THE NEW OLD URBANITES

Care and Transnational Aging in Dar es Salaam, Tanzania

Dissertation
zur Erlangung der Würde einer Doktorin der
Philosophie

vorgelegt der Philosophisch-Historischen Fakultät
der Universität Basel

von
Andrea Patricia Kaiser-Grolimund

aus
Basel-Stadt

Basel, 2023 [2018]

Buchbinderei Bommer GmbH

Originaldokument gespeichert auf dem Dokumentenserver der Universität Basel
edoc.unibas.ch

Dieses Werk ist lizenziert unter einer Creative Commons Namensnennung 4.0 International Lizenz.

Genehmigt von der Philosophisch-Historischen Fakultät der Universität Basel, auf Antrag von Prof. Dr. Brigit Obrist, Prof. Dr. Till Förster und PD Dr. Peter van Eeuwijk

Basel, den 13. Februar 2018

Der Dekan, Prof. Dr. Walter Leimgruber

CONTENTS

Contents ... *iii*

Detailed Table of Contents ... *v*

Figures ... *viii*

Notes on Transcription Conventions, Revision and Transparency ... *ix*

Abbreviations ... *xi*

Acknowledgments ... *xiii*

Part I Introduction ... *1*

The New Old Urbanites in Dar es Salaam ... **1**

Older Urbanites' Agency As A Lens ... **9**

Researching Aging in Urban Spaces ... **13**

Structure of the PhD Thesis ... **34**

Part II Aging and the City ... *37*

Encountering Bongoland's Older People ... **39**

Dar es Salaam's "First Generation" of Older People ... **47**

Becoming Old in Dar es Salaam ... **74**

Aging in the Former Civil Servants' Milieu ... **100**

Conclusion: Urban Aging Between Challenges and Opportunities ... **113**

Part III Care Dynamics ... *115*

Old Age Care ... **115**

On Relational Care ... **131**

On *Kujitunza* or Everyday Self-Care ... **163**

Conclusion: Dynamics of Care ... **193**

Part IV Care in Transnational Triangles ... *197*

Transnational Care ... **198**

Caregivers in the United States ... **209**

Triangles of Care **240**

Conclusion: Transnational Triangles in Care **258**

Part V Conclusion ***261***

Concluding Summary **261**

Putting Self-Care on the Spot **266**

Urban Aging: African Cities' Future **268**

Questions for Further Research **271**

References ***273***

Websites ***285***

Appendix ***287***

Study Participants' Information **287**

List of Swahili Words **299**

DETAILED TABLE OF CONTENTS

Contents .... *iii*

Detailed Table of Contents .... *v*

Figures .... *viii*

Notes on Transcription Conventions, Revision and Transparency .... *ix*

Abbreviations .... *xi*

Acknowledgments .... *xiii*

Part I Introduction *1*

The New Old Urbanites in Dar es Salaam **1**

Aging in Diverse Urban Milieus 3

Urban Health from an Anthropological Perspective 4

Different Ways of Caring 6

Organizing Care from Abroad 8

Older Urbanites' Agency as a Lens **9**

Researching Aging in Urban Spaces **13**

On Collaborations and Shared Lifeworlds 13

Circular Research Approach and Applied Methods 20

First Research Phase (2012): Gaining an Overview 20

Second Research Phase (2013): Zooming in 23

Third Research Phase (2014): Following Links 27

Dissemination (2015): Dar es Salaam and Zanzibar 29

On Data Analysis, Field Notes, and Memos 29

On Multi-Sited Ethnography and "Coming Back" 31

Structure of the PhD Thesis **34**

Part II Aging and the City *37*

Encountering Bongoland's Older People **39**

Who's City? 39

Social Differentiation in African Cities: The Concept of Milieu 43

A Note On Urban Milieus in Dar es Salaam 46

Dar es Salaam's "First Generation" of Older People **47**

Encountering Bongoland: Four Diverse *Mitaa* as a Starting Point 56

Ilala Ilala Mafuriko 57

Temeke Azimio Kichangani 58
Kinondoni Manzese Mnazi Mmoja 59
Kinondoni Kinondoni Ada Estate 61
Repertoires of Old Age....64
Legal Age: Dar es Salaam's Institutional Landscapes 65
Social Age: *Sema Shikamoo* 70

Becoming Old in Dar es Salaam.... 74

Aging Urbanites 75
U*najua, Maisha Ya Mjini*—You know, City Life....75
The City Makes You Sick But Also Cures You 84
Living or Leaving the City....91
Zamani Versus *Leo*—Village Versus City 97

Aging in the Former Civil Servants' Milieu 100

Socio-Economic Dimensions: "Middle Class" Civil Servants.... 102
Belonging to Dar es Salaam's Middle-Income Group.... 103
Civil Servant-ness and Legal Age 105
Socio-Cultural Dimensions: Caring For Health.... 107
Future Preparations for a "Good" Old Age 107
Conducting a Healthy Way of Life 109
Living a Socially Embedded Old Age 112

Conclusion: Urban Aging Between Challenges and Opportunities....113

Part III Care Dynamics.... 115

Old Age Care....115

On Relational Care....131

Older People's Narratives About "Good Care".... 131
Nguvu as a Point of Departure for Care 141
Care for Older People.... 145
Care when Frail and Dependent 145
Care with Daily Adaptations.... 152
Care After a Health-Related Crisis.... 158

On *Kujitunza* or Everyday Self-Care....163

"Successful Aging" in Dar es Salaam 164
A Conducive Environment for Self-Care.... 167
Caring Older People.... 169
Spiritual Care and "Good" Food 169
Care For One's Own Chronic Conditions 178
Care for Oneself and Others 185

Conclusion: Dynamics of Care 193

Part IV Care in Transnational Triangles *197*

Transnational Care **198**

Caregivers in the United States **209**

Tanzanian Communities as Research Sites in the USA 210

The “DMV” Community in Washington D.C., Maryland and Virginia 210

Tanzanian Migrants in Massachusetts 211

The “NYTC” in New York 212

The “TCCA” in Ohio 213

Why Legal Status Matters for Care 214

Migrants Who Care 219

“Overstayers” 219

“Well-Established” 226

“Temporarily Employed” 236

Triangles of Care **240**

From Tanzanian Migrants to Older People in Tanzania 245

Visits to Tanzania—Visits to the USA 248

From Tanzania to Tanzanian Migrants in the USA 251

Observing Eyes in Tanzania 252

Conclusion: Transnational Triangles in Care **258**

Part V Conclusion *261*

Concluding Summary **261**

Putting Self-Care on the Spot **266**

Urban Aging: African Cities’ Future **268**

Questions for Further Research **271**

References *273*

Websites *285*

Appendix *287*

Study Participants’ Information **287**

List of Swahili Words **299**

FIGURES

Figure 1 Living arrangements of older study participants 80

Figure 2 Care between older people and Tanzanian migrants 251

Figure 3 Care between Tanzanian migrants and observing eyes 255

Figure 4 Care between observing eyes and older people in Tanzania 258

Notes on Transcription Conventions, Revision and Transparency

As the research for this PhD thesis dates back some time, the figures and statistics used in the texts have not been updated so as to describe the reality as it was at the time of the research (2012-2015). After the defense of this dissertation in 2018, the document has been revised based on the recommendations of the referees. Otherwise, the text remained largely the same and is therefore also based on the debates in the literature at the time.

All quotes in the text are in English, although some of the interviews were conducted in Swahili and English. When a Swahili translation exists, it is mentioned in a footnote indicated at the end of the quote. The research team that transcribed the interviews we conducted in Swahili, together translated the Swahili passages into English. I corrected quotes with regard to language, that is, whether they contained spelling or syntax mistakes that would have hindered the flow of reading. Thereby I tried to keep the right tone. Language mistakes not only occurred while speaking but could also be due to transcription errors.

After each quote or description, the name indicating gender as well as the year of the interview or informal conversation is shown. Old age is indicated by adding *Bibi* (grandmother) or *Mzee* (older man) to the name. More information on the encountered person and the exact interview dates or days of visits can be found in the appendix of this PhD thesis. Field notes are provided with a date.

In order to assure anonymity of the participants of this study in the USA as well as in Tanzania, I decided not to use their correct names. All members of the research team, however, wished to be referred to by their own names. In addition, as the information on the localities within Dar es Salaam seemed important for my research, I decided to use the correct names of the Tanzanian sub-wards. However, due to the partly illegal status of some research participants residing in the United States, detailed information about migrants' places of residence in the United States was omitted.

Finally, some ideas, arguments and results of the PhD study have already been published in the articles or book chapters listed below, before this PhD thesis was published. Whenever possible, a reference has been placed in a footnote.

Kaiser-Grolimund, Andrea. 2020. "Transfigurations of Aging." *Medicine Anthropology Theory*, 7(1). https://doi.org/10.17157/mat.7.1.649 .

Staudacher, Sandra, and **Andrea Kaiser-Grolimund**. 2020. "Triangles of Care in Transnational Spaces of Aging: Social Engagements between Urban Tanzania, Oman and the United States." In *The Cultural Context of Aging: Worldwide Perspectives*, edited by Jay Sokolovsky, 4th edition, 633-656. Santa Barbara/California: Praeger.

Aceska, Ana, Barbara Heer, and **Andrea Kaiser-Grolimund**. 2019. "Doing the City from the Margins: Critical Perspectives on Urban Marginality." *Anthropological Forum* 29 (1):1-11. doi: https://doi.org/10.1080/00664677.2019.1588100.

Kaiser-Grolimund, Andrea. 2018. "Healthy Aging, Middle-Classness, and Transnational Care between Tanzania and the United States." In *Care Across Distance. Ethnographic Explorations of Aging and Migration*, edited by Azra Hromadžić and Monica Palmberger, 32-54. New York: Berghahn Books.

Kaiser-Grolimund, Andrea, Carole Ammann, and Sandra Staudacher. 2016. "Research Assistants: Invisible but Indispensable in Ethnographic Research." *TSANTSA* 21:132-136.

Staudacher, Sandra, and **Andrea Kaiser-Grolimund**. 2016. "WhatsApp in Ethnographic Research: Methodological Reflections on New Edges of the Field." *Basel Papers on Political Transformations* 10:24-40.

ABBREVIATIONS

AAH	Aging, Agency and Health in urbanizing Tanzania, research project
ACS	American Community Survey
ADE	The sub-ward of *Ada Estate* in the Kinondoni ward
CCM	*Chama Cha Mapinduzi,* political party
CHF	Community Health Fund
CNCDs	so-called chronic non-communicable diseases
COSTECH	Commission for Science and Technology of Tanzania
CUF	Civil United Front, oppositional political party
DMV	stands for the first letters of the US States D. C. (Washington D.C.), Maryland, and Virginia. It is a Tanzanian migrant community which encompasses Tanzanians in the US States of Washington D.C., Maryland, and Virginia.
EEA	Emic Evaluation Approach
Ghana TransNet	is a research program that explores how transnational networks can affect local economies in the countries of Ghana and Holland
HelpAge Tanzania	Non-Governmental Organization
HSSP III	Health Sector Strategic Plan
IHI	Ifakara Health Institute
ILM	*Ilala Mafuriko,* Mafuriko is a sub-ward of the ward Ilala located in the district of Ilala in the city's center
IMF	International Monetary Fund
IOM	International Organization for Migration
KICH	*Azimio Kichangani,* the sub-ward Kichangani is located in the ward Azimio in the district of Temeke, south of the city center
KKKT	*Kanisa la Kiinjili la Kilutheri Tanzania*, Evangelical Lutheran church in Tanzania
MAXQDA	is a software for qualitative and mixed methods data analysis
MDG	Millennium Development Goals
MNM	*Manzese Mnazi Mmoja*, Mnazi Mmoja is a low-income residential area in the ward Manzese
M-pesa	the *m* stands for mobile, *pesa* is the Swahili word for money. M-pesa is a money transfer system based on mobile phones; it also provides financing and microfinancing services. M-pesa was launched by Vodafone in 2007 for Vodacom and Safaricom, which are the largest mobile phone network providers and operators in Tanzania and Kenya.
NGO	Non-Governmental Organisation
NHC	National Housing Corporation
NHIF	Nation Health Insurance Fund
NIMR	National Institute for Medical Research
NRI	Non-Resident Indian
NSGRP II	National Strategy for Growth and the Reduction of Poverty (or in Swahili MKUKUTA II)
NSSF	National Social Security Fund (Tanzania)
PHSDP	Primary Health Services Development Programme 2007-2017
REPOA	Research on Poverty Alleviation
SHIB	Social Health Insurance Benefits (Tanzania)
SMS	Simultaneous Matched Sample method
SUZA	State University of Zanzibar
Swiss TPH	Swiss Tropical and Public Health Institute
TANU	Tanganyika African National Union

TAZARA	The Tanzania-Zambia Railway Authority was established in 1968. The TAZARA project, the construction of a railway connecting the two countries Tanzania and Zambia, started in 1970 and was funded by China.
TBC	Tanzania Broadcasting Corporation, government radio channel
TCU	Ten-cell Unit
TZS	Tanzanian Shilling
UK	United Kingdom
UN-HABITAT	United Nations Human Settlements Programme
URT	United Republic of Tanzania
USA	United States of America
VoP	Views of the People survey conducted by REPOA in 2007
WESTADI	Welfare Scheme for Tanzanians in the Diaspora Insurance. NSSF has now ventured into extending its services to Tanzanians living abroad through special Diaspora coverage scheme called WESTADI; aimed to cover all Tanzanians living abroad (including students) and 4 dependents selected by the insured person for Social Health Insurance Benefits (SHIB) in Tanzania.
WHO	World Health Organization

ACKNOWLEDGMENTS

Study participants, assistants, collaborators, supervisors, colleagues, friends, and family in different localities around the world have contributed to this PhD project over the years of its making. I am indebted to all the older study participants and their families in Tanzania and the USA without whom this PhD thesis would not have been possible—*Ahsanteni kwa kukubali kushiriki katika utafiti huu, kwa kupoteza muda wenu mwingi na mimi pamoja na timu nzima ya utafiti huu, kwa kutukaribisha majumbani mwenu kwa moyo wenu wote, kula, kufurahi, na wakati mwengine hata kuhuzunika pamoja. Hili sio jambo la kulichukulia kama ruzuku*.

The older study participants offered me insights into their lives and shared their ups and downs with me during almost six years. During all this time, while witnessing events in their lives, my life also provided me with joyful moments such as when our twins Dana and Kian were born in March 2016, but also with sad days, for instance, when my grandmother in Switzerland passed away while I was in Tanzania. Working on aging is naturally and sadly connected to witnessing older people pass on. For this reason, I would like to dedicate this ethnography to all the older people in Tanzania and in Switzerland whom I have lost during this journey.

I am grateful to my supervisors Brigit Obrist and Till Förster who supported me during this project. To Brigit Obrist for her guidance in theoretical and methodological questions and for her concerns about my safety and well-being during my field research; to Till Förster for his precious feedbacks during presentations as well as for his elaborate emails to clarify my understanding of certain concepts or theories.

I am happy that Peter van Eeuwijk agreed to serve as external expert for this PhD thesis and would like to thank him for his countless valuable inputs and his far-reaching overview over the literature on aging that always kept me up to date. Thanks to Brigit Obrist and Peter van Eeuwijk I was given the unique opportunity of joining an already established research team on aging. I was able to profit from the experiences of conducting research on aging in Tanzania and I am especially grateful to Jana Gerold and Vendelin Simon who shared insights into their field experiences in Tanzania that proved helpful when I started on my own project.

Special thanks go to Sandra Staudacher with whom I had innumerable discussions on aging in Dar es Salaam and the city of Zanzibar. We embarked together on the journey of conducting our PhD theses within the same research project and conducted our field trips more or less simultaneously. I thank Sandra for sharing precious time when traveling together in Tanzania but also to different international

conferences around the world, and for staying cool when I worried about our residence permit in Tanzania.

I am indebted to my colleagues and friends Carole Ammann, Barbara Heer, and Sandra Staudacher for sharing the ups and downs during our weekly writing group meetings as well as when we traveled outside of Basel for inspiring writing retreats. Especially in the process of writing up, I learned much from our ongoing discussions. For their valuable feedbacks on the different chapters and parts of this PhD thesis I thank (in alphabetical order), Carole Ammann, Benjamin Brühwiler, Anna Christen, Maja Grolimund-Daepp, Jana Gerold, Barbara Heer, Constanze Pfeiffer, Melina Rutishauser, Sandra Staudacher, and Florian Stoll. A special thanks goes to Gernot Biersack and Nigel Stephenson for their English copyediting efforts and the formal revision of the final product, as well as to Saleh Mohammed Saleh for the Swahili language editing.

I am grateful for the comments and feedbacks on presentations and papers at various stages of this work from the members of the Medical Anthropology Research Group (in alphabetical order), Leah Bohle, Andrea Buhl, Silvia Büchi, Angel Dilip, Zuzanna Drozdzak, Peter van Eeuwijk, Jana Gerold, Karin Gross, Kristen Jafflin, Arlena Liggins, Victoria Moffatt, Brigit Obrist, Constanze Pfeiffer, Marion Rivière, Fabiana Rodrigues, Miriam Rülke, Melina Rutishauser, Richard Sambaiga, Patricia Schwärzler, Vendelin Simon, Sandra Staudacher, Noemi Steuer, Amina Trevisan, Caro van Leeuwen, and Kristina Würth.

I thank the members of the Research Group on Political Transformation for being open to my medical anthropological topic, and their valuable comments (in alphabetical order), Balz Alter, Carole Ammann, Miriam Badoux, Anna Christen, Michelle Engeler, Till Förster, Barbara Heer, Franziska Jenni, Kathrin Heitz Tokpa, Andrea Kaufmann, Rita Kesselring, Lucy Koechlin, Bobby Luthra Sinha, Silke Oldenburg, Gilbert Rüegg, Aidas Sanogo, Sabine Schultz, Fiona Siegenthaler, Tina Tra, Frederik Unseld, Adama Ousmanou. I am also grateful to Sandra Burri, Filomena Mazumdar, and Regina Stalder for their administrational support.

The conversations at the meetings of the Department of Epidemiology and Public Health and the Society, Gender and Health Unit meetings at the Swiss Tropical and Public Health Institute were always illuminating and motivated me to look at this PhD thesis from different angles and disciplines. I am indebted to the former director of the institute, Marcel Tanner, who supported my academic journey ever since my bachelor's studies. Special thanks go to Hannah Brown of Durham University, who agreed to reduce my workload in the Anthro-Zoonoses Network and give me time to focus on this PhD thesis.

I am indebted to Joyce Nyoni, Richard Sambaiga, and Vendelin Simon from University of Dar es Salaam, Tanzania, who supported this project especially at the beginning when their input was crucial

for getting our research permit. I thank Vendelin Simon for being an important contact person in Dar es Salaam and for taking me to visit his father in northern Tanzania which taught me much about aging in rural areas. I thank the researchers at the Ifakara Health Institute in Dar es Salaam for fruitful exchanges. I would like to express my gratitude to Saleh Mohammed Saleh, Sara N. Seme, and Saada Omar Wahab from the State University of Zanzibar who facilitated especially the start of this project. I thank the language teachers at the State University of Zanzibar for their patience when teaching me their language, and my host family in Zanzibar for teaching me not only vocabulary but also a great deal about their lives in Zanzibar.

My field stays in Dar es Salaam became a wonderful experience thanks to many people. I thank Elisha Sibale Mwamkinga for his commitment in supporting older people in Tanzania. Elisha Sibale Mwamkinga was expert, research assistant, translator, and organizer of this research project in one, and contributed considerably to the successful realization of the research. Even now, when this PhD thesis is published, Elisha is still a regular visitor to the older study participants in Dar es Salaam. I thank Monica Mandao and Frank Sanga for their support when visiting older people, spending time with them, and listening to their stories. I am indebted to Neema Duma, Emmanuel, Lucy Kira, Deogratias Rwechungura, Judith Valerian, and William who supported this project at different stages in Tanzania. A special thank goes to the Ten Cell Unit Leaders in the sub-wards of this research project who facilitated our coming and going and kept me up to date about important events within the sub-ward.

I would like to express my gratitude to my host family in Dar es Salaam who took good care of me during many months of different field stays. I thank them for being concerned about my wellbeing and always ready to discuss any of my questions. In their compound, I had wonderful co-tenants (neighbors), Juan Blanco, Noemie Boillat, Stefan Dongus, Maarten Hoek, Varia Lipovsek, Constanze Pfeiffer and their kids who often invited me for dinner and with whom I exchanged much about research challenges and opportunities. Special thanks go to Constanze Pfeiffer and Stefan Dongus whose contacts in Dar es Salaam opened many doors for me. I thank them for letting me be part of their family activities on many weekends. I am grateful to Yacinta Peter and Jan Derksen for spending time with me in Dar es Salaam and asking me critical questions about my research. I thank Dominik Grieder, Lukas Holm, Michelle Lachenmeier, Emmanuelle Landmann, Anna Lüthi, and Sarah Saner for taking time to visit me in Dar es Salaam.

I would like to express my gratitude to Sarah Lamb, who supported me as a mentor during my study visit to Brandeis University in Boston, USA, and for the inspiring discussions we had about transnational aging as well as for her supportive recommendations about conducting research in the USA. I owe my gratitude to those Tanzanian families in the DMV area and Ohio who agreed to accommodate me at their homes without ever having seen me before. I thank them for sharing their

lives with me during my short stays. I thank Barbara Corneo and her partner for being ready to host me in New York. I am grateful to Agnes Brühwiler for linking me up with her friends.

This research was generously funded by the Swiss National Science Foundation. The support from the Medical Anthropology Research Group enabled the last stage of writing up. The University of Basel supported this study in different ways through Avuba (writing retreat), get on track (assistance from Gernot Biersack), Reisefonds (travels to international conferences), and the G3S Graduate School (workshops).

