eventually decreased. As illustrated above, Mzee Cheetah was an extremely social person and he had countless friends and acquaintances, but after the stroke many of these relationships faded. Several of his friends and neighbors told me that he no longer was the person he used to be, and one even made fun of him by imitating him. The family lived off Mzee Cheetah's pension and the income of his first wife. While the contributions of friends and neighbors decreased together with their visits, the family rented out the newly built house outside of the

city and thus gained a small additional income. From that time on, things did not change much anymore, and two years after his stroke, Mzee Cheetah passed away.

The case of Mzee Cheetah shows how social relations and engagement in the city can change with specific chronic conditions. I met many frail older people who went through similar experiences over longer periods, often over many years, finally finding themselves with a streak of dementia, or feeling weak and tired all the time. The social network of such a person could be very well-disposed towards them, but after a while, visits become less frequent, and the majority just passes by to ask them one or two questions and do not stay longer than a few minutes. One of the female research participants complained to me that nowadays people pay fewer visits and would just quickly call her on her mobile phone instead of spending time together.

Even though it is an extreme example we can see well, how the body can be understood as a context of action. This situational context decreases Mzee Cheetah's capacity to influence his care arrangement drastically. Not being able talk or move anymore he can hardly express his ideas to his relatives and friends, let alone invoke for example any religious or intergenerational norms or expectations of reciprocity. He can only through his pure presence remind them of who he was and is and hope that they know and remember what he did as preparations foresighted towards his life as a pensioner.

3.2.4. Bi Khadija – Between urban margins and transnational spaces

In chapter one I have described how Bi Khadija, the around 85 years old and very frail woman, suffering from *pumzi* (asthma) and *pressure* (high blood pressure), was living in Mpendae. Her case shows how social relations are crucial to receiving care in the city. We have already seen (see chapter 1) that even though she is living in a well-situated family it is not easy for her to stay social engaged with others due to her health situation and the built environment, that rather keeps her at what I had called urban margins. Bi Khadija, who is also not having her own offspring, had to establish social relations over the course of her life and nowadays lives between urban margins (see chapter 1) and transnational spaces (see chapter 5).

Since Bi Khadija is not mobile anymore, she needs help with almost everything:

> If there is travel, we get in a car, (for) going to town, or outside the city (*shamba*), or to weddings, which are important to us. Sometimes we go out for a visit in the evenings, I, Mama, Baba (which means father, but she refers to the husband of Mama as Baba), and the children. But I do not do anything, they do everything, they just tell me to wait for my plate.

Besides the help she receives during the day, she sleeps in a room together with two young girls, the daughters of Mama (her niece's daughter), who assist her at night. Bi Khadija was married three times. In the first marriage, she bore a child who died soon after birth. Because she could not have any more children on her own, she raised two of her nieces' children and took on the responsibilities of a mother when she helped one of her niece's daughters during the first months after she had a child. The first and second husbands divorced her, and her third husband died twenty years ago. After his death, she lived on Pemba, a smaller neighboring island that is part of Zanzibar, where she had built her own house with the financial help of relatives in Oman (see chapter six). She lived alone in the house on Pemba for one year. Then Bi Khadija spent some time with members of her late husband's family. When she became weaker, Mama encouraged Bibi to stay with her in the city of Zanzibar, together with her husband, children, and two household helpers who do not sleep in the house. Bi Khadija mentioned Mama and the son of another niece, who lives in Oman, as the most important people who helped her. About Mama, Bi Khadija says: "She does everything. She is my Mama. It is not one or two things that she does for me. She does everything, all the work is up to her: eating, dressing, traveling, sleeping." Depending on the day, Bi Khadija either praised Mama or complained that no one is interested in her advice anymore and that she cannot help the children with their schoolwork or Mama with the cooking because all the recipes have changed. Bi Khadija often stays for several months with other relatives whom she helped when she was younger, and the last time I met her, she had moved in with her niece, who is just a few years younger than her. She told me that it was very peaceful to live with another older person since she would understand her concerns best.

The example of Bi Khadija shows that the situations of older people in chronic situations can shift constantly. She needs help, but she can also influence, to a certain degree, with whom she stays with and she makes her children compete over hosting her. In four different houses, people told me that they appreciate it when Bi Sharifa stays with them. I argue that Bi Sharifa moves around so much as a strategy to receive the best treatment she can. And by addressing, for example, her niece's daughter as Mama, she invokes Mama's responsibilities to take care of her like a child and thus habitually refers to kinship norms as a context of action.

3.3. An unspectacular necessity

Having gone though the above presented cases we can see that long-term care-giving has many facets. It is not a specific package of certain people who perform specific activities but involves many different patterns of sociality related to chronic conditions, their treatment or endurance (Whyte 2012, 63). I got the impression that even though especially, during health crisis, all kinds of people like friends and neighbors were involved in the care-giving, the longer the period of care-giving took the more it was focused around a small circle of own or social children or a person living in the same house or close neighborhood.

There are more obvious elements of long-term care related to the specific health problems, such as monitoring the intake of medication, accompanying a person to a health facility or measuring blood pressure or helping with physical hygiene and assisting to walk to the bathroom. Two other elements were firstly doing the household work like cooking, sweeping and washing clothes and secondly providing financial support, in cash, by going to do shopping for an older person, paying for everything that was needed in the house and for medication. Much of what we could frame conceptually as *care* was not articulated verbally. Except, if specifically prompted (*Nani anakusaidia kufua?* Who helps you to wash?), often older people would not articulate verbally that a daughter helps (*kusaidia* – to help) them with certain household tasks or that a son contributes financially. Many aspects of care happen habitually as the older people as well as their care-givers relate more or less unconsciously to contexts of action such as concepts and norms of kinship, intergenerational support, gender or religion, when helping them as relatives, elders or mothers.

Less obvious elements of taking care of someone were at least as important, especially when support was needed over a longer period of time. What Kleinman had coined as "presence" - in a completely different though, in the context of clinical doctor-patient interaction – might cover some of these aspects well:

> I mean the intensity of interacting with another human being that animates being there for, and with, that person. Presence is a calling forward or a stepping toward the other. It is active. It is looking into someone's eyes, placing your hand in solidarity on their arm, speaking to them directly and with authentic feeling. Presence is built out of listening intensely, indicating that the person and their story matter, and explaining carefully so that you are understood." (Kleinman 2017, 2466)

While Kleinman stresses here the intensity of interactions, I would argue that also spending time together was important for older people in chronic situations even less intense interactions were valued. It was not always necessary to have visitors who stayed for hours but just to see someone who passed at their house and greet them or an adult child who popped in after work to see if everything seemed ok, could be seen as caring. Especially in the context of chronic conditions "to be concerned with someone" *(kushugulikia)* as Bi Safi and others had voiced it or to "take care, provide for and reward someone" *(kutunza)* were important aspects of caring. These elements can be better understood if we think them intertwined with the concept of *heshima* (honor), I have introduced previously (chapter three).

The cases have illustrated how challenging it can be, to provide long-term care for an older person in a context in which most responsibilities are limited to private spaces. It is well-known that elder care can be difficult to be provided over an extended period of time. Not in the context of sub-Saharan Africa but in another low-income country, in Indonesia, Eeuwijk (2006) has shown how care-givers experienced

many-fold burdens when providing care for frail older people. He analyzed how the care-givers tended to reduce their support as the severity and duration of their relative's illness increased. He associated the older person's vulnerability to inadequate care provision, or its withdrawal, to marital status and gender, whereby unmarried women and widows were most at risk. Additionally, Eeuwijk identified poverty, weak support networks, and having care-givers who are themselves vulnerable as crucial barriers to providing care to older people. Even though in my examples relatives struggled to provide adequate care my analysis showed that especially older women were well experienced to negotiate long-term care-giving, by balancing their claims, freedoms and weighing them up with sustained care-giving over a long period of time.

In relation to enduring care-giving Beckmann found similar patterns analyzing the support for HIV/AIDS patients in Zanzibar:

> Together, the social network of family, neighbours, friends, colleagues and employers (…) works as an insurance system in which moral debts are created for which a return can be claimed afterwards. But members of the social network do not only extend economic support; the emotional support they give by enquiring about a sick person's health, by visiting and generally by showing that they care is often regarded as important as material aid. Nevertheless, long-term illness puts enormous strain on a social network and with rising costs it is often impossible to provide comprehensive and enduring care. (Beckmann 2010, 209)

What Beckmann called an insurance system with moral debts, can be also understood as reciprocity. As she adumbrates, a return out of the moral debts can only be claimed if the given context allows this. We have seen in the examples that the structural contexts clearly could facilitate or complicate care-giving. For example the financial capacity of a family is in the given context, in which elder care is widely understood as a family matter and scarcely supported by the state, of course a major precondition for taking care of an older person (Jong 2005) or at least to provide appropriate care. The access to economic capital is one relevant context of action besides many others we have seen in this chapter, such as the environment of an area or if one has own children or not. Most older people for example knew very well what was financially possible, and they appreciated whatever they received within these limits. Especially in poorer areas, care did not just happen but was negotiated and worked hard for through establishing reciprocal relations and invoking religious arguments of what one was supposed to do for a mother, a parent, or any older person having in mind the given context and possibilities.

3.4. Methodological Side Note: Grasping absence of care

A phenomenon I always found difficult to grasp and to write about was the absence of people who possibly could care for an older person. Bi Safi for example mentioned that she had some of her

children[127] and her older sister in Oman. The way she talked about them, her voice sounded a bit disappointed that they did not support her more but she did not clearly say so. She explained that they would hardly contact her and only care about her once there was a problem or an Islamic holiday (*siku kuu)* like Eid al Fitr. With these statements the conversation on the topic of transnational care was over. When we tried to meet these relatives in Oman we struggled first to receive their contact from the relatives of Bi Safi in Zanzibar but then also to arrange a meeting in Muscat. My assistants and I did not want to force an encounter as this would have been ethically questionable. I thus never met her relatives in Oman and could not hear their perspective on how they should or could (not) be involved in the care-giving of Bi Safi. I was left with speculative ideas having been exposed to many discussions about kinship and religious norms of what children, including nieces (as usually, they are verbally not distinguished from own descendants) should do and usually tried to do. According to these norms, they should care for their aunt and support her with whatever they had, at least in situations of crises. In her chronic situation though, their potential support was slumbering and Bi Safi kind of tolerated this or at least did not want to complain to us about her children which she was also expected to come to their defense.

A limitation of this study thus was that in my analysis I could only limitedly write about the absence of potential care-givers. I mean here not only relatives abroad but also living close by or even in the same house of a research participant. While in addition to the interviews, I could observe who of the relatives or neighbors passed by or called a research participant, while I was there, I had to rely on what the older people told me about certain possible care-givers who refrained from care-giving.

4. Conclusion: Closing Spaces of Aging and Caring

To understand chronic conditions, functional disabilities and frailty from the perspectives of older people, it is essential that more than the bodily changes as such, the meanings that come with them matter, as for example a limited capacity to everyday self-care (Kaiser-Grolimund 2017) and to care for others (Eeuwijk and Obrist 2016, 191). As suggested by Whyte (2012, 71) my approach also asked in a first step how differently situated people live with, and try to control, chronic conditions in a context of health care more orientated to acute health problems. All older research participants experiencing situations of chronic conditions, told and showed me how their health condition went up and down. My analysis illustrated that most older people and the social spaces they can engage in understand chronic conditions as part of elderhood, which only to a limited degree can be influenced.

The socially constructed narrative is one about continuous decline in elderhood. This kind of getting used to chronic conditions and the related understanding of decline in elderhood though, is differently

[127] She called them children but actually they were her older sister's children.

interpreted for and by men and women and possibly enhanced by the neglect of (multimorbide) chronic health conditions and other specific health problems of older people in the Zanzibari health system. While for the construction of femininity it was acceptable to "just be there" *(nipo tu)*, to be a man and to "just be there" was contradicting to hegemonic forms of masculinities but could become acceptable during elderhood, when decline was expected. For both though, older men and women, social spaces became more difficult to access in situations of chronic conditions. If we understand the evaluation of situations as always combining functional and value-oriented components, but being influenced by emotional and affective relationships (Förster 2018), we see how complex the action of long-term care-giving is.

Whyte urged us to "take a pragmatic, even teleological, view that the meaning of a condition is heavily shaped by what people (policy makers, health professionals, affected individuals and their families) think they can do about it" (Whyte 2012, 63). I was surprised to hear how many people were talking about chronic illnesses like "pressure," "sukari" or "pumzi" (asthma) and thus on one hand recognizing them as something specific, an illness possibly but at the same time not treating them but rather understanding them as part of elderhood. This means that partially, older people and their families used public health concepts about biomedical disease but at the same time, public health agents as well as relatives often did not see chronic conditions or NCDs as needing priority.

As mentioned earlier, (Eeuwijk and Obrist 2016; Obrist 2018; Gerold 2017) distinguished older people who have energy (*nina nguvu*), who have sometimes energy (*nina nguvu baadhi ya wakati*) or who do not have energy (*sina nguvu*) to better understand the diverse experiences of aging, health and care-arrangements of older people. The authors emphasized the fluctuating and volatile health situation of some older people. Since the local concept of having energy or not was common, I tried as well, at the beginning of the analysis, to categorize the older research participants accordingly. But exactly because of the volatile health situation of older people I found it impossible to group the older people into these three groups of having, sometimes having or not having energy. I met most of them in different health conditions and was not able to choose one state of energy for one person. What came out of my data to be crucial in how elderhood was experienced, was more than the actual health situation or energy level per se but the way older people and their families could cope with this situation. This again was related to how they were prepared for and used to health issues. In the end, it was thus all about how the situation was assessed and evaluated by the actors, and not so much about the actual situation.

Throughout this dissertation, I argue that a situational approach to analyze aging and caring is crucial. In the cases presented in these chapters, we could see that chronic conditions need to be understood as an important situational context of action. All of these older people referred in their implicit and explicit considerations as agents also to their physical situation, and thus taking their body as a context of action,

like the built environment of their house or area, as well as norms of gender, kinship and generations or religiosity, reciprocity and cosmopolitanism.

In the terminology of Emirbayer and Mische (1998, 963) and also in this situation the three component elements of agency (iterational/habitual, practical-evaluative and projective) are relevant to understand different forms of social practice, but often we have seen that especially the habitual element is predominant. Habitual practice is given when agents reactivate earlier patterns of action if they face the same or similar situations as in the past. On the one hand it is about the phenomenological "I can again and again," and on the other hand about the "and so on," which Schütz and Luckmann have already pointed out as the basis of all idealizations of the lifeworld (Schütz and Luckmann 2003, 72). But agents, in our case the older people and their relatives, need to establish a relationship between past and present situations and perceive them as equal or at least comparable. Only then can they overcome this situation with familiar means (cf. Förster 2018). As I have discussed in the last chapter on crisis, among others Vigh (2008) and Das (Das 2006), argued that in certain contexts of war or extreme poverty, crisis can be the norm rather than the exception and thus be understood as chronic.

I am aware that having constructed urgent health problems as crisis provokes questions of when a crisis starts and when it becomes to be a chronic condition. While in some of the health crises like strokes or a bone fracture, a beginning was clearer to be determined, with other problems related to health to make out a clear point of departure of a crisis could be more difficult. Vigh stated that "crisis as an interruption of 'normal' life, seems, however, to obscure the fact that a great many people find themselves caught in prolonged crisis rather than merely moving through it" (Vigh 2008, 8). Whether described as a prolonged crisis or a chronic condition, I think, it became clear that I aimed less at dismember these notions than showing how people got used to certain health problems and accordingly, usually acted in a habitual way.

Generally, the older men and women and their social networks in such situations of chronic conditions had already established strategies to deal with their health issues and upcoming necessary care re-arrangements. Becoming used to living with their chronic condition, however, the response towards this health situation could be either fatalistic, having come to terms with their situation or actively, continuously trying to control and influence it. Thus, people experiencing this situation were used to ups and downs and while some simply took note of these fluctuations, others aimed at controlling their health condition by measuring it and reacting in case of downs, by taking medicine, changing diet and doing exercises.

Even though people who were chronically ill needed a lot of support and care, my data showed that, in contrast to people who experienced a health crisis, they often were not able to activate several of their

social networks simultaneously. They already had had to adjust or even reduce their previous involvement in social spaces. The spaces of aging and caring in such situations were relatively stable since the older people and their social networks could estimate the situation and knew the expectations and each other's habits. Nevertheless, this kind of fluctuating stability was often achieved by a shrinking group of people, mostly a handful of close relatives, spouses or neighbors. Accordingly, they became less and less involved in social spaces of aging and caring I have introduced earlier (Introduction) but their care-giving arrangement usually circled around a narrow, localized space of aging and caring.

Chapter VI:
Creating and Maintaining
Transnational Spaces of Aging and Caring

Picture 7 – A son in Muscat having his father in Zanzibar.

VI. Creating and Maintaining Transnational Spaces of Aging and Caring

Worldwide, but especially in the scarce literature on aging in sub-Saharan Africa, older men and women are by the majority depicted in a one-dimensional way. First they are often presented, as very much tied to local places, spaces and local moral worlds (Kleinman 1992, 128-30) and second, generally as passive objects at risk instead of agentic subjects who interact actively with others in diverse situations of aging to provide and to receive care in a very broad sense. Throughout this dissertation I argued, that ideas and practices of aging and caring in urban Africa, in a context in which the state is not seen as responsible to take care of older people, must not be exclusively understood as locally bound.