My deepest gratitude goes to my family in Switzerland who believed in me and supported me during the years of this project. I thank my grandmothers, Susy Probst and Marguerite Grolimund, for their encouragement and accepting my absence. I thank my parents, Ursula Grolimund and Markus Grolimund, for always being happy when I returned home safely and for their precious help with child care. I am truly grateful to my sister Nicole Brütsch and her husband Tobias Brütsch who accepted the task of daycare providers for my children so that I had enough time to finish this PhD thesis. I thank my brother Fabian Grolimund and Carmen Solenthaler for being wonderful neighbors and supported me in balancing small children and work. I thank my parents-in-law Elisabeth Kaiser and Karl-Heinz Kaiser for their help with child care and small household tasks that gave me extra time to write. I am indebted to my godfather Hans Furer and his wife Monika Furer for their constant support.

I am deeply grateful to my husband Ralf Kaiser for his patience and support during the last years. I appreciated his visits to Dar es Salaam that made being away easier for me. I thank him for being a wonderful daddy to our children while providing me with much needed time to finish this project over the last months. I cannot express in words the joy that my children Dana and Kian give me, and for making sure that I did not think of work when spending time with them during the day and during sleepless nights.

Lastly, I would like to emphasize that I take full responsibility for all the remaining deficiencies in this work; any opinion and conclusion herein are my own.

PART I INTRODUCTION

Kuzeeka vizuri ni kule ambako unajicontrol mwili wako kama kufanya mazoezi ndiko kuzeeka vizuri, kwa sababu badala ya kufa leo unakufa kesho, badala ya kufa wiki hii unakufa wiki ijayo …

A good way of getting old is when you are able to control your body like when you are doing physical exercise [like] that you are getting old in the best way, because instead of dying today you will die tomorrow instead of dying this week you will die next week …

(Mzee Dunford 2013)

THE NEW OLD URBANITES IN DAR ES SALAAM

This PhD thesis is about older people's everyday lives in changing urban milieus of Dar es Salaam, Tanzania, and their imaginations of possible future trajectories of old age.

In the city of Dar es Salaam, people above the age of sixty are confronted with different repertoires of old age that shape their personal aging experience. They may be asked to plan their life after compulsory retirement as civil servants, but they may also work until their body no longer allows them to make a financial contribution to the family. They may have children abroad, who advise them to take vitamin pills in order to age "successfully" or they may invest in self-care because they came across a second-hand Yoga book—or because there is simply no other option available. In this PhD thesis, taking these different repertoires into account, I explore older people's imaginations about *kuzeeka vizuri* (aging well).

The city provides a context of aging that is shaped by an ongoing urban transition, as Dar es Salaam belongs worldwide to those cities with the fastest population increase in recent years (URT National Bureau of Statistics 2013). This context of aging is not only shaped by urbanization processes but also by a demographic transition, with an increasing number of older people. Tanzania, like many other countries in sub-Sahara Africa, can be described as a youthful country that directs development and health agendas mainly to the young population (Aboderin and Beard 2015, 9). However, despite the fact that older people make up only a small proportion of the overall population in most countries of sub-Sahara Africa, their number is growing fast. While, in 2005, there was an estimated number of 34 million older people aged 60 and older, this number is expected to nearly double to 67 million by the year 2030 (Velkoff and Kowal 2006, 57). For Tanzania this means that, while at the time of this study, 4.8 percent of the Tanzanian population were above the age of sixty years, it is estimated that this number will increase so that, in 2050, 7.2 percent of Tanzanians will be over sixty (HelpAge International 2015). While this may still seem a small proportion of older people, it should not lead to what demographer Velkoff and global public health specialist Kowal describe as a misconception of

"no older people" as the number of this particular age group is growing rapidly (Velkoff and Kowal 2006, 57). Also, life expectancy at birth is rising steadily; in 2015, overall life expectancy in Tanzania was 63 years (World Bank 2022b) and thus slightly higher than the average of 60 years in sub-Saharan Africa overall at that time (World Bank 2022a). Not only in Tanzania, but also worldwide, the growth of the older population is expected to take place mainly in urban areas. The World Health Organization estimates that by 2050 the proportion of older people in cities of the Global South will rise to one fourth of the total urban population (WHO 2007, 4).

In the light of the massive population aging, topics around aging, health, and care have recently gained new relevance on a global scale. Especially on the African continent, current research on aging gives rise to what linguist Makoni calls "lament discourses" with a focus on how the "unprepared" continent can cope with the increasing number of older people (Makoni 2008, 201). In this connection, international gerontology alerts us to yet another ongoing transition that concerns health (Eeuwijk 2011, 92-93). Experts talk of a "double burden" when referring to the combination of infectious diseases and chronic diseases as presently observed in the Global South (Manderson 2008, 198). This double burden is again a concern for older people, who are likely to cope with frailty due to their advanced age. At the same time, it is a concern for those who are supposed to care for them.

Non-governmental organizations have started to put pressure on governments to formulate policies on aging (Makoni 2008, 200) since they expect that the inter-linked transitions mentioned above will lead to an increased demand for health services and care support of the older population. While this development discourse puts forward a problematic view of urban aging, it can be criticized for rarely basing its arguments on the older people's articulated experiences, thus disconnecting the two perspectives (cf. Makoni 2008; Cohen 1994). This PhD thesis, therefore, takes up the challenge of going beyond the suffering subject (cf. Robbins 2013a) and explores older peoples' own constructions of what a "good" old age means for them. Hence, this PhD thesis is about the older people's own articulations and my interpretations of them; verbal and non-verbal articulations, about aging, health, and care.

The aging policy of Tanzania describes "… an older person … [as] an individual who is 60 years and above" (URT Ministry of Labour 2003, 3). The definition by the Tanzanian State that is also relevant for retirement as well as access to free health care, guides the conception of the "legal age" in this PhD thesis. An older person who experiences compulsory retirement at the age of sixty may in some instances refer to this definition of old age while somebody who is not formally employed and works until their body simply gives in may refer to another repertoire. Apart from the legal age definitions around old age in Tanzania, based mainly on institutional landscapes, people also draw on their social age.

In order to define social age, gerontologists point to the processual nature of aging as "socially constructed, fluid, performed from one moment and situation to another" (Makoni 2008, 203). The experience of social age is not defined in numbers but in the way older people are perceived as being old by others as, for example, when greeting them in a respectful way. I understand these repertoires of old age to be situational. Depending on a particular interaction, but also on the older person's intentions in a particular situation, a person may refer to different definitions of aging and old age which in turn shape her or his experience of the city as an older person. Perceived social age can, for example, become important when an older person traveling by public transport has to struggle for a seat on a bus. Often, based on negative experiences when not being granted a seat—although perceiving themselves as old and therefore entitled to a seat—older people may voice their discomfort of living in the city as an older person. At the same time, legal age becomes relevant when it comes to improved access to free health care that is rendered when providing proof that one is over sixty.

In this PhD thesis, I start from the assumption that Dar es Salaam is an ordinary city in its own right (Robinson 2006) that contains creative social spaces (Förster 2013) that may lead to new imaginations of late (retired) life. The country's socialist past makes Dar es Salaam a particular place for older urban dwellers as the idea that only the productive workforce is allowed to live in the city sticks in the head of some people to this day. I therefore analyze how a "first generation" of older people who decided to stay in the city grows old and document their expressed considerations about living or leaving the city, while I discuss their perceived tensions between their parents' "traditional" old age in the village and their "modern" ways of aging in the city.

Aging in Diverse Urban Milieus

As yet, not much literature has focused on financially "better-off" older people, who have more possibilities to actively shape their own old age. In Tanzania the group that can be called "middle class" has grown since the mid-1980s economic and political liberalization (Mercer 2014, 230). The international debate on "African middle classes" usually departs from an economic definition of "class" and attributes particular values, lifestyles or political orientations to the group of people while these ascriptions are rarely empirically based (Stoll 2016, 195). Due to the shortcomings of the term "class" and its development for a Western context, in this PhD thesis I use a social milieu approach (cf. Grathoff 1989).

This PhD thesis therefore looks at older urbanites through the lens of social differentiation and explores how people live their everyday lives and age differently in different social milieus of Dar es Salaam—and who is supporting them in doing so. It hereby lays a particular focus on a former civil servants' milieu that belongs to Dar es Salaam's middle-income strata and explores what it means for older people and their relatives to age in this milieu. Being part of Dar es Salaam's "middle class," the

retired civil servants form part of a minority of older Tanzanians who are entitled to some amenities such as pensions and formal health protection schemes. For them, living in the city is linked to certain advantages as, for example, access to quality health care; their knowledge of how to navigate the health system facilitates this access. As former state employees, most of the older participants of the study stood quite close to the dominant political party *Chama cha Mapinduzi* (CCM; former TANU), which means they often embraced the ideology of the state. Together with the dominant force of the former single party CCM that has led the country since independence, the associated socialist past after Tanzania's independence provides a special context for older people.[1] Especially after the country's independence, the "golden age" of civil service (Eckert 2014, 232) led to privileges for this particular group working "for the nation" that are no longer available today. As in many African countries, city dwellers experienced a decline in public services during the economic crisis of the 1980s that were offered for free before; instead, they witnessed a privatization of basic services in which financial means and social relations facilitated access to quality services.

URBAN HEALTH FROM AN ANTHROPOLOGICAL PERSPECTIVE

Today, a growing body of social anthropological literature on aging in Africa exists, despite the fact that the discipline of social anthropology holds to be a late entrant into the field of aging (Marzi 1998, 13). Invaluable for this PhD thesis were, therefore, the insights gained through the in-depth ethnographic research conducted by my colleagues on aging in Dar es salaam (Gerold 2017), Zanzibar city (Staudacher 2019a), and rural Tanzania (Büsch 2014; Simon 2015). While especially Vendelin Simon's study revealed the physically demanding activities around farming to shape the way old age was lived in rural Tanzania as a *ngoma*; a dance that you have to dance whether or not you are a good dancer (Simon 2015), the study conducted by Fortunat Büsch emphasized further the harsh side of the rural environment when needed care is mostly lacking (Büsch 2014). Inspiring is also Sandra Staudacher's work who explores diverse spaces of aging and caring in Zanzibar City, with some of them being rather localized while others reach transnational dimensions (Staudacher 2019a).

A seminal book for me was Jana Gerold's ethnographic study on Mbagala, a sub-ward in the Temeke district of Dar es Salaam where she explored what living the city means for the older urban inhabitants living different mobilities, urban-rural connections being one among them (Gerold 2017). While Gerold's work explored one particular urban neighborhood, it remains open whether older urbanites from other geographical areas or other milieus experience growing old in similar terms. Furthermore, shaped by their urban environment, different priorities may emerge. Hence, aging in the city can be

[1] See also Blommaert who discusses the role of the Swahili language in the history of Tanzania's Ujamaa politics and state ideology (Blommaert 2014).

studied from many different angles. Putting older people as social actors in the spotlight, this PhD thesis seeks to bring forward their concerns, struggles, wishes, and imaginations about their late adulthood. Very prominent hereby is the topic of health, taken in a broad sense.

The WHO defines health in their constitution signed in 1964 in a positive sense as "… a state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity" (WHO 1967, 1). This often criticized[2] but much cited formalized WHO definition takes a rather holistic approach to health. Also when it comes to urban space, Obrist puts forward a broad definition that understands urban health as a result "of the complex interactions of people with each other and diverse aspects of the urban environment in which they live" (Obrist 2006, 27). Hence, health can be described as "…grounded in people's embodied experience, partly enacted and partly verbalised, reflected upon and recreated in social interactions with other persons, yet at the same time constrained by larger structures of social, political and economic conditions which manifest themselves in particular localities, for instance, an African city" (Obrist 2003, 276).

Urbanization is not per se a threat for health (Obrist, Eeuwijk, and Weiss 2003, 267). Much research from a public health perspective explores aspects of "urban health" and its determinants that may lead to an unwanted outcome of mortality and disease, as the urban population is exposed to particular (objective) risk factors shaped by urban life and the urban context (Obrist 2010a, 412). Hereby concepts such as "urban penalty" (cf. Harpham 2009) discuss how far living in an urban space may shape people's access to health care or their exposure to new risk factors. With a focus on health systems, the field of urban health has significantly contributed to an understanding of how diverse social, political as well as economic risk factors may lead to particular health problems, by taking into account the important fact that different social groups' access to the theoretically available better biomedical facilities in a city may vary greatly (Obrist 2010a, 412).

Medical anthropologist Obrist aptly describes the field of tension, when the everyday reality of city dwellers comes together with such positivist public health approaches and linked development discourse as well as with theories of medical anthropology, or social sciences in general (Obrist 2010a, 411). This field of tension drives this PhD thesis' quest for putting the older people's experiences of urban aging in the spotlight while taking into account the wider structures and forces that shape their own capacities to act and critically reflect about their actions (Obrist, Tanner, and Harpham 2003, 367). For now, many medical anthropological studies are conducted in urban settings, but do not always critically reflect on how the medical knowledge and practices relate to urban contexts (Obrist 2010b, 349). Focusing on older people's everyday lives in the city, we may thus ask which forces structure their

[2] For example, the definition by the WHO has been criticized for being unrealistic by using the word "complete" (Alli and Maharaj 2013, 54).

aging in the city, by taking into account the diverse physical, economic, political, social, and cultural cityscapes in which health is threatened or taken care of (Obrist 2010b, 349).

From an anthropological point of view, there is a need to look at a particular context in order to find out what is perceived as a risk to health by whom (Obrist 2010a, 422). What are the dangers of life in the city that are perceived as "afflictions" (Obrist, Eeuwijk, and Weiss 2003, 270) by older urbanites? Cities are highly complex settings with intricate processes of social and cultural change (Obrist 2010b, 349), and as such they are embedded in a wider global context. Older people's experiences of aging and health in the city are thus linked to wider social, economic, and political forces that shape local experiences of sickness and suffering (Janes and Corbett 2009, 167-183). Much research with a global health lens in African contexts focuses on the wanted and unwanted outcomes of global health programs and the changing links between biomedicine and national states. Nonetheless, Obrist and van Eeuwijk urge not to forget the "blind spots;" such as older people who might not be targeted by global health programs but act in complex local settings while engaging in "diverse ways of doing medicine" (Obrist and Eeuwijk 2020, 3). As will be emphasized later, an ethnographic approach is well suited to account for such a social actor's perspective.

When older people in this study describe their own health to me, they often refer to their strength (*nguvu*). The loss of strength is, at the same time, often linked to becoming frail as age advances (Eeuwijk and Obrist 2016, 189), while noting that frailty, "with gradual loss of bodily and mental strength, and increased episodes of illness, is … part of the normal process of becoming old" (Eeuwijk and Obrist 2016, 189). At the same time, these illness[3] episodes and loss of strength increase a need for care. In a positive sense, having strength does not only encompass physical strength or health but also point to a general mental wellbeing that is missing when somebody says about himself or herself *sina nguvu* (I do not have strength). As will be discussed later, not having strength can be linked to a general malaise in the city, leading to the image of the "guilty city" when accusing the city of its unhealthy environments as well as its unreliable social networks which results in lacking care through related others.

DIFFERENT WAYS OF CARING

Having or not having strength also influences the care that an older person is able to give and receive. One focal point of this PhD thesis is, therefore, the provision and reception of care in private settings. As the above mentioned study by Gerold on aging and care in Mbagala, a low-income sub-ward of Dar es Salaam reveals, many older people struggle in the city to make ends meet while social relations and,

[3] Kleinman coined the now classic distinction in medical anthropology between illness, that is the experience and meaning of symptoms and suffering and disease, as a biomedical category (Kleinman 1980, 72-73). I will use the two terms accordingly in this PhD thesis.

as a consequence, care become a fragile asset (cf. Gerold 2017). Hence, as Kleinman and van der Geest aptly note, care has "various shades of meaning" (Kleinman and Geest 2009, 159) which is also reflected in the Swahili semantics of care. In this PhD thesis, I distinguish two spaces of care, namely, care that is provided by others for an older person (relational care) and care that is provided for the self (everyday self-care).

In Tanzania and many other countries on the African continent, there are only few institutional arrangements for care of older people. Tanzania's Aging Policy (2003) even stipulates that the family is the "basic institution of care" in old age. A great deal of the published literature on aging and care therefore emphasizes reciprocal duties among family members, in particular between parents and children (for example, cf. Geest 2002; Roth 2008). Care that is provided by others, mainly by the family, takes place within a complex whole of responsibilities, obligations, norms, and values while it is linked to being part of a specific generation too (cf. Geest 2002; Klerk 2011; Alber and Häberlein 2010). At the same time a particular care arrangement is prone to dynamic changes for several reasons. One essential aspect is the health of the older person. In relation to the broad definition of health, I adopt a broad understanding of care that encompasses not only practices directly targeted to improve an older person's health, but also activities that target their emotional well-being, for instance spending time with them or holding their hand when not feeling well. Care in this sense does not only happen within given social relations but may also create new ones (Klerk 2011, 11). Furthermore, I understand practical household tasks (e.g., cleaning) to be part of the care provided for an older person, also by non-kin. While such a broad understanding of care allows for a focus on a wide range of practices, it could also create the impression that all older people in this study receive care. Kuzeeka vizuri is therefore linked to what is perceived as "good" care by the older city dwellers.

This PhD thesis addresses yet another aspect that is currently missing in literature on aging in Africa, namely the older people's own efforts in what I call everyday self-care. Especially healthy older people are in a position to invest in forms of self-care for health promotion and disease prevention, thus contributing favorably to their old age in future. However, as Hickey, Dean, and Holstein (1986, 1368) aptly emphasize, in this context self-care represents a "two-edged sword." It may not only be due to a neoliberal rationality that they engage in self-care practices, but also because there is no one else who could take over. Hence, self-care practices have different nuances that require a closer look.

The fact that in Tanzania and elsewhere in Africa more people age in the urban space 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 the elderly and the sick" is currently at stake (Makoni 2008, 200). The romantic picture of "African solidarity" is thus seen to be threatened by urbanization processes and demographic change that overburden families and, as a consequence, lead to the neglect of older people (for a critical debate cf. Aboderin 2004). These narratives of neglect have been

documented by colleagues doing research in rural areas of Tanzania (cf. Simon 2015; Büsch 2014; Klerk 2011). In this PhD thesis, I instead wish to call to attention that urbanization and population aging do not (necessarily) weaken family structures and care; in fact, some older people even perceive them to be more intact, particularly *in* the city.

ORGANIZING CARE FROM ABROAD

The discussion around transnational care again broadens the understanding of activities that can be described as care for older people, since care provided across national borders takes on different shapes in order to fulfill expected norms. In this PhD thesis, I will therefore point to virtual forms of caring "about" an older person (cf. Baldassar and Merla 2014b) provided across national borders, when for example, telephone calls or Skype conversations replace physical care in order to show concern for an older person and invest in kin work (cf. Dossa and Coe 2017). Furthermore, medical remittances (cf. Zanini et al. 2013), as a form of care may also contribute to shape older people's own ideas and definitions of health and old age.

Most relational care in the private setting in Dar es Salaam is provided by younger and/or healthier caregivers living in the city, in other parts of the country, but also abroad. In the past decades, social anthropologists began exploring care from a transnational perspective with the assumption that migrants as well as those who stay behind form part of "multi-layered, multi-sited transnational social fields" (Levitt and Glick Schiller 2004, 1003). While a number of studies are concerned with transnational care provided for children, only few studies have looked at aging in connection with transnational care provision so far (among them, Dossa and Coe 2017; Lamb 2009; Mazzucato 2008b; Torres and Karl 2016; Hromadžić and Palmberger 2018).

Instead of following the narrative about neglect based on the assumption that younger people emigrate to "greener pastures"[4] and leave their parents behind, some Tanzanian migrants in the USA engage in transnational care and thereby actively shape older people's daily aging practices. At the same time, their engagement in what is described in this PhD thesis as "transnational triangles of care" depends on their possibilities as (il)legal migrants in the USA. This PhD thesis explores, therefore, the ways in which children or relatives living in the USA are involved in the care for their parents or relatives in Tanzania. Furthermore, I assume that the provision of transnational care is shaped by the American context, where there is yet another aging discourse at stake. Trying to mitigate the increase in older people in the Global North and the Global South, international gerontologists currently opt for concepts such as "successful aging" (cf. Rowe and Kahn 1997) or "active aging" (cf. WHO 2002) to

[4] For a discussion on an image of "greener pastures" in Cameroon, see Förster (2010).

address health promotion and illness prevention in old age. In this international discourse on aging, older people are expected to remain productive and healthy without becoming a burden to anyone, through which aging thus becomes ageless (cf. Lamb, Robbins-Ruszkowski, and Corwin 2017). "Promoting engagements in various techniques of the self," the positive aging discourse that reflects a particular neoliberal ideology thus shifts responsibility to the older people themselves as individuals (Rudman 2015, 19).

Focusing on transnational aspects of care thus allows for a broader view of care that encompasses not only the flows of people but also of goods and ideas (cf. Appadurai 1996). While care circulates sometimes asymmetrically among multiple family members in Tanzania and the USA (cf. Baldassar and Merla 2014a), it consequently shapes the way older people are cared for and care of themselves—while being embedded in transnational social fields (cf. Levitt and Glick Schiller 2004).

The older people's own imaginations about aging well, which are also shaped by these care circulations, are an important part of their agency, that guides how they act (cf. Emirbayer and Mische 1998). In a next step therefore, the theoretical lens of agency is discussed.

Older Urbanites' Agency as a Lens

"Africa's urbanites are actors and subjects of continuous social, political and economic transformations and actively situate themselves in their cities as economic, social and political spaces" (Förster and Ammann 2018, 8).

In order to explore how older people actively shape their own old age, in this PhD thesis, agency is used as a theoretical lens. In the city of Dar es Salaam, which counted almost 4 million inhabitants at the time of research, aging is obviously perceived and lived differently in different social milieus. These milieus shape the social contexts in which older people and their relatives act. The concept of agency serves as a lens to capture the complex interplay of older people's experiences and actions with the urban space and beyond. Hence, while the city serves as a context in which people grow old facing rapid change due to the above-mentioned mega trends, this PhD thesis wants to go a step further and explore how far the urban shapes people's everyday practices in diverse social milieus and vice versa.

Social anthropologist Förster points to the fact that the English word agency is often misleadingly translated into the German *Handlungsmacht*. He pleads for an translation as *Handlungsfähigkeit*, because social actions do not necessarily always have to be related to power or any form of profit but can have different dimensions (Förster forthcoming, 3-4). In order to analyze *Handlungsfähigkeit* in this PhD thesis, I adopt an approach put forward by the American sociologists Emirbayer and Mische which tries to move away from what they call "flat" or "impoverished" conceptions of agency, that tend "to

remain so tightly bound to structure that one loses sight of the different ways in which agency actually shapes social action" (Emirbayer and Mische 1998, 963). Based on their analysis of social movements, the much cited authors therefore propose to re-conceptualize human agency as "the temporally constructed engagement by actors of different structural environments—the temporal-relational contexts of action—which, through the interplay of habit, imagination, and judgment, both reproduces and transforms those structures in interactive response to the problems posed by changing historical situations" (Emirbayer and Mische 1998, 970). Especially when analyzing health-related crises of older people in this study, "dynamic possibilities of human agency … within the flow of time" become important (Emirbayer and Mische 1998, 964). Emirbayer and Mische advance a temporal orientation of actors and distinguish three elements, namely iteration, projectivity, and practical evaluation (Emirbayer and Mische 1998, 970).

Listening to older people in Dar es Salaam, they usually describe their becoming old in the city with a reference to their past experience of how aging and care was organized for their parents. Their reference to the past can be situated in the iterational dimension of agency. Although this dimension is closely linked to what Emirbayer and Goodwin (1996) call cultural context of action that guides how actors act, the authors claim that one should focus on "the precise ways in which social actors relationally engage with those preexisting patterns or schemas" (Emirbayer and Mische 1998, 975).[5] Older people therefore recall past social experiences and embodied practices around care, aspects that are usually taken for granted.[6] They base their habitual actions on reciprocal norms that guide the provision of care for an older person. Hence, in these situations, actors make a link between a situation in the past and a situation in the present. If this is the case and actors perceive these situations similarly, they may act by building on their past experience (Förster forthcoming, 7).

If, however, a situation changes as, for example, when a health crisis emerges, older people, as everyone else, have to adapt to a new situation and make judgments about their abilities and needs in order to act. This practical-evaluative dimension of agency is oriented towards the present (Emirbayer and Mische 1998, 971). However, while adapting to a health crisis and exploring alternative possible trajectories in response to the crisis, the older persons' agency is not detached from past experiences and expectations towards the future, as in each of the described dimensions the other two temporal

---

[5] Emirbayer and Mische therefore emphasize that "[t]his problem is also reflected in most attempts to theorize the habitual dimension of action since they focus upon recurring patterns of action themselves and thus upon structures, rather than upon the precise ways in which social actors relationally engage with those preexisting patterns or schemas" (Emirbayer and Mische 1998, 975).

[6] Using a phenomenological perspective, I understand the body as an "existential ground of culture" and self (Csordas 1990, 5). The body is not only a *Körper* that can be inspected it is at the same time a *Leib* through which we experience the world (basing amongst others on Csordas 1990, Desjarlais and Throop 2011, 89).

elements also play a role. Hence, the three elements rather have to be taken as analytical distinctions (Emirbayer and Mische 1998, 971-972).

When looking at older people's engagement in particular practices around everyday self-care in order to age well, especially their orientation to the future becomes relevant. Actors disassociate themselves from certain habits and imagine "possible future trajectories of action, in which received structures of thought and action may be creatively reconfigured in relation to actors' hopes, fears, and desires for the future" (Emirbayer and Mische 1998, 971). If a situation is unclear, and people are not able to relate to other situations they are familiar with, situations have to be judged anew. Although imagination is yet undertheorized in social theory, it constitutes a crucial element of agency because we have to imagine the consequences of our actions in every situation, otherwise we lose our agency (Förster forthcoming, 10). Imagination can be practiced in different ways (Förster 2023, chapter 1), while the process is always interactive and culturally embedded. Actors thus "construct changing images of where they think they are going, where they want to go, and how they can get there from where they are at present" (Emirbayer and Mische 1998, 984).

McLean highlights that the concept of imagination has offered "a mean of engaging with rapidly changing reality and a basis for understanding the ways in which people whose lives are caught up in contemporary historical transformations themselves seek to make sense of their altered circumstances" (McLean 2007, 6). As new old urbanites, a first generation that is currently aging in the city of Dar es Salaam, older people are sometimes asked to imagine alternative possible future trajectories with regard to their urban aging. They may become creative in their engagement in new forms of everyday self-care through, for example, exploring Yoga. In doing so, they may contribute to new images of how older city dwellers become old. Although they imagine innovative ways of how to age well, when they, for example, invest in health promotion in order to not become a burden to their children, their practices do not necessarily constitute a disconnect or break with existing values.

From an anthropological perspective on urban health, this PhD thesis does not only want to shed light on people's agentic orientations but also draw attention to the particular structuring environments shaped, among other things, by the urban context and their being embedded in a transnational network of care. These structuring environments are described by Emirbayer and Goodwin as structural or relational contexts of action that are themselves temporal and relational fields (see also, Emirbayer and Mische 1998, 963).[7] Actors are accordingly always embedded in multiple temporal-relational contexts

[7] For their analysis of revolutions and collective actions, the authors divide these contexts of actions analytically into a cultural, a social-structural, and a social-psychological context of action (Emirbayer and Goodwin 1996, 358). While these contexts might overlap with some of the situations described in this PhD thesis, my aim is to rather openly empirically explore diverse contexts of actions from the perspective of the older city dwellers themselves.

at once (Emirbayer and Mische 1998, 1008). Together these contexts guide how actors act while "actors may switch between (and reflexively transform) their orientations toward action, thereby changing their degrees of flexible, inventive, and critical response toward structuring contexts" (Emirbayer and Mische 1998, 1012).

Taking this approach and its analytical elements as a starting point, this PhD thesis explores how older people from different urban milieus are able to engage in and consequently shape particular contexts of actions.[8] Hence, older people from similar urban milieus may share certain enabling and constraining situations and may similarly experience the limiting power of the urban (infrastructure etc.) when, for example, living at the urban margins (Aceska, Heer, and Kaiser-Grolimund 2019, 4). At the same time, people who share similar interests and ways of life may base these shared interpretations of the world on their habitual side of agency (Heer 2019, 34). Urbanites belonging to the same social milieu consequently may share certain ideas about values in life, that are often also shaped by their past experience. Based on this experience they articulate some expectations towards the city, that are reflected in their image of the city; as an "unhealthy" place of hardship, or an enabling place of opportunities. Retired former civil servants, who are in the focus of this PhD thesis, can be described as such a group or milieu that shares some ideals of socialism and expectations towards the state (and its provision of health care) when also facing similar aspects of legal age. While Emirbayer and Goodwin (1996) suggested that these above-mentioned structuring environments have to be distinguished from formal state and administrative structures that may shape people's repertoires of old age in the city in particular ways, it is nevertheless important to consider that older people make claims towards the state by imagining their city as a place of hardship or opportunity.

In order to analyze older people's agency, I mainly observed problematic situations in their everyday lives whilst conducting long-term ethnographic field research. During health-related crises of older people, experiences of aging, health, and care are articulated "through discursive and enacted practice" (Obrist 2016, 96). The next chapter will present therefore the methodological approach of this PhD thesis.

[8] As put forward by Staudacher in her analysis of aging in Zanzibar, older people might thereby be able to access different spaces of aging and care, whereas some are more bound to a localized space, their agency might be limited to a rather narrow local field while others may also have access to a transnational space of aging and care (Staudacher 2019b).

RESEARCHING AGING IN URBAN SPACES

"*What* the ethnographer finds out is inherently connected with *how* she finds it out" (emphasis in original, Emerson, Fretz, and Shaw 1995, 11). Methodologies describe and analyze the process of data collection and analysis and, more concretely, the methods (Carter and Little 2007, 1318). In this section I will consequently elaborate on *how* the contents of this PhD thesis came about. Although this methodology section is rather long for an introduction, I have decided not to shorten it significantly in order to provide a transparent description of how I came to my conclusions and who was involved in the process.

ON COLLABORATIONS AND SHARED LIFEWORLDS

Campbell and Lassiter aptly state "…at the end of the day, doing and writing ethnography is about engaging in, wrestling with, and being committed to the human relationships around which ethnography ultimately revolves" (Campbell and Lassiter 2015, 4).

This PhD thesis is based on diverse relationships and collaborations at different levels; with a project team, with a tandem PhD candidate, and with a local research team. These various collaborations enriched the project but also raised questions about authorship during the analysis and writing process. Although, ultimately as a qualification document in form of a PhD thesis, it became a single authored piece and thus cannot address many of the criticisms that evolved around collaborative ethnography (see Campbell and Lassiter 2015) or the plea for a decentered medical anthropology that works more "for and with Africa" (Obrist and Eeuwijk 2020, 8). Nevertheless, I think it is important to unfold the different kinds of collaborations and also critically reflect on the topic of team work. As Fluehr-Lobban states, critically reflecting on these collaborations in the field also involves how we write about them: "If a central goal of collaborative research is to work *for* as well as *with* research communities and to develop reciprocal relationships that allow projects to be initiated, discussed, reviewed, and evaluated through a process of continuous consultation and collaboration, *then* the language of the research relationship needs to evolve and change" (emphasis in original, Fluehr-Lobban 2008, 178).

This PhD study was part of the larger research project *Aging, Agency and Health in Urbanizing Tanzania* (AAH).[9] Conducting a PhD thesis within a project team not only influenced data collection but also the process of the interpretation. Working in a project team necessitates a greater transparency when it comes to deciding what is the product of the team and what is that of a single project member. Due to the iterative process of doing fieldwork and analyzing and interpreting data, it becomes difficult

[9] The Swiss National Science Foundation funded our project from 1st April 2012 to 31st March 2014 (Grant No. 140425) and from 1st April 2014 to 31st January 2016 (Grant No. 152694). The project is led by Brigit Obrist.

to clearly distinguish single lines of thought. In this PhD thesis, whenever possible, I therefore point to ideas that developed in the course of ongoing discussions within the research team, while all others can be interpreted as my own.

Especially at the beginning of the PhD study, the project team[10] met regularly to develop the "homecare tool," a semi-structured interview guide based on findings of a former project headed by Peter van Eeuwjik in Tanzania.[11] The tool was developed in order to come up with a typology of care arrangements. By applying the interview guide we intended to ensure certain degree of comparability on care in different localities. My PhD tandem partner Sandra Staudacher conducted her research in the city of Zanzibar, and MA student Fortunat Büsch applied the same interview guide in a rural context in Ulanga.[12] The long-term aim of the homecare tool was to be able to conduct a baseline study concerning the actually provided care for older people in rural and urban Tanzania. The project team developed the homecare tool in close collaboration with HelpAge International, and, during a dissemination event, a workshop with NGO representatives helped to further improve and adapt it.

The AAH project was designed as a comparative project where two PhD studies in two different localities look at similar questions around aging in urban space. As a consequence, a very close collaboration developed with my tandem PhD partner Sandra Staudacher. Conducting our PhD studies in the framework of a comparative project, we made an effort, especially at the beginning, to look at similar questions in the two different settings. This also meant that we went to the field simultaneously and engaged in constant communication and some regular physical meetings. Being only three hours apart by boat and within the same national borders, facilitated our collaboration greatly. We were able to conduct a workshop for our research team together in Zanzibar, and also joined forces for the dissemination events.

During the various field stays but also beyond, this study was supported by a whole team of local collaborators in Dar es Salaam. The local research team consisted of collaborators from different age groups, with diverse social and cultural backgrounds who were involved at different stages within the project and all contributed with their skills to the success of this study.

---

[10] Our team consisted of Brigit Obrist (project leader), Joyce Nyoni (principal investigator, Tanzania), Peter van Eeuwjik (senior researcher), Vendelin Simon (Tanzanian counterpart), and Sandra Staudacher (my PhD tandem partner).

[11] The Swiss National Science Foundation funded the project *From Cure to Care: Old Age Vulnerability in Tanzania* (1st July 2008 to 31st December 2011), looking at care of older people in rural (Rufiji) and urban (Dar es Salaam, Mbagala) Tanzania (Grant No. 117857).

[12] Fortunat Büsch conducted a tropEd Masters Program in International Health; his thesis with the title *Giving the elderly people a voice. Care Arrangements for and by Frail Elderly People in Rural and Remote Communities in Tanzania* tragically reveals the neglect that some older people in one of the most remote areas of Tanzania experience (cf. Büsch 2014).

During the first field phase in 2012, Elisha Sibale Mwamkinga and Neema Duma joined the project. While Elisha is the executive director of a Tanzanian NGO supporting older people, Neema also had her own small NGO for HIV positive women. Elisha who was himself already sixty plus, was and still is very committed to support older people and, through his work, greatly experienced in conducting research on and with older people. Due to his experience in organizing research permits, he was a precious support when visiting public authorities in the city or at district, ward, and sub-ward level. Neema, in her late forties at that time, was already supporting another project in our research group and thus had experience in conducting qualitative interviews with older city dwellers. When Neema was not able to support the project anymore, Judith Valerian, who had just come back from conducting her master's degree abroad, jumped in to translate during the interviews. The presence of Judith, who was my peer, interestingly led to slightly different focal points during the interviews.

From the second phase of fieldwork onwards, Frank Sanga and Monica Mandao, who studied together for their bachelor's degree in social sciences at the University of Dar es Salaam, came to support the research project. Frank, originally from the Western part of Tanzania, quickly became familiar with the former civil servants from the same region. Monica, who grew up in Moshi, quickly related to the elderly women from the same area. Regarding urban settings, Hannerz points to the importance of working with collaborators with "varying backgrounds, so that they can complement each other not only as participant observers but as interpreters and study participants as well" (Hannerz 1976, 80). Furthermore, with some medical training, Elisha supported the team as an expert, advising and jumping in when medical knowledge was needed.

With their multifunctional support, the members of the local research team, were more than just simple "field workers." Middleton and Prahdan's description of a research assistant "as an interlocutor and 'fixer' of ethnographic relations—not merely a worker *of* the field, but rather constitutive of the field itself" (emphasis in original, Middleton and Pradhan 2014, 357) therefore also fits well as a description of the local collaborators.[13]

Hence, this research project could not have been successful without the local team.[14] Apart from their very practical support in authority visits and direct translation, the local research team served as cultural brokers to whom I could always turn with my questions. Only through our innumerable discussions after our visits, when we sat and ate or drank a soda together, I gained a deeper understanding. By

[13] A fixer is somebody who involves in "establishing meetings, providing short introductions, and then often vanishing from the scene" (Middleton and Pradhan 2014, 364).

[14] In a contribution with the title "Research Assistants: Invisible but Indispensable in Ethnographic Research" together with my colleagues Carole Ammann and Sandra Staudacher, I elaborate more on the collaboration with a local research team (cf. Kaiser-Grolimund, Ammann, and Staudacher 2016).

doing so, we engaged in a kind of co-production of knowledge. Middleton and Cons write, "the dynamic between researchers and assistants … comes into view as one of co-production, rather than a simple conveyance of data" (Middleton and Cons 2014, 283). Usually, I entered the notes in my computer after having spent a day with an older study participant, and the next day Frank and Monica would comment on my notes so that we were able to clarify some remaining question. Our discussions significantly shaped my understanding of aging, health, and care in Dar es Salaam and thus significantly shaped the content of this PhD thesis. In the team we also discussed short reports or dissemination documents, before finalizing them.

It is thus worth to not only depict their technical support, but to also reflect on the teams' impact on the interpretation of data. Data collection in qualitative research and its interpretation are part of an iterative process; consequently there is no clear-cut distinction to be made between the two work steps; Gupta also emphasizes that "the 'raw data' is itself interpretative, relational, affective, and contextual" (Gupta 2014, 398). We should therefore not forget to reflect on the role of the research team in this second, more interpretative and analytical part of the research, which means "to be explicit about the process by and through which data comes to be recorded, to diagram as carefully as possible its multiple mediations, and to record and chart the conflicts and difficulties of 'data collection'" (Gupta 2014, 399). We have to be aware that "the ideas themselves have come from a complex history of interaction, negotiation and exchange …" (Middleton and Pradhan 2014, 358).[15]

During my absence, Monica and Frank continued work on the project by transcribing the recorded interviews. Also, after the fieldwork in Tanzania had finished, they continued transcribing the interviews I recorded in the USA; this also led to interesting discussions when they gave me their impression on these conversations. Through the transcription process, interviews already undergo a kind of hidden interpretation. Expressions used by our interviewees can be described by means of a certain mood (for example funny, or sarcastic etc.). Some Swahili expressions describing a person's relatives could be interpreted differently, as for example when referring to a niece or a nephew.[16] In addition, when Frank and Monica translated the transcribed Swahili interviews into English, there was much room for interpretation. Being aware of this early interpretation in transcription, in this PhD thesis I will always provide the Swahili version of the interview in a footnote.

---

[15] However, some anthropologists might be afraid that "reference to a field assistant might expose her linguistic incompetence" and thus "embarrassment, concealment, and postcolonial guilt may all be important reasons why the native assistant's role is not acknowledged as fully and explicitly as it might" (Gupta 2014, 398).

[16] The Swahili language does not use gender attributions and when transcribing and translating interviews, it was part of the interpretation of the context that revealed if the child who supported an older person was a niece or nephew.

While making various relations and collaborations transparent may be seen as an attempt to democratize and decolonize the process of ethnographic field work and writing, the postmodern turn in anthropology of the 1970s as well as important contributions by feminist and other critical theorists also led to a higher awareness of critically reflecting on the ethnographers' position in all of this (Campbell and Lassiter 2015, 122).

Robben writes, "the conscious self-examination of the ethnographer's interpretive presuppositions enriched fieldwork by making anthropologists pay much closer attention to the interactional processes through which they acquired, shared, and transmitted knowledge" (Robben 2007, 443). I consider it therefore crucial to uncover some of the processes that led to the interpretations presented in this PhD thesis, paying close attention to my positionality within the various collaborations and exchanges and how it possibly shaped the research process. Being a relatively young female Swiss researcher conducting funded research for an academic degree in an African city does have various implications that cannot be neglected when publishing a book about its results.[17]

Collaborations and relationships do not only evolve within the research team but also through diverse encounters with research participants. Living for all in all more than a year in a rapidly growing city, obviously lead to various planned and unplanned encounters out of which also close bonds emerged.

One crucial aspect of my "second socialization" (Fischer 1998, 75) in Dar es Salaam and in the USA was staying with host families. During my fieldwork in Dar es Salaam, I had the privilege of staying with the same host family over the whole research period (from April 2012 to February 2015).[18] I call it a privilege here as the continuous stays at the same compound helped to deepen the relationships with the host family, who became important research participants over the years.[19] Late Mzee and late Bibi Ngowi had been living in the same compound already since the seventies.[20] In the course of my

[17] As Fluehr-Lobban aptly states with a focus on ethics and anthropology, "Anthropologists in the postcolonial, postmodern and post-9/11 world can expect 'the field' to be a far more complicated prospect than it has been for previous generations. The assumption, from another era, that anthropological researchers can go anywhere and do anything is simply no longer operative" (Fluehr-Lobban 2013, 157).

[18] They were able to build four houses on their land, of which three were let to others. I was able to rent the attachment to the Ngowi couple's house with the water tank on top, and I shared the living room with the TV with the landlord and his family.

[19] Although one could also criticize the fact that I missed the opportunity of living in other sub-wards of the city which would have extended my city experience.

[20] The contact to my host family had been mediated through a colleague from the Swiss Tropical and Public Health Institute (Swiss TPH) who rented a house on the same compound. My Tanzanian host family owned four houses, and the attachment I stayed in. They rented out three houses to three families. When I arrived, two of these families were from the French speaking part of Switzerland, and one family from Germany. Through them I was not only able to glimpse into the expat community of Dar es Salaam, but also to hear their view on where to go and where not to, being of the same noticeable perceived rich population. Furthermore, their support in establishing links to, for example, the diabetic unit of one of the district hospitals proved valuable for my research.

fieldwork, I became a part of the family which manifested itself in my being allowed to enter the house through the backdoor informally and to even visit Bibi Ngowi in her bedroom when she was sick. Through sharing the compound with my hosts, I was able to closely follow the lives of a Tanzanian "middle class" family in one of the former civil servant's areas of Dar es Salaam.

Living with a host family would, in Häberlein's words, be part of what she calls "thick involvement" (cf. Häberlein 2014), meaning living closely with the groups that form part of the research topic and by taking up certain roles within the groups (Spittler 2014, 221). By staying with a Tanzanian family, data gathering did not stop in the evenings. Being constantly immersed in the field can be perceived as a risk as it does not allow for enough reflection on what is being experienced. In Dar es Salaam, I had my own annex to the house and could join the family any time, but was not forced to do so. I therefore had enough time to write up my field notes and think about my data.

Häberlein describes her involvement in kin relations in northern Togo when she lost her neutrality and started to engage in kin relations (Häberlein 2014, 131). In the threefold process of what she calls *Beziehungsarbeit* (relationship building) in German,[21] Häberlein not only points to the establishment and maintenance of relationships but also to the reflection on these established and maintained relations (Häberlein 2014, 138). Of course, being perceived as a part of the family also raised ethical questions concerning the degree of active involvement.

Being close to one family also provided more opportunities to witness everyday dynamics; the daily ups and downs with regard to their health conditions as older persons. In addition, I could discuss my impressions gained in the course of my research on a more analytical level with my landlord. I also discussed with them what kinds of gifts I should bring for an interview, or how much I was expected to contribute to a wedding or a funeral. My hosts were thus not just study participants but experts, advisors, teachers, and family all in one. As a former security officer under president Nyerere, Mzee Ngowi also offered me advice on how to move around the city safely.

Our relationship even became closer still when I was able to visit Bibi Ngowi's family in the Kilimanjaro region. They organized a relative who took me to their village where I was able to visit the house where Bibi Ngowi grew up, and I met two of her brothers and one sister, who were all living in the village. After my return, they always proudly announced to any guests at their home in Dar es Salaam, that I was the one who already reached their "home." [22]

---

[21] Relationship building consists of three parts which Häberlein describes in German as *Aufbau von Beziehungen, Beziehungsgestaltung, Reflexion der eigenen Beziehungen*.