So far I have been writing about how place and localized spaces matter for older people in how they experience their aging and in which way place and caring interact (in the first chapter). I went on to illustrate how depending on different health situations the involvement in social spaces is impacted (chapter two to four). Now this chapter aims at shedding light on the other side of the spatial extreme, on how transnational spaces of aging and caring are being created, maintained and dissolved. Transnational caring in elderhood connects several actors within a space of aging and caring, while the actors are dispersed over national borders. Such social spaces can be described as "transnational" when departing from the assumption that those who migrated to another country or their offspring, as well as those who stay behind remain connected in "multi-layered, multi-sited transnational social fields" (Levitt and Glick Schiller 2004, 1003) exchanging care over some time. As I have already argued in the Introduction chapter, I prefer the concept of transnational social space as it represents a holistic approach connecting places and bringing together human interactions and contexts. Transnational migration is commonly described as a process of "simultaneous embeddedness in more than one society" (Glick Schiller, Basch, and Szanton Blanc 1995, 48). Transnational migration and connected flows of people, goods and ideas can be observed all over the world (Appadurai 2003). I argue that transnational care, however, that circulates within such transnational spaces becomes particularly crucial in contexts in which formal social protection like pension and health schemes are not accessible for all and much of the care work is relying on informal agents, such as relatives.

The long-standing interconnections between Zanzibar and Oman provide an exemplary case to illustrate in more detail how ideas, practices and goods related to aging can be negotiated, translated and conveyed not only in a cosmopolitan context but also transnationally between older people, their relatives in Zanzibar and their kin on the Arabian Peninsula. Firstly, I will briefly sketch out the historical background and portray today's transnational interactions of governmental, commercial and religious actors between Zanzibar and Oman to show on which grounds these transnational aging and caring spaces are built on. In a second step, I will present the perspectives of the older research participants in

Zanzibar on their transnational connections, and complement it with their relatives' and acquaintances' involvement in Oman. With this approach we will then understand, how, what I mean by transnational moralities, in the sense of prescriptions for good behavior and practices, become visible in the aging process, especially once older people become ill or frail and are confronted with the finiteness of life.

1. Entangled Histories and Relatedness of Zanzibar and Oman

Having been exchanging in many ways across the Indian Ocean, Zanzibar and Oman on the eastern part of the Arabian Peninsula, have a tightly interwoven history,[128] which is visible until today in border-crossing relations and connections. "We actually have the same culture" and "Zanzibar and Oman are the same," I often heard such statements about the similarities and closeness of the two places when I did research among Zanzibari-Omani, people originally from Zanzibar staying in Oman. Also Verne and Müller-Mahn (2013) mentioned such discourse in their study. These narratives underline the cosmopolitan identities of people in Zanzibar, I have introduced in the introduction, under the multi-ethnic umbrella of being Swahili (Middleton 1992, 1). In Oman, the term *Zinjibari*, is commonly used for this to refer to any Arab descendent with historical connections to East Africa (Kharusi 2012, 335) and others in the literature call them, referring to the language as, Swahili-speaking Omani (Valeri 2007). In the context of this dissertation it would be confusing, I thus stick to the term Zanzibari-Omani for those research participants I have met in Oman.

1.1. Building on a historical social space

Since the eighth century a transcultural space has been created between Oman and Zanzibar. This transcultural and later transnational social space was developed through political expansion and exchange of goods, people and ideas resulting in dense networks across the Indian Ocean. The following sketch depicts firstly, how on the island the cosmopolitan orientations, especially in relation to Oman, developed. Furthermore, we will see how later the multi-ethnic grounds became increasingly contested and how the events of the 1970s impacted on the lives of most Zanzibari of whom many who did not conform with the desired "Africanness" were displaced or decided to leave themselves.

In the early eighteenth century Zanzibar became part of the overseas stocks of Oman and fell under the control of the ascending and politically powerful Sultan of Oman, who expulsed the Portuguese and controlled the entire East African coast (Middleton 1992, 48). In the early 19th century Said bin Sultan moved the capital of the Sultanate from Muscat to Stone Town, today's old part of Zanzibar city. He put into power an Arab elite and encouraged the development of clove plantations using slaves from Zanzibar and from all over East Africa. The sultans and the Arab elite encouraged traders from the

[128] In this dissertation, the historical relations do not get the depth they deserve but it would go beyond the scope of this book to present it in more detail.

Indian subcontinent to settle on the island to stimulate the trade between East Africa and other regions having access to the Indian Ocean. Until the late 19th century, the Sultan of Oman controlled large parts of the East African coast. During the 19th until the beginning of the 20th century, Zanzibar used to be the center of the Swahili mercantile civilization under the Omani rule and still is to a large extent oriented towards the Islamic world and Arabian and Asian countries (Gilbert 2007; Caplan and Topan 2004; Myers 2000).

Zanzibar was granted independence from Britain in December 1963 becoming a constitutional monarchy under the Sultan of Oman. One month later on 12 January 1964 the Sultan of Oman and the mainly Arab government of Zanzibar were overthrown and succeeded by a revolutionary African government that took over (Triplett 2008 [1971], 612). In 1964 the Arab population in Zanzibar was estimated to have consisted of around 50'000 people of which approximately 5000 to 15'000 were killed in the course of the revolution and thousands more were imprisoned (Kharusi 2012, 338). In April 1964 Zanzibar and the mainland Tanganyika formed a union, which resulted in the United Republic of Tanzania. In the process of these events, any person on the island being assumed to have Omani ancestry was supposed to leave the country.

In 1971, seven years after the overthrow of the Sultan of Oman and the mainly Arab government of Zanzibar, the US ambassador,[129] staying in the consulate in Zanzibar at that time, who wrote critically under the pseudonym Triplett (Triplett 2008 [1971], 612) about the situation on the island. His accounts correspond to what I could gather to some extent from the statements of the research participants in Zanzibar and Oman, when I listened to their personal stories of these times. He emphasized that the revolution had, headed by "African" Socialists from the mainland Tanganyika, three major goals: First, that an African majority rule should be implemented through the installment of a one-party system; second, the nationalization of the land and "the abolition of what were deemed to be the capitalist, exploitative classes"; and third "an end to racial discrimination and favoritism, which, in practice, was to mean easier African access to jobs, schools, medical treatment, and land ownership" (Triplett 2008 [1971], 612). This happened on the basis that before, decedents of "foreigners," (Arabs, Indians, Portuguese, British etc.), who had immigrated centuries ago, were in powerful positions in Zanzibar. I want to stress here again that these racial categories were largely ideological constructions of British colonialism (Sheriff 1994) and were of less relevance in everyday life of the Zanzibari I spoke to. The majority of Zanzibari-Omani, their relatives or at least their social network, were during this period confronted with governmental expropriation and redistribution of land, residential property and their

[129] He reveals in an oral history project of the Association for Diplomatic Studies and Training on Tanzania how he leaked this information on the situation in Zanzibar: https://adst.org/oral-history/country-reader-series/ (accessed 6.6.2018).

businesses or at least did not see themselves building up a future on the island they had considered their home until then (Triplett 2008 [1971], 612). Young women of "Persian origin" were at risk of being forcibly married by senior government officials, while any relative who opposed such a marriage has been given strokes or has been sentenced to jail (Triplett 2008 [1971], 616-7).

To give an idea of how the situation might have looked like in Zanzibar in the early 1970s, when many of the research participants I met in Oman fled or emigrated from the island, I let Triplett speak, as he nicely described the consequences of the so-called Zanzibar revolution at the time[130]:

> Travel outside Zanzibar is extremely difficult for those who are not government officials. In an attempt to halt the flow of people leaving the islands, the Government [in Zanzibar] has instituted a number of preventive laws and regulations. Permits are required to travel even to mainland Tanzania. Two years ago it was announced that anyone desiring to marry a Zanzibari girl and take her to the mainland must first pay the Government 56,000 shillings (about $8,000) - see The Standard (Dar es Salaam), 30 December 1969. This was the value of free education, medical benefits, and other social services received, according to official calculations. Later, the applicability of this regulation was extended so that the Government could require a deposit of 56,000 shillings from anyone requiring travel documents for the mainland. The latter rule is not applied across the board, but can be invoked for any reason and is often used to prevent Asians from leaving. (Triplett 2008 [1971], 613)

This account shows how difficult it must have been for people in Zanzibar who wanted to leave the island. Additionally, Zanzibar withdrew from participation in the examinations for the East African Certificate of Education and introduced its own exams which made it harder for graduates to leave and find a job on the mainland or abroad (Triplett 2008 [1971], 613). The mentioned amounts, people needed to pay as a deposit to leave the island was beyond the capacity of virtually all people living in Zanzibar at that time. On the one hand, it was thus very difficult to leave and on the other hand the political climate became unbearable for racial minorities. Triplett further described how people left Zanzibar illegally:

> People continue to escape to the mainland under cover of darkness. Those who do, sacrifice their property and personal belongings, which are confiscated by the Government without compensation. The families of those who leave illegally are imprisoned for varying lengths of time under the assumption of complicity in the escape. Parents whose children have left the islands are, under Presidential Decree No. 7 of 1970,

[130] Many Omani-Zanzibari were very critical about calling this event a revolution. For them it was not a rebellion of the ordinary Zanzibari but a well calculated ethical cleansing of the government in Tanganyika. I had an extensive discussion on these topics with the artist and Professor Ibrahim Noor Sharif Al Bakry, in Tanzania better known as Prof. Ibrahim Noor Shariff who kindly invited me to his home in Muscat. This conversation had shaped my understanding of the historical perspective.

> to be imprisoned until the return of their children, unless they pay instead compensation to the Government for the cost of the education received in Zanzibar - see *Official Gazette,* 3 September 1970. The East African press has quoted President Karume as saying that anyone who does not agree with the Zanzibar way of life may leave - e.g. *East African Standard* (Nairobi), 30 September, and *The Nationalist* (Dar es Salaam), 29 October 1970. But this is simply not true. One may only leave illegally and at great personal sacrifice. If allowed to take their assets, practically all members of the Asian community would leave immediately, for the nation being built by the revolutionary leadership offers no role for non-Africans to fill. (Triplett 2008 [1971], 614)

Parkin depicted how through this "class-like" differentiation of people, those who could afford it, first fled to Kenya or Oman and to Britain (Parkin 2006, 699). Few of the Zanzibari-Omani of this generation I have met came directly to Oman but went first to study in another country. In Zanzibar, "Non-Africans" were only tolerated to work in governmental agencies as long as their roles could not yet be filled by "Africans" and they were only accepted in low positions (Triplett 2008 [1971], 612). And while these "non-Africans" were taken out of the workforce, the new government requested for development assistance from Soviet, East German, and Communist Chinese assistance (Triplett 2008 [1971], 612). Today we know, that ironically this furthered the cosmopolitanism of the inhabitants of Zanzibar as new people, goods and ideas reached the island.

The new government not only restricted the mobility of most people residing on Zanzibar – except for its members - but additionally abolished the possibility to be treated in private health facilities. This made it not only more difficult to receive specialized health care but also rendered it almost impossible for people with Omani or any other newly as "foreign" categorized ancestors, who often had obtained excellent formal education to find employment on the island:

> Favoured medical treatment is available to families of members of the Revolutionary Council in the V. I. Lenin Hospital, even though they are allowed - unlike the average citizen - to travel to Dar es Salaam for specialist care. Private clinics, formerly patronised by those who wished to pay rather than avail themselves of free, Chinese-run government treatment, were closed to ensure 'equality' for all - see *The Standard*, 3 August 1970." (Triplett 2008 [1971], 614)

Research participants in Zanzibar, but especially many of those who had left Zanzibar and whom I have met in Oman, described the deterioration of the infrastructure, the health and educational system in Zanzibar until today. The older Zanzibari-Omani had experienced Zanzibar before the revolution as a flourishing place. While many of the Zanzibari-Omani research participants who migrated to Oman during this period claimed to have built up the Arabian country when there was no running water and electricity in the 1960s/1970s a time Zanzibar was perceived as more developed compared to Oman. The accounts of the research participants accordingly, highlighted how the Sultan of Oman, Qaboos ibn Sa'id Al Sa'id, head of state since 1970, invited the mostly comparatively well-educated former residents

of Zanzibar and other East African Arabs to come "back home" (Al Rasheed 2005; Valeri 2007). A (new) home these Zanzibari had never been to before and they wanted to build up to stay there in the future.

Also in the 1990s and 2000s, after the socialist era and the introduction of the multi-party system, Zanzibari left their home to settle abroad. Some left the island for political reasons, being harassed participating in oppositional parties, other were searching for better employment and entrepreneurial opportunities. Starting from the 1990s though, it became more difficult to immigrate to Oman. Parkin argued that those who left, rather migrated to Britain than to Oman or Kenya (Parkin 2006, 700). Nevertheless, I also met people who migrated in this period to Muscat. Some as students, others got married to Omani in arranged marriages; again others entered the country as family members or helpers (for example as domestic workers, drivers or gardeners) for the established Zanzibari-Omani.

1.2. Kinning states and reviving transnational spaces

Today on the contrary, the Tanzanian embassy in Muscat emphasizes the close relation of the two countries on its website. The two states breathe new life into the above sketched out transnational space by not only referring to history but to personal and kinship ties:

> Tanzania and Oman have historical and blood relations which date back to the 19th century. This relation is very special as Oman is the only country outside Africa where Swahili is spoken as first language and its people have blood relations with people of Tanzania. The major role of the Embassy is to translate this specialty into more tangible results for the mutual benefit of the two countries and its people.[131]

This narrative of closeness through "blood relations" is not only created to possibly help each other mutually as brother and sister or as children and parents but to create "more tangible result," which later on the website turned out to be in the majority, touching on financial aspects. This emphasis on the economic relations is echoed in the research I have found dealing with today's relations between the countries (Verne 2012), while other aspects of the transnational exchange today, going beyond commerce and business, as we will see bellow, were left aside. On the national level, Oman and Tanzania have signed a number of agreements aimed at encouraging trade and investment by creating favorable environments and building up investors' confidence, for example by establishing an agreement on political consultation, a memorandum of understanding in higher education and a joint business council. As there is a large demand of housekeeping personal in Oman, the embassy has also

[131] Website of the Embassy of the United Republic of Tanzania, Muscat Sultanate of Oman. http://www.tanzaniaembassyoman.com/pages/8 (accessed 2.6.2018).

dedicated a part of their website to how to proceed if one intends to employ a "Tanzanian housemaid."[132] The newly migrated Tanzanian and in particular Zanzibari housekeepers, nannies, henna artists and other helpers of the well-established Zanzibari-Omani, who often spend just some years in Oman, constitute today a second group of people. They are often hardly formally educated, and not from privileged families in Zanzibar and thus relating differently to the transnational space than those who have lived in Oman for many years as we will see later in this chapter.

Another part of the website of the Embassy suggests investment opportunities in Zanzibar (among others in mining and oil exploration, hotel and resort construction, service sector ICT, education, health, infrastructure development or in road construction). Not only in relation to Oman but for general exchange with the Zanzibari Diaspora the government even established a website to further financial flows from the migrated communities abroad to Zanzibar in terms of remittances, financial investments on the island in Zanzibar and through the Diasporas to integrate their "home country" into the global economy.[133]

Also in Oman, the historical relations are resurrected. As I do not master Arabic, I am not able to gather information from governmental or any other sources in the official language in Oman. The research assistants could tell me what they knew about the governmental and economic relations of Oman in Zanzibar. For example, Oman offers free heart surgeries to Zanzibari and in particular children from the islands as this is an expertise the medical system in Oman offers. The sultanate also offers/provides every year a number of school and university scholarships to young people from Zanzibar, who would like to come to Oman. They finance educational institutions in Unguja and Pemba such as a vocational school or a school for engineering. The Sultanate of Oman not only supports water programs in Zanzibar but the petrol business in Oman, which is in the hands of the state, is also said to be closely linked to the islands.

Several research participants in Oman told me about a documentary series on the public channel *Oman TV* about the relations between Oman and East Africa in 2014, which underlines the cultural relatedness of the two places.[134] The English version of the documentary shows similarities, which are relatively

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[132] Registration of housemaid. Website of the Embassy of the United Republic of Tanzania, Muscat Sultanate of Oman. https://www.tanzaniaembassyoman.com/pages/11 (accessed 2.6.2018).

[133] Website of the Serikali ya Mapinduzi ya Zanzibar, President's Office and Chairman of Revoultionary Council. Zanzibar Diaspora. http://www.zanzibardiaspora.go.tz/ (accessed 2.6.2018).

[134] Possibly they were referring to a documentary, which was broadcasted in Arabic as well as English on the East African Historical Relations with Oman. A report by Abdallah bin Ahmed Al Rubaiey, https://www.youtube.com/watch?v=vjAOT9Bb_T4 (accessed: 2018).

obvious to anyone who visited the two places like common styles of dressing, for example *kanzu* and *kofia*, or dishes like the *Omani halwa* (a soft, sweet gelatinous candy flavored with saffron) combined with coffee. It frames Zanzibar as "a natural destination for many Omanis due to its historical relationships" and refers to Zanzibari as "brotherly Tanzanians" and thus suggesting again the existence of kinship between the two places.

Not only the state agencies of the two countries express their relatedness, but also the research participants positioned themselves for example by invoking the head of state in Oman. Sultan Qaboos, recipient of the International Peace Prize, is even today a crucial figure to which many of the research participants applied a vocabulary of kinship ties when talking about the closeness of Zanzibar and Oman. Especially those Zanzibari-Omani who migrated in the 1970s to Oman, identified with his demonstrated openness and liberal attitude towards foreigners (he lifted the entry and exit restrictions upon taking office), towards women, religious minorities and the international community at large (Oman joined the UN and Arab League in 1971).[135] Sultan Qaboos, who was trained like many Zanzibari-Omani, partly in European countries, embodies what the research participants in Oman identified as typical traits of Zanzibari: to be cosmopolitans who are open and tolerant towards others. At the same time, the research participants emphasized this entanglement between Zanzibar and Oman, having in mind that the Sultan of Oman resided in Zanzibar before. In our conversations they dissociated themselves on one side from mainland Tanzania, which interfered into their cosmopolitan home in Zanzibar, and on the other side from less liberal Arabian countries, like Saudi Arabia.