[22] Due to the close contact, I was very sad to learn in August 2017 that my landlord Mzee Ngowi had passed away. His wife followed him four years later, in August 2021.

In the USA, too, I experienced such closeness when sharing a home with Joy and Yacinta, who were friends of a friend of mine in Switzerland. I only stayed with them for a bit more than a week, but it was striking how much I could grasp from their moment in life, while sharing rooms with them. I was able to share their experience of living in a shared room and getting only little sleep due to their being considerate of each other and working in several jobs at the same time.

Also, when being hosted in Ohio by the daughter-in-law and grandchildren of one of the study participants, Bibi Veronica from Dar es Salaam, I was able to gain a much better picture of how the family lived. Although Anna, the daughter-in-law, was terribly busy with working and taking care of the children and the household, I got to know her well and many informal talks resulted about issues relevant for my research. Especially when talking to Tanzanians in the USA without legal permission to stay in the country, staying in host families helped to establish trust on the part of other potential study participants of their social network.

Although I had conducted a two-month language course in the city of Zanzibar before coming to Dar es Salaam,[23] it was mainly in the course of the field research, that my language and communication[24] skills further improved. Already during the first phase of interviews, when language wise, I very much relied on the local research team but being able to say hello in a correct and respectful way helped to create a good interview atmosphere. The ubiquity of the national language *Swahili* facilitated many observations and conversations.[25] After some time my language skills improved and I was able to engage in conversations with the older study participants. Being able to talk with them contributed to a more natural atmosphere during the time we spent together—without being interrupted by translations.

Nevertheless, Swahili remained a foreign language to me that I did not speak as well as English, which is also a foreign language for me. When I conducted field research in the USA, I realized the difference. Especially when asking rather delicate (interview) questions, I felt more comfortable to do so in English than in Swahili. While in Swahili I had to rely on the research team supporting me with the formulation

---

[23] Together with my PhD tandem Sandra Staudacher I went to language school at the State University of Zanzibar (SUZA) for almost two months. Staying with a Zanzibari host family during this time proved to be valuable. In my host family, only the father of the house was able to speak English and my language skills improved quickly. I was invited to join the family activities at the weekends and participated whenever there was an event, such as for example some of the countless funerals I joined during my stay. My initial stay in Zanzibar contributed a lot to my appraisal of the claimed differences between aging in the city of Zanzibar and Dar es Salaam, which I encountered later during my research.

[24] By pointing out the communication skills, I want to emphasize connotations of certain impressions and head or body movements that accompanied some of these impressions.

[25] Fortunately, all of the fifty-one study participants I met were able to speak and understand Swahili, although for most of them it was not their first language.

of such questions, in English I could ask them on my own. However, it might be important to emphasize here that language and cultural translation go hand in hand. While in the USA, most interview partners suggested or agreed to speak English, at least for the formal interview; nevertheless, my Swahili knowledge also proved valuable in the American context. By being able to speak "their" language, I was able to show that I had much time in their country of origin. The knowledge of the language thus helped to provide confidence, which was crucial in the American context of migration. Hence, when the Tanzanian study participants introduced me to somebody else, I had the impression that they were always very proud to say that I am able to speak their language.[26]

CIRCULAR RESEARCH APPROACH AND APPLIED METHODS

FIRST RESEARCH PHASE (2012): GAINING AN OVERVIEW

During a first research phase in 2012 I was guided by broad research questions developed by the project leaders that sought to explore the everyday life of older city dwellers in different milieus. *How do people aged sixty years and above live their everyday life in four different sub-wards of Dar es Salaam, and who is supporting them in doing so? Which health conditions determine which form of appropriate care and how does care correspondingly change over time? How do the agentic orientations of older people shape their living and care arrangements? Which activities are perceived to be part of old age care? Which extra-familial care supports are accepted and used by older people and their social environment?*

Inspired by grounded theory, I worked with sensitizing concepts (cf. Bowen 2006) such as "care" that also guided the choice of my methods. In addition, the phenomenological orientation of my research led to a focus on older people's articulated experiences (verbally as well as through practices) about becoming old in the city.

In order to get started, the project team mapped governmental and non-governmental organizations that worked with or for older people in the city of Dar es Salaam. The mapping of societal and social actors was an initial step to become familiar with the topic of older people's health and care in Dar es Salaam. In meetings with representatives of NGOs for older people, as well as with groups of older people and governmental officers concerned with the health of and welfare for older people, the project team started to capture some of the discussions at stake when it came to the topic of aging in Dar es Salaam. Most of the organizations we visited had their offices in the city but had their projects

[26] My knowledge of the Swahili language approximately reaches a B2 Upper Intermediate Level. I was able to engage in everyday talk, ask for directions on the street, to write greeting cards, and with my specialized vocabulary on old age and care, I was able to conduct interviews or conversations on the topic.

elsewhere, as Dar es Salaam was not considered as the setting where support for older people is most urgently needed.

As a first step together with the local research team, I began sampling research participants within the group of people above sixty years of age.[27] We sampled the four *mitaa*[28] based on talks with local experts and experiences from other research projects situated in these areas.[29] Apart from achieving a heterogeneous sample with inhabitants from different social and economic backgrounds and different kinds of settlements, I also established contact to ten cell unit (TCU) leaders[30] who were able to facilitate the access to the mtaa leader as well as to the study participants. The TCU leaders turned out to be valuable resource persons during the whole process of data collection, and even years after finishing the data gathering, I regularly got informed through these contact persons about the well-being of the study participants.

By applying transsect walks,[31] we randomly sampled study participants aged sixty years and above in their private households.

While three of the research sites were rather poor in economic terms, one was an area where people were economically better off. Conducting research in these socio-economically heterogeneous sub-wards, I experienced the city's extreme divide between rich and poor. Visiting an older person in the

---

[27] The common agreement within our AAH project team to use a threshold of sixty years is based on the National Aging Policy of Tanzania that defines an older person as sixty years old or above (URT Ministry of Labour 2003).

[28] *Mtaa* can be translated as quarter or neighborhood. It depicts an official level of division. A ward is divided into several *mitaa* (plural of mtaa), in this PhD thesis I therefore translate mtaa as sub-ward.

[29] Researchers from the project on *Sexual and Reproductive Resilience of Adolescents in East and West Africa*, led by Dr. Constanze Pfeiffer worked with a cluster sampling in order to come up with a random and heterogeneous selection of mitaa. Three mitaa were chosen based on their selection, while a fourth mtaa was purposively sampled in order to add a slightly better off area. During the process of selecting the better off area, I was supported by Christina Makungu and her team who conducted research in this area for a project at the Ifakara Health Institute (IHI).

[30] As it is emphasized by the term, Ten Cell Unit Leaders are representative for a number of ten houses within a sub-ward. The TCU is the smallest unit, followed by sub-ward, ward, and municipality.

[31] Transsects are much used in urban geography, when a team of researcher walks through the research area to capture certain environmental attributes that are relevant for the research project, but also in biology to examine animals and plants at certain geographical points defined through transsects. By starting at the geographical center of the mtaa, which was defined either by the mtaa leader or by the TCU leader, we identified three streets in three different directions. When walking down the streets we identified every tenth house on the right side. With the support of the local authority, we then found out, whether 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 neighboring the identified house was chosen. If more than one older person was staying in the appointed house, we decided on the study participant who would add new knowledge to our typology (also by considering a gender quota). If the road ended before we identified three to five study participants, we decided to turn right. However, if we would have left the borders of the mtaa we turned according to the mtaa border. During the sample procedure, we informed every study participant—mostly together with their relatives, about our research setup and that they were free to decline the request for participation in the project. In case a participant's health condition did not allow them to answer our questions, we asked a main caregiver to support the person.

economically better off sub-ward in the morning while talking to an older person in one of the deprived areas in the afternoon sometimes revealed this quite plainly.[32] In addition, research projects on "studying up" caution the fact that as a researcher we might take on a "middle class" view (see discussion further below).

After having sampled our study participants, together with Elisha and Neema, we conducted fifty-one semi-structured interviews (twelve to thirteen in each mtaa, equal number of women and men). We tape-recorded the interviews as long as the older person agreed to be recorded. Usually, we talked for one or two hours. After the official interview visit, a so-called "goodbye" visit followed in order to fulfil the expectation that one asks for permission to take a leave when traveling and to bring a small *zawadi*[33] (usually rice, beans or sugar according to the needs). Through applying the semi-structured interview guide developed by the AAH project team, we investigated how the older study participants experienced aging and health, in concrete living and care arrangements. The interviews were conducted during a six months' field visit in Tanzania in 2012 (April to October) and I was present at all interviews.

Adhering to the guidelines of the WHO, the AAH project team developed an informed consent document that had to be signed by the study participants.[34] Of course the above-described procedure of approaching the older study participants "top down" and holding an informed consent document under their noses before starting an interview shaped our first encounters. The (historical and symbolic) meaning attached to signing or fingerprinting such documents has to be explored for each situation (Shannon 2007, 230). Signing an informed consent may also have influenced the answers provided to our interview questions, as the formality of such a document may shape the interaction between the research team and the study participant.[35] It is therefore crucial to include this context of the formal interviews into the analysis of what was said.

[32] As a project team we agreed not to pay our study participants money before or during the interviews. However, when older people were sick and needed immediate support, we became involved. Elisha who formerly worked as a nurse in the national referral hospital was well trained to judge whether the health condition of an older person needed our emergency assistance. Especially when coming back in 2013 to the research sites not in the focus of the second research phase, our visits mainly consisted of following up on the older study participants' health condition and becoming involved where needed through Elisha's NGO. These follow-up visits continued and are still taking place at the time of printing this PhD thesis.

[33] *Zawadi* can be translated as present or gift, it is also a common name in Tanzania.

[34] The informed consent rested upon the WHO guidelines published on their website on how to prepare an informed consent document (cf. WHO 2017).

[35] See also Mark Israel and Iain Hay's book on research ethics for social scientists were they discuss in their chapter 5 challenges faced with informed consent (Israel and Hay 2006).

In the course of the research, we no longer had to show any official documents, and the situations became more "natural." With the blessing of the mitaa officers,[36] we were allowed to enter and leave the sub-ward for visits, and thus we never had to show our research permission to the older study participants or their families. However, losing the official touch, raises the risk of study participants giving us information while no longer being aware that the conversation is part of the research. These lines became much more permeable so that I decided to reconfirm with them, whether I wanted to write down aspects of which I was no longer sure whether they were meant to be written down. Becoming more and more familiar with the elderly study participants, more private topics evolved (such as for example the HIV status of family members). Of course, the above-described change in the relationship between the study participants and me and the local research team could also be observed when interviewing the family members in Tanzania and the USA. However, since we usually had already known the older person for a year, the interview with the family member never started on a formal basis, despite of the informed consent document.[37]

SECOND RESEARCH PHASE (2013): ZOOMING IN

In a second phase in 2013, through my focus on older people's agency, I expanded my methods further to incorporate biographical interviews in order to learn more about their past experiences and health-related crises that could only be captured when accompanying older people over a longer period of time. Furthermore, in the course of the first research phase, after having spent much time with the older people I became interested in what kuzeeka vizuri means for older people. I realized that aging well or successfully does not mean the same for older people belonging to different urban milieus, and I was curious to learn more about that. *What does it mean for older people and their relatives to age in a former civil servants' milieu of Dar es Salaam? What are older residents' imaginations about "aging well" and what should or can be done by whom and when and under what circumstances to contribute to them? How is care bargained within the family? How do children or close relatives engage in their parents' aging? Which practices do older people explore in order to age well?*

[36] This blessing was given to us after a long process of research permission (Research permits No. 2012-386-NA-2012-125 and No. 2013-305-NA-2013-81) and ethical clearance (Ethical clearance No. NIMR/HQ/R.8a/Vol.IX/1376 and NIMR/HQ/R.8a/Vol.II/266). The AAH project received valuable support by University of Dar es Salaam (especially Joyce Nyoni and Vendelin Simon from University of Dar es Salaam) and the newly established collaboration with the University of Zanzibar (especially Sarah Seme, Saleh Mohammed Saleh and Saada Omar Wahab from University of Zanzibar). Together with Elisha, I had to visit regional offices that introduced us to the district offices of all three districts of Dar es Salaam. With the permission from them, we were then able to visit the municipalities and then the ward offices of our research sites. Again, with their permission we were allowed to visit our sub-wards and show our letters to the mtaa officers. The mtaa officers then assigned a person responsible for us, who became our "mediator" of the area for the following years. In Ilala and the two sites in Kinondoni these were TCU leaders, while in Temeke we were supported by a young man, known to the mtaa leader. TCU leaders were perceived to voice the concerns of the residents, and thus people were not afraid to speak up in their presence.

[37] In the USA, we used an information sheet whereby consent was confirmed orally. The oral confirmation was recorded on the mp3 recorder right before the interview started.

In this second phase of research, we applied a range of complementary ethnographic methods, but mainly relied on participation, observation, and informal conversations in order to analyze older people's daily practices. The wide range of ethnographic methods allowed to triangulate data gathered through methods based on different epistemological aims (Förster 2011b). Furthermore, I included caregivers in my research as I realized their importance in older people's care arrangements. In the course of the second research phase, I focused on the economically better-off area but visited the study participants in all four mitaa on a regular base. Although the visits were usually short due to the logistics, they provided insights into the dynamics of old age.

Based on the findings of the interviews in the first field phase, in a second phase in 2013, I selected a small sample of eleven older people in the better-off area, in order to conduct "life world case studies" of the older people and their families.[38] In the first phase of the research, we relied predominantly on spending days with the older study participants and applied the research methods of participation, and observation and had many informal conversations (February to May 2013). Whereas, in the second half of the year, we, in addition to spending time with the people, also extended our methodological data collection strategy to conducting a round of formal in-depth interviews (October to December 2013). Frank and Monica continued the follow-up visits while I returned to Switzerland from June to September for an in-depth data analysis.[39]

While in 2012 I greatly relied on the verbal articulations of study participants, during the all in all six months of fieldwork in 2013, I laid much more emphasis on social practice. The interviews provided insight into what the older study participants expressed and wanted me to know about their situation in old age; however, as Förster emphasizes, they have a certain "performative character" and thus often there is a gap between "oral information and daily practice" (Förster 2011b, 5). Discourse is rather "based on a particular intentionality" and practice is part of daily routines "that seldom surface in the

[38] Of the thirteen older people that we initially sample in the better-off area for the transsect walks, two decided not to be part of the continued study in 2013. Therefore, we continued with a sample of eleven older people, of the initial transsects. I use the wording "life world case studies" based on the AAH project proposal. Apart from the eleven older study participants I learned much during conversations with my host family as well as other older neighbors in the sub-ward, whom I did not include here in the randomly sampled group of eleven older people.

[39] Frank and Monica agreed to continue with monthly visits to our eleven study participants in Ada Estate; Monica visited the older women, and Frank the older men. When they were not able to visit, due to other job assignments, they checked on the older people's condition via the phone. They both used an "observation sheet" that we developed together and reported their findings to me after their visits. On the basis of these arrangements, I was kept updated during my absence and we were able to detect and analyze health-related crises in the lives of our study participants over a long period of time.

consciousness of the actors" (Förster 2011a, 43). Hence, some parts of experience can only be accessed through action and not through language only (Spittler 2001, 8). [40]

In addition, care is very much informed by social norms and values and thus, what people answer when talking about who *does* what for their care, has very much more to do with who *is supposed to do* what. Spittler also described this phenomenon when he said that "for different reasons there is almost always a variation between actual behavior and the articulations about it"[41] (my translation, Spittler 2001, 16).

When capturing daily practices, it is crucial to distinguish between participation and observation. While participation helps us to arrive at an intersubjective perspective, which can lead to a collective intentionality, when observing the ethnographer is driven by his or her research questions and thus oriented towards an aim. Observation is an intentional act. It implies that the ethnographer has already developed an interest in what he or she wants to observe (Förster 2001, 466-467). Förster indicates that participation and observation are two different methods that are falsely taken together. When we want to access the reality of our study participants' lifeworlds, we need to participate in their social practices because interviews and observation alone are not sufficient (Förster 2011b, 7).[42]

Together with Frank, I therefore started to participate in the daily activities of older men, while with Monica, I did the same with the older women. During the six months, in an approximately two-weeks rhythm we spent full and half days with the older study participants, joining them in whatever they were doing. With the older women we, for instance, prepared food, went to the market, or to the hospital or sold items at a beauty store. With the older men, we, for example, went to work, did *mazoezi*[43], watched TV, farmed or visited the hospital. With both we went to church regularly. Joining them in their activities revealed much about their old age and care.

In her paper, Kesselring is concerned with the embodiment of experience which means "that subject and object have merged into a way of being in a world" and she therefore asks how we can grasp bodily and what she calls "non-predicated"[44] dimensions of experience (Kesselring 2015, 9). Regarding older

---

[40] The Emic Evaluation Approach (EEA) addresses these tensions between verbal articulations (as in interviews) and practice (cf. Förster et al. 2011).

[41] "Aus verschiedenen Gründen weicht das tatsächliche Verhalten fast immer von den Aussagen darüber ab" (Spittler 2001, 16).

[42] In Förster's words, "[i]f ethnographers participate in the lifeworld of others, it increasingly becomes theirs" (Förster 2011a, 42).

[43] The Swahili word *mazoezi* can be translated as physical exercise but also as custom or habit. In this PhD thesis, the word is mainly used in the sense of exercise. The meaning and use of the word of mazoezi will be discussed in more detail in Part III.

[44] Kesselring uses the term "non-predicated" to point to "things not yet, or not anymore, discursively apprehended" (Kesselring 2015, 4).

people, much is experienced through a body that is no longer functioning as it did before. However, for me, sharing bodily experiences with older people seemed more challenging, because much was linked to their aging and impaired body. A body, that for example creates difficulties when using public transport or carrying food home from the market, but also causes periods of pains that make a visit to the hospital necessary. With a slightly younger body (my own), it was therefore difficult to grasp their experiences. Okely also describes this challenge with her inactive study participants with whom she had to find ways to connect differing lifeworlds (Okely 1994).

While the main emphasis was on participation, I was also able to make observations on which I reflected after the visits with Frank, Monica, and Elisha. While being aware that "there is no observation without interpretation"[45] (my translation, Spittler 2001, 18), observations on social interactions (as, for example, how many people came to visit an elderly women on a Sunday, or how many spoons of sugar does the older diabetic patient take in his tea) were valuable as well as providing ample content to discuss and reflect on. When applying the methods of observation and participation, sometimes separately, sometimes combined, I found Spittler's *Dichte Teilnahme* (thick participation) inspiring (cf. Spittler 2001). While by terming it "thick" he refers to Geertz' thick description (1973) in an interpretative depth, he also wants to emphasize "the social closeness as well as the shared experience"[46] (my translation, Spittler 2001, 12). Thick participation is also about social closeness, about experiencing with all our senses (Spittler 2001, 19). Thick participation, as a radicalized form of participant observation, again combines methods of participation and observation but critically reflects on the differences between the two methods that cannot be lumped together but need differentiation, not least in the subsequent analysis.

Often, informal conversations emerge from *Dichte Teilnahme*. Hence, in combining observations with questions about what is actually happening and being observed, much can be captured (Spittler 2001, 17). And as Spittler rightly points out, if we want to get around the more artificial interview situation and its disadvantages, we should rather focus on more naturally occurring talks (Spittler 2001, 8). For the author, observations and questions or talks about it are consequently not two distinguishable methods, but complement each other (Spittler 2001, 16). In the course of my visits to older people, I gained much information through informal talks.

After having accompanied the older study participants for a considerable length of time, we were able to recognize their most important care providers. In addition, we asked them whom they would consider to be their (three) most important care providers. Based on the information, we conducted

---

[45] "Es gibt ... keine Beobachtung ohne Interpretation" (Spittler 2001, 18).

[46] In Spittler's words: "Dicht bedeutet aber auch soziale Nähe und gemeinsames Erleben" (Spittler 2001, 12).

sixteen semi-structured interviews with those mentioned family members, while many informal conversations evolved naturally around our visits to the older study participants. While before, I centered only on the older person and his or her view, with the care provider interviews, my aim was to incorporate those actors identified to be important by the older people themselves. Many times, the most important caregivers were adult children, sons or daughters, but in the odd case also a good friend of an older man, or the brother of an elderly woman without children, or a spouse. When conducting the interviews, I remained very much on the discursive level, but was able to mirror what the caregivers said on the basis of what I already knew from the older study participant. As these caregivers were put forward by the older people themselves, their perspective does not necessarily provide insight into overburdened care relationships or situations of lack of care.

As a complementary method, I conducted life-story interviews. The decision to conduct such narrative interviews derived from the first round of interviews in 2012, where I realized how much the older people's (past) life experiences influenced their present ideas and actions. Therefore, to better understand some of their motivations, it seemed crucial to learn more about their past. Together with Frank and Monica, we decided to capture these life-stories. According to Luttrell, life-stories are "[f]alling somewhere between autobiography and biography, the narration of these stories is meant to provide the listener a sense of what life is like or what it means to be a member of a particular culture" (Luttrell 2005, 502). For the interviews, we had broad questions that encouraged our study participants to talk for one to two hours. During the interviews, we learned much about their past, as well as about how they experienced some of the historical milestones. The older study participants also told us much about the development of the city. On the one hand those life stories are "factual accounts of … experiences, views, and values …" and on the other hand there are stories that represented what our study participants wanted us "most to know and what they construed as being worth talking about" (Luttrell 2005, 502). Hence it was not only interesting for me to listen to the accounts, but also to hear what they wanted to tell me of their many years of life.[47]

THIRD RESEARCH PHASE (2014): FOLLOWING LINKS

A third research phase took me to the USA, where I had to immerse myself again in a completely different setting. Guided by my research questions, I sought to find out more about care given by Tanzanian migrants across national borders. *How are children or relatives living in the USA involved in the care for their parents or relatives in Tanzania? Who are these Tanzanian migrants and what are their motivations to care for*

---

[47] Interestingly enough, we also learned how partial the information retrieved from the first round of interviews was when it suddenly became clear that the "daughter" of an older woman was actually not her biological daughter or that an elderly widow was not divorced only once but several times.

their older relatives? How does care circulate in both directions? Which perceptions or ideas on health in old age are transmitted to older people in Tanzania from Tanzanian migrants in the USA and vice versa?

In order to explore these research questions, I had to adapt the methods used up to now to the relatively short field stay. Many of the findings from this third research phase will be presented in Part IV of this PhD thesis.

First findings from the case study research in 2013 revealed that the older people considered the financial support they received from abroad important. Many of the older people's children went abroad to study, and while some remained there others came back. Those who retained contacts to people abroad had children or other relatives in the USA, in Japan, the UK, Russia or South Africa. Due to the highest availability of links of older study participants to the USA, the third phase of field research in 2014 (April to May and December) was conducted in the Unites States. As the relatives of the older study participants interviewed in Dar es Salaam were scattered over the whole of the USA, in connection with a study visit to Brandeis University, Boston,[48] I focused on communities in cities and suburbs of Massachusetts, New York; the DMV area as well as in Ohio. Hereby established contacts with children of older study participants in Dar es Salaam as well as with relatives or friends of Tanzanian colleagues in Basel, Switzerland, or Tanzania who helped me to approach interview partners in the cities and suburbs.

By conducting semi-structured interviews with twenty-seven children (half of them daughters and half of them sons) in the USA who care for their parents and other older relatives in Dar es Salaam or in wider Tanzania, my intention was to find out more about their motivations to provide transnational care. Furthermore, I investigated their ideas about practices relating to aging, health, and care, as they might be influenced by their present host country as well as by their country of origin.

One focus during this shorter third research phase was on the flow of ideas and practices and how global ideas of "successful aging" influence the health practices of aging parents and their care givers. Here the use of social media was also of interest to the project. Informal talks with other members of Tanzanian communities helped to round up the research. While only two direct family links to older people interviewed in Dar es Salaam could be followed, other Tanzanian migrants living in the selected communities were found by applying a snowball strategy. After the field stay, I was able to keep contact mainly through WhatsApp or Skype in order to connect to them over a longer period of time.

[48] I was lucky enough that Prof. Dr. Sarah Lamb from Brandeis University agreed to become my mentor for my stay in the USA and I could conduct my research in the framework of a study visit to Brandeis.

DISSEMINATION (2015): DAR ES SALAAM AND ZANZIBAR

"Unfortunately, a majority of the elderly who serve as our study participants are rarely provided with opportunities to comment on the research findings of the research carried out ON them; ideally, we should carry out research not only ON them but WITH them and FOR them as well" (emphasis in original, Makoni 2008, 202).

With Makoni's words in mind, the project team conducted dissemination events twice. One event was held at the beginning of the AAH research project together with the research team of the previous project *From Cure to Care* led by Peter van Eeuwijk. At the event, I was able to discuss first impressions of the fieldwork with NGO representatives, scholars from university as well as government employers concerned with older people.

When back in Tanzania for two months at the beginning of 2015 (January to February), together with the AAH project team we conducted two final dissemination events together with our collaborators at the University of Dar es Salaam and the State University of Zanzibar. Also Bibi Helen, a research participant, attended the presentation at the university. For the events, my tandem PhD colleague Sandra Staudacher and I developed a program brief with some of our findings about old age care in Dar es Salaam and the city of Zanzibar. I handed out these program briefs to the older study participants and discussed the content with them for the purpose of a face-to-face dissemination. In the discussions that evolved based on the presentation of my findings, much was confirmed but also some new and interesting aspects emerged. Discussing my findings with the research participants and other researchers at both the University of Dar es Salaam and the State University of Zanzibar therefore helped to sharpen again my analysis and confirm some of my interpretations.

ON DATA ANALYSIS, FIELD NOTES, AND MEMOS

Field research and analysis followed each other in an iterative research process, while adhering to an empirically grounded research approach, as further developed by Charmaz (2006) from Glaser and Strauss (1967). I decided to follow Charmaz' approach as she advances a more constructivist use of grounded theory: she claims that "we are part of the world we study and the data we collect" (Charmaz 2006, 10). Data and analysis are thus "created from shared experiences and relationships with participants and other sources of data" (Charmaz 2006, 130),[49] they thus show one possible reality. The beauty of conducting qualitative research is that we can fluently move between data gathering and analysis.

While the grounded theory-inspired approach to data analysis allowed me to explore older people's own perspectives on aging in the city, it is important however, to also think about its limitations.

---

[49] Charmaz refers here to her earlier publications.

Although viewing aging and caregiving through the lens of older civil servants allowed for deep insights into their unique lifeworlds, the analysis should also take a step back and think critically about their more privileged position, which in turn shaped the way they navigated the city. As aptly described by political scientist Dunleavy (1980) when researching urban politics, it is important not to become an "inside dopester" who would then loose the sense for contextualizing these "middle class" views into the broader setting.

While grounding my analysis in the data, data gathering was initially guided by sensitizing concepts (such as care, for example) that served as "starting points for building analysis to produce grounded theory" (Bowen 2006, 20). By drawing on Blumer (1954) Charmaz describes sensitizing concepts as concepts that "give you ideas to pursue and sensitize you to ask particular kinds of questions about your topic" (Charmaz 2006, 16).

A first reflective step after visits to the elderly study participants was to note down what we had experienced or what we had observed and learned through talks. Emerson et al. describe ethnographic research as consisting of two steps: "Firsthand participation in some initially unfamiliar social worlds and the production of written accounts of that worlds by drawing upon such participation" (Emerson, Fretz, and Shaw 1995, 1). According to Emerson et al., "[f]ieldnotes are accounts *describing* experiences and observations the researcher has made while participating in an intense and involved manner" (emphasis in original, Emerson, Fretz, and Shaw 1995, 4-5).

In the course of my field research, I engaged in memo writing. Writing memos forces the researcher to analyze the data and the codes early in the process, it keeps him or her involved in analysis and helps to increase the level of abstraction (Charmaz 2006, 72). Thanks to my early analysis in the circular research process, I was able to build one research phase onto the next. In order to do so, the local field team and I made a big effort to finish transcribing interviews shortly after my travels back to Switzerland. Being geographically "out of the field," I was then able to gain a certain distance to the field and, based on my countless field notes and the transcripts, I could start a first round of data analysis. For the analysis, I used the software MAXQDA. Within the program, I coded my interviews and field notes by following a grounded approach. Hence, I did not predefine my codes but created them by defining what I saw in the data (Charmaz 2006, 46). "Coding means categorizing segments of data with a short name that simultaneously summarizes and accounts for each piece of data" (Charmaz 2006, 43).[50] All in all I developed more than 10,000 codes and used colors, for example, to group the different perspectives of relatives (in Tanzania and the USA) as well as the perspective of the older people themselves. While in the first round of (initial) coding the data gathered in 2012, the codes

[50] I found Charmaz' hint to use gerunds for codes very helpful as a means to point to processes (Charmaz 2006, 49).

remained rather close to what was asked in the interviews (such as described activities or housing situations), the second round of (focused) coding after the second field stay revealed some important aspects emerging from the data without having explicitly asked for it (such as "living in the city"). Further codes developed in more theoretical categories such as "self-care." While coding, I continued writing memos; since "[t]he memo hints at how sensitizing concepts … may murmur during coding and analysis" (Charmaz 2006, 76). Furthermore, according to Charmaz, memos help to find out which codes to treat as analytic categories (Charmaz 2006, 82). I used several coding strategies, one was the "in vivo codes" (Charmaz 2006, 55-57), that are named after the study participants' own terms. One of those terms was for example "observing eye" which was then further developed to a conceptual category. In a next step when back in Tanzania, I theoretically sampled those observing eyes.

Based on a first round of analysis and interpretation, I decided to theoretically sample the former civil servants' milieu out of the fifty-one study participants' sample. "The main purpose of theoretical sampling is to elaborate and refine the categories constituting your theory. You conduct theoretical sampling by sampling to develop the properties of your category(ies) until no new properties emerge" (Charmaz 2006, 96). Furthermore, "[c]ategories are 'saturated' when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories" (Charmaz 2006, 113). I witnessed these processes of saturation twice, once when interviewing the fifty-one older people in different sub-wards of Dar es Salaam, and then again after having spent six months with the sub-sample of the older people in the former civil servants' milieu.

Apart from interviews and my notes and reflections about participating and observing at several occasions, other documents were also incorporated into my analysis. These were, for example, newspaper articles in Tanzania and the USA on the topic of older people (for example, health advice in Tanzanian newspapers or advertisements for old age facilities in the USA). Furthermore, much information that I gained through the Internet and social media was taken into account. I incorporated WhatsApp messages, Emails, Facebook posts or posts on certain Blogs.

ON MULTI-SITED ETHNOGRAPHY AND "COMING BACK"

Sluka and Robben write, "the postmodern critique of fieldwork and its compassionate reaction have stimulated new conceptions of what constitutes 'the field' and ethnography" (Sluka and Robben 2007, 24). Research for this study took place in more than one setting or one transnational social field that encompassed different localities. I experienced the process of following people and things across national borders as challenging as well as fruitful for the research. Both the Tanzanian and the American context were part of the circular research process and again shaped the information that I was able to receive in these two contexts by being connected to both at the same time. Through the multi-sited design and the research phases that were followed by an analytical phase of reflection in Switzerland, I

conclude that my "coming and going" positively impacted on becoming familiar with my research context and consequently with the study participants.

Due to my research interest in transnational care that flows across national borders, I followed the people, things (amongst others, monetary flows), and metaphors (amongst others, discourses), as described by Marcus (1995) who coined the term "multi-sited ethnography" in the nineties.[51] Hannerz rightly emphasizes that already Malinowski's research on the Kula ring was multi-sited, however only later did it become more prominent as a "style of doing ethnography" (Hannerz 2012 [2003], 360). A multi-site study (as it is called by Hannerz) differs from a comparison of different localities, but emphasizes the interconnections between the different sites that are studied (Hannerz 2012 [2003], 362). Already the Manchester School emphasized the networks stretched between more than one locality, rural and urban belonging to the same social field (Levitt and Glick Schiller 2004, 1009). Their extended case study method had been developed in the 1940s to respond to the complexity and messiness of social life and to explore how everyday practices at some particular places were related to larger structures (Mills, Durepos, and Wiebe 2010, 374).

Multi-site studies can be criticized for not being able to go into great depth, as time in each locality is usually shorter. However, as Hannerz emphasizes for his study about foreign correspondents in Jerusalem, Johannesburg, and Tokyo, his aim was not to study the "entire culture and social life" (referring to Evans-Prichard, Hannerz 2012 [2003], 364) of these localities, but to follow a certain group, namely the correspondents. While my aim was to fully immerse myself in the field site of Dar es Salaam (where I also spent a considerable amount of time doing so), for my third research phase in the USA, my plan was to find out more about transnational care that Tanzanian migrants in the USA provide for their parents in Tanzania. I am therefore aware that during the two to three months of field research in the USA, I was not able to go into much depth. As mentioned above, the relatively short stays at different locations also informed the methods I chose for the research part in the USA, as I had to rely much more on interviews and less on observations and participation in the daily lives.

While Dar es Salaam was my only research site in Tanzania, I ended up with four research sites in the USA through following people and their contacts. My experience also confirms what Hannerz underlines: "… multi-site ethnography almost always entails a selection of sites from among those many which could potentially be included" (Hannerz 2012 [2003], 363). Hence, I could have visited Tanzanian families living abroad and caring for their parents at home in many more localities. Due to the direct connections of a few older study participants to the USA, and some of my private contacts

[51] Marcus writes, "empirically following the thread of cultural process itself impels the move toward multi-sited ethnography" (Marcus 1995, 97). Therefore "the object of study is ultimately mobile and multiply situated, so any ethnography of such an object will have a comparative dimension that is integral to it …" (Marcus 1995, 102).

to Tanzanians staying there, I decided to conduct the second part of my research in four Tanzanian communities in the USA. The fact that I was able to draw on previous in-depth ethnographic fieldwork in Tanzania during this third phase of research facilitated my entry into the field in the USA, resulting in a much faster familiarization than would have been possible if US communities had been my first entry to this study. It seems therefore not only crucial to think of the selection of sites as mentioned by Hannerz above, but to also think through the sequence in a multi-site study.

Kokot nicely describes the process of following particular contacts, when she writes "… 'being in the field' means being part of a shifting web of relations and, if necessary, following these relations to wherever they may spread to" (Kokot 2007, 18). Cultures, and thus also cultures of care, are not anymore "fixed in places" (Gupta and Ferguson 1997, 4). As it is nicely described by Hannerz, it is thus about "being there … and there … and there" (Hannerz 2012 [2003]) and therefore much more about "social relationships, and only derivatively, and not necessarily, about places" (Hannerz 2006, 29).[52]

While focusing mainly on the care and engagements in social relationships over distance, I found the concept of a "transnational social field" useful as put forward by Levitt and Glick Schiller (2004). The authors ask for new tools that are able to simultaneously capture multiple locations since persons can "engage simultaneously in more than one nation-state and a nation-state does not delimit the boundaries of meaningful social relations" (Levitt and Glick Schiller 2004: 1029). In their study for the Ghana TransNet project, Mazzucato and colleagues developed a simultaneous matched sample (SMS) methodology, in order to overcome some of the shortcomings of conventional multi-sited studies.[53] They worked in teams and were present at two localities simultaneously. My simultaneous engagement became possible through the use of social media.[54] In addition, I realized how important it was to visit both places in order to personally experience both contexts, an aspect that is rather missing in Mazzucato's SMS methodology. Encounters with study participants in the USA were facilitated through my previous stay in Tanzania. Returning to Tanzania after having visited relatives in the USA again contributed to rich conversations. Being able to experience both settings allowed me to understand

[52] This methodological decision to consider the field as a network does not exclude to look at the experiences of older people when it comes for example to the importance of home as a lived space in advanced age and frailty (cf. Obrist 2016). As mentioned earlier, an agency lens allows for an exploration of how older people from different milieus live social spaces through their daily practices.

[53] "A simultaneous matched sample (SMS) methodology refers to using a sample of informants who are linked to each other by being part of a same social network and studying these informants in a simultaneous fashion so that information obtained from one informant in one locality can be immediately linked up with information obtained from another informant in another locality" (Mazzucato 2009, 3).

[54] For more reflections on the use of WhatsApp in ethnographic research see Staudacher and Kaiser-Grolimund (2016).

some of the differences that people try to overcome—especially when it comes to how one is supposed to care for a parent.

Coming back to Tanzania after my stay in the USA again deepened my contacts to those older people who gave me the contact details. I was, for example, able to take curtains from Maria in the USA to her mother Bibi Veronica in Dar es Salaam, and showed pictures from my visit to her daughter's family—which resulted in interesting exchanges about the family members and their life abroad which again brought the researcher closer to the study participants. In addition, I was also able to visit a few older people, whom I did not know before, but had encountered their children in the USA. It was interesting to compare what the children told me about their parents and what the parents told me about their children.

Circulating not only between data collection and analysis but also between two research contexts therefore enriched a dynamic research process.

Structure of the PhD Thesis

Owing to the research focus and the related questions of the study, this PhD thesis is structured into three main parts (Part II-IV); these are interlinked but also stand for their own. All three parts are equally grounded in empirical evidence but shed light on the topic of aging and care from different angles and point to different scientific debates that are linked to them. Despite their different perspectives, they all contribute to the overall focus of this PhD thesis when it comes to older people's imaginations of aging well (kuzeeka vizuri) in the city of Dar es Salaam and beyond.

Part II "Aging and the City" starts from the assumption that the milieu an older person belongs to shapes the ways this person experiences aging in the city. It starts with a theoretical chapter on approaches to cities and their older inhabitants, with a main focus on cities in the Global South. Furthermore, it introduces the phenomenological concept of milieu that is used in this PhD thesis. The next chapter will then historically develop the argument that the aging study participants in the city belong to a first generation of elderly city dwellers. The country's socialist past advanced a particular form of socialism (*Ujamaa na Kujitegemea*) that asked people to leave the city after ending their productive contribution to the Nation in order to grow old in the countryside. Although this philosophy is still in some people's minds, the older study participants I encountered are among the first who are currently aging in the city. Then I go on to introduce the four different mitaa (subwards) that served as a starting point for this study.

The introduction to the research sites is followed by a discussion of different repertoires of old age that people relate to in the city; namely legal age and social age. I argue that especially former civil servants

who sometimes faced compulsory retirement at the age of sixty orient themselves towards the legal age definitions, that, amongst others lead to preparations for old age. In a next step, I will use three stories of older people in order to underpin the argument that older people from different milieus perceive the city differently. My research data shows that their experience of the urban ranges between perceiving the city as a place of challenges as well as a place of opportunities. I present different images of the city, for example, when the city is made guilty and responsible for people's misery, while the enabling city is praised for its amenities. I critically reflect upon older people's expressed differences between aging in the "traditional" village and in the "modern" city. The last chapter in this part, zooms in on a particular milieu that became relevant in this study, namely the milieu of the former civil servants, by pointing at socio-economic and social-cultural particularities of the milieu.

While Part II focuses on the city, Part III is concerned with "Care Dynamics." This part is subdivided into two aspects, the care that is provided through related others and the care that is provided for oneself. A chapter on the analytical concept of care in old age serves as a theoretical introduction to these two aspects of care. The argument of the second part is that the provision of self-care as well as relational care very much depends on the older person's perceived health condition. Frailty in old age, for example, may lead to bed confinement and thus the frail older person becomes a care receiver dependent on others for conducting daily activities such as bathing. A healthy older person, instead, may well be able to conduct these daily activities independently and even invest in exercises or other forms of self-care to promote health and to prevent illness. I point out that health conditions are not stable and older people experience ups and downs which in turn shape their daily care arrangements.

In the chapter on relational care, normative aspects of what good care entails are discussed and contrasted to the actual care that is then provided. Again, three stories of older people provide empirical evidence for the dynamics that care is subject to. Furthermore, they show different health conditions that imply different forms of care when identifying the strength (*nguvu*) of older people as a point of departure for care. In a chapter on everyday self-care, the care that older people provide for themselves is presented. The chapter starts by drawing a parallel to the international aging discourse around "successful aging" and discusses what kind of environment facilitates self-care. Again, three stories help to reveal different forms of self-care that older people in the former civil servants' milieu engaged in, thereby exploring a broad definition of care that not only targets an older person's physical health but also his or her mental wellbeing in order to age well. The conclusion to the part points to the dynamics of particular forms of care and their arrangements.

In Part IV, this PhD thesis supposes that certain aspects of care circulate in transnational triangles ("Care in Transnational Triangles"). They do so with the help of someone who becomes an organizer of these care circulations in Tanzania. Hence, I argue that the "observing eye" in Tanzania becomes crucial in transnational care triangles as this person makes sure that remittances from abroad arrive at

the older person's home and, furthermore, organizes the communication with abroad. The part starts with an introductory chapter on the concept of transnational care, followed by some information on different Tanzanian communities visited for the research. It is then concerned with Tanzanian migrants in the USA who give care to older people in Tanzania, thereby shifting the perspective from the older people to their care givers in order to explore how their involvement from a distance may contribute to a "good" old age in Tanzania. The chapter points to the importance of the migrants' legal status, as the data shows that their status impacts on their ability to provide care. The chapter is followed by three stories of Tanzanian migrants with different legal statuses and their involvement in care across national borders. The subsequent chapter then presents the concept of a triangle of care that I developed based on empirical findings.

Finally, this PhD thesis is rounded off with a Part V "Conclusion" in which, after a concluding summary, two aspects are highlighted in particular, namely "Putting Self-care on the Spot" and "Urban Aging: African Cities' Futures." Lastly, questions for further research allow a look into the future.

PART II AGING AND THE CITY

> A conversation with Bibi[55] Maimuna made me think about aging and the city. When Neema and I talked to her in the deprived sub-ward of Manzese Mnazi Mmoja about her age and the care she is giving and receiving, at several instances she pointed to the fact that the city negatively impacted on her social relations and thus her care arrangements in old age. While sitting in front of her two rooms that she shared with three of her grandchildren and her son, Neema asked her—translating my question formulated in English—if she received some help or support from her neighbors. Bibi Maimuna was very indignant over the question and asked back why Neema would ask her such a question for she must know how the conditions of the city are. "And you, I wonder why you are asking me these questions? You know the conditions of the city, why do you ask such questions?"[56] (Bibi Maimuna 2012). Neema then had to explain to the elderly woman that she would just translate what I, as a foreign researcher wanted to know and that I do not (yet) know how "the city" is and therefore will ask this question. Neema again, asked the same question and Bibi Maimuna's answer—again—pointed to the fact that she lives in Dar es Salaam and therefore she does not get any support from her neighbors, "No, the city life, I don't know if you know it's the city…"[57] (Bibi Maimuna 2012). She confirmed then that in the countryside she thinks that there is more assistance from the neighbors: "In the countryside you can get help from your neighbors, and you will be helped, but not here"[58] (Bibi Maimuna 2012). The conversation continued and we talked about friends. Bibi Maimuna explained that in Dar es Salaam it is difficult to make friends. "These friends, when you see that you got a friend here in the city, you will get troubles"[59] (Bibi Maimuna 2012). Bibi Maimuna went on to say that since she came to the city, she was just observing but not making friends with other people.[60] When I asked her however, whether she plans to move back to the countryside she negated. She explained that she does not have any close relatives anymore in her village, as most of them either passed away or moved to another place. Bibi Maimuna therefore seemed stuck in the city without an option to move away for more care and support in old age.

In this part on Aging and the City I explore the particularities of aging in an urban space and "set the scene" for the sections on care and transnational care that will follow this segment. While conducting the research for this study in Dar es Salaam, I heard elderly people referring to "the city" several times when talking about their experiences of old age and care. They explained why their health condition or social network of support is the way it is by using the description *mjini* which is composed of two

[55] The word *Bibi* is a Swahili denomination for Grandmother. Respectful Swahili greetings will be discussed later in this text.