These examples show how historical relations are used in conversations, with the language of family and relatedness, to revive a transnational space. These discursive formations though, are here not only constructed between individuals but also between states[136] and individuals and the two states. By "doing kinship" (Carsten 2004, 19) and "kinning" (Howell 2006), which usually happens between social actors who actively engage to create kinship and its related possibilities and responsibilities, especially between non-blood related individuals. Only recently, Thelen and Alber depicted research gaps in reconnecting state and kinship (Thelen and Alber 2018), which I argue would have potential to be done in more detail between Zanzibar and Oman for future research.

[135] Biography of His Majesty Sultan Qaboos bin Said Sultan of Oman on the Website of the National Council on U.S.- Arab Relations. https://ncusar.org/publications/Publications/1998-10-15-Peace-Award-Bio.pdf (accessed: 3.6.2018).

[136] Many Zanzibari-Omani referred to Zanzibar as country, a state or a nation, I thus take up their understanding of how they perceive Zanzibar.

1.3. Experiencing shared cultural spaces between Zanzibar and Oman

I swore to myself I would not provide the readers of this dissertation with an "arrival story" (cp. Evans-Pritchard 1969 [1940]; Malinowski 1978 [1922]), as they are so widespread and have an ambiguous history in social anthropology of showing the entry into a field (Caputo 2015). Nevertheless, during the first days of the field research in Muscat, a city I had not been before, I was overwhelmed by the multitude of what I had so far understood as Zanzibari or Swahili cultural elements and which illustrate the longstanding intertwined history of the two places. In order to spare the readers of an arrival story, I will thus just briefly depict some of my first experiences in Muscat to then more generally describe shared cultural elements throughout this transnational space.

The first morning I had left the house of Saleh's cousin and her family, my kind hosts in the surroundings of Muscat, I bumped into three Zanzibari-Omani at different places: First, I went along the street and asked an older vegetable vendor, who had an Arabic appearance and was wearing what I knew from Zanzibar as a *kanzu* (and turned out to have a different name in Oman: *dishdasha*) in English, if he'd know where I could find a bank. He turned around to a middle-aged man and asked in Swahili, what I had said. Realizing that, we had a common language, I started chatting in Swahili with him. While I was totally surprised to have found a Swahili speaker, he seemed less astonished that we both could communicate in Swahili in Muscat. His son then explained to me the way to the bank in English, even though he understood Swahili. Further on my way to the bank, I met a taxi driver who spoke broken Swahili. After I had fulfilled my mission to withdraw some Omani Rial bills (all of which pictured Sultan Qaboos), I went on to buy a SIM-card at a mobile phone shop far away from tourist attracting places. The man behind the counter who must have been in his early thirties, asked me why I came to Oman. I told him about my research and I have literally seen the joy and pride in his eyes, when he told me that his mother originated from Pemba. I was prompting him in Swahili but he just laughed and excused himself, that my Swahili was better than his. At times, it was just an excuse not to speak Swahili, I heard from second generation (return-) migrants, but it also mirrors the fact that many of them do really not speak the language of their parents. Thus, relatedness to Zanzibar in Oman was not only expressed by speaking Swahili and not all who felt close to the East African region were able to speak the language. Swahili is one of the connective cultural elements between the two places that developed in the interaction with Arabic speakers, among others trough the exchange with Omani. The language consists to a large extent of words derived from Arabic (Mazrui and Shariff 1994). Officially, it is not clear how widely Swahili is spoken in Oman. In 2015, the Ethnologue estimated 44'200 out of 4'425'000 speakers in the country, thus only around one percent of the population mastered the language.[137] Some of the

[137] According to the Ethnologue Swahili is mostly spoken in Masqat and Janub ash Sharqiyah governorates; urban centers Muscat and Sur. Website of the Ethnologue. https://www.ethnologue.com/country/OM/languages (accessed 2.6.2018).

research participants though, were convinced that at least ten percent of the population were originating or coming back from coastal areas of East Africa, speaking Swahili. Having been walking around and spending time in various areas in Muscat, I was indeed surprised to hear Swahili everywhere. My guess is, that especially in some urban areas around Muscat, like Al-Amrat the percentage must be higher than officially reported. Another explanation could be that some of the people I heard speaking in the streets were visitors, as all families I have met in Oman had regular guests from Zanzibar, who stayed there for up to three months. I will write more about this culture of hosting as a practice of transnational caring in the next sub-chapter.

Close to the vegetable vendor, I had encountered early that morning, I spotted a Zanzibari restaurant. I first thought that this was just serendipity but I later realized that such restaurants, bakeries and other Swahili food stores were very popular and could be found all over Muscat. While in Zanzibar people told me about Arab influences in many of their foods and dishes like *mishkaki* (kebab), *shawarma* (meat and chips in flat bread), Omani bread, dates, and *halwa* (dessert), these (often take-away) restaurants branded them as typically Swahili. They served those dishes in the mixed, cosmopolitan way it is done in Zanzibar, together with more Asian influenced meals like biryani or pilau rice and added to all of these East African specialties like *ugali* (staple dish made of maize) *wali na maharage* (rice and beans) or *mchuzi wa pweza* (octopus curry). Several research participants in Oman have invited me to such restaurants. These places were usually crowded and I heard a lot of Swahili there, but even more Arabic. We will see later in this chapter, how Zanzibari food is one of the elements nurturing feelings of nostalgia of Zanzibari-Omani and thus being influential in transnational spaces of aging and caring.

The fusion I describe here in the Zanzibari dishes, is also typical for other cultural elements such as *taarab* music of the Swahili people living along the East African coast and particularly in Zanzibar (Topp Fargion 2014). During several occasions, I came across announcements of taarab concerts. Once, I joined my hosts to the famous yearly Muscat Festival, where typical cultural traditions such as clothes, food, music or handcraft of different ethical groups in Oman were portrayed, I attended such a concert that concluding on the numerous audience enjoyed great popularity. Taarab developed over the last centuries and combines the East African, Indian and Arab musical elements again in a cosmopolitan way. Similar to the Zanzibari dishes, this music can thus not be related only to the place Zanzibar, but can only be grasped as a product of interactions in transnational spaces. That this music is still played in both places, by musicians who move between the two places (Topp Fargion 2014), contributes to the argument that this transnational space is more than just an interactions between individuals. It is also about at least partially sharing identities and cultural elements or fragments, re-discovered and nostalgic memories of these.

2. Caring over a Distance: Practices and Agents

Having provided a more general picture on the entangled history and cultural spaces between Zanzibar and Oman, I will now focus on how in this context transnational spaces of aging and caring are created, maintained and dissolved in personal interactions. In the course of my account, it will become apparent that this focus on transnational aging and caring I aimed at depicting, is not as easily distinguishable from the broader cultural spaces and the historical relations I describe above. Obviously, the broader we understand what caring is, the more complex the phenomenon of caring over a distance appears. Transnational aging and caring have many commonalities with aging and caring within national borders. Nevertheless, it is different, as extra efforts need to be done to maintain the relations and practices of caring as well as the underlying context of actions. The moral ideas structuring caring are marked by the fact that the social actors live apart in different countries.

Relatives in Oman were not mentioned every day among older people in Zanzibar. At the beginning of the total sixteen months of research I did in Zanzibar, I first got the impression that the relations between people in Oman and Zanzibar which filled up history books, broke up already. In everyday life of my informants, they did not seem to be worth to be mentioned at all. And having ancestors from Oman or other places was often not talked about in an environment where a silent agreement exists that almost all people on Zanzibar do have some forefathers abroad but should represent themselves just as Zanzibari. Only briefly, some of the research participants mentioned that they receive phone calls from Oman or that somebody sends money to them. Through only talking about their transnational living was often not so obvious. To realize and better understand these connections I had to wait and observe. As I have by now, depicted throughout the chapters of this book, that the older research participants in Zanzibar related to the transnational spaces of aging and caring, on the one hand as long as they were in good health and actively engage in staying in contact with relatives and acquaintances abroad or could potentially even travel themselves to Oman. On the other hand, and possibly more importantly, just staying in contact especially in situations of a health crisis. The latter were moments, when theses social spaces opened-up for them and the relations became more tangible for me as a researcher. To get a feeling of the complexity of transnational caring I present in the following two typical cases. One case is about an older frail woman, whom I had accompanied over the complete phase of the field research in Zanzibar, the other one of a younger male relative. Both will provide a vivid basis to reflect on practices, agents and ideas within these transnational spaces of aging and caring.

2.1. Mzee Omar and his “mother” Bi Sharifa - Doing everything and feeling imperfect

I have already introduced the situations of Bi Sharifa, who is around 85 years old, physically frail and lives in Mpendae, a better off area in the city of Zanzibar in several previous chapters (chapter 1 and 4). I have also mentioned her relative Mzee Omar in Oman. Bi Sharifa was married three times, but never had own children, after she had lost several pregnancies and newborn children. Instead Bi Sharifa

brought up her sister's grandson Omar and took over the responsibilities like a mother. She once explained: "I raised him with difficulties, his mother got pregnant again before she stopped breastfeeding. So, I took him."

When I was with her, she did not talk often about him, but she gave us his phone number and some sweet and salty snacks for him, when we told her that we were planning to go to Oman to meet the relatives of older people in Zanzibar. Omar, who is 48 years old, mostly lived with Bi Sharifa before he went to Oman with a scholarship to study Arabic more than twenty years ago:

> I think I studied until 1994, and then, when I had finished there, then I got a scholarship to go to Oman it was September 1995, I think. Throughout that period, I was still living with Bi Sharifa except during travel, she stayed home but when I went home I went to live with her because I was given to her by my mother since I was very young. So, in 1995 I came to Omani and when I went home I always went there to live with Bi Sharifa. In 2001 I completed studying and by 2002 I got married and I have now a family. They allowed me living here and being responsible of the mosque. From 2001, I officially started living here. I used to go home every three months during school leave. When I completed school, it became difficult to do so after every three months because I am no longer in school. It was five years ago since my last visit to Bi Sharifa. My last visit was during my marriage. After five years of marriage I sent a visa to Bi Sharifa and she was able to come here for about four months. Then my mother came. I now have a routine of going there after every year. My last visit was June 9th and back July. Therefore, we have good communication with Bi Sharifa because all her children love her very much. I recently talked to her and she told me that she needs money. You know she has money but she gave it to Mr. Saleh so she feels unhappy to go there every time asking for money. It was just recently when she got 16 million shillings from her inheritance. So, I called Ali, my little brother in Dar es Salaam and ask him to send some money to Bi Sharifa. So, communication is good although we don't meet physically each other. Yesterday I received her photograph (on his mobile phone) from my little sister Shadya so as to look at her health because she has decreased her body, but communication is good. So, there is no problem, the main issue is aging. The problem is a house because she has no house of her own, she lives in somebody's house, a private house so she can't invite her visitors as she feels uncomfortable but people come to visit her. Bi Nasra, the one you see keeps a mobile phone less than four to five years without any problem but to Bi Sharifa, she has used many of them and sometimes she says it has problem, sometimes, someone has taken it. She was not responsible because Bi Nasra often puts her phone in wallet for safety while hers is taken by her children, (her grandchildren). Therefore, I have no communication problem with her and those who stayed with her are responsible to her. They take care of her because since early time she was not a woman of segregation. And she does not like to come here (to his place in Oman) because she says she is unable to go around here.[138]

[138] "Nikasoma mpaka 1994 nafikiri, ikawa nimemaliza pale, nilipomaliza pale nikapata post ya kusoma huku 1995 kama mwezi wa tisa hivi. Kwa hiyo miaka yote hiyo alikuwa mlezi wangu ni huyo huyo bi Sharifa, labda vile kusafiri tu sisafiri nae kwa sababu ndio anakuweko kule, lakini nikirudi popote ninapokuwepo ndio ninafikia

Nowadays, Omar and his wife and children stay in a house with several bedrooms for guests, in the center of Muscat. He calls Bi Sharifa almost every day, even though it is not always easy because she has lost many mobile phones. If he does not reach her, he can call his siblings because she lives with them in Zanzibar. I asked Saleh to prompt Mzee Omar what he sees as his responsibilities towards her:

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kwake yeye. kwa hiyo ina maana atakapokuwepo yeye ndio nitakuwepo mimi, kwa sababu yeye kakabidhiwa na mama tokea nina meno mawili. kwa hiyo tena tabu zote kumuhangaisha ndio nimemfanyia mimi, rabsha rabsha za utoto. Tena 1995 ile ndio nikaja Omani, kwa hiyo nikirudi narudi anapokaa bi Sharifa na ni Chake, inakuwa sirudi tena Dar es Salaam ninarudi anapokaa bi Sharifa. Kwa hiyo mpaka 2002 ndio nikaoa, halafu tena ilipofika 2001 na moja ndio nikamaliza kusoma. sasa nilipomaliza kusoma ndio nishakuwa na familia kwa hiyo tena ikawa nikabaki hapa na kukaa hapa na wakanikubali kubaki kwa ajili za kusimamia msikiti na nini. Sasa nimeishi hivyo2001 nikaja rasmi kukaa hapa na mpaka leo niko hapa. sasa mawasiliano na mimi na bi Sharifa mawasiliano yetu ni kwamba kabla ya kumaliza kusoma kabla za 2000 ilikuwa kila baada za miezi mitatu ninakwenda kukaa na yeye, kwa sababu inakuwa ijaza, tunafunga off kule inakuwa miezi mitatu inakuwa ninakuwa nae pamoja. Nilipoanza sasa 2000 sipati tena ile ya miezi mitatu kwa sababu siko tena skuli,niko kwenye, sasa ilipitia kipindi sasa ikawa sijenda kule nyumbani,ushaona haipungui miaka 5, kwasababu 2000 nilikwenda kwa kuoa wa ibadhi, basi sasa pale 2000 tena baada ya kwisha kuoa ikakaa kama miaka 5, nikamtolea viza bi Sharifa tukaja tukakaa nae hapa miezi minne halafu ndio akarudi, halafu ndio akaja huyu, sasa baada ya kurudi sikumbuki kwamba ni mwaka gani alikuja, lakini kabla kipindi cha miaka mitano baadae akaja na mama, halafu tena miaka mitano nikenda nilivyorudi, ikawa kila mwaka ninakwenda mwezi, na mwaka huu uliomaliza nilikwenda mwezi wa 6 tarehe 9 mpaka julai nikarudi. kwa hiyo mawasiliano ni mazuri kwa sababu yeye bi Sharifa wale wote ni watoto wake na wale watoto wote wanampenda kusema kweli. Kwa sababu hata hivi karibuni nimezungumza naye akanambia anahitajia pesa, sasa alikuwa kafuatana na mdogo wangu shadya, ushaona he, hasa nikamwambia kasema nini, akaniambia kasema hivi, basi nikamwambia basi asipate tabu kwa sababu pesa anazo yeye, lakini kampa maalim saleh, sasa anasema anaona tabu ile kuwaambia nipeni nipeni kwa hivyo anataka zile zibaki ili apewe nyengine, anaona ile muhali kama anawakera ile kwamba kila mara anahitajia awaambie kila mara. kwa hiyo fedha anazo kwa sababu hata hivi karibuni katika mirathi aliyorithi alipata milioni 16 ndio akampa huyo mtu, sasa anaona tabu ile kuwaambia nipe nipe, kwa hiyo mimi mara nyingi humwambia Ali mdogo wangu aliyeko Dar es salaam na nafikiri leo ya 5 ninamwambia mpelekee pesa bibi kidogo. Kwa hivyo mawasiliano ni mazuri japo kuwa hatuonani kwa macho, lakini na juzi nimeletewa picha na Shadya vipi hali yake, unamuhisi kwamba anadhoofu kidogo lakini mawasiliano mazuri. Kwa hivyo hakuna kasoro ambayo anahisi kuwa kuna tatizo kubwa, nahisi yuko Okay ni uzee tu basi zaidi lakini yuko safi, isipokuwa tatizo kuwa hana nyumba kwamba labda hapati wale wageni wake, kwamba yeye labda yuko private house akapata kuwaalika marafiki, yuko kwa mtu kwa hiyo anaona muhali kwamba sina watu kunitembelea kwamba mimi naalika mtu, lakini watu wanakuja kumtizama, lakini mawasiliano ni mazuri na simu kila ikiharibika tunampelekea nyengine, kwa sababu simu wanazichezea wale watoto. Bi Nasra huyo unaemuona ndugu yake ana simu zaidi ya miaka mitano au sita haijaharibika, kwa sababu anaitia kwenye kipochi anaifunguwa basi, lakini yake yeye zimeshakwenda nyingi na nyengine zinaibiwa halafu, mara nyengine anakwambia simu zake imeibiwa sijui nani kaichukuwa, kwa hiyo mawasiliano sina matatizo nayo na wanaokaa nae wanamhudumia vizuri, kwa sababu yeye asili yake tokea mwanzo hana ubaguzi, na kuja huku anasema hawezi kusafiri anasema yeye mzito hawezi."

> Omar: My responsibilities are to be honest whatever she needs. We are pleased to fulfill (whatever she wants), putting into consideration what she has done to us, we will be imperfect if we don't do our responsibilities to her. But we need to perform diligently, and to listen to her what she needs and to accomplish everything (she wishes).[139]

After having told us this, he started crying. He sobbed and whispered: "I really miss her." It was a very long and emotional moment. Even now, when I am writing these lines I still feel his pain. We interrupted the conversation for around half an hour. We could hardly comfort him. I experienced many emotional moments during my research in Oman and Zanzibar and this was one of the moments, which made me reflect more about these transnational relations again as different from those of relatives living close by. No matter how hard he tried to support her, to be perfect as a son towards the one who raised him and even though he did much more than others staying close by her, he felt the distance between him and her. He could not be close to her and possibly had a guilty conscience, but his specific emotions and those of all other research participants were first difficult to be verbalized by the research participants, and then to be captured in recorded interviews through us researchers.