[56] Bibi Maimuna: "Na wewe maswali mengine unayouliza mbona wewe unajua hali halisi ya mjini kwa nini unauliza?"

[57] Bibi Maimuna: "Hapana maisha ya mjini si unayajua mji huu."

[58] Bibi Maimuna: "Bara unaweza ukapata msaada kutoka kwa jirani haya na wewe hukutumia lakini sio hapa."

[59] Bibi Maimuna: "Hao mafriends wenyewe ukiona umepata friend katika jiji hili si unatafuta matatizo."

[60] Bibi Maimuna: "Tangu nilipoingia mji huu nilipochunguza sikuwa na rafiki [Since I came to this city, I have observed only and I do not have a friend]."

elements; *mji* for city and *-ni* for place.[61] Sometimes, like Bibi Maimuna, they also blamed the city for not providing them with what they needed.

Also, how I perceived the city of Dar es Salaam changed during the course of my fieldwork and was very much linked to the different stages of my immersion in the field. I experienced phases of getting familiar to the setting while improving my language and communication skills. However, being able to communicate did not make me feel comfortable yet to move alone through the—at that time—city of four million. However, after having become "street wise" (cf. Hannerz 2010) and thus able to cope with the challenges of everyday life (for example, traveling to other districts of the city with public transport), the city became more manageable for me.

Especially when I reflect on conducting ethnographic research in an urban locality like Dar es Salaam, I realized that through bodily experiencing the city, I could better understand the lifeworlds of those I was interested in.[62] Hence, I could much better understand when people ended their explanations by saying "you know, it's city life." I knew how it was to wait for several busses that were more than full. I knew how it was to be late for an appointment because traffic did not move at all for two hours. And I imagined how these experiences must be for a frail older person.

In this part I present my approach to the city and its older people by using the phenomenological concept of milieu. The milieu concept proved helpful to describe the group of non-poor study participants whose aging experiences constitute the focus of this PhD thesis. As mentioned earlier, people who belong to the same urban milieu may be able to engage in particular contexts of action. I will then historically reconstruct the arrival of this study's elderly people in Dar es Salaam, arguing that the participants belong to a "first generation" of older people, over the age of sixty. The fact that they are among the first older people that did not leave the city after retirement as was common under *Ujamaa*[63] politics, impacts on how they perceive aging in the city; their persons of reference are their parents who aged in the countryside. At this stage, a brief introduction to the four research sites of the study will be presented. Although the social milieu approach emphasizes the less tangible elements that constitute the urban from the perspective of its members, we should not forget to take into account the material and non-material infrastructure of the diverse mitaa that can be considered as a limiting or enabling power of the urban. These geographical contexts with their particular urban infrastructure may shape people's experience with the urban and consequently their images of the city. In a next step,

---

[61] In Swahili the suffix *–ni* is used to turn a noun into an adverb.

[62] A similar experience is also described by Andrea Kaufmann in her vignette on doing fieldwork in post-conflict Monrovia, Liberia (Kaufmann 2011, 26).

[63] The Swahili word *Ujamaa* can be translated as "familyhood."

I will distinguish between two different repertoires of old age that I encountered in the city, namely a "legal age" and a "social age" in order to explain the older people's frames of reference when aging in the urban space. The main chapters of this part explore the city in a tension field between challenges and opportunities. By presenting three stories, my aim is to show different encounters with the city that lead to different experiences within the urban space. The case studies reflect older people with different reaches of their social networks, thus supporting my argument that depending on whose city we are looking at, different experiences of urbanity can be made. The case studies are followed by a chapter on the often-mentioned distinction between aging in the urban and the rural space. The last chapter relies on the concept of milieu to describe an older, middle-income milieu in Dar es Salaam. As most data for this study derives from the former civil servants' milieu while other milieus served as a mirror in order to contrast and compare, the milieu will be described here by using socio-economic as well as socio-cultural dimensions that shape the members' aging experiences. Some aspects of these dimensions will be taken up later again, when discussing care (cf. Part III and IV).

ENCOUNTERING BONGOLAND'S OLDER PEOPLE

WHO'S CITY?

Bibi Maimuna's account, presented at the outset of this part, reveals her rather negative experiences of urbanity, by describing the city as a place of struggle and loneliness where it is difficult to make friends or receive support from others. In addition, Bibi Maimuna struggled to remain healthy as her access to medical services and her possibilities to prevent disease remained limited. A similar experience will be presented when showing Bibi Ruth's case. Bibi Ruth's and Bibi Maimuna's complaint discourse regarding the city's hardships was mirrored in many conversations during the course of this study. Although, by far not all participants related to the city in a negative way but also praised it as a place of "modernity": a place that enables them to lead a good life, even in old age. Taking a closer look at the literature on cities, a city can be perceived in various ways: as a state of emergency (Simone 2004), as a place where you need "brains" to survive (when calling it Bongoland), as an age-friendly city (WHO 2007), as an ordinary city (Robinson 2006), or as a place of creativity (Förster 2013). I will therefore argue, that the way aging is perceived in the city depends on "whose city" we are looking at (see also Heer 2019).

When arriving in Dar es Salaam for the first time, I was amazed by the huge number of inhabitants living in the "chaotic order" of the metropolitan city. And I could identify with Simone who describes African cities as "work in progress" (Simone 2004, 1). In Dar es Salaam, every single day the traffic breaks down and people wait hours in their cars or in public busses to pass certain streets, as for example the Selander bridge that is the only connection between the city center and the northern

Peninsula. In the market area called Kariakoo in the city center, people are busy earning money in different ways: some sell fruits in the street, others "borrow" phones from others without asking in order to sell them on to their customers (the market area is famous for this, according to William, a musican, taxi driver and member of the project team). Many people are busy following their chores, although as an outsider it is hard to identify any "structure." Also, the name that local people in Dar es Salaam use for the city reflects the chaotic order very nicely: "Bongoland." *Ubongo* in Swahili means brain; you need to have brains to survive in Bongoland.[64] Simone takes his arguments so far as to describe African cities as places where "life is reduced to a state of emergency" (Simone 2004, 4). Hence, cities are in constant flux, everything is in the making. Due to the dynamics, new thinking and practices may emerge, but may also disappear again. But do these aspects also apply to the group of older people within urban spaces?

When looking at African cities through the eyes of older people, it becomes evident that the infrastructure of these cities is not particularly welcoming for them. If we observe the aspects raised in the WHO report that make cities "Global Age-friendly Cities," cities like Dar es Salaam are definitely not made for older people. Dar es Salaam would indeed be categorized as age-un-friendly, because many older people already struggle to cross busy streets or to use public transport—because buses are usually over-crowded without free seats for older people. During rush hours one has to be fast to catch a bus and many older people wait a substantial amount of time at a bus station in order to get on. Standing in the sun at a bus station can be extremely tiring. In addition, bumpy dirt roads create challenges for older people who have trouble walking. However, only by walking or using the overcrowded public busses, the vast distances in the city can be managed in order to reach certain infrastructures such as hospitals—if no private car or means for a taxi is available. Moving around in a wheelchair is almost impossible. And thus, the city was at the time of the study far away from creating outdoor spaces particularly for older people, as for example older people in European or Asian countries demanded (cf. WHO 2007).

I agree with Robinson who promotes an "ordinary-city approach," which claims that we should look at all cities as "ordinary" instead of reducing them to categories such as "developing" or "developed" (Robinson 2006, 1). I do not wish to compare Dar es Salaam with other more "age-friendly"[65] cities in the East or West. In order to describe aging in Dar es Salaam we should therefore not depart from a (Western) idea of what a city has to be (i.e., how a city has to be age-friendly according to global—

[64] The meaning of "Bongoland" will be taken up in more detail later in this text.

[65] For their report on "Global Age-friendly Cities," WHO collected data on advantages and barriers experienced by older people in thirty-three cities (of WHO regions). Based on the results the WHO came up with eight areas of urban living that were mentioned by the older people interviewed for the report: 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 (WHO 2007).

often meaning Western—standards). This development thinking by applying "Euro-American understandings of modernity and development" is overcome (Obrist 2013, 10). Rather, we have to tackle Dar es Salaam as a city in its own right.[66]

Also when it comes to how people relate to each other, the urban space—be it in a state of emergency or not—shapes how people experience and use "people, things, places and infrastructure" (Simone 2004, 5). The intangible elements of life in African cities as described by Simone mirrors shifting forms of social collaboration with other people in particularized relationships—so the author (Simone 2004, 5-6). In cities, many relationships can thus remain provisional and without clear responsibilities. While some scholars argue that in urban social environments, networks become more fragmented and less dependent on kin, for Dar es Salaam's older people, support provided by relatives seems to be all they have. Hence, according to Simone, extended family ties in cities are becoming more and more politically and economically strained and hence, falling back on extended family systems and forms of social capital (for example in old age), is described by the author as falling into harm (Simone 2004, 11). While Simone probably only focused on the young workforce, he seemed to miss that different (age) groups within a city relate differently to others. Only few older people manage to keep up with the "constant flux" of the city, and due to their health condition, most of them are more or less restricted to stay in a particular place or area. They no longer mingle at work, and do not easily trust others, for example neighbors. Their encounters with other urbanites are thus limited.

The older people's social networks are sometimes more and sometimes less fragile, sometimes they get overburdened but they exist and are the reason why many older Tanzanians decide to remain in the city. Some of these networks span across different wards of the city while others remain within one particular sub-ward (cf. the story of Bibi Anna). Other elderly people are well linked with their home village (cf. the story of Mzee Sanga). Links are established and maintained either through regular visits or phone calls. For some older people, these networks even span over national borders (cf. the story of Bibi Veronica). We will see later in the text that although—or especially because—the welfare system of Tanzania is rather weak, family support is said to be the only support available in a city, where you cannot trust or rely on neighbors. Interestingly enough, in the case of this study, the city even increased the older people's likeliness of being supported by kin (cf. Part III Care Dynamics).

Förster argues that cities like Dar es Salaam can contain places of creativity. They are "full of initiatives that create, despite all obstacles, social spaces that emancipate from the constraints of an oppressive political climate" (Förster 2013, 246). How does this description relate to the group of older people

[66] Robinson claims that "ways of being urban and ways of making new kinds of urban futures are diverse and are the product of the inventiveness of people in cities everywhere" (Robinson 2006, 1). I will come back to the aspect of creativity in urban space below.

who are commonly perceived as being the "stronghold" of tradition? As will be emphasized later, older people in Dar es Salaam often struggle to balance the perceived tensions between what they would call "tradition" and "modernity." Of course, they take part in creating new social and cultural spaces where for example, new ideas on what good aging means emerge. Through my focus on the former civil servants' milieu I encountered some practices of older people that seemed influenced by their financial means as well as their connectedness to other countries with other ideas on how people should age successfully. Later, I will introduce the case of *Mzee*[67] Dunford who started with Yoga at the age of seventy.[68]

At the same time, however, they are anxious to build their small "islands of peace" within the city, in order to cope with the rapid changes that are going on "out there." These islands are at once limiting as well as protecting. On the one hand, they restrain older people from "living" in the city and making encounters with others possible, while, on the other hand, they provide the older people with a safe haven within a "complete mess," protecting them from cars, thieves, and the harsh city reality. I find it important that Förster points to the fact that although urban popular culture, studied prominently in the 1970s and 1980s, was largely described as playful and creative, there is another side to the coin: urban life can also be "hard and cruel" (Förster 2013, 237).

The tensions and dilemma of the city are also articulated by Bibi Maimuna who "blames" the city for not providing her with reliable social relations, in the introduction of this chapter. Already at this stage, however, I find it important to mention that how people talk about the city is not necessarily also correspondent to how they actually live the city.[69] While trying to make sense of the perceived differences of their lives in the village as young adults, the older people's articulations on the city are shaped much by their current life situation within that city.

It would be too simplistic to generalize Dar es Salaam as a homogenously aging city. How aging experiences are shaped very much depends on the area we look at. Förster emphasizes that the design of a city and its size are important to understand an urban society. Thus, the segregated spaces of Dar es Salaam deriving from the colonial past can impact on where encounters become possible and where not. Roots of urban life are found in "interaction of those who live the city" (Förster 2013, 242).

[67] The word *Mzee* is a Swahili term for a respected elderly man, and depending on the context, it can also be used to refer to an older woman. Respectful greetings in Swahili will be discussed later in this text.

[68] Förster says that in order to examine creativity in urban spaces we have to look for "social and cultural spaces that did not exist before." Hence, it necessitates the imagination of new spaces (Förster 2013, 245). In my view, when examining aging practices of the elder members of the middle class in Dar es Salaam, I might be able to look for these new social spaces, as these older people are the first generation to age in the city.

[69] By phrasing it this way I intentionally make a link to the edited volume "Living the City in Africa" by Obrist, Arlt and Macamo (2013). Older people are not only living *in* the city, but they are also living the city as an urban context.

Urbanity that can be described as "the production of a social and cultural space by intentional actors" (Förster 2013, 242) may then emerge only for specific parts of the city.

In this part, the concept of the milieu will be used as an analytical tool in order to differentiate urban aging experiences of the older study participants. In her book on urban spaces in Johannesburg and Maputo, Heer writes: "Understanding urban difference through social milieus is a useful path towards becoming more aware about whose city we are writing about" (Heer 2019, 34). For some older people, who have troubles with daily survival, not least because jobless adult children and grandchildren depend on them, "their" city becomes a place of hardship and struggle. At the same time, for others who can profit from the partially existent social welfare system, plus their children providing regular financial support from within and outside the country, the city can be a place of opportunity that enables the creation of new ideas about what good aging means.

The urban will serve as a context here in which people grow old. At the same time, however, I will discuss how far the "urban" impacts on how older people live their everyday life in Dar es Salaam and how they experience aging in the city. By showing how they act towards others and urban spaces, my analysis will reveal how they are not only shaped by, but are also shaping the city. Three stories from different urban milieus will serve as a basis to describe how old age in Dar es Salaam is lived. The stories will further help to illustrate my argument that old age can be experienced differently in different milieus. I will highlight one particular milieu (the former civil servants' milieu) in more depth; in order to depict the creation of potential new social spaces of old age in the city.

Social Differentiation in African Cities: The Concept of Milieu

In urban anthropology, unfortunately "methodological and analytical instruments still build on the Western historical trajectory" (Förster 2013, 238). One example is the concept of class deriving from Western history. Therefore, a conceptualization "of how social, cultural, and political articulation unfolds in African urban settings" has to go "beyond the theoretical frameworks inherited from Western history" (Förster 2013, 239). Neubert also criticizes one-dimensional structural concepts used in research in the African context and stresses that social structures cannot be captured by only looking at concepts such as "ethnicity" (socio-cultural differences) or "poverty" (socio-economic differences), while in the discipline of sociology of industrialized countries those two perspectives are usually combined (cf. Neubert 2005). When looking at the development of these concepts in sociology, the economic dimension derives from the sociology of social stratification to study economic differences in (culturally and ethnically rather homogenous) European societies at the beginning of the 20th century (cf. class theory by Marx and Weber). Later, however, it became clear that in a particular class people develop different life styles. Thus, theories of milieu and lifestyle groups became prominent in the study of social differentiation.

Neubert underlines that in the African context empirical evidence on socio-cultural differentiation that considers both dimensions is scarce (Neubert 2005, 185).[70] Scholars working on "African middle classes" (cf. Quénot-Suarez 2012; Mercer 2014) confirm Neubert's criticism and emphasize that a purely economic definition that accounts for income and expenditure only, cannot capture the "better-off" group they intend to describe. Furthermore, class may imply stable futures, savings as well as consumption (Stoll 2018, 4). When conducting research in four different areas of Dar es Salaam, I realized that the aspects that distinguish older people from others within the same city, reach much further than "class" differences or "ethnic" differences. Especially, when exploring health-related practices and explanations as well as perceptions on aging and old age, further differentiation is essentially needed.

To capture social differentiation in African contexts, Neubert proposes a two dimensional perspective that combines socio-economic *Lebenslagen* and socio-cultural *Lebensstile* (Neubert 2005, 185).[71] While Lebenslagen and class definitions are more concerned with what Hradil calls "objective" conditions, milieu can give us more information on the "subjective" conditions in life that inform social inequalities (Hradil 2001, 45). However, in this connection Neubert cautions against the use of (pre-defined) milieu dimensions to explain social differentiation that are applied in the West (i.e., consumption behavior). They might not be adequate for other contexts. I agree with Neubert that it is important to develop locally relevant dimensions of social differentiation (Neubert 2005, 187).

The concept of social milieu used here follows Grathoff (1989).[72] He uses a phenomenological definition of the term and focuses mainly on the subjective aspects of a milieu. Social milieus can be defined as "groups within a society whose members are connected through their lifestyles, life scripts, and values" (my translation, Bauer 2007, 318).[73] Especially work or other occupations can be constituting for a milieu since work affects experiences of the everyday reality of its members and thus leads to certain interests and motivations and to typical concepts and orientations of actions

[70] We will see later, however, that there are some earlier studies and also some recent studies that are concerned with social differentiation on the African continent (cf. Förster 1997; Bauer 2007; Stoll 2016; Neubert and Stoll 2015; Heer 2019).

[71] Furthermore, the author emphasizes that we need new categories that are not culture specific to understand values. In Neubert's words: "Um soziokulturelle Differenzen zu untersuchen, müssen 'kulturübergreifende Kategorien zu Bestimmung von Werten' entwickelt werden" (Neubert 2005, 187).

[72] I was inspired by Förster's (1997) and Bauer's (2007) use of Grathoff's phenomenological approach to social milieu and will follow their approach. Furthermore, discussions with my colleague Barbara Heer helped me to sharpen my understanding of the concept.

[73] "... (Gross-)Gruppen innerhalb einer Gesellschaft, deren Mitglieder durch ihre Lebensweise, Lebensentwürfe und Wertvorstellungen verbunden sind" (Bauer 2007, 318).

(*Handlungsentwürfe und Handlungsorientierungen*) (my translation, Bauer 2007, 51).[74] While work and other occupations are especially relevant elements of a milieu in historical Western contexts, in the Global South other aspects may become important too, such as diaspora contacts or the degree of a person's attachment to the home village (for Nairobi, Neubert and Stoll 2015, 9).

The boundaries of a milieu are defined by what is perceived to be "normal" by a group (Grathoff 1989, 347).[75] However, milieus never have sharp boundaries with other milieus, and there can be changes in belonging to one or another milieu (Bauer 2007, 51). Furthermore, people can also move between different milieus at the same time if they are familiar with the *Sinnenszusammenhänge* that became normal to them (Förster 1997, 166).[76] Especially when problems arise and are articulated (i.e., a health-related crisis of an older person), motives that are shaped by the milieu (i.e., staying healthy in old age, having children who take care) and that are followed by the actors can be observed (Förster 1997, 159).

Milieu approaches gained relevance above all in globalization processes as they counter the idea of a homogenous nation state (Isenböck, Nell, and Renn 2014, 7) and developed in different directions (for an overview, cf. Isenböck, Nell, and Renn 2014). Quantitative analyses use the same word milieu for their macro sociological approaches as qualitative phenomenological approaches (Isenböck, Nell, and Renn 2014, 9). Some approaches are closely linked to the social position of a group and thus use milieus to further differentiate within a socio-economic group with reference to values and lifestyles (Burzan 2011, 104) as, for example, the work of the Sinus Institute and the milieu approach they developed for marketing research (cf. Sinus Sociovision 2017). Some approaches to milieu take class analyses into account in order to analyze milieus (cf. Vester et al. 2001) while a more descriptive approach rejects this practice and focuses rather on descriptions of lifestyles (Neubert and Stoll 2015, 4). My use of a phenomenological approach to milieu that is inspired by Grathoff (1989) comes close to the approach of the Sinus institute (Sinus Sociovision 2017) that looks at the milieu members' socio-economic position but emphasizes especially the "subjective" socio-cultural aspects of a milieu that is located within a particular socio-economic position (in this case, "middle class" or middle income strata). These can then again be considered as contexts of action in which people act.

---

[74] "Konstituierend für soziale Milieus sind zu einem grossen Teil die Tätigkeit und Arbeit eines Menschen. Sie führen zu unterschiedlichen Alltagserfahrungen, zu spezifischen Interessen und Motiven und somit zu typischen Handlungsentwürfen und Handlungsorientierungen der Menschen der einzelnen Milieus" (Bauer 2007, 51).

[75] By using Grathoffs words: "…durch normalisierende Grade der Bekanntheit" (Grathoff 1989, 347).

[76] "Milieu geht auf einen alltäglichen Handlungszusammenhang zurück, der von den Beteiligten als 'normal' typisiert wird und zu entsprechenden Sinneszusammenhängen führt" (Förster 1997, 167).

The elderly study participants belong to different social milieus in the city of Dar es Salaam. They may share their interpretations of the world and consequently of the city, based on their habitual side of agency (Heer 2019, 34).

A Note On Urban Milieus in Dar es Salaam

This PhD thesis is limited to a closer analysis of one particular milieu; pointing to its particularities and its dimensions, while I compare it to other milieus I encountered during this project. However, to figure out the values and lifestyle of the former civil servants' milieu, I consider it important to contrast their milieu to other milieus that I encountered during my research. Because most of my empirical material derives from the group of former civil servants, I encountered in the mtaa of Ada Estate, here I can only circumscribe tendencies of other milieus in Tanzanian middle-income groups but also with regard to other socio-economic positions. Further research would be needed to provide more in-depth information about these other possible urban milieus to which older people belong. Below I will describe how members of the former civil servants' milieu are oriented towards a future as an older person which requires certain preparations. They engage in practices around healthy aging when investing in self-care. In addition, older people stress the importance of their ethnic belonging and actively live relations with their places of origin beyond the city.

Nevertheless, there could be a tendency towards a further middle-income milieu that could be described as "older wakubwa"[77] who belong to a "young middle class" that acquired means through investments and private businesses. Some members of this milieu are also to be found in Ada Estate. Older people from this milieu tend to invest in economic ventures for their old age as they do not primarily rely on state pensions or health insurances as former civil servants would do. Older wakubwa are aiming at a "good" old age with assets such as houses and cars, while it seems important for them to invest in "good" food although being aware that this food is not necessarily healthy for them (more on "good" food will be presented in Part III). On the basis of their means, they are able to profit from the urban opportunities, for example, the service of private hospitals.

In addition, my data reveals a tendency towards a milieu with working class properties that could be described as "older working poor," who's members age without adequate financial means at hand and who usually have children with insecure jobs. In contrast to the former civil servants, who were formally employed and thus experience legal age, these working poor tend to experience social age as they work until health does not allow to do so anymore. Many older people of this milieu are either self-employed

[77] I will refer to the wakubwa later in this part when discussing the development of two Tanzanian middle classes. The wakubwa are described in literature as the newly rich (Moyer 2003, 59).

or work in badly paid jobs without social security. Their aim in old age is to be cared for by their children, while mainly basing their efforts on relational care with little available means for biomedical health care. Many working poor have a rather nostalgic image of the village, while some of them have lost ties to their place of origin and therefore do not see an option of going back in old age. While former civil servants perceive the city more as a place of opportunities, these working poor preferably emphasize the challenges they face in the city that makes people poor and life hard.

There are many urban milieus with older urban dwellers that I do not mention here, with other socio-economic positions (for example, "upper class" older people) or other relevant socio-cultural dimensions (for example, older people who are able to sustain themselves, who do not have expenses for health care, older people from other countries residing in Dar es Salaam or from other religious groups, such as the Hindu community in Dar es Salaam).

Common to most of these older people though, is the fact that they were born in the countryside and arrived in the city when still young. In the next chapter, I will therefore highlight some relevant historical developments of Dar es Salaam, at the time when most of the participants of this study migrated to the city. I consider it important to describe the developments and rapid changes in the urban context, as it helps to understand how the older urban dwellers live the city in old age.

Dar es Salaam's "First Generation" of Older People

In this historical overview, my aim is to describe the urban context in which the older participants of this study arrived in the city in their youth. A special focus lies here on the provision of services that has changed drastically in the last decades. At the time of the politics of the first president of the United Republic of Tanzania (1964-1985), Julius Nyerere, people were expected to leave the urban space when they were no longer working. Only the "productive" were allowed to live there. Although this policy changed, it remained logged in many heads until today and thus, the city of Dar es Salaam represents a special case, as this former policy seems to shape the older people's relation to the city up to this day.

The older participants of this study were among the first to remain in the urban space after the end of their "productive" years. For this reason, I describe them as Dar es Salaam's "first generation" of older people, using "generation" as a descriptive notion rather than as an analytical concept. This historical account reveals the discrepancy between the growth and development of the city that is mainly linked

to young people as a driving force (that is also reflected in the local name of the city—Bongoland), and the participants of this study, namely people above sixty years of age.[78]

The city of Dar es Salaam was founded by Sultan Majid in the 1860s and replaced the small fishing village called Mzizima[79] (Brennan and Burton 2007, 14). The new name derived from the Arabic *Bandar as-salâm* (harbor of peace) and served as a place of refuge for the Sultan of Zanzibar. In the early nineteenth century, the former village was a place where the *Wazaramo* people (from the Uluguru mountains around 200 kilometers inland) and the self-described *Shomvi* people (described by Brennan and Burton as Swahili or "Shirazi" people, from the coastal town of Barawa in today's Somalia) met (Brennan and Burton 2007, 14).

After a period of decline during the 1870s and 1880s, the place came alive again as the designated capital of *Deutsch-Ostafrika* (German East Africa) in 1891. The population grew rapidly, however, it remained a "modest urban centre" at the time (Brennan and Burton 2007, 26). The British, who came to occupy the city in 1916 (Brennan and Burton 2007, 29), took over the existing colonial division into three zones. Zone I was for the European inhabitants: the old German quarter, northeast of the city and the comfortable suburbs with well-spaced houses in the north called *Uzunguni*[80]. Zone II was for Indians: the area of the bazaar, Acacia Avenue, also called *Uhindini*[81]. And Zone III was for Africans: Kariakoo, and from 1920s Ilala, as well as the townships of Gerezani and Keko, also known as *Uswahilini*[82] (Brennan and Burton 2007, 31-33). The city's architecture of today mirrors not only the colonial past but also "cultural influences from Arabia and Asia" (Obrist 2006, 73).[83]

Between the two world wars and under colonial rule, many groups migrated to the city. This also caused tensions between the *watu wa pwani*[84] and the *watu wa bara*[85]. Zaramo and Shomvi, as well as Rufiji and Ndengereko ethnic groups, opposed the arrival of upcountry immigrants (as for example many of this

---

[78] Although, it is important to mention that the older study participants rarely used the denomination "Bongoland" when referring to the city, as the name is associated with the language of the youth. I use it on purpose, however, in order to point to these frictions between the young and the older people in the city.

[79] The name originates from *Mji Mzima* which means "complete town" (Brennan and Burton 2007, 14).

[80] Place of Europeans.

[81] Place of Indians.

[82] Place of Swahili people. The use of the description of a place as uswahilini will be discussed further below.

[83] When it comes to the organization of space, also today the legacy of the colonial period is observable; there is, for example, the northern part of the city, which was formerly known as *Uzunguni* (where the white population lives). Also the business part of the inner city; the "old African settlement" remained the principal area of commerce (Brennan, Burton, and Lawi 2007, 3).

[84] People of the coast.

[85] People from the mainland.

study's participants from the group of *Wachagga*[86] from the Northern Kilimanjaro region). The upcountry immigrants were less well integrated in the predominantly Islamic Swahili urban culture (Brennan and Burton 2007, 35-36). Between the wars, investment in houses was common and, at that time, especially women "were amongst the highest profile property-owners" (Brennan and Burton 2007, 37).[87] Rents were high and the government encouraged self-constructions. In those days, many (of the 12,000 African-owned houses) were owned by women (Leslie 1963, 168).[88] "African" estates emerged in the north, west, and south of the city, containing government quarters (as for example the area of Ada Estate in Kinondoni) and privately built houses, whereby the Swahili houses (one-storied, with six rooms) remained the favored design (Kironde 2007, 108).[89]

Under colonial rule, the city of Dar es Salaam attained its pre-eminence, generally described by Obrist (2006, 72) as the "economic, social, demographic, and political dominance of the largest city in a country." In the 1950s, although there was an economic boom in the building industry, living conditions for the African population were not good. The increase in social services introduced by colonial initiatives attracted again more people to the city. As a result, the problem of urban unemployment increased again. Other people migrated to the city because they were assigned by the British government to work in Dar es Salaam, such as Mzee Ngowi who came to the city as a civil servant and was in his mid-seventies when we met: "I arrived in Dar es Salaam in 1957, I was a civil servant, working as an inspector … from Police College, in those days. I was selected to come to Dar es Salaam, to start working in the first African public police" (Mzee Ngowi 2012).

Independence in 1961 with the late Sir Julius Nyerere as first president of the country brought changes to the city and again increased rural-urban migration (Brennan and Burton 2007, 53). After independence the city population was very young, with almost 80 percent below the age of thirty-five; also the number of female inhabitants increased (Brennan and Burton 2007, 53). It is in the years after independence that most of the participants of this study came to the city, then between the age of

---

[86] In Part III, the ethnic group of the Chagga, in Swahili *Wachagga* will be discussed in more detail.

[87] Although the authors do not disclose why, the fact that women were enabled to buy houses in the city is also visible in this study. Many women bought their own houses and not did inherit them from their late husbands.

[88] Leslie emphasizes however, that it is difficult to come up with these numbers, since also applications for houses were made under the name of a wife or daughter (Leslie 1963, 168).

[89] Leslie describes Swahili houses as followed: "There is the main house itself, divided by a central corridor of which are three rooms each side. There is thus s single front door, opened and shut first and last thing by the landlord (if he lives in the house) or his agent. Once inside one looks straight through to the courtyard, half as big as the house, where all the laundering, dishwashing and general chores go on. At the back of the courtyard are usually three rooms, which are latrine, kitchen and store when the house is comparatively empty ..., or all three may be used for sleeping and rented out, the latrine and kitchen being set at one side instead" (Leslie 1963, 69).

twenty and thirty.[90] As, for example, the almost hundred-year-old Bibi Khadija from Kichangani who came to the city for the first time when she was twenty-three years old:

> Neema: For how long have you been staying in this house?
>
> Bibi Khadija: I have been here for a long time. I remember this plot was bought in 1966 and then my aunt was staying here. By that time, I was moving from one place to another. I was married and my husband was a soldier, therefore we moved from region to region. And then we came here and my husband was appointed to go to teach *mgambo*[91] at the villages. After he left, you know our Swahili marriages, we separated … so then I stayed here since 1983.[92]
>
> (Bibi Khadija 2012)

Nyerere's new society was founded on the basis of Ujamaa, a particular form of socialism in Tanzania, which stipulated basic social rights for the inhabitants and emphasized the equality of all human beings as well as "the pivotal principle of self-reliance, i.e. the belief in own strength and resources in order to build the new nation and to overcome dependency from others" (Strahl 2006, 32). Nyerere formulated this vision as a "starting point to development from below" (Obrist 2006, 74).

In 1964, Tanganyika and Zanzibar united and formed the United Republic of Tanganyika and Zanzibar; Tanzania. Under the political party TANU (Tanganyika African National Union), the newly formed Union was governed as a one-party state. At the Arusha declaration in 1967, Ujamaa politics where further developed into a policy on socialism and self-reliance (Obrist 2006, 75). By concentrating on rural development, the idea of Ujamaa encouraged people to remain in rural areas and resettle in larger "Ujamaa villages." Furthermore, attempts were made to reduce regional, individual, and rural-urban income differences and avoid the creation of a class society (Strahl 2006, 33); the capital of Tanzania was moved to Dodoma in 1974 while the city was divided into the three districts of Temeke, Ilala, and Kinondoni (Brennan and Burton 2007, 61), and Swahili was promoted as a national language. In 1967, all land was nationalized (Moyer 2003, 46).

In the 1960s and 1970s the country successfully developed in economic as well as social terms while much of the resources was invested in education, health, and further services. At the same time, health was seen as a central value, "an asset that would permit people to lead a socially and economically

---

[90] Forty-seven of the fifty-one elderly participants of this study came to Dar es Salaam when still young, while only four of them were born in the city. The average age at their arrival was twenty-six.

[91] *Mgambo* can be translated as public proclamation and is also used to refer to a civilian militia involved in community policing.

[92] Neema: "Umeanza kishi lini hapa kwenye hii nyumba tuliokaa?" Bibi Khadija: "Muda mrefu hiki kiwanja kilinunuliwa toka mwaka 1966 akawa anakaa aunt yangu basi na mimi nikawa nimezunguka niliolewa na baba mmoja mwanajeshi nikakaa kule yule alionioa mwezi wa pili mwaka 1966 nikawa nimezunguka katika mikoa halafu nikarudi hapa niliporudi hapa akapata kwenda ukufunzi mgambo vijijini baada ya kwenda huko matokeo yake tukaachana si unajua ndoa za kiswahili hizi basi mimi ndio niliporudi hapa nyumbani kitu [kiasi] mwaka 1983 ndio niko hapa nimekaa."

productive life" (Obrist 2006, 75).[93] Since the 1960s, Tanzania was a role model for other countries (Newell 1975)[94] by giving importance to the equitable distribution of health services. Policies and education programs on health, furthermore shaped people's conceptions of health (Obrist 2006, 76). Many older study participants praised the health care system in those days compared to today. Mzee Mohamad from Kinondoni Ada Estate, when reflecting about the health care of today, underlined the experienced changes:

> The problem is that from colonial time people are used to free treatment but as time went on, actually policy changed [so] that people have to pay for the medical expenses. When it came to that, not all the people could afford the medical expenses because it depended [on the] nature of the illness. [If it] is a great [severe] illness you have to spend more money because for example the operation itself costs about TZS2 million shillings and the drugs about TZS3 million shillings.[95] (Mzee Mohamad 2013)

With more and more people migrating to the city, the government encouraged them to remain in the rural areas, and to only immigrate with an assured employment and to leave again when employment ended or people retired. Soon, it became even an official offence to stay in the city without employment and people risked being deported to their home areas, with moderate success however (Obrist 2006, 77). Due to the shortage of houses, squatter settlements emerged. Under the Slum Clearance Program, the National Housing Corporation destroyed old thatched houses and built "new houses of 'better' quality" (Lugalla 1995, 54). The sub-ward of Ilala Mafuriko, where we visited research participants, was among those sub-wards that were rebuilt by the National Housing Corporation. This is still evident today since the houses are built in rows.

As a consequence to the rapid urbanization and an economic decline, Obrist speaks of an urban health crisis that especially marked the early 1980s. A fall of living standards for most city inhabitants, combined with a decline of basic services when it came to quality and distribution, and a quality loss in the built and natural environment impacted severely on the life of city inhabitants (Obrist 2006, 79)[96] including the participants of this study, who were young at that time. A campaign called *Nguvu Kazi,*[97]

---

[93] Obrist mentions in this connection several audio-visual mass communication campaigns such as *Uhuru ni Kazi* (Freedom is Work), *Mtu ni Afya* (Man is Health) and *Chakula ni Uhai* (Food is Life) (cf. Obrist 2006, 75).

[94] In her book, Obrist (2006) points to a WHO Report by Newell where Tanzania was among the case studies in terms of equal health distribution and served as an example for other developing countries.

[95] Two million Tanzanian shilling are approximately US$885 dollars and three million Tanzanian shilling are about US$1325 dollars (numbers base on the currency converter September 2017, OANDA 2017).

[96] Obrist describes the mentioned three aspects (fall of living standards, deterioration of basic services, quality decline of environment) as "typical manifestations of an urban health crisis" (Obrist 2006, 79).

[97] *Nguvu kazi* can be translated as hard work, productive force.

the Human Resource Deployment Act, was launched and people without a valid identification card and proof of "productive" employment were sent home to their villages of origin (Burton 2005, 276).[98]

As a result of the growth of the urban population that overburdened the capacity of the health care system and economic constraints, poor health services were the topic of daily complaints. The same is true of the environmental services, since city authorities were unable to provide water and to organize waste disposal (Strahl 2006, 38). This of course had a negative impact on people's health. In the 1990s the city of Dar es Salaam became what Yhdego (1991, 147) calls a "garbage and mosquitoes city." With more and more people arriving in the city, the residential areas became denser. However the densification process proceeded according to the types of residential areas, partly reflecting the colonial division of the city (Obrist 2006, 81). The ongoing agricultural crisis increased the movement of people to the city. Or as Obrist describes: "Rural poverty drives people to the city and keeps them there, and urban poverty forces them to live under adverse conditions. The result is an 'urbanization of poverty'" (Obrist 2006, 85).

In 1985, Ali Hassan Mwinyi became the new president of the country.[99] At the time the economy was in crisis. Nyerere resigned from the post as a president but remained present as the chairman of the political party *Chama Cha Mapinduzi,* CCM (Moyer 2003, 39). As in many other countries in Africa and elsewhere, the global economic predicament was also felt in Tanzania. External incidents such as oil shocks and droughts and floods were also among the reasons why the country's debt burden rose while trade declined (Strahl 2006, 35). While parents had to pay ever rising school fees in order to have their children attend a better-quality school, hospital patients were also required to pay for treatment. Hospital charges were introduced during 1993 (WHO 2004, 14-15).

After the country had tried to reconstruct itself through a National Economic Survival Program (1981) and a three-year Structural Adjustment Program (1982), from 1986 onwards negotiations with IMF and World Bank forced the government under Mwinyi to revise its economic policy (Strahl 2006, 39). The government was asked to improve foreign exchange allocations and to improve domestic savings and infrastructure, as well as to launch rehabilitation projects (Obrist 2006, 85). For many Tanzanians 1985

---

[98] Nyerere's presidency is known as *kipindi cha fimbo* (time of the stick) meaning a strong state who carried a stick in order to "intimidate people to clear the way in the name of national progress" (Moyer 2003, 38). In a conversation with my landlord, Mzee Ngowi, who worked for Nyerere, this attitude also shines through: Mzee Ngowi said that while he was in the government under Nyerere they had a system to check regularly who invested money (e.g., by buying a new car or house) and from which financial source. No state employee was able to enrich himself or herself as is the case at the time we talked, according to Mzee Ngowi (Informal talk with Mzee Ngowi 2012).

[99] Ali Hassan Mwinyi is also known as Mzee *Ruksa*, which is translated by Moyer to "the old man who granted permission." His name derives from a speech early in his presidency where he emphasized, after a food stall that was serving pork meat burned down, that the government does not have any religion and those who would want to eat pork are allowed to do so (Moyer 2003, 37).

is seen as a "benchmark year of change" (Moyer 2003, 36).[100] The Economic and Social Action Program (with the Priority Social Action Program) in 1989 reinforced measures to counteract the ongoing deterioration of social services (Obrist 2006, 86).

At the time, "the socialist stigma of urbanization" remained however, and there was what the authors Brennan and Burton call a "middle-class anxiety towards the urban migration of unemployed and under-employed male youth" (Brennan and Burton 2007, 62). While under president Mwinyi corruption was a huge issue, people also like to think back to the time when soap and other daily products were suddenly available and affordable (Moyer 2003, 40). The newly emerged "competitive consumerism" also allowed poorer people to "fashion themselves in a middle class style."[101] The changes also lead to changes in the labor market as many more women were engaged as traders in private income generating activities (Brennan and Burton 2007, 63).

With the introduction of a multi-party system in 1992, under president Mwinyi, political reform began and by the mid-1990s foreign aid was stopped and the government was facing pressure to implement reforms (Obrist 2006, 86). In 1993 therefore, the ministry of health adopted user fees for medical care (Mubyazi et al. 2005, 24). But not only the government was under pressure; for city inhabitants, too, this was a difficult phase, since "people suffered from the manifestations of the urban crisis but also under the rapid reforms which caused much anxiety and social as well as economic insecurity" (Obrist 2006, 88).[102]

The decade of President Mkapa that followed (from 1995 to 2005),[103] was strong in economic terms and a new agreement with IMF in 1996 showed the improved relations between government and donors. National decentralization took place and apart from the existing and once dissolved City Council, municipal councils were also installed; in the following, these were responsible for services and tax collection (Obrist 2006, 90). At the time, a private garbage collection system was introduced

---

[100] However, peoples' view on their participation in bringing change differs according to Moyer. Her study participants, who resided in the city without identification card, would not consider themselves as having participated but rather claim that the state "happened to them" (Moyer 2003, 36).

[101] However, this was against the ideas of the established middle class who, "nostalgically long for the lost days of egalitarianism" (Moyer 2003, 57).

[102] Obrist further emphasizes that especially on the household level as the "place in the social system where diverse socioeconomic influences and cross-ties come together in a complex knot," the influences of existing economic hardship and urban change on daily health practices could be observed (Obrist 2006, 88).

[103] According to Moyer, the presidency of Mkapa is known as *ukapa* pointing to the "belt-tightening" rhetoric. It made fun of a speech of the president, who's own belly growth was observable while talking about belt-tightening (Moyer 2003, 38). Mkapa's presidency is seen as corrupt to the same degree as the presidency before, however, wealth did not seem to "trickle down" anymore to the mass population (Moyer 2003, 40-41). While those who had already earned big money under Mwinyi (also called *wakubwa* (the big ones)) continued to do so, entry into the league of the wealthy became more and more difficult, not least because taxes were increased and regulations tightened (Moyer 2003, 42).

and many women were employed as street cleaners. In the same effort, the municipal councils formed health boards to "streamline delivery of health care and related services" (Obrist 2006, 90). Furthermore, government dispensaries and health centers as well as the three today still existent municipal hospitals (Amana Hospital in Ilala, Temeke Hospital in Temeke, and Mwananyamala Hospital in Kinondoni) were refurbished while the stock of medication was increased and the health staffs' institutional capacity was strengthened (Obrist 2006, 90). Thus, Obrist calls the years after 1997 as an era of partial recovery (Obrist 2006, 89).

What can be observed until the moment of this study, is the state withdrawing as far as the provision of public services is concerned. This holds true for old age care as well: the Tanzanian state assigns the families the responsibility for care work. After the structural adjustment policies mentioned above, the health sector was fragmented. The fragmentation of the health sector consequently led to new (empowerment) approaches coming in with international organizations bridging the gaps (Dilger 2012, 65). In Part III on care dynamics, these approaches, tackling the health and well-being of individuals, will be discussed in more detail.

The ongoing population growth during the recent years has "hastened the transfer of peri-urban land from traditional landowners (mawinyi), most of whom are Zaramo, to more recently arrived immigrants, mainly from the salaried or trading middle-class" (Brennan and Burton 2007, 65). Strahl describes the city as marked by cultural heterogeneity with a mix of African, Arab, Asian, and European culture which is also "reflected in different styles of architecture, food, religion and ways of life" (Strahl 2006, 28). There are no official accounts of how many Muslims and Christians live in Dar es Salaam, since religious denomination is not considered in the population census. However, according to people's estimations half of the inhabitants belong to Muslim faith, the other half to Christian faith. At the time of this study, many Muslims in Dar es Salaam "feel underrepresented in government and ill-served by national educational institutions" while Christianity "also continues to attract the disaffected and dispossessed who live in Dar es Salaam, particularly Pentecostalism" (Brennan and Burton 2007, 64).

The city of Dar es Salaam "offers the paradox of unprecedented economic growth despite a plainly failing infrastructure" (Brennan and Burton 2007, 65). Poverty continues to be a "primary concern" at the community or household level (TzPPA 2002/2003, 59), since the majority does not profit from the city's economic growth. This "paradox" is also reflected in a newspaper article of *The Citizen* from 2013. Rents in Dar es Salaam's prime areas are comparable with rents in Johannesburg and Manhattan, NY.[104]

[104] According to the newspaper article from 2013, rental yields in Tanzania are together with Uganda among the highest in Africa (8.57 percent). Monthly rents in fully furnished two-room apartments in prime areas such as Masaki, Mikocheni and Oyster Bay range from $3,000 to $8,000 (cf. Masare 2013).