Once we took up our conversation again, Omar, who is an imam and takes care of the neighboring mosque, explained that the Quran advises people to live with their parents and other older people, and to provide them with whatever they want without complaining. Additionally, he mentioned that one should help a mother three times more than a father. Omar aims at helping his mother in several ways, besides staying in daily contact with her, supporting her financially, sending medication and advices her for example just to relax and not to do any work or walking anymore. Omar orders Asthma medication for his "mother" from a cousin who regularly travels to India and buys it there. Bi Sharifa sends through visitors honey, passion fruits, beans and fried rice to him.

Without being asked, Omar regularly sends pocket money to Bi Sharifa since she is moving from one relative to another and likes to have some financial independence. Only from Omar we learnt that Bi Sharifa does often not use this money personally but buys gifts for others and contributes a major part of it to continue building Omar's house in Zanzibar. She wishes nothing more than to have him close. The house building is also one of the topics they always discuss, when he calls her. Bi Sharifa hopes for him to return to Zanzibar. If she suddenly needs more financial means, for example for a health treatment, he arranges for his brother in Dar es Salaam to send her the amount. The year before we met

[139] Saleh: "Na yepi unayaona ni majukumu yako kwake?"
Omar: "Majukumu ni yote kusema kweli yaani kila anachohitaji. Basi, sisi wajibu wetu kumtimizia yeye, na kwa hasa alivyofanya yeye sisi tutakuwa na kasoro kubwa kwake. Lakini ni kujitahidi tu na kumsikiliza kitu gani anahitajia na kumtekelezea kila kitu."

Omar, Bi Sharifa asked him to finance the Hajj, the pilgrimage to Mecca, so that a niece in Zanzibar and her husband could do the pilgrimage on behalf of Bi Sharifa's late parents. Omar agreed to pay for this important journey in a Muslim's life. Omar tried to convince Bi Sharifa to live with him in Muscat, but she did not want to because in Oman she could not move around independently without driving a car. Omar told me that he would like to go back to Zanzibar with his family, and once his house would be ready, Bi Sharifa could stay there with him. Nevertheless, he later on explained that it is unlikely that he and his family will go back to Zanzibar as the children do have better schooling opportunities in Muscat. Like many other caring relatives Mzee Omar is thus often in a dilemma of who in the family should get which and how much care. Especially, the financial and practical support often had to be divided among several people needing it asserting a claim to receive care (children, parents, wives).

2.2. Mzee Thaani and frail Bi Bimkubwa– Consulting, stepping in and backing up

Mzee Thaani is the 75 years old nephew of the around ninety years old Bi Bimkubwa who stayed with her late brother's grandchild and his wife and children in Shangani. He is also an extended relative of Bi Mchanga (see chapter four and five) who is living in Kikwajuni just next to his own house. She is his late uncle's wife. In his youth, Mzee Thaani was staying with Bi Bimkubwa and her husband until she moved to Pemba for some time.

Mzee Thaani's case shows representatively for many migrants, how their journeys often do not go from place A to B, are rarely following a meticulous plan and depend on other people, possibilities and coincidence rather than the initial plan of a single rationally choosing actor. Caring can be interrupted and depending on the context be facilitated or complicated. Mzee Thaani left Zanzibar in 1979, when he was 44 years old, because of what he summarized as "political misunderstandings," afterwards he was trained in hospital administration in the UK and had worked in Zanzibar. Mzee Thaani had no intention to leave Africa but wanted to move to Nigeria for a while. His aunt though, who organized his travel had, as he joked again, no idea where this was and thus just had sent him, to as he said, "anywhere," referring to Oman. He soon took on a job in the Emirates where he worked for eighteen years in the public sector of the army. As they have no system to pay pensions to foreigners, he had to leave the Emirates after having received a lump sum and settled down again in Oman where he is a national and has his wife and children, while he also has children in Zanzibar.

During the first twenty years after he had left the island, Mzee Thaani did not return to Zanzibar. He was too afraid of becoming a target of the political leaders, even when only visiting his relatives. But once Bi Bimkubwa's sister, his other aunt, became very sick, he decided to travel back hoping to meet her once again. Unfortunately, he was too late; she had already passed away before he arrived. This was a turning point, when he realized that nobody bothered him anymore. After this incident he, started to go back to Zanzibar regularly.

The first time I had met Mzee Thaani in 2013, when he was just spending again three months in Zanzibar, where he had his own house in Kikwajuni. Even though he was aged himself, he had a younger appearance, was walking around to meet relatives and to organize the reconstruction of his house. Sometimes when he came to visit Bi Bimkubwa, who was slightly demented, she had forgotten that he lives in Oman. He was joking that he came to Zanzibar to prepare his legs, as on the island he enjoyed walking around by foot. I heard this not only from Mzee Thaani, but this was a common narrative when comparing the two places Zanzibar and Muscat. To walk around is not common and often not possible in Muscat, a bit due to the strong sun there, but mostly because it is not usual to do so. There are only few sidewalks and most Omani take their cars also for very short routes. Like many, Mzee Thaani told us that he would like to spend his elderhood in Zanzibar. The place, where he could speak Swahili, "his language" and not Arabic, which I had the impression, Mzee Thaani was not mastering a lot, possibly due to his long stay in the UAE, where English is widely spoken. In practice though, I never met anyone who settled back to Zanzibar after having lived for years in Oman. While most Zanzibari-Omani referred to Zanzibar as a poor but natural and healthy place, where people could move their bodies and fresh fruits were available, many Zanzibari on the island imagined or described Muscat as a place of affluence and having a good health system, where health could be maintained and in case of disease could be treated. Nevertheless, as we will see later, the Zanzibari-Omani I talked to did not only make a point of highlighting positive aspects of Zanzibar, but were also worried about neglect of the islands condition in terms of politics, infrastructure and waste management. They also were aware of the rising costs of living in the city of Zanzibar and explained that people would be suffering because of this.

Because Mzee Thaani does not receive a regular pension, he was a bit embarrassed not being able to support his relatives in Zanzibar better financially. Through a local agent in Zanzibar, he was usually just sending some money to Majid, Bi Bimkubwa's grandson, who then was in charge of dividing it. This seemed to be his strategy to disguise the exact amount and individual requests for support or as he said, "to avoid questions." He was thus helping her, but not regularly. He gave medicaments to someone to bring it to Zanzibar, if they were not available there.

Shortly before I had left Zanzibar to travel to Muscat, Bi Bimkubwa had problems to swallow. She was not able to eat anything anymore, and there was a constant danger for the very frail and slightly demented older woman to choke on something and to lose more bodyweight, even though she was already very thin. I was wondering what Mzee Thaani and his brother in Oman had heard about this situation. During the interview in Muscat, he told me that mostly he calls Majid, with whom Bi Bimkubwa stays, to get

to chat with her almost every week "just to please her." If there "is happening anything" they also call him. This was the moment I wanted to dig deeper[140]:

Sandra: Do you remember in what cases they called you? Can you give an example?

Mzee: When she was sick. I don't know what was wrong with her but she could not eat, they informed us that her condition was not good. In that time, I was in England (to visit his siblings). She (Bi Bimkubwa with the help of Majid's wife) telephoned me and told me her condition.

Sandra: And what did she say?

Mzee: They (Bi Bimkubwa and the relatives with whom she was staying) were just informing all of us in here. They keep close contact with us. Because they are not supposed to do anything without our knowledge. And mostly they regard us as elders, so they must seek advice from us.

Sandra: And what kind of advice did you give?

Mzee: When she was sick, I advised Majid straight away to send her to hospital or to bring the doctor at home to see her and we sent some money to support them, it is our burden not their burden, she is our mother.

Sandra: If you say "our" whom do you mean?

Mzee: Me, Hafidh (his brother in Muscat) and our cousin here, those who are here in Muscat and those who are in England.

He further advised Majid to let her blood be checked and to go to Dar es Salaam to get better treatment. It was usual for him to be contacted by his relatives, who live with Bi Bimkubwa if they have anything to decide about her situation. Without being prompted, he provided different ways, in different moments of the interviews, how he explained this fact: On one hand his relatives would perceive him as knowledgeable in medical affairs, and on the other hand he was an elder who needed to be contacted for major decisions. Mzee Thaani was thus caring for Bi Bimkubwa through sending money and providing advice concerning her health. To Bi Mchanga, the other older relative in Zanzibar I have been accompanying, he was bringing small gifts only during Ramadan. While Bi Bimkubwa nowadays was not sending anything to Mzee Thaani, other relatives, like those she is staying with, do so. When they came to Oman they brought for him especially foods like *achari* (Hindi for pickles, usually dried, red colored mango slides), *ubuyu* (candy baobab seeds) and *shokishoki* (rambutan) or as he said "the things that we miss here (in Muscat)."

By emphasizing that Bi Bimkubwa was their mother, Mzee Thaani was referring to norms of kinship and intergenerational relations as contextual factors, which are tightly interwoven with Islamic norms. He even articulated norms of Islamic faithfulness as a context of action: "The religion forces us to take care of our relatives, those who are near us, our parents." For Mzee Thaani, like for many Zanzibari and

[140] With Mzee Thaani, like other highly educated men who were typically sent abroad for studies and finally migrated to Oman, I could thus speak English.

Omani, it was clear that the generation of Bi Bimkubwa's children, which included her nieces and nephews to whom he belonged, was responsible to take care of their mother and that this was not the duty of the generation of Bibi's grandchildren. He also articulated that actually the daughter of Bi Bimkubwa would be the first responsible but gave directly explanations why she can be excused, if she was not supporting her much: She was older than Mzee Thaani, and thus he needed to help her, further she lived in a rural area of Zanzibar and had not much to offer in terms of financial support. He did not mention that she was a woman as a valid reason to provide less, but it is culturally and based on Islamic values accepted that women do not necessarily have to contribute financially, even though it is appreciated and especially for women living abroad a way to compensate their absence. Normally, women, especially as daughters, are expected to rather be with an older parent in person. But as we have seen, even if this discursive formation exists, in practice the duty to help or - how many relatives framed it - the "right to help" often differed from the norm, which had a clear order of responsible people, by going down the ladder of the "rightholders" to those who are able and willing to help.

2.3. Practices of transnational care

As we have seen in these two cases, within transnational spaces of aging and caring various forms of care practices circulate between older people in Zanzibar and their relatives or acquaintances abroad. As Kleinman and van der Geest aptly noted, care has "various shades of meaning" (Kleinman and Geest 2009a, 159) and especially in transnational social spaces, caring cannot be of a physical kind as when providing practical support for an older person in the person's house (such as preparing food for this person or helping him or her to bath). Through distance and national borders, other forms of care become important, as for example, emotional and moral support (Baldassar and Merla 2014a, 49). Tronto's distinction between *caring for* and *caring about* can be helpful here to emphasize that when care is delegated to a third person or an institution, the family member may still be "caring about" (Baldassar and Merla 2014a; Tronto 2001). Therefore, if emigrated children or other relatives do not have enough means to financially care for their parents, they can still care *about* their parents. In the following examples, I show how practices of mutually caring for and caring about are performed between relatives abroad and their senior relatives in Zanzibar. The range of practices and intensity in which these practices were performed were diverse.

2.3.1. Sending money: Financial remittances

In both cases I have presented above, financial flows go from Oman to Zanzibar. Constant remittances, which were made either to the family/family members or directly to an older person, enabled older Zanzibari to live with a higher standard of living and thus, almost all the houses of the research participants with relatives abroad, were in a better shape. Many older women told me that they appreciated to receive their own money, even if it was not much, but to make sure they could contribute

small things to the household and not being forced to ask for every single piece of soap from the people they stayed with. The around fifty years old Bi Shenuna, who was staying with her older deaf mother, Bi Mgheni in Kikwajuni, explained once the effects on her mother's self-determination through the remittances she received:

> She is taking care of herself, she is eating well, she is eating what she wants, at breakfast time you can't force her to eat this or that, she is telling you what she wants, and she is having money from her grandchildren who are staying abroad, she is not waiting for your (referring to herself) money to buy what she wants, when she is feeling sick, she is asking for medicine, but if you don't have money she is giving you money to buy her medicine. For the lunch, she is choosing what she prefers to eat, like recently she asked me to buy pizza for her, sometimes chips, if I don't have money than I am telling her that I don't have money and she is giving me money to buy what she wants. Like today, she gave 10,000 TZS to her grandchild to buy painkiller for her.

Some of the remittances were sent regularly, comparable with a pension, others received money in special situations, typically if a health crisis needed to be tackled, a house needed a renovation or also just sporadically, if Zanzibari-Omani came for a visit, or during an Islamic Holidays.

Related to the sending of money is the practice to send money to build houses. In Zanzibar it was common in at least three ways: First, to improve the standard of living for an older relative, secondly, that a Zanzibari-Omani has built a house for the time he was in Zanzibar, or thirdly, relatives were hired to organize and oversee the construction of a house, as an investment, that later on would be sold. Besides, in Stonetown and its surroundings, and in a small village of the east coast of Zanzibar in Bwejuu, many Omani Zanzibari are having luxurious houses, enjoy the cooler months of June and July there, when the temperature in Oman becomes unbearable (Verne and Müller-Mahn 2013, 85).

2.3.2. Sending Goods: Material exchanges

Many Zanzibari-Omani and older people in Zanzibar sustain material or financial ties, which often go in a unidirectional way from Oman to Zanzibar. Gifts that typically flew to the older research participants in Zanzibar were mobile phones, perfumes and clothes (like *kanzu*, *buibui* or *kanga*). I found it especially astonishing that, what is usually perceived as a specialty of Zanzibar, the women's clothes khanga, with its imprinted Swahili poems, were sent from Oman to Zanzibar. These khanga were actually produced in China or India for Zanzibari or Swahili people more generally, and sent through Muscat to the island. Relatives abroad sent also medical aids (like blood pressure gauges or crutches) and medicaments. Sometimes goods were transferred between the places through relatives or friends. I also heard of some people who had friends at the airport who could (kind of) smuggle in good into airplanes if there was enough space or they just trusted travelling Zanzibari, whom they talked to at the airport, if they knew a flight was leaving for Zanzibar. Often though, Zanzibari-Omani also used companies, which made the material exchange between individuals in the two countries to their business

model. They have specific points in Muscat, where people bring their goods to and then again pick-up stations in Unguja and Pemba, where usually a younger man of the family was sent to receive the goods and distribute them among the relatives. Zanzibari on the other side, brought along mostly fruits, sweets, snacks, honey and other specialties from Zanzibar, as we have already heard it from Mzee Thaani.

Some tried to make these relations beneficial for both sides by involving personal business. I heard from several research participants who invested in Zanzibar, for example in building a store for a relative, or facilitating the trade of electronic goods or clothes. But often Zanzibari-Omani became frustrated in how their money and business "disappeared." Also Verne and Müller-Mahn described how often these business relations failed, as the people in Zanzibar have to use the money for more urgent purposes instead (Verne and Müller-Mahn 2013, 86). This indirectly contributes to my argument that especially during times of health crises, relatives abroad become crucial in care-giving, even if this happens not always purposively from the side of the Zanzibari-Omani. Zanzibari-Omani did not only invest in businesses with relatives but they also supported the *umma* (public or religious community) in Zanzibar, especially in rural areas, more generally. They financed the building of mosques or sent money, *kanzu* and generally clothes for the "deserving poor" (among them many older people) or dates to mosques. The research participants in Oman told me how they often share the costs of containers full with such material to be shipped to Zanzibar. Usually, one of the organizers, including women, then used the opportunity to travel to Zanzibar to oversee the distribution of the sent goods, and at the same time to visit relatives.

2.3.1. Flows of people: Travelling, marrying and dying

To visit each other was one of the main and most important practices of caring about an older relative. As we have seen in the two exemplary cases, travels were organized to both places. All the people I have met in Oman had several guest rooms, and I was impressed by a culture of hosting I had never experienced in any other place I have been to. First, I was confused about all the small signs of attention they gave me in the three households I have spent the two months in Muscat. I felt like a queen in very friendly and familial hotels, where everything was cooked, cleaned and served to perfection. And not only this, I was often not able to convince my hosts that I could use public transport or a cab, and I was driven about all over Muscat. Only after some time, when I met in literally every household guests from Zanzibar of all ages and gender, I slowly understood that this was not only me who was spoilt but many Zanzibari who spent two or three months there on a family visit visa. While many older Zanzibari went to Muscat if they still felt strong enough, others were deliberately taken over once they were sick and needed special treatment, which was either better or cheaper in Oman than in Zanzibar. The treatments were actually often cheaper as the older people from Zanzibar were slipped into the health system of Oman, because residents of Oman pay only a symbolic fee. The research participants explained to me that if the elder people look Omani, which meant not to dark and "typically African," they were normally

accepted without any ID card. They further added that it was also typically common that older people only spoke Swahili and not Arabic, and thus could make use of the medical services undetected.

Most of the research participants in Oman visit Zanzibar once a year. Compared to the salaries and costs of living in Oman, a flight to Zanzibar was for the majority bearable. At least for those, who migrated between the 1970s to the 1990s to Oman, it was legally relatively easy to travel between the two places, because they were also in the meantime naturalized in Oman and could enter Tanzania with a visitor's visa. In Zanzibar, the visitors stayed either in their own house or with relatively affluent relatives. As I have argued earlier on in this dissertation, this aspect contributed to a reinforcement of unequal care relations as those Zanzibari who had little to offer, for example in Chumbuni, could not host relatives and thus not create virtual debts in the reciprocal system towards their visiting relatives, and it was more difficult for them to keep in touch with their relatives abroad, even if these came to the island in person.

At first glance, you might be wondering, why I mention marrying and keeping love relations as transnational practice, in relation to care for the older: It is common that men who migrated abroad tried to find a wife in the country of departure and bring her to the new country of residence (Levitt and Schiller 2004, 1016). This has been the case for many of the women whom I had met in Muscat. It seemed to be an ideal match for the husbands and wives, who often were distantly related. Zanzibari women had a reputation to be especially beautiful, had the desired cooking skills, and the marriage union also kept alive the familial relations between the two places. Already in Zanzibar, I had observed how some young women, talked about desiring to have an Omani husband, who could support them and their family's life financially more easily than most men living in Zanzibar, but also had a reputation of being well-educated and not beating women. The visiting men coming from Oman were ensnared by Zanzibari women, who wanted to have their phone numbers and after the physical encounters, months of virtual encounters, chatting through mobile phones, could follow. While many women moved to their husbands in Oman, others remained – often as a second wife - in Zanzibar. More than once I heard behind closed doors, that these relations were not always formalized, but were sustained and more or less tolerated over years.

This practice is connected to caring about older people, as on one hand this often strengthened ties between relatives in the two places, if a cousin or another relative was married, and that was something, most older people in Zanzibar favored. On the other hand, no matter whether the spouse or lover moved to Oman or not, this practice usually lead to more exchange, be it financial or personal between older Zanzibari and people in Oman. Thus, some Zanzibari-Omani combined in their regular visits to Zanzibar a multitude of interests, as well as duties, and one among the many was visiting and taking care of issues related to older Zanzibari relatives.

Another care practice I did not think of in advance were travels due to attend funerals. I have learned that not only people from Oman travelled for funerals to Zanzibar, but that especially older men from Zanzibar, who were feeling strong enough to travel to Oman, had to fulfill important roles as elders during the funerals. Additionally, they were for example taking decisions related to the consequences of the death, like settling the inheritance. The following example will illustrate this practice:

The sad coincidence was that my host Salem in Muscat, who was in his mid-forties lost his 40 years old brother, who lived in the next street, in the weeks of my visit due to a sudden, unexpected death. I had met this brother, his wife and children, already occasionally, usually when we went over to Ali, another brother of Salem and their frail father close by their house in an outer neighborhood of Muscat. Once early in the morning, Salem came knocking at the door of my room and told me about his loss. Of course, nobody had expected anything like this and at moment's notice everything needed to be organized within few hours for the funeral and especially for the family he had left behind. According to Islamic norms, the funeral needed to take place within the following twenty-four hours. After having informed all relevant relatives in Oman and Zanzibar, Salem booked quickly several flights for different older relatives from Zanzibar to come to attend the funeral or at least to arrive shortly after for the mourning period, as already the flight time would take six hours. Salem was especially concerned about the presence of one older man from Zanzibar: their uncle (his father's brother). Without him, they could not take any legitimated decision as he was the oldest close male relative. Once he arrived, they could decide for example how they share the financial care-giving in the future for the widow and their children, one of whom was highly pregnant, who did not have any income on their own. Thus, while the (older) men were holding meetings, the three-day funeral took place at the house of Ali. It was a huge funeral. I could not count how many mourners have been there, but it must have been several hundred people, who passed by during the next three days. Most mourners were speaking Swahili and residing in Oman, some were already in Muscat as visitors, and others came especially because of the incident from Zanzibar. The women were not wearing the black scarves as usually, but Swahili *kanga* with comforting sayings or prayers imprinted. The mourners were reciting the Quran (as in Zanzibar) in Arabic, while sitting on large mats in three big living rooms of the house. All visitors went to the close relatives to offer their sympathies. Besides, they chatted about other news and gossip. Large quantities of food, which the women in the house had prepared, were consumed. Obviously, this sudden death was shocking and very sad for the deceased's family and friends. If he had lived just two weeks longer, he could have carried his first grandchild in his arms. Nevertheless, the funeral with the involvement of many Zanzibari showed, how also in Oman in times of sudden crisis, transnational networks could be quickly activated. Additionally, it illustrates, how an older man, who sometimes received financial and medical support from his relatives in Oman, suddenly turned into a care-giver, which highlights the volatile character and problematic divide of care-givers versus care-receivers, I challenge throughout this dissertation.

2.3.2. *Exchanging ideas and giving advice*

As we have seen in the two cases as well as in the example of Salem's brother's funeral, transnational care does not only involve the exchange of financial resources and goods. Transnational caring does include the communication of ideas and practices "associated with other societies (…) adopted and adapted by various social actors" (Coe 2017, 543). Exchanging gifts is thus more than purely exchanging material goods as these goods carry also immaterial values. One example is the sending of the white kanzu, the garment faithful men wear in Zanzibar on Fridays and in Oman throughout the whole week - even if not on purpose – is bearing meaning of Islamic religiousness and reinforces related Islamic values. The same is true for example for gifts at the end of Ramadan, the mentioning and honoring of Zanzibari-Omani who financially supported mosques or enabled their older relatives in Zanzibar to do the *Hajj* (pilgrimage to Mecca), gifts which are very common and welcomed.

Exchanging ideas also includes giving advice for example in cases of ill health and difficult situations such as loss of a family member. Also through medical remittances and other gadgets associated with the improvement of health (for example medical equipment such as blood pressure monitors, e-cigarettes, walkers or medication as for example painkillers) circulating within transnational spaces, ideas about practices of care and health in old age travel along with it. Kaiser-Grolimund has shown in more detail how global policy concepts such as "successful aging" (Rowe and Kahn 1997) circulate with transnational care – in her case between Tanzania and the USA (Kaiser-Grolimund 2018) - and can be mirrored in older people's aging practices somewhere else. Recommendations of how to deal with aging, health or illness and the aforementioned medical equipment were sent with particular ideas and ideologies over national borders (Yeates 2011, 1126).

2.3.1. *Transnational technologies and virtual care practices*

Baldassar and Merla claimed for a broad definition of care that also encompasses virtual forms of "caring about" (Baldassar and Merla 2014a, 40). Especially Information and Communication Technology (ICT) can facilitate virtual forms of care-giving and enable what can be called an "ICT-based co-presence" (Baldassar et al. 2016, 134). Thus, it makes the presence in the country of origin and in the country of migration at the same time possible. Baldassar and Merla described the product of the emergence of new media, including social media platforms and smartphones. Madianou and Miller were introducing the concept of polymedia environments, which they defined as "the new emerging environment of proliferating communicative opportunities" (Madianou and Miller 2012, 8).

Through phone calls and the use of social media, Zanzibari-Omani and their parents and other relatives in Zanzibar remained potentially connected.[141] The range in the use of ICT was very wide among older people in Zanzibar town as well as in Muscat. While some older people had no mobile phone at all (most of them living in Chumbuni), and few older people in Zanzibar had access to a smartphone, others were involved in sophisticated ICT arrangements. Those who had access to smartphones used them to have video-calls, for personal chats, sending pictures, not necessarily photographs but pictures often with wishes, wisdom or prayers. One older bedridden woman in the city of Zanzibar for example had a tablet installed over her bed, by which her son in Oman, an IT-specialist, could surveil and chat with her round the clock. But even though some researchers argued that new communication technologies have transformed the migrant experience from one of disruption to one of ongoing intimacy across distance (Wilding 2006), having Mzee Omar's example in mind, virtual care practices are still limited compared to actual co-presence, especially if an older person is not able to use the necessary devices on her/his own and needs to rely on others, is frail or demented or obviously if a person has no access to such polymedia environments.

2.3.2. Medical remittances

Medicine that travels between two countries is described by Zanini et al. (2013) as "medical remittances." With that concept the authors indicated "the circulation of medicines within personal networks, which also rely on the disparities in income and different therapeutic options available in the respective national and social context" (Zanini et al. 2013, 15). Zanini et al. (2013) base their concept of medical remittances, which they understand as taking place in what they loosely define as medical spaces. They have built their concepts on what Kane (2012) called flows of medicine, and Pribilsky (2008), who uses the concept but rather as a descriptive notion without a closer definition of it. Medical remittances (Zanini et al. 2013, 15) encompass many of the above mentioned elements. The expectation, that family members abroad should help especially in times of emerging health crises, when advice or a treatment (medicaments, operation) was needed, was fulfilled by many relatives of the research participants. Often, relatives abroad were the ones who organized and paid medical treatments, operations/surgeries, medical aids or a housekeeper to unburden an older person from household activities. Some sent medication, because those in Zanzibar were not trusted, as they could potentially be fake medicaments coming from China. One Zanzibari-Omani also told us how he had organized a physiotherapist for his mother in Zanzibar. I had never met a physiotherapist on the island before and even to think of physiotherapy in the contexts of Zanzibar, where I have done research, was rare and reserved to those people having access to cosmopolitan or transnational spaces. What I heard several

[141] Kaiser-Grolimund and I have published on the use of the mobile phone application *whatsapp* and its consequences for doing research in the given context in more detail elsewhere (Staudacher and Kaiser-Grolimund 2016).

times though, was that relatives abroad organized and paid for surgeries, either in Dar es Salaam, Kenya or in India. In Muscat many of the research participants ranked health facilities in India much higher, than those in Oman, even though medical staff told me that the health system in Oman was better or at least very good compared to India. An older research participant in Oman, whom I had accompanied to a health facility, deliberately chose one of the many Indian led health facilities in Muscat. That transnational migrants use multiple health systems with the help of "personal networks and their knowledge about, and entitlement to, more than one national health system" (Zanini et al. 2013, 14), is well documented (Kane 2012). The imagination of older Zanzibari that abroad in general one can expect a better health system and diet, adapted to individual health problems, and that thus people can become older, let many older people ask their relatives abroad to bring medicaments and lifestyle products like sugar surrogates or vitamin pills.

2.4. Agents of transnational caring

As I have introduced in the historical part of this chapter, the majority of relatives living in Oman, stayed there since the 1970s or 1980s, had the citizenship of the Sultanate of Oman, and many were state employed, and financially and educationally privileged compared to other Omani. In Oman no double citizenship is allowed, which means that they had to give up their Tanzanian nationality. After a period without direct contact to their relatives in Zanzibar, and based on memories about the islands, they consequently managed to overcome the difficult times of their arrival in Oman and had time to establish themselves economically. This enabled them from the political opening of Zanzibar onwards to provide care for their older relatives, who still reside on the island. Even though, I do not speak Arabic, it seemed to me that most other Zanzibari-Omani I met in Muscat were fluent in speaking Arabic. There was a clear gender and status gap, with many middle aged and older women as well as the more recent immigrants from Zanzibar, who spoke less Arabic but continued speaking and living in Swahili communities.

A second and smaller group, at least in my perception, were Zanzibari migrants, who were "temporarily employed" mostly by their "well-established" countrymen, often people with whom they are distantly related. Normally they travel to Oman with a short-term visa, or since immigration became more difficult, sometimes also with modified identity papers. Because their stay was short-term, they rather focused on accumulating money for example, to pay for their children's education or to build a house in Tanzania, than sending it home and to older relatives on a regular base. Many of them had hardly any contacts outside the household they were working in. Usually, they did not know Arabic and were off work only half a day per week or even every second week. They had to adjust their transnational caring practices according to their financial possibilities, which usually meant to have relatively contact with older relatives and provide only little care in situations of crisis. Most of whom I had met for example had a regular mobile phone, which was very expensive to use internationally.

The first generation returnees, the Zanzibari-Omani who had lived for sometime in Zanzibar and then migrated to Oman, clearly maintained stronger relations to people on the islands as compared to their children, the second generation after the immigration, who sometimes not even once have travelled to Zanzibar, even though their parents may go there annually. Possibly due to how this research project was set up, in Zanzibar it occurred less as a topic to have relatives in Oman, then it was the other way around in Oman. As I already mentioned, I also prompted the people in Oman directly about their relations to older relatives in Zanzibar, while in Zanzibar transnational care was just one among many other aspects of a care arrangement.

As I have depicted in a previous methodological note, it was more difficult to find out about the ones who do not care for or about their older relatives, than those who do. Accordingly, mostly I heard of positive examples. In general, older people in Zanzibar expect their children and younger relatives to support them no matter where they are, but even though many younger people abroad help their parents, not all offspring do: Talking about her children abroad Bi Mchanga, who is also an extended relative of Mzee Thaani said:

> They (my children abroad) make calls to me. Sometimes they send money for food and then they inform me through mobile phone to go and collect the money. (They call me) after every two weeks, but specifically one among my children (abroad). The other one is jobless, even his life is not good, and again another one does not care about his mother, my first born. He does not care even that he was born. All people come, they call him, they inform and tell him about me, and they tell him that he needs to greet and even visit his mother in order to succeed in his life but I always pray for him so that he can change his attitudes. But now at least he sends some money if he has information about someone in the family who is sick or in case of a problem.

Bi Mchanga, who stays in Kikwajuni, narrated about her frustration not because of her first born did not send anything back home, but she complained that he forgot her as a mother. By saying that he would not succeed that way, she was implicitly referring to Islamic norms, where figuratively spoken, paradise lays under one's parents' feet. Similar to care relations when caring is based in the same locality, not cultivating these relations over distance can lead to a process of de-kinning (Schnegg et al. 2010, 24).

As to analyze the involvement of different agents in a transnational care space, I would like to emphasize the concept of triangles of transnational care Kaiser-Grolimund (2017) has introduced, in which the older people who did not migrate themselves, their spatially close-by, or otherwise said co-present care givers, as well as their relatives abroad are connected. This concept is underlying the assumption that transnational old age care circulates asymmetrically between the different places (Baldassar and Merla 2014b). The perspective of a triangle allows to analyze transnational care from a holistic perspective,

not only including the lived experience of one part of the transnational arrangement (usually older migrants or care-givers in the Global North), but of several involved parties (i.e. also the "non-migrants" (Baldassar, Baldock, and Wilding 2007b, 14), the older people and their relatives) connected over distance through translocal and transnational aging and care spaces.[142] There are usually not only one caregiver abroad and one care receiver "at home," who exchange care in one direction only, but people living physically close by the older people oversee and facilitate caring between older people and their relatives abroad. Like Mama, the daughter of the niece of Bi Sharifa, who is the one who engages in the practical and technical elements of care. By "being there" Mama and other people staying close-by can provide practical forms of care and closely observe the health condition of an aging parent. They provide information for those far away, like Omar, which is crucial as often not all aspects are exchanged over the phone when the older person is not telling the migrated child every detail, for example about the health condition. In addition, they were also important facilitators when flows of goods and money arrived in Zanzibar, since the travel of financial support but also gifts or medical equipment has to be organized by somebody trustworthy on-site. If Omar wanted to financially support Bi Sharifa, he contacted his brother in Dar es Salaam, who served as an interlocutor. Furthermore, these "observing eyes" (Kaiser-Grolimund 2017) support the communication between the older person and the relative abroad through their knowledge of the new communication technologies, such as WhatsApp, Skype or Viber. Also, to facilitate the interaction of Bi Sharifa with Omar, Mama took care of the older woman in everyday life by providing a mobile phone or organizing the visits of her brother to her house. Due to their involvement in care provided by Zanzibari-Omani to their older relatives in Zanzibar, it became evident that transnational care circulates among several family members involved, as it was brought forward by the authors Baldassar and Merla (2014d). The authors argue that transnational care cannot be seen as one-directional, traveling only from the migrated relatives to the home country, but it rather circulates among several family members in different locations.

Looking at the different agents involved in the creation of a transnational space, I argue that it is first important to consider the context in which the older Zanzibari and physically co-present relatives or acquaintances live, like the area they stay at, the financial or cultural capital they can rely upon to maintain relations over national border. This context of action is highly relevant to understand their kinning or de-kinning with relatives abroad. Second, we should take into account the economic and legal situation of the caring relative abroad (Lutz 2018, 585). For those, who came to Oman as housekeepers or henna painters, it was hardly possible to acquire enough means in order to send back regular support due to low-paid jobs. The social and legal position of the group of irregular, illegal or undocumented migrants is "one of almost total exclusion from rights and entitlements" (Vertovec 2007, 1039), while

[142] As Wilding and Baldassar state, "[t]he image of the 'left-behind' elderly abandoned by their migrant kin is becoming increasingly anachronistic" (Wilding and Baldassar 2018, 230).

some migrants of the first generation had enough time to establish themselves in Oman and are nowadays in advantaged positions and able to engage with older relatives in Zanzibar in transnational spaces of aging and caring.

3. Crystallization of Transnational Moralities

As we have seen in the examples of the transnational practices, Zanzibari-Omani have been living for decades in Oman, but still "care about" and feel responsible to "care for" older family members in the city of Zanzibar. Building on the concept of local moral worlds (Kleinman 1992, 128-30), I have introduced earlier, I argue, that presented transnational practices are shaped by transnational moral worlds to which the involved actors relate to as a context of action.

Relying on past experiences of social norms of reciprocity and filial responsibility, and imagining a future of relying on one's (family) network, the older research participants in Zanzibar often mentioned two preparations they made in hopes of receiving care one day: first, they showed their children how to take care of people; and second, they taught their children how to be faithful, respectively good persons (*watu na imani*), which entails following Muslim faith. This education was viewed as helpful independent of whether the children stayed in Zanzibar or moved abroad. The relationships between older Zanzibari and family members in Oman were reciprocal: Both sides contributed to sustaining the relationship. But it was clear that, at least in elderhood, this reciprocity became asymmetrical, and the Zanzibari-Omani usually contribute more, especially financially, to the care relationship.

Even though morality is for many anthropologists at the core of caring (Kleinman 2006, 2012; Mol 2008; Geest 2002; Livingston 2003), rarely it is looked at what happens if moral aspects of aging and care are negotiated over national boarders in a cosmopolitan and transnational context, while having in mind that many aspects of caring are habitual and embodied as Aulino (2016) argued. In the following, I will elaborate how I came to the conclusion that discursive formations of reciprocity, religious duty, and nostalgia bridge long distances and foster transnational caring. Moralities of care that are neither located in the city of Zanzibar nor in Muscat, but are (re-) created in a transnational space of ageing and caring.

It is not astonishing that one moral element in these transnational care spaces was reciprocity, which is a well-established aspect of caring between generations, as for example Geest illustrated for Ghana (Geest 2002). The relationships between older Zanzibari and family members in Oman are reciprocal, and thus, both sides contribute to sustaining the relationship. The older research participants in Zanzibar mostly understood obligations to transnational caring as resulting from the education of their children and from their familial relationships, which created expectations and duties for both sides. Even though it might look at first glance like older urban residents were just receiving this care over a distance, these

transnational spaces result, as we have seen in the two cases of Bi Sharifa with Mzee Omar and Bi Bimkubwa with Mzee Thaani, from interactions and exchanges between older Zanzibari and their relatives abroad, which grew over decades. At least in elderhood though, this reciprocity became asymmetrical, and the Zanzibari-Omani usually contributed more, especially financially, to the care relationship.

The moral concept of reciprocity was not only observable on an individual level between relatives but also tying together the two places more generally. For example, the discourse of mutually building up each other's places, was present in Zanzibar as well as in Oman. While in Zanzibar Omani were said to have built up major parts of the city, in Oman the research participant reiterated that the ("returning") Zanzibari-Omani "modernized" and have built up the country where they have seen "only desert" before. Even though, given the historical context of displacement, this mutuality could be interpreted as a kind of delayed reciprocity.

A further aspect of the shared moralities in these transnational spaces constitute of discursive formations about religious duties and ideas between family members as well as towards older people in general. When I talked to older Zanzibari and to relatives in Oman, during almost every interview or informal talk about care-giving they referred to how to behave well. When I dug deeper, it was commonly explained with religious duties, that being for example a good son, means being a person who behaves as a good son according to the Quran and the Hadith. Very common were the views that older people have to be respected, and that one should not contradict elders. Many relatives described the care giving for older relatives not only as a duty but rather as *baraka* (a blessing, luck or a gift). The further explain the discursive formation that according to Muslim faith, one can only reach paradise by taking care of one's elders. Another widespread religious norm that was expressed, was the understanding that mothers should receive three times as much help from children as fathers, because mothers have gone through the hustle of giving birth and raising children. Research on transnational care and mother child-separation, even though usually among younger generations, showed that "differing conceptions of care and motherhood result in transnational families from different regions, communities, and class backgrounds expressing emotions about mother-child separation as they creatively enact their family repertoire in the world" (Coe 2014, 27). Understandings of care giving, which build on an understanding of Islamic values and interpretations of the world, start not only when a parent in Zanzibar becomes old and frail, but - as mentioned - begins much earlier. While in both places, people usually rely on Islamic moral ideas, they become repeatedly emphasized through religious objects and initiatives that are transferred from Oman to Zanzibar through relatives and public sponsors, who support for example the building of Mosques or through embodied norms like that every Muslim, should go on a Hajj once in lifetime.

Kresse interpreted from the common Swahili expression *dini na dunia,* religion and the world, that "proper (religiously informed) learning and understanding provides guidance to follow the right way in Islam as well as in social life" (Kresse 2013, 79). Compared to Western ideas of what I would summarize in wanting to control one's life up to the end,[143] many older Zanzibari tend to see "good aging" as a result of how they behaved in the past but also as a period in which one should endure certain challenges - being tested by Allah. Bi Sharifa for example said once: "Everything(s) are just God's plans."[144] I have already extensively elaborated on aspects of *majaliwa* (endowment, destiny; God's will) in chapter four. Aging constitutes for older people relating their actions to this concept a narrow path of agency between acceptance and resistance of bodily, mental and social changes. Thus, while challenges, including health problems and frailty, were rather perceived as fate, if one received care in such situations was then again a question of agentic negotiations, whereby cosmopolitan answers could be found eventually among relatives abroad.

What it means for Zanzibari-Omani to care for their relatives in Zanzibar is not only grounded in the discursive formation of following religious duty and reciprocal filial responsibility, but has also much to do with a feeling of relatedness and nostalgia to the place Zanzibar, where most of the research participants lived at least in their childhood. As we have seen in the first part of this chapter, these nostalgic ideas are fostered by the official representation of the relations of the two countries by governmental agents, and mirrored in the reviving transnational cultural elements, such as food, clothes, music, and more generally cosmopolitanism. In the narratives of many of my informants a nostalgic picture of Zanzibar came up. The fact that a bigger number of Zanzibari-Omani fled from the island, seems not to deteriorate their imagination of "former" Zanzibar as a place where people with different origins are said to have lived peacefully together and to have respected each other, where there existed an exemplary educational system, health services, houses and infrastructure were well maintained and corruption was not as rampant as today. Besides the flourishing former "independent" Zanzibar, my informants rave about the fresh fruits there, the healthier life of moving around and chatting in the own language, about the pleasant climate, the family members and friends and memories they have there. These memories are also nourished by food which older Zanzibari send to their relatives in Oman. Also, all Zanzibari-Omani houses I have been to, are full of drawings and handicrafts imported from Zanzibar. Further, the attendance of the funeral of Salem's brother in Muscat showed me how important it was for women to wear *kanga.* Finally, the frequency of Zanzibari-Swahili restaurants all over Muscat reflected this too.

[143] For some this cumulates in the decision and realization of one's own death through assisted suicide.

[144] "Yote ni mipango yake mungu tu."

Nevertheless, complaints of Zanzibari-Omani about the situation nowadays in Zanzibar are widespread. While many Zanzibari-Omani, who migrated to Oman during the 1960s or 1970s, claimed to have built up the Arabian country when there was no running water and electricity, a time Zanzibar was perceived as more developed compared to Oman, things have turned around. The research participants see Zanzibar as more and more collapsing, while Oman is boosted through the economic rise in the oil industry and prospers in all parts of infrastructure and public services.

Very common among Zanzibari-Omani was a guilty consciousness towards people in Zanzibar, whom they perceive to have economically much less, what constitutes an imbalance; they feel they have to bridge through offering more to them. Torn between perceiving Zanzibar as a paradise and a developing country, some also mentioned that health problems in Zanzibar and Africa generally were related to the environment's *(mazingira)* cleanliness or pollution thereof. The research participants in Oman, as Mzee Omar or Mzee Thaani, were often torn between the two places, missing the family members in Zanzibar and feeling that they cannot give to them what they would like to. Not so much concerning economic support, but rather in terms of being close, being there to visit the older relatives spontaneously.

I use nostalgia as a notion to summarize their feelings and expressions for the place Zanzibar. It fits especially well, as in its Greek origin it combines two words meaning "homecoming" and "pain." Different practices as building houses, doing regular visits and phone calls to Zanzibar, as well as trading were very common and furthered contact with Zanzibar. This was one way of keeping the possibility open to return to the island one day. The attempts to stay in contact with the place Zanzibar, which was translated into staying informed about events going on in Zanzibar, visiting the island, and regularly receiving guests from Zanzibar, fosters indirectly the care for older people as these nostalgic feelings and practices shape a common moral understanding and provide opportunities to stay in contact not only with the place, but also with the people who live there.

4. Conclusion

The findings of this chapter show how relationships of transnational caring are maintained across great distances. Interactions between relatives, acquaintances, and an older Zanzibari began long before a parent in the city of Zanzibar becomes old and frail, and are structurally facilitated by relatively liberal migration policies and the economic situation of many Omani families. Transnational links were activated particularly often in health crises or incidents. I add to Levitt and Schiller's theoretical reflections about transnational social fields and agree that "some people do not have many actual social relations across borders or rather these relations are not as visible at first, but they can enter the social field when and if they choose to do so" (Levitt and Schiller 2004, 1011). The older research participants in Zanzibar mostly understood transnational aging and caring as resulting from the moral education of

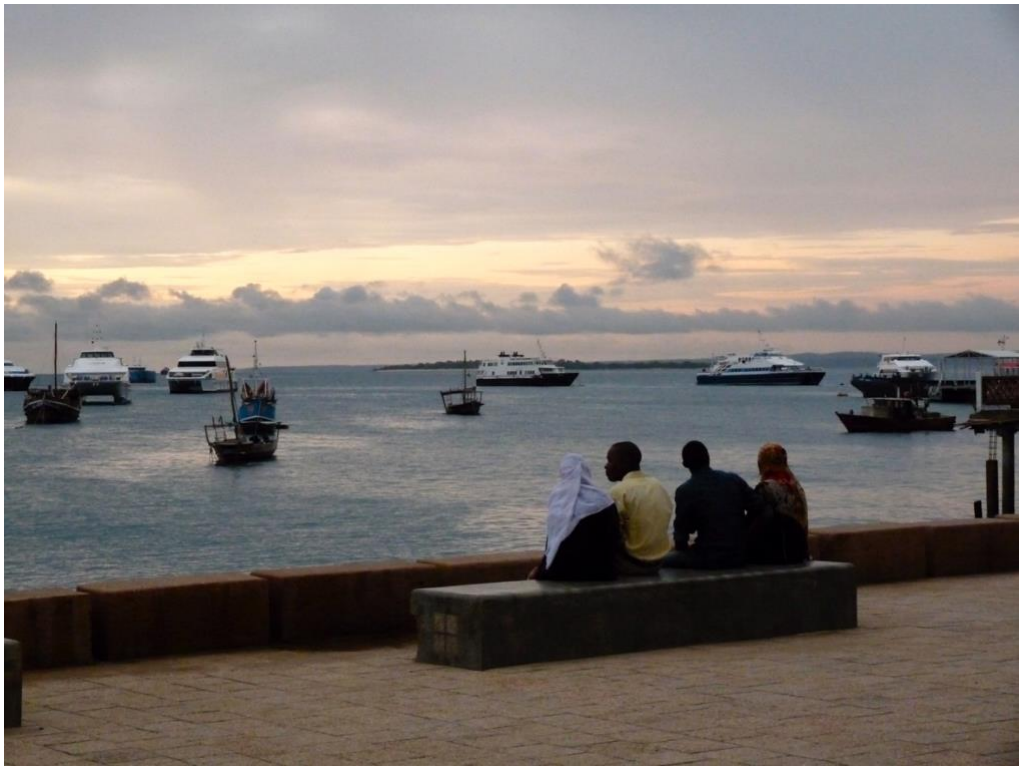
their children and from their familial relationships, based on moral concepts of Islamic faith, which implicate expectations and duties for both sides.

Over distance, relations between relatives cannot be sustained or reinforced through physical practices of caring, but the involved actors have to use other practices to create closeness and cultivate relatedness. Engagements in different forms of caring over distance are thus used to express solidarity and belonging (Baldassar and Merla 2014d, 11). Hence, despite the physical absence, a sense of "co-presence" among relatives can be maintained (Baldassar and Merla 2014d, 6) by fostering these relationships through caring. The practices I presented here can be understood as flows of people, goods and ideas (Appadurai 2003) between the two countries, and thus as transnational flows. Similarly, Castell thought of "spaces of flows" that is "the material organization of timesharing social practices that work through flows" (Castells 2004, 147), a concept he developed out of theoretical research on new media. These flows should be thought together with the context of action the different agents relate to like their common history, rhetoric of the governments in Oman and in Zanzibar/Tanzania, diverging discourse of Zanzibar as a lost (behind) paradise needing help, as well as, social norms of reciprocity, filial responsibility and Islamic faith. The interrelation of all these aspects will then constitute what I understand as transnational spaces of aging and caring.

Already in 1998, Smith and Guarnizo (1998, 11) argued for a more differentiated perspective on transnational practices: "transnational practices, while connecting collectivities located in more than one national territory, are embodied in specific social relations established between specific people, situated in unequivocal localities, at historically determined times." A holistic approach, as I have presented it, allows to not only to look at personal relations, but to include historic, social, cultural and economic societal developments in the analysis of transnational caring. It is not enough to analyze personal relations, for example by people who exchange certain goods or money like remittances, as well as it is not enough to think only of political or economic situations to explain transnational aging and caring. The private, work related and economic biographies of the concerned agents as well as the histories of the involved countries matter, as much as do cultural elements and socially grown ideas of morality. While in this endeavor, the concept of agency (Emirbayer and Mische 1998) was of use to grasp how older people and their relatives act based on their experience, practical evaluation and imagination and relating to diverse context of action, it did not facilitate the analysis of hierarchies and power relations as they actually occur in and characterize these connections (Latour 1986, 276). A future analysis in this direction might help to better understand the unequal relations not only based on different experiences but different positions of men, women, younger or older people, and other more or less privileged and powerful social groups in society.

Chapter VII:

Conclusion - Cosmopolitan Aging in Urban Zanzibar



Picture 8 – People sitting in front of the Indian Ocean in Forodhani Garden

(Public Garden in Stonetown Zanzibar).

VII. Conclusion: Cosmopolitan Aging in Urban Zanzibar

This dissertation emerged out of the context of the tension between the view that older people in Africa would live isolated, neglected and abandoned (Klerk 2018; Makoni 2008) and additional literature that presented transnational aging as a global phenomenon (Baldassar, Baldock, and Wilding 2007a; Dossa and Coe 2017a; Näre, Walsh, and Baldassar 2017; Schweppe and Horn 2015). However, how, and to what extent older people actually age transnationally (or not) and are cared for across national borders and what this means for them, has hardly been investigated to date. The aim of this study was thus to find out how aging, elderhood and care are lived and experienced in rapidly aging societies that increasingly live in cities. The historically grounded cosmopolitan reputation of Zanzibar (Mazrui and Shariff 1994; Caplan and Topan 2004) has lent itself to have a focus on cosmopolitan and transnational phenomena. The approach of studying these aspects in urban Zanzibar with a heterogeneous group of 50 over 60-year-olds offered the opportunity not only to focus on people with relatives abroad, but also to include those who did not have such relationships and thus allowed to obtain a more diverse picture of elderhood than most research on transnational aging I have read about was able to portray.

In the course of this book, I have shown a broad spectrum of practices and experiences of aging and caring in urban Zanzibar and illustrated these with ethnographic examples of older people living in four heterogeneous areas in the city. My aim was to put the older urbanites at the center of the analysis. I have pursued this goal by repeatedly highlighting various aspects of their agency. Emirbayer and Mische (1998) have pointed out the importance of structural context in addition to the temporal orientation of the actors towards the past, present and future. On the basis of detailed descriptions of the four quarters in which I accompanied research participants, I have shown different local worlds. These places provide context of action to which the older people and their social environment refer. However, with this I see some limits to the concept of agency when analyzing aging and caring. Since the concept of agency focuses on the experiences of actors, it is less helpful to capture structural and factual inequalities like social positions. Nevertheless, I showed the unequal circumstances and different character traits of the quarters in which the older people mainly stayed. The places where the research participants stayed did not only matter for example in terms of how healthy they could live, how they could move around or go to a medical facility but where they lived also influenced in how far they could keep in touch with relatives abroad or how easily they could adopt a cosmopolitan lifestyle. The different places can thus facilitate or complicate engagements in specific social spaces. These residential situations are crucial to understand how flows of people, commodities and ideas between these local worlds and other places can happen.

One of my main arguments in this book was that experiences of elderhood can be better understood by thinking with spaces of aging and caring. Understanding space as a social product, which provides both

the condition for and the symbolic representation of different types of social interaction (Levine 1979, 21), I have argued that not all older people can interact in all kinds of spaces at all times. I have introduced the concept of spaces of aging and caring because it allows to grasp especially well, not only personal networks but much more, also to apprehend cultural exchange. This allowed in addition a differentiation between transnational (phenomenon that span over two or more nations) and cosmopolitan (cultural mixing) spaces. Levitt and Schiller criticized that literature on cosmopolitanism abandons an exploration of social relations and social context and the intersection of the individual and the global (Levitt and Schiller 2004, 1008) but I on the contrary argue, that exactly this differentiation allows to analyse cultural mixing as it is prevalent in Zanzibar within its national borders.

Focusing on different health situations (being in relative good health, health crises and chronic conditions), I have shown how in certain moments, especially during health crises, interaction becomes possible in transnational spaces, while in other situations there is hardly any exchange. It makes a big difference if somebody has a long-term chronic condition like diabetes or experiences a loss of energy, which might hinder him or her in certain situations from doing what he or she would like to do on their own (*kujiweza*), compared to somebody who suffers a life-changing health condition like the consequences of a severe stroke. Such impairments require responses to aging and become urgent. The degree of health problems, impairments, or frailty thus fundamentally affects an older person's position in urban society and within transnational spaces. This shows how situational aging and (transnational) support in old age is practised. Transnational care can be lived very differently and relatives abroad are no guarantee for it. While a few are regularly in exchange, most have relatively little contact, only during crises or hear nothing at all from their acquaintances and relatives abroad.

The focus on the different health situations in which the older people are (often alternately), have above all more generally shown that elderhood is not a uniform or static phase of life. Furthermore, the health situations are also decisive for how older men and women are regarded in society, what they (can) do, how they care for others and what is done for them. Similar to the role of places in people's actions, I also found in analysing health situations that the concept of agency is only useful when thinking of the body as a context of action, which people had experienced or came to experience, but not as limiting per se (for example due to frailty or disability). The concept of agency thus sharpened my analytical eye, how older people experienced continuity or ruptures of their previous experience, how they imagined or become used to health problems. The open approach allowed me not only to pay attention to transnational aspects but also to analyse other contexts of action such as norms of kinship, piety, gender, generations or reciprocity.

A major result of this study is the unequal experience of elderhood by men and women. Depending on the health situation they are in, older people relate differently to (hegemonic) masculinities and

femininities as contexts of their actions. I showed how men's and women's lived experiences of masculinities and femininities change in old age depending on which health situations they are confronted with. I argued that a situational approach to masculinities is crucial because masculinities are experienced, interpreted and lived variably. They cannot only change during the life-course but especially through the changing of health and body, which will have an impact on many aspects of the life of men and their social network. Older men's masculinities are thus contested and jeopardized in multiple aspects. Accordingly, it is not enough to look at masculinities of older men as something, which begins at retirement (as it was often argued in European literature) but that masculinities build on a variety of experiences, are fluid, highly situational and diverse.

Older women typically related to what I call "relaxed" femininities and discursive formations of passivity. Against the representation of men in a WHO report on long-term care in Africa, in which men are depicted as no longer providing care for older people (WHO 2017, 6) the ethnographic material illustrated how being able to provide care is a main signifier of hegemonic masculinity, whereby fatherhood and masculinity are overlapping. This finding is also contrary to what has been described for the European context by Elliott (2015) as "caring masculinities," whereby what she described with this name would be just the opposite of hegemonic masculinity. The question thus is rather, what care means and as this study has clearly shown, this again is situational, an element of social organization (Thelen 2014), and not only about practices (Borneman 1997) and what care is shifts according to historical and cultural contexts (Nguyen, Zavoretti, and Tronto 2017, 200). In this research, their engagement in care spaces changed for almost all research participants in the course of the research due to their changing health situation or because children and relatives take turns in caring for an older person. Caring is thus rather a flexible practice. Generally, care-giving was reciprocal and thus mutual but not a simultaneous process throughout the life-course, rather than as a dichotomous division between care-givers and care-receivers. I thus argue to use the term caring, is to comprehend care-giving and care-receiving as one.

As a consequence of the results of this study I argue that especially in the global South – but not only there - it is important to get away from dichotomy discourses framing older people as either neglected victims of modernity or as honored and well cared for by the larger family. In this book I presented one way of analysis how older people engage in their everyday lives with others by combining an actor centered approach, analyzing experiences of elderhood holistically in different health situations and older peoples' unequal access to and engagement in social spaces. The analysis also shows that poverty as a constraining factor is important but we have to think beyond financially poor versus rich older people, when trying to understand the complex situations older urbanites are involved in. It is crucial to analyze people's interaction in localized, cosmopolitan and transnational spaces separately but to think them together, as first, many older people are involved in several spaces at once and second, not being able to access certain spaces has also consequences for how elderhood is experienced.

If we look at how older people experience their aging and caring in different social spaces, we should take their structural context, local social practices and norms, and their imagination of the future into account. Aspects as where they live, if they had relatives who migrated abroad, their economic situation, education, gender, the body and with it last but not least their health situation influenced their agency in living transnationally or in a cosmopolitan way. Considering these aspects, we can see that social relations are crucial for receiving care and that certain older inhabitants of the city are not only able to mobilize their social network on the island; they are also able to mobilize transnational and cosmopolitan agency. For many more though, the cosmopolitan Swahili spirit and the Zanzibari transnational links praised in the literature, are rather rhetorical and connected to the past then having a noticeable impact on their present situation.

The opening of Zanzibar after the socialist era and the partial privatization of the health system have not improved the diversification and availability of medical services for most people. The results of this study show that the political and economic changes had a negative impact for most older Zanzibaris. While some older Arabs, Asians, and other minorities who had not left Zanzibar in the 1960s and 1970s were able to re-establish their economic and social positions (Saleh 2004, 153) after regaining access to their family networks outside of Zanzibar — a network they had been denied access to during the twenty years of socialist rule following the revolution (Keshodkar 2013, 12) — however, the majority of older people in Zanzibar did not seem to profit from this shift. Accordingly, what I have referred to as cosmopolitan aging, thus to draw on a variety of ideas or practices stemming from diverse cultural contexts, which might be expected in a culturally mixed place like Zanzibar was consequently not self-evident. It was mainly reserved for healthy older men who had studied in other countries in their past, travelled a lot and had the financial opportunity to put these ideas into practice. People, goods and ideas circulate between places and countries but this did not at all mean for everyone to be able to translate that into life-changing consequences. I thus agree with Aboderin and Beard (2015) that aging is never just a medical issue about older people as subjugated objects in public health spheres but needs to be understood holistically as more complex phenomena.

Zanzibar as well as many cities in Africa, is currently witnessing rapid transitions related to a growing and aging population, continuous urbanization and an increasing number of older people living with chronic illnesses. In this rapidly changing context actors on all levels from older persons and their relatives up to national and international agents are struggling to handle the transforming and newly emerging issues of elder care. While in some countries' government policies call for a return to the "virtues of the past" (Geest 2018b, 21), new forms of elder care emerge. As described for Ghana, new services for older people outsourced from the family and organized by returning migrants come to exist (Coe 2017). In contrast the handful of "old age homes" in Zanzibar were described by the research

participants as a last resort. While I could not observe a tendency to build nursing homes or care services for older people in Zanzibar for now, some attempts to outsource care exist for example by relatives living in Oman who employ a nurse or a physiotherapist for their aging parents in Zanzibar, while emphasizing at the same time the importance of having someone close-by the older person supervising these services.

The importance of the possibility to engage as an older person in informal transnational or cosmopolitan spaces of aging and caring becomes especially obvious in contexts with little formal structures that offer social protection like strong pension schemes, free access to health care or support in care-giving at large. Fostered by access to new media and travel opportunities, the role of informal support networks that go beyond the local or proximate scale are growing and need thus to be further acknowledged in research and policies (Wilding and Baldassar 2018, 232). Within these networks, not only money and goods travel across national borders, but also ideas shaping (future) aging imaginations of transnational non-migrant older people. In order to explore transnational aging and connected dynamics, a multi-sited research approach is crucial as to take into account the local, national and international changing contexts as well as the diverse and sophisticated ways of being connected that are at stake in elder care over a distance within transnational social spaces. Such an approach allows for the required acknowledgement of processuality, relationality, heterogeneity, situatedness and thus, the making and unmaking of social relations in aging and caring.

Glossary

A

adabu

Good manners

afaya

Free health

afya bure

Slogan of free health care which was advertised by the government on TV and radio in Zanzibar. Literally

Alfajiri

Islamic morning prayer around 5 a.m.
Morning prayer

anaependa

The person who would like to

Asalaam Aleykum

Islamic greeting

B

babu

Older frail men

bara

Tanzania mainland

baraza

Cemented benches in front of the houses

Beit al Ajaib

House of Wonders, which was built in 1883 for Barghash bin Said, the second Sultan of Zanzibar and was at that time the first building with an elevator in East Africa

Bibi Bomba

A popular TV show in whole of Tanzania

boflo

White tin loaf bread

Bububu

A town located eight km north of Zanzibar City on the island of Zanzibar ,

buibui

A long dark veil often with glittery and colorful embroidery over their clothes to go out

C

chai

Breakfast, literally meaning tea

chakula kizuri

Good food

Chama Cha Wananchi

Civic United Front (CUF) is the main opposition and a liberal party of Tanzania

chini

Lower

chukichuki

Unkindness
chumbu

Field or countryside, which is the Pemba dialect for the Swahili word (*shamba*)
Chumbuni

A poorer ward or neighborhood (*shehia*) at the outskirts of the city of Zanzibar
D

dada

Household helper
dagaa

Small dried fish
Small fishes
daladala

Are buses which were legalized in 1983 and
Darajani

Central minibus *(daladala)* station of the city of Zanzibar
The big market in Zanzibar, which is very well frequented by people of all age
dawa

Medicine
dawa za Kiswahili

Literally Swahili medicine
Traditional Swahili medicine
dhambi

Sin
dhikri

Extra Islamic prayer at night, in addition to the five daily prayers 75
Extra prayer
dini

Faith ,
dua

Prayer
Prayers
E

Eid al Fitr

Important Islamic religious holidays, breaking the fast of Ramadan
F

fikira

Thoughts / worries
fikra

Heavy thoughts
fitina fitina

Agitation
Forodhani

Public garden in the city of Zanzibar
fundi

Herbalist, literally meaning ‘skilled person’

G

ganzi

Numbness ,

Goans

Indian Christians from Goa (India)

H

habari ya dini

Religious messages

hadith

Prophet Mohammad's traditions

haikusikia

It did not listen/get cured

hajali

He/she does not care

hajambo kidogo

Small problem

Hajj

Pilgrimage to Mekka.

hali nzuri

But still in good condition

halwa

Dessert.

hatima

To complete my end

HelpAge International

Non-governmental organization

heshima

Respect

Respect, reputation, dignity or honor

hijab

Hair scarf

hodari

Clever, intelligent, experienced, knowledgeable, shrewd and powerful

huduma

*(*Institutional care) services

hujali

Do not care

If you do not care

huko

Outside

I

ibada

I worship / do ggod deeds, *ibada* refers to service, servitude, and by extension the very notion of religious worship in Islam

Worship/do good deeds. ʿIbādah (pl. ʿibādāt) refers to service, servitude, and by extension the very notion of religious worship in Islam

ICT

Information and Communication Technology.

Infaaq

any spending to please God

Isha

Last prayer in the evening at about 7.30 p.m.

J

jamaa

Extended family

jamii

Community

JUWAZA

Jumuiya ya Wastaafu na Wazee Zanzibar (Zanzibar Association for Retirees and Older People)

K

kanzu

Garment worn by men. Different name in Oman *dishdasha.*

The typical white long cloth

kanzu (white)

The garment faithful men wear in Zanzibar on Fridays and in Oman throughout the whole week, is bearing meaning of Islamic religiousness and reinforces related values.

kazi

Task / job

kazi ndogo ndogo

Small tasks

khanga

Clothes for women with imprinted Swahili poems.

Khoja

Muslims from South Asia with Iranian descent

kiafya

Health

kichochoro

A small alley

kikiri kikiri

Crowding

kikombe

Specific practice of Islamic healing. The spiritual healer writes Koran verses with saffron on paper, which he then puts into water. Then, after a while, the patient drinks this water. Literally meaning cap

Kikwajuni

A section of Stonetown

Historical area (shehia) of Zanzibar city, a place where

Kikwajuni Juu

The higher located part of *Kikwajuni* an area that lies just outside of Stonetown Zanzibar City

kila kitu unafanyiwa

Everything is done for you
Kilimani

An area, at the seaside, by foot ten minutes away from Kikwajuni
kofia

?.
A white, brimless, cylindrical cap
kubaguliwa

Discriminated
kufanya mchango

Make a contribution/donation
kuheshimu

Respect, honor and esteem
kujiweza

Be able to do without help / be alright
Being fit, being all right, being able to do without help, lit. being able to do it themselves. *Kujiweza* is the reflexive form of *kuweza* (to be able to/can) including the prefix *ji-* (oneself)
Would like to do on their own
kuletea msaada

To bring help to someone
kumwangalia

she has not even someone to take care of her (literally observe her)

kunishughulikia

I have no one who could take care of me (literally could be concerned with me)

kuoa

To marry a wife, take a wife (used only for men)
kuolewa

Being married (only for women)
kupakua

Serving food
kupumzika

To rest, relax, take a break
kusaidia

To help ,
kushapitwa na wakati

having already exceeded their time
kushugulikia

To be concerned with someone
kusukuma

To survive
kuthaminiwa

Not be valued
kutunza

Take care, provide for and reward someone

Kuwa na heshima

Being respectful
kuwa na imani

Having faith
kwa nguvu

With energy, strongly
M

madarasa / chuo

Islamic school
madawa ya kisunna

Supererogatory Islamic medicine
madrasa

Islamic educational institution
Islamic educational institutions
Islamic school
maharagwe

Beans
majaliwa

Endowment, destiny, God's will
majaliwa ya Mwenyezi Mungu

Almighy God's will
malengo

Moderate aims
mama ya nyumbani

Housewife
mandazi

Doughnut, sweet bakery
manga

Arab
maradhi

Disease
Sickness
maradhi ya safura

Anaemia
masheha

Ward leaders
matunzo

Care, attention, honor, protection
Received his care
maumivu

Pain
mawaidha

(Islamic) religious sermons and advive
mazoezi

Sports

mbara

Mainlander
mbovu

Bad, defective, rotten, unhealthy, worthless, dilapidated
mchango

Contribution
Payment, contribution
mchuzi

Sauce ,
mishkaki

Pieces of meat roasted on a skewer
miskiti

Mosques
mitihani

Examinations from God
Mji Mkongwe

Ward or neighborhood (*shehia*) of the old part (Stonetown), of city of Zanzibar
mjomba

Maternal uncle
mjukuu

Grandchild
mkeka

Mat
Plastic mat
mkongwe

Extremely old person
MKUZA I (*Mkakati wa Kukuza Uchumi na Kupunguza Umasikini Zanzibar I (2006-2010))*

Zanzibar Strategy for growth and reduction of poverty 2006-2010
MKUZA II (*Mkakati wa Kukuza Uchumi na Kupunguza Umasikini Zanzibar II (2010-2015))*

Zanzibar Strategy for growth and reduction of poverty 2010-2015
mkwe

In-law
mlezi

Guardian
Mnazi Mmoja

Main public hospital
Public hospital
Mnyonge hali samaki

A frail/neglected/poor person does not eat fish
Mombasa

Vegetable and fruit market in the city of Zanzibar
Mpendae

Shehia
Young ward, one of the biggest *shehia* located at the boarder of the city of Zanzibar
msaada wa fedha

Financial help
mtu au jamaa nje ya nchi

Acquaintances or relatives outside the country
mtu mzima

An adult/older person, see also (*wazima*) literally translated as complete persons meaning adults
mwanangu

My child
mwenzi

Companion
mwepesi

Quick / agile
mwili wa sukari

Diabetic body
Mzee

Polite way to address an older man
mzee anathaminiwa

An old person is cared for/respected
Mzungu

White person/European
N

najitahidi mwenyewe ivyo ivo

Endeavoring by herself
nakua afadhali

I feel better
nchi nzima

Whole country
ndogo

Little
Ngome Kongwe

Old Fort, that was constructed in the late 17th century by the Omani to defend themselves against the Portuguese
nguvu

Energy ,
Strength
nguvu ya kiume

Literally translated as male power
nimeshakuwa mtu mzima

I am now already an older person
Nimeshakuwa mtu mzima

I am already an older person
nina nguvu

I have energy ,
nina nguvu baadhi ya wakati

Feels strong only sometimes
nina nguvu baadhi ya wakati

I have sometimes energy
nina nguvu baadhi ya wakati

I have sometimes energy
ninajiweza

Being able, I can do it myself. It meant that he was in relatively good health
Ninamshukuru, sihaba

I am thankful, it is not little
ninaridhika

I am satisfied
ninaridhika

Satisfied
nipo tu

I am just here. I don't have any matter
Nipo tu

I am just here
Nipo tu!

I am just here!
niqab

A black cloth to cover the face except the eyes
nje ya nchi

Outside of the country
nyumba ya matofali

Mixed mud houses and brick houses
nyumba ya matope

Mud houses with wooden vertical poles and horizontal sticks, which keep the mud
nyumba ya wazee

Old age home ,
P

Pemba

The neighboring island which forms together with the main island Unguja Zanzibar, a semi-autonomous part of Tanzania
pikipiki

Motorcycle
pirika

Daily activities
polisi jamii

Community police
pressa

Blood pressure
pressure

Hypertension
pumu

Asthma
pumzi

Asthma

Respiration / asthma ,

R

rafiki

Generally a friend

raha

Happiness /comfort

Ramadan

Islamic religious rite of fasting

S

sadaka

Religious offering, alms ,

Sadaqat

Swahili sadaka. To let someone stay in a house without collecting rent for philanthropic purposes

safari

Journey, originally from the Arabic (safar) meaning a journey

salama

Secure, safe, in good condition

Sebleni Kwa Wazee

Nursing home, entirely state governed

shakuwa mtu mzima

Being already an older person

shamba

Countryside

Farm, field, country side

Shangani

Ward or neighborhood (*shehia*) of city of Zanzibar

shawarma

Meat and chips in flat bread.

sheha

Ward leader

shehia

Ward or neighborhood of the city

Sheikh/Shehe

Muslim teacher / patriarch /respected wise man

shoga

A woman's female friend

shughuli zangu za nyumbani

Personal activities at home, like washing oneself, or going to the market

shugulika

She will be cared for and concerned with her

si haba

It is not insignificant

sihaba

Fine enough, it is not little

sijiweza

I am not able anymore / weak
Not able anymore/weak

sijiwezi

I am not able to take care of myself

siku kuu

Islamic holiday like Eid al Fitr

sina nguvu

I am without strength
I do not have energy ,

SNSF

Swiss National Science Foundation

starehe

Living in comfortable circumstances

sukari

Diabetes

T

taarab

Music of the Swahili people living along the East African coast and particularly in Zanzibar (Topp Fargion 2014). Taarab developed over the last centuries and combines the cosmopolitan East African, Indian and Arab musical elements. Similar to the Zanzibari dishes, this music can thus not be related only to the place Zanziabr but can only be grasped as a product of interactions in transnational spaces.

tafrani

Annoyance

taraab

Traditional music

U

ugali

Dish made of maize flour

ujamaa na kujitegemea

Villagization and self-reliance

ukishakuwa mtu mzee

But if you are already an older person

umri

Age

unafikiriwa

You are thought of

unajiweza

Was still able

unaletewa

Brought for you

Unguja

Main island of Zanzibar
The main island Zanzibar which forms together with the neighboring island Pemba, a semi-autonomous part of Tanzania

upendo

Out of love
uradi

Burial prayers
Urojo

Typical soup mix
usalama

Security
Uswahilini

The place where, (*Waswahili*) literally people who are Swahili speakers, live
uzee

Old age
V

vijana

Youth/children
Vikokotoni

Ward (*shehia*) of Zanzibar city
visheti

Sweet snacks ,
W

wabara

Mainlanders
walevi

Drunkards
wanajiweza

They can do it by themselves
wanyama

Animals / beasts – bad spirits
waqf

An endowment made by a Muslim to a religious, educational, or charitable cause.
Waqf

Withholding of property in order to use the revenue it generates for philanthropic purposes
wastaarabu

Civilized people
watoto wa kumzaa mwenyewe

Children oneself has given birth to
watu wa kuangaliwa

People of whom should be taken care of
watu warzuri

Good people
watu wazima

Literally complete people, meaning adults
Older people, lit. people who are being complete, whole, healthy, well, physically fit
wazee

Elderly
Elders, older people or even respected people and ancestors and is also used for (older) parents

Older persons or parents

wazee tu lakini wanajiweza

Elders *(wazee)* that they were still able to care

wazima

Literally translated as complete persons meaning adults, see also (*mtu mzima*) an adult/older person

wazungu

White person/ European

Welezo

Nursing homes. Led by three sisters of the Diocese of Zanzibar *Sisters of the Precious Blood* together with an employee of the Department of Social Welfare

Y

ya zamani

Ancient

Z

Zakat

Constitutes the third pillar in Islam, and commands to pay a kind of mandatory tax in the form of alms to the poor

Zakat, Infaaq and *Waqf*

Caring for the needy and the destitute

Zinjibari

Is commonly used for this to refer to any Arab descendent with historical connections to East Africa (Kharusi 2012, 335) and others in the literature call them, defining them in relation to the language as, Swahili-speaking Omani (Valeri 2007).

Z-NCDA

Zanzibar Non-Communicable Disease Alliance (Jumuiya ya maradhi yasiyo ambukiza)

ZSSF

Zanzibar Social Security Fund

zungukazunguka

Literally translated to go round and round

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Appendix

1. Overview Field Research (FR) Phases

Field Research	Place	Time Frame	Data Collection
I	Zanzibar	April-Oct. 2012	- **Actor mapping** (NGOs, State, Associations, Privates) - **Demographic interviews *(Demo)*** - **Main interviews *(Main)*** - Observation, participation - Informal talks
II	Zanzibar	Feb.-May 2013	- **Thematic interviews *(2nd Int)*** focus sample - **Structured observation, participation,** focus sample - **Biographic interviews *(BIO),*** 4 men & 6 women - **Interviews with care-givers** of focus sample - Informal talks
II-III	Zanzibar	June-Sept. 2013	- **Monthly phone calls** to older people by assistants, focus sample
III & V	Zanzibar	Oct. 2013-Feb. 2014 & April 2014	- **Problem-centered interviews *(3rd Int)***, focus sample - **Observation, participation** - Informal talks
IV	Oman	Feb.-April 2014	- **Interviews with relatives in Oman** - **Observation, participation** - **Informal talks**
VI	Zanzibar	Jan-Feb. 2015	- **Dissemination and discussions of results with older people,** focus sample - Observation, participation - Informal talks

2. Research Participants

2.1. Older People in Zanzibar

Abbreviation (Shehia Number Gender)	**Pseudonym**	**Dates of interviews (Int),** Demographic Interview (Demo), Main Interview (Main) Biographic Interviews (BIO) **and visits (Visit)**	**Background information (age in 2012)**
Shehia Chumbuni			
C1f	Nachum	I: 25.7.12 (Demo) 6.9.12 (Main) 27.11.13 (Visit) 30.11.13 (Visit) 31.1.14 (Visit)	Ca. 75
C2m	Salum	I: 25.7.12 (Demo) 15.9.12 (Main) 30.11.13 (Visit)	Ca. 70
C3m	Bakari	I: 25.7.12 (Demo) 15.9.12 (Main) 28.11.13 (Visit) 30.11.13 (Visit)	70+
C4f	Mwajuma	I: 25.7.12 (Demo) 6.9.12 (Main) 28.11.13 (Visit) 30.11.13 (Visit) 18.4.14 (Visit)	60+
C5f	Zuhura	I: 25.7.12 (Demo) 6.9.12 (Main) 27.11.13 (Visit)	70+
C6m	Juma	I: 25.7.12 (Demo) 15.9.12 (Main) 27.11.13 (Visit) 18.4.14 (Visit)	62
C7f	Mawazo	I: 25.7.12 (Demo) 11.9.12 (Main) 28.11.13 (Visit) 18.4.14 (Visit)	68
C8f	Mwinyi	I: 26.7.12 (Demo) 11.9.12 (Main)	60+

		28.11.13 (Visit) 18.4.14 (Visit)	
C9m	Jabir	I: 26.7.12 (Demo) 17.9.12 (Main) 19.5.13 (BIO) 18.4.14 (Visit)	62
C10m	Kassim	I: 26.7.12 (Demo) 17.9.12 (Main) 18.4.14 (Visit)	60+
C11m	Hassan	I: 26.7.12 (Demo) 18.9.12 (Main) 18.4.14 (Visit)	91
C12f	Sikuroja	I: 26.7.12 (Demo) 11.9.12 (Main) 30.4.13 (BIO) 18.4.14 (Visit)	60+
C13f	Patina	I: 26.7.12 (Demo) 12.9.12 (Main) 18.4.14 (Visit)	70
K1m	Nassor	I: 21.8.12 (Demo) 19.9.12 (Main) 1.5.13 (Visit) 23.11.13 (Visit) 17.4.14 (Visit) 7.2.15 (Visit)	68
K2m	Masoub	I: 22.8.12 (Demo) 18.9.12 (Main) 12.5.13 (Visit) 2.11.13 (Visit) 4.11.13 (Visit) 2.11.13 (Visit) 16.4.14 (Visit) 7.2.15 (Visit)	75
K3f	Maua	I: 22.8.12 (Demo) 25.9.12 (Main) 16.4.14 (Visit) 27.1.15 (Visit)	75+
K4f	Mwana	I: 22.8.12 (Demo) 25.9.12 (Main) 24.4.13 (Visit) 6.5.13 (Visit) 1.11.13 (Visit) 16.4.14 (Visit) 27.1.15 (Visit)	79
K5m	Hafidh	I: 22.8.12 (Demo) 18.9.12 (Main)	75

		12.5.13 (Visit) 23.11.13 (Visit) 17.4.14 (Visit) 7.2.15 (Visit) 10.3.15 (Visit)	
K6f	Msimu	I: 21.8.12 (Demo) 27.9.12 (Main) 17.4.13 (Visit) 20.4.13 (Visit) 1.11.13 (Visit) 17.4.14 (Visit) 27.1.15 (Visit)	77
K7f	Mgeni	I: 23.8.12 (Demo) 4.10.12 (Main) 17.4.13 (Visit) 27.4.13 (Visit) 6.5.13 (Visit) 28.5.13 (Visit) 21.10.13 (Visit) 6.2.14 (3rd Int) 27.1.15 (Visit)	100 core sample
K8f	Mchanga	I: 21.8.12 (Demo) 27.9.12 (Main) 19.3.13 (2nd Int) 20.4.13 (Visit) 6.5.13 (Visit) 8.5.13 (BIO) 28.5.13 (Visit) 22.10.13 (Visit) 2.11.13 (3rd Int) 9.1.14 (3rd Int) 27.1.15 (Visit)	65 core sample
K9f	Halima	I: 21.8.12 (Demo) 25.9.12 (Main) 6.5.13 (Visit) 1.11.13 (Visit) 17.4.14 (Visit) 27.1.15 (Visit)	63
K10m	Omar	I: 21.8.12 (Demo) 20.9.12 (Main) 13.3.13 (2nd Int) 14.5.13 (BIO) 2.11.13 (Visit) 2.11.13 (Visit) 20.1.14 (3rd Int) 16.4.14 (Visit) 24.1.15 (Visit)	70 core sample
K11m	Mohammed	I: 23.8.12 (Demo) 28.9.12 (Main) 18.4.13 (2nd Int)	70 core sample

		3.5.13 (Visit) 13.5.13 (Visit) 2.11.13 (Visit) 27.1.14 (3rd Int) 16.4.14 (Visit) 24.1.15 (Visit)	
K12m	Cheetah	I: 22.8.12 (Demo) 19.9.12 (Main) 16.3.13 (2nd Int) 29.4.13 (Visit) 22.5.13 (BIO) 2.11.13 (Visit) 10.11.13 (Visit) 11.1.14 (3rd Int) 16.4.14 (Visit) 24.1.15 (Visit)	70 core sample
K13m	Rama	I: 22.8.12 (Demo) 1.10.12 (Main) 1.5.13 (Visit) 23.11.13 (Visit) 7.2.15 (Visit)	65
M1f	Khadija	I: 23.7.12 (Demo) 5.9.12 (Main) 10.5.13 (Visit) 27.1.15 (Visit)	Ca. 64
M2m	Maulid	I: 23.7.12 (Demo) 2.9.12 (Main) 11.5.13 (Visit) 5.2.15 (Visit)	75
M3m	Saidi	I: 23.7.12 (Demo) 2.9.12 (Main) 11.5.13 (Visit) 5.2.15 (Visit)	80
M4f	Mwaramili	I: 24.7.12 (Demo) 3.9.12 (Main) 10.5.13 (Visit) 28.11.15 (Visit)	67
M5m	Makame	I: 24.7.12 (Demo) 4.9.12 (Main) 8.11.13 (Visit) 5.2.15 (Visit)	63
M6f	Mwanaali	I: 23.7.12 (Demo) 3.9.12 (Main) 23.4.13 (BIO) 27.1.15 (Visit)	80
M7m	Omar	I: 26.7.12 (Demo) 4.9.12 (Main)	63

		5.2.15 (Visit)	
M8f	Sharifa	I: 12.9.12 (Demo) 12.9.12 (Main) 12.3.13 (2nd Int) 15.4.13 (Visit) 23.5.13 (Visit) 28.5.13 (Visit) 22.10.13 (Visit) 6.12.13 (Visit) 28.1.15 (Visit) 29.1.15 (Visit) 6.2.15 (Visit)	80 core sample
M9m	Mohammed	I: 24.7.12 (Demo) 2.9.12 (Main) 21.3.13 (2nd Int) 2.5.13 (Visit) 11.5.13 (BIO) 29.5.13 (Visit) 8.11.13 (Visit) 13.1.14 (3rd Int) 5.2.15 (Visit)	65 core sample
M10f	Fatma	I: 24.7.12 (Demo) 3.9.12 (Main) 10.5.13 (Visit) 28.11.15 (Visit)	Ca. 75
M11f	Mosi	I: 23.7.12 (Demo) 5.9.12 (Main) 10.5.13 (Visit) 28.11.15 (Visit)	60
M12f	Mtumwa	I: 24.7.12 (Demo) 5.9.12 (Main) 18.3.13 (2nd Int) 23.4.13 (BIO) 10.5.13 (Visit) 28.5.13 (Visit) 22.10.13 (Visit) 28.11.13 (3rd Int) 5.12.13 (3rd Int) 7.12.13 (3rd Int) 27.1.15 (Visit)	80 core sample
M13m	Haji	I: 23.7.12 (Demo) 4.9.12 (Main) 12.3.13 (Visit) 11.5.13 (Visit) 8.11.13 (Visit) 5.2.15 (Visit)	76
S1m	Attai	I: 17.9.12 (Demo) 2.10.12 (Main) 16.4.13 (Visit)	80

		11.11.13 (Visit) 26.1.15 (Visit)	
S2m	Juma	I: 23.8.12 (Demo) 29.9.12 (Main) 29.4.13 (Visit) 11.11.13 (Visit) 26.1.15 (Visit)	65
S3f	Masika	I: 23.8.12 (Demo) 2.10.12 (Main) 8.5.13 (Visit) 20.11.13 (Visit) 17.4.14 (Visit) 26.1.15 (Visit)	65
S4f	Safi	I: 25.8.12 (Demo) 4.10.12 (Main)	80+
S5f	Bimkubwa	I: 17.9.12 (Demo) 2.10.12 (Main) 14.3.13 (2nd Int) 17.4.13 (Visit) 8.5.13 (Visit) 28.5.13 (Visit) 21.10.13 (Visit) 6.12.13 (3rd Int) 30.1.15 (Visit) 6.2.15 (Visit)	Ca. 90 core sample
S6m	Sleiman	I: 23.8.12 (Demo) 1.10.12 (Main) 29.4.13 (Visit) 11.11.13 (Visit) 17.4.14 (Visit)	Ca. 85
S7f	Marina	I: 24.8.12 (Demo) 4.10.12 (Main) 29.4.13 (Visit)	73
S8m	Abdalla	I: 24.8.12 (Demo) 8.10.12 (Main) 1.5.13 (2nd Int) 12.5.13 (Visit) 29.5.13 (Visit) 11.11.13 (Visit) 17.4.14 (Visit) 25.1.15 (Visit)	72 core sample
S9m	Bwanakheri	I: 27.8.12 (Demo) Drop out (Main)	70
S10	Drop out	////////// Drop out	////////
S11m	Custodio	I: 27.8.12 (Demo) 4.10.12 (Main) 17.4.14 (Visit)	77

		26.1.15 (Visit)	
S12f	Mariana	I: 24.9.12 (Demo) 24.9.12 (Main) 30.4.13 (Visit) 22.10.13 (Visit)	71
S13f	Fatma	I: 24.8.12 (Demo) 2.10.12 (Main) 15.3.13 (2nd Int) 30.4.13 (Visit) 8.5.13 (BIO) 22.10.13 (Visit) 6.12.13 (3rd Int) 13.12.13 (3rd Int) 30.1.15 (Visit) 10.2.15 (Visit)	70+ core sample

2.2. Relatives/Acquaintances in Zanzibar

Code (Shehia Number Gender)	**Pseudonym**	**Dates Interviews (Int), and visits (Visit)**	**Background Information**
K7f_R1 Mgeni	Rahma	6.5.13 (Int)	cousin
K7f_R2 Mgeni	Binuna	27.4.13 (Int)	daughter
K8f_R1 Mchanga	Nassra	6.5.13 (Int)	daughter
K8f_R2 Mchanga	Sharifa	6.5.13 (Int)	daughter
K10m_R Omar	Mohammed	14.5.13 (Int)	son
K11m_R Mohammed	Arafa	13.5.13 (Int)	wife
K12m_R Hassan	Selma	21.5.13 (Int)	wife
M8f_R1 Sharifa	Maryam	15.3.13 (Int)	granddaughter
M8f_R2 Sharifa	Zuwena	15.3.13 (Int)	granddaughter
M8f_R3 Sharifa	Suleikha	23.5.13 (Int)	niece
M12f_R1 Mtumwa	Bimkubwa	23.4.13 (Int)	*dada*
M12f_R2 Mtumwa	Fatma	23.4.13 (Int)	daughter
S5f_R Bimkubwa	Thaani (Oman)	21.4.13	nephew

S8m_R Abdullah	Abdullah	12.5.13	son
S13f_R Fatma	Kauthar	8.5.13 (Int)	daughter

2.3. Relatives/Acquaintances in Oman

Code (Number, Gender, Relative Zanzibar)	**Name**	**Pseudonym**	**Dates** Interviews (Int), and visits (Visit)	**Background information**
Oman				
O1mS5f	Thani Hafith		23.2.14 (Int) 3.4.14 (Visit)	Raised Son; his brother Hafith
O2fS5f	Maryam		24.2.14 (Int) 11.3.14 (Visit) 3.4.14 (Visit)	Raised Daughter
O3mM8f	Biubwa Omar		22.2.14 (Int)	Niece of Bi Sharifa. Sharifa mother of Omar She raised him
O4fS8m	Sheikha Abdalla		3.3.14 (Visit) 13.3.14 (Visit) 14.3.14 (Visit) 24.3.14 (Visit)	Daughter of wife's sister
O11m	Nassor		First days (Visit) 16.3.14 (Visit)	Brother of Shakir Mother now in Stonetown (Zanzibar)
O12f	Saade		20.2.14 (Int) Almost daily (Visit)	Wife of Ali (brother of Salem) From Pemba, knows also Saleh's family Mother in Pemba (Zanzibar)
O13f	Shemsa		6 weeks every day	Married to Salem Parents in Zanzibar
O14m	Salem		6 weeks every day	Husband of Shemsa I stayed in their family
O15f	Sheikha		18.2.14 (Visit) 19.2.14 (Visit) Many (Visit) 27.2.14 (Int)	Wife of Seleh's father's late brother (Abdallah Saleh)
O16f	Fatma		26.2.14 (Visit) 23.3.14 (Int) 24.3.14 (Visit)	Relative of Bi Latifa
O17m	Mohammed		26.2.14 (Visit) 2.3.14 (Int)	Relative of Zakaria Parents in Zanzibar Brother in Zanzibar: Nassor
O18f	Salma		19.2.14 (Visit) 25.2.14 (Int)	Oncles in Vuga (Zanzibar)

O19f	Uleda	20.2.14 (Int) 4.4.14 (Visit)	Jokha's friend
O20f	Samira	25.2.14 (Int)	Sister of Salum
O21f	Fatuma	23.2.14 (Visit) 24.2.14 (Int)	Girlfriend of Mussa working as housekeeper
O22f	Safia	17.3.14 (Visit)	
O23f	Zuwaina	18.3.14 (Int)	Mother of Abdullah
O24m	Said	20.3.14 (Visit)	Mother (he is the only child) in Malindi (Stonetown, Zanzibar), supervised by aunt
O25m	Muhammed	26.2.14 (Visit) 23.3.14 (Int) 24.3.14 (Visit)	age: 73 Husband of Fatma, Friends in Zanzibar
O26m	Abdul-Halim	24.3.14 (Int)	Cousin in Pemba (Zanzibar)
O27f	Mgeni	24.3.14 (Visit)	Henna artist Grandmother in Mpendae (Zanzibar)
O28f	Zaina	25.3.14 (Visit)	Brother in Vuga (Stonetown, Zanzibar)
O29f	Salima	29.3.14 (Visit)	Sister Halim Cousins (Chake Chake), neighbors, friends in Pemba (Zanzibar)
O30f	Moza	Two weeks	I stayed in their family
Dubai			
D1mS13f	Khamis	9.3.14 (Visit) 23.3.14 (Visit) 24.3.14 (Visit)	Grandchild of younger sibling

Utapojua maisha, yatakuwa yamekwisha.

At the time you will know life, it will be over. (Swahili proverb)