As mentioned earlier, the city's paradox is also reflected in the name that was given to it. In contrast to the official name Dar es Salaam, the name Bongoland was given to it by its people, "disseminated by a multitude of energetic, young neo-urban migrants" (Calas 2010, 3). The name is composed of a Swahili and an English term and thus can be seen as a "sign of the expanding world economy enclosing the city, from the west Indian Ocean to the outside world, the sign of an emerging 'globality'" (Calas 2010, 3-4). The Swahili word *bongo* means brain. The name Bongoland thus points to the fact that urban dwellers need brains to survive in the city. It reflects especially the more informal sectors where people become creative to earn money. Specifically young people refer to the city as Bongoland or "Bongo." Older people only randomly spoke about Bongoland when pointing to challenges that arise from living the city.[105]

Due to the described cultural heterogeneity of Dar es Salaam, I distance myself from the literature that describes the city as a Swahili city (Strahl 2006; Brennan and Burton 2007).[106] When conducting field work in Dar es Salaam, I noticed a gap between what I had previously read about Dar es Salaam being a Swahili city and what I observed. Not a single elderly urban dweller that I encountered during my research would identify as a Swahili during our encounters. The denomination Swahili derives from the Arabic word *sawahil*, which means coast. Thus, Swahili can be described as the "People from the Coast" (Middleton 1992, 1). Strahl (2006) and Brennen et al. (2007) are the only authors I read who confirm—at least partially—these observations and point to the fact that Dar es Salaam is not a typical Swahili city. In her dissertation Strahl emphasizes that Dar es Salaam has to be distinguished from other Swahili towns. It was founded as one of the last Swahili towns and it can be described mainly as a colonial town (Strahl 2006, 28-29). Also Brennen et al. say that Dar es Salaam represents "a modern reformulation of the Swahili city" due to its late and rapid growth during the twentieth century (Brennan, Burton, and Lawi 2007, 4). Brennan and Burton mention however that when considered linguistically, the city can be described as a Swahili city, as the language served as a lingua franca in many different areas (Brennan and Burton 2007, 13).

Nevertheless, most of the older participants of this study would not identify with being "Swahili," as they would attribute this denomination to people from Zanzibar or those originating from the coastal area.[107] As mentioned above, the city has developed as a Swahili town, taking part in the Indian Ocean

---

[105] Förster describes a city's name as a "collective point of reference" (Förster 2018, 408).

[106] Strahl conducted research on hypertension in a sub-ward of Ilala and describes the residents of the area as Swahili people, although she emphasizes that Dar es Salaam's residents differ from "other longstanding Swahili societies along the East African Coast" where a "distinguished Swahili society" was able to develop contrary to the young city of Dar es Salaam (Strahl 2006, 49).

[107] Although Middleton especially mentions people from the ethnic group of Zaramo, who are coastal people, according to his definition they are not considered Swahili despite being closely related when it comes to language (Middleton 1992, 1).

trade, connecting people from the Near East and the East-African coast. However, people from different regions in Tanzania migrated to the city after independence and thus contributed to a heterogenic mix of inhabitants that shape the city of today. Many of the upcountry immigrants belong to a Christian denomination; for them, being Swahili is linked to being Muslim. Furthermore, the historically used term *uswahilini* for the zone of the city inhabited by local "Swahili" people serves today as a marker for deprived areas. Many of the elderly study participants belonging to the middle-income milieu would talk about informal settlements as uswahilini places that are overcrowded and feature a high rate of criminality. Belonging to a "middle class," they distance themselves from uswahilini places and "Swahili" people. Consequently, although Swahili serves as a lingua franca in the city of Dar es Salaam it does not bring about a sense of identity for many city dwellers.

This short historical overview highlights the changes that the older participants of this study witnessed in different times and areas of Dar es Salaam. It helps to explain some of their complaints about the city in connection to health and care which will be explored later. As already mentioned, most of the study participants migrated to the city during the presidency of Julius Nyerere (1964-1985) and were part of the euphoric growth of the city after independence. Years later, they witnessed the economic crisis as well as the privatization of the health sector, linked to increasing costs for services. These increased costs of course impact differently on older people in different milieus of the city. Although Nyerere's Ujamaa politics encouraged people to leave the city after their productive years, the elderly study participants decided to remain in the urban space. I will highlight their reasons for staying later in this text.

ENCOUNTERING BONGOLAND: FOUR DIVERSE *MITAA* AS A STARTING POINT

Located on the Indian ocean, the city of Dar es Salaam is the major city of Tanzania. It is also the center of government administration, industry, commerce, and banking activities. While it became the country's capital in 1891 it lost the official status as national capital city to Dodoma in the mid-1970s (UN-HABITAT 2009, 6). The city has a land area of 565 km² (UN-HABITAT 2009, 6) and witnessed a rapid growth in recent years, and was at the time of the research home to more than four million people, that is, 10 percent of the total population of mainland Tanzania. At the time of the study, the city's inhabitants were comparatively young, with only 3.5 percent above the age of sixty; however, this number is expected to increase in the coming years (Census 2012, URT National Bureau of Statistics 2013, 47). The city is a vibrant social hub and as Gerold aptly describes "[p]eople from all walks of life meet, interact, separate, continue, re-encounter and connect, thereby making the city a dynamic space" (Gerold 2017, 49).

Dar es Salaam's emblem reflects how the city presents itself to the outside world. It has a blue and white shield in the background, which depicts the Indian ocean bordering the eastern side of the city. The two fish point to the fishing activities in the nearby ocean, while the anchor symbolizes Dar es Salaam as a port city. The coconut palms and the color green indicate that the city commands fertile land for farming and that coconuts are one of the major crops. Furthermore, at the center stands the independence monument, the country's symbol of freedom, peace, and unity (URT Dar es Salaam City Council 2004, 4). The name of the city, *Bandari ya Salama* means harbor of peace. Bryceson describes the city as an exceptional case in East Africa for living up to its name as it managed to remain a peaceful place with very few ethnic tensions (Bryceson 2010, 1).

Dar es Salaam has a regional administration as well as a city council administration. The city is divided into three districts as a result of the process of decentralization during the mid-1990s (Gerold 2017, 49). The three municipal councils of Kinondoni, Ilala, and Temeke are at the same time the three districts of the region. The districts are divided into ten divisions, which in turn are divided into 93 wards (*kata*). The wards are divided into 448 streets or sub-wards (*mitaa*) (URT Dar es Salaam City Council 2004, 12). Sub-wards are further divided into ten cell units (TCU). Research for this study was conducted on the sub-ward level by focusing on four sub-wards in different parts of Dar es Salaam.

ILALA ILALA MAFURIKO

> *Mafuriko* in Swahili means flood and especially during the long rainy season from March to May and the short rainy season from November to December, the sub-ward reflects its name by flooded streets. Due to the rain, the streets that lead through the sub-ward are bumpy also during the rest of the year and become a challenge for older people. On the map, the mtaa Mafuriko has a square-cut, and also within the sub-ward, the grid-like structure of the area stands out. Along these planned streets, houses however have different shapes from newly built posh houses with trees in front, sometimes with more than one floor, to typical "Swahili houses" that did not witness much renovation since they had been built by the National Housing Corporation. Especially at the Western end of the mtaa, towards the railway line that constitutes the border of the mtaa, houses have a rather unplanned character. As diverse as the houses of the sub-ward, this diversity was also reflected in the mix of residents which appeared when one wanders through the streets of the neighborhood. We also had the impression that the ruling political party CCM was very present in the mtaa, and especially many older men engaged in regular political meetings. (Field notes 11.09.2012)

Ilala Ilala Mafuriko (later referred to as Ilala Mafuriko or ILM) is located in the district of Ilala in the city's center. Mafuriko is the sub-ward of the ward with the same name Ilala, and Ilala had a population of 31,083 inhabitants (URT Ministry of Labour 2003). Uhuru Road borders the mtaa in the north and the railway line serves as a boundary in the south. The wards Kariakoo and Ilala were the only "African settlements" of Dar es Salaam in the 1930s (Obrist 2006, 98) and because in the late 1920s the British used the area to provide housing to "African workers," the inhabitants of the area Ilala Ilala "do not represent a localized community which has developed shared cultural values and practices over centuries" (Obrist 2006, 98) but as reflected in the field notes above, represent a rather mixed group of inhabitants.

The Ilala municipality in which the Mafuriko sub-ward is situated is often described as the "administrative municipality" (Gerold 2017, 49). Ilala as a district had "the first Government sponsored African Housing Scheme in Dar es Salaam" (Kironde 2007, 108). In the early 1960s, therefore, the National Housing Corporation (NHC) built new houses in a uniform style sponsored by the government; these houses were then loaned to the inhabitants (Obrist 2006, 98). In the 1960s, the area can be described as a "model of a working class neighborhood in a new urban society," while a similar description also applies to other planned residential areas (Obrist 2006, 99). In Mafuriko, the common type of house are so-called Swahili houses that contain six rooms, three on each side of a corridor. The corridor leads through the whole house and ends in a backyard where toilets and the kitchen are located. Often, these houses are inhabited by more than one family (Obrist 2006, 99).

According to the census data from 2012, Ilala Mafuriko had at the time 7,471 inhabitants, 2,842 of them women and 2,653 of them men.[108] Mafuriko can be described as a residential area with some bars and shops along the main road. According to the information of a TCU leader, apart from some houses that are rather run down, there are also newly built, "posh" houses belonging to immigrants from the Arabian Peninsula and Somalia. According to the TCU leader's information, there are more inhabitants of Muslim faith than Christians living in the area. Mafuriko has no school but a kindergarten. The closest health facility is the Amana hospital, which is the district hospital of the Ilala district and considered to be far away from the sub-ward. There is no health facility in Mafuriko itself. Some houses in Ilala Mafuriko have tap water. The majority of houses do not have running water and people are therefore entitled to fetch water at one of the pumps of the sub-ward for free.[109] Other places sell water. In recent years, many investors bought plots for the purpose of developing housing facilities. Hence, the area, which is preferred by many business people because it is very central, undergoes constant transitions.

TEMEKE AZIMIO KICHANGANI

> Arriving at Kichangani was usually challenging for our research team. Located towards the South of the city, we spent almost two hours in public buses in order to arrive at the mtaa from the places where most of us stayed in the northern part of the city. Although, after some time we were able to drive together by car, we still used approximately an hour to arrive there because of the traffic yams. Each time we struggled to find the right entry into the neighborhood from the main street, as it was rather hidden. The neighborhood was usually quiet and not many people were on the unpaved roads, since people seemed to rather gather in the backyards of the houses or at the squares between the houses aside of the main roads passing through the sub-ward. The roads were clean and bordered by a rainwater drainage canal. Each time, when we arrived, we announced our coming at first at the mtaa office, which was recognizable through a big tree next to the house and marked the geographical center of the sub-

[108] The information about the census data from 2012 derived from an informal conversation with the Mtaa Leader on 12.03.2013, since these figures were not accessible online.

[109] At least this was the case in 2012 due to an ongoing NGO project.

> ward. Together with either, Frank, Monica or Elisha I then met with Bakari who usually accompanied us to the older people's houses. Grown up in the mtaa, Bakari knew the short cuts through the narrow streets which usually made me forget where we initially came from. The sub-ward is more or less surrounded by busy tarmac roads, so each time we reached a tarmac road we knew that we would have to turn in order to not leave the borders of the sub-ward. (Field notes 08.11.2013)

The sub-ward Kichangani (in the following text, Azimio Kichangani or KICH) is located in the district of Temeke, south of the city center. The sub-ward is embedded in other residential sub-wards of the ward Azimio, west of Kilwa Road that leads to the south. At the time of the study, Azimio's number of residents was 76,832 people (URT National Bureau of Statistics 2013). The mtaa is described by Bakari and others as a quiet neighborhood bordered by highly frequented tarmac roads.

During colonial rule, the district of Temeke in the south of Dar es Salaam was considered an African residential settlement, which could supply labor for the emerging industrial area along Pugu Road. In 1950, the construction of neighborhoods began; however at first these were unpopular as the city center was far away (Kironde 2007, 109). The municipality of Temeke can be described as the "industrial municipality" of the city, not least because the city's port is located within its borders (Gerold 2017, 49). Furthermore, as a landmark, the National stadium is located in Temeke as well as the exhibition square.

The population census in 2012 revealed a high number of 7,900 inhabitants in the sub-ward of Azimio Kichangani, about 4,500 of them women, and about 3,000 of them men. At the same time, the sub-ward had a strikingly low number of people above the age of sixty years, amounting to merely 79 people in 2012 (47 of them women, 32 of them men). The area is described as a predominantly Muslim area, with only few Christians settling in the sub-ward. The sub-ward has no school, and the closest health facility is located in the neighboring mtaa. While some houses had tap water, others had to buy water for TZS50 Tanzanian shillings per bucket (20 liter). In 2012, the mtaa Kichangani had a leader who belonged to the oppositional party Civil United Front, CUF, while most of the surrounding mitaa was in *Chama Cha Mappinduzi*, CCM hand. The CUF is a nationally based political party, but most supporters are from Zanzibar. The political differences led to disturbances during the leader's reelection when, according to Bakari, CCM supporters tried to get rid of the ballot box.

KINONDONI MANZESE MNAZI MMOJA

> Well, [there are] places like Manzese, other places like Manzese, there are many places in Dar es Salaam which are like Manzese—you walk—you walk [and] you find that stinking septic water … mmh, I think you [Andrea] have met something like that—that type of life—I don't like it at all! (Bibi Helen 2013)

Two sub-wards that served as research sites for this study, Manzese Mnazi Mmoja and Kinondoni Ada Estate are both located in the district of Kinondoni. The northern district of Kinondoni is the district with the most inhabitants at the time of the study (1,775,049) when compared to the other two district

in the middle, Ilala (1,220,611) and in the south, Temeke (1,368,881) (URT National Bureau of Statistics 2013).

Although Kinondoni is often referred to as the "high income municipality" (Gerold 2017, 49), it contains also several low income residential areas such as Manzese. The mtaa Mnazi Mmoja (referred to as Manzese Mnazi Mmoja or MNM) is located south of Morogoro Road, bordering the road on its northern frontier, just before arriving at the well-known Ubungo bus station that serves as a nodal point for buses traveling outside the city. The ward of Manzese is known for its huge market and business area, called Manzese Manzese. Mnazi mmoja, which is a sub-ward close to the marked area, can be described as a residential area. Although, apart from many private houses there are many food stalls, bars, stores, and guesthouses.

The population of Manzese witnessed rapid changes as the ward grew massively from 5,000 (1967) to 60,000 (1988) inhabitants, and the place became "Tanzania's largest unplanned settlement" (Brennan and Burton 2007, 54). The growth of Manzese was stimulated by the construction of the Morogoro Road in 1950s and the industrial area that was built nearby Ubungo in 1968. At the time of the study, the population of the ward numbered 70,500 inhabitants (URT National Bureau of Statistics 2013). The place became known for illicit services as, for example, one particular area close to this study's research site that was given the nickname *Uwanja wa Fisi*[110], "where prostitution and the illegal manufacture and sale of alcohol were important commercial activities" (Brennan and Burton 2007, 54). Also, today people not living in Manzese epitomize the area as a place of Kinondoni's harsh city life; a place of leisure, however, where it is difficult to survive. Many study participants in Dar es Salaam as well as in the USA usually referred to Manzese when pointing out the city's deprived areas with high criminality. The experience of hardship was also to be felt when inhabitants of the area themselves talked about their sub-ward. In addition, encounters with many inhabitants of the mtaa revealed their being annoyed by international NGO's coming to the area. According to some study participants, they usually conduct short-term research and promise interventions that then never benefit the inhabitants.[111]

According to one of the TCU leaders, Manzese Mnazi Mmoja is said to be the mtaa with the highest number of bars in the city of Dar es Salaam. In recent years, the business of building residential houses or guesthouses boomed and many privately-owned houses were sold to investors (usually from Arabian countries) who then built multi-storied guesthouses. Private plots were sold for sums of around TZS2

[110] In English, *uwanja wa fisi* can be described as "field of hyenas."

[111] Due to past experiences with these NGO's which often paid study participants for their replies to a questionnaire my research team had to take much time to introduce and explain our research that was different from what they experienced before.

million and the area was consequently in constant change. According to the mtaa officer, data from 2006 revealed 9,189 inhabitants in the sub-ward.[112]

One of the TCU leaders, a politically active middle-aged woman who usually helped us visit older study participants, described the area as inhabited approximately half by Muslims and half by Christians, with a tendency for a slight majority of Christians. Most houses in Manzese Mnazi Mmoja have electricity, however most of them do not have tap water. Water is therefore sold at different places in the mtaa. At the governmental water source, water was sold at that time for TZS50 shilling for the bucket, while private places usually charged TZS100 shilling. The mtaa does not have its own school, however the school area borders the sub-ward and according to one of the TCU leaders there was an ongoing discussion about the school ground's belonging either to Manzese Mnazi Mmoja or the neighboring mtaa.

KINONDONI KINONDONI ADA ESTATE

> Bibi Mbujuni: … After all the house is in a very good location [Ada Estate].
>
> Andrea: Yes, people like to stay in this area.
>
> Bibi Mbujuni: Yes, even where our son is staying [in a small bungalow within the same courtyard] … when it was completed, everybody, many people were coming to ask "are you letting this for rent?" And we said no—So people want to stay in this area because it is near to the town—you could walk to town—in case you have a problem with transport you can just walk! I also used to walk to town; my children were schooling at Muhimbili primary school they used to walk in the morning for seven years from standard one to standard seven.
>
> (Bibi Mbujuni 2013)

Apart from the low-income area of Manzese, there are also some areas in Kinondoni that were built for state employed people. These areas were often constructed under colonial rule and then taken over by the Tanzanian government (Brennan and Burton 2007, 45). Later, the houses were sold to its inhabitants. Ada Estate in the ward, which is called the same as the district, Kinondoni, is such an area. The number of inhabitants in the ward of Kinondoni is smaller than Manzese and numbered merely 21,239 inhabitants (URT National Bureau of Statistics 2013). In 2012, the Ada Estate area had a low density of 2,821 inhabitants (Census, 2012) whereby 4.5 percent were above sixty years old. The number of older people is rather high, compared to other areas of this research project. In Azimio Kichangani, for example, only 1 percent of the inhabitants were above sixty years (Census, 2012). Kinondoni Ada Estate is a Christian dominated area with only few Muslim inhabitants.

[112] Unfortunately, the mtaa office was not able to provide me with more recent statistics, however, I assume that the number from 2006 is likely to have increased in recent years (Informal conversation with mtaa leader, 26.03.2013).

The sub-ward of Kinondoni Ada Estate (referred to as Kinondoni Ada Estate or ADE) is located in the northern part of the city. It is situated west of Ali Hassan Mwinyi Road and, when arriving from the city center, just behind Selander Bridge. The official boundaries of the neighborhood are marked by a well-known graveyard, called the *Kinondoni Makaburini*. The former government officers club "Leaders club" forms another landmark of the area, close to one of the main connecting streets to the northern parts of the city (and the north of the country) separating the area from the ocean. Especially at night, Tunisia Road, where the Leaders Club is situated, turns into a red-light district. Moreover, the district of Kinondoni is known for its lively character with many bars and pubs—a feature that is also visible in Ada Estate. According, to the voices of inhabitants, in the last twenty years former playgrounds for children in the area were turned into bars. At the time of the study, the mtaa hosted around ten different bars and two hotels. There is no primary school, one big nursery school and some smaller (private) nursery schools. There are two churches, a Pentecostal church and a Lutheran church (KKKT), and also one mosque. A few non-profit organizations (Sikika, World Food Program, Afri Care, Care International, amongst others) are located in Ada Estate as well as three bank branches (Stanbic, NBC and Axim). The CCM (Chama Cha Mapinduzi, leading political party) Women Group and a newly formed Group for Vulnerable Children are also located in Ada Estate. Furthermore, Ultimate, one of the biggest security companies, has its headquarters in the area. There is one police station and no market, but several dispersed small *genge*[113] in the mtaa. The closest health facilities are Dr. Mvungi and Mwananyamala Hospital, the district hospital. The mtaa does not have a hospital but three private dispensaries (one of them is a recently built Chinese diagnostic center). The garbage collection is organized in many parts of the mtaa and the inhabitants have to pay for it on a regular basis.[114] The Ada Estate area is located favorably between the city center and the northern Peninsula[115] and connected to those areas and others through three different daladala stops.[116]

Ada Estate stands out for its particular historical development. During the colonial period, it was an area of employees who worked at the Peninsula (Brennan and Burton 2007, 33). Later, the area transformed into a civil servants' area, where the government, after independence, provided housing to government employees. But already under colonial rule, in the 1940s and 1950s, Brennan and Burton describe the people living in the government "quarters" as being "better off" residents who belonged to the "more responsible, the clerical, and the artisan classes of job" and who were mostly from the

[113] A *genge* is a food stall or shop where apart from food, and mainly vegetables, also detergent or soap is sold.

[114] A lorry arrives to collect garbage on a regular basis; the costs amount to TZS 3'000-30'000 per month depending on the household size. Some people prefer to pay 1'000 per week instead of 3'000 per month.

[115] The Peninsula is known for its upper-class houses where high government officers and also foreigners reside.

[116] Informal conversation with mtaa leader in Ada Estate (26.11.2013).

upcountry (Brennan and Burton 2007, 45). While the Christian population in the city was estimated at 12 percent by that time, in the government quarters 57 percent of the inhabitants belonged to the Christian religion (Brennan and Burton 2007, 45). In those quarters access to services was improved and density of housing was low.

Under colonial rule there were three types of government employee accommodation; grade A for British government officers, grade B and C for Tanzanian, Indian, Goan government officers.[117] Ada Estate apparently hosted grade A officers. Built by the British, the houses were then handed over to the first government of the country during the independence process. Apart from the so-called bachelor bungalows with two bedrooms, there are also flats that were built for government officers with families. Government officers were then entitled to stay in the houses or flats without paying rent, instead a small amount was deducted directly from their salary. Each flat had a "servants" house' in the back yard (those servants' houses are today good sources of income when rented out, or provide living space by renting out the apartment itself). Another complex of flats was built by the Swedish development cooperation, right after independence; shortly afterwards it handed over to the new Tanzanian government.

Between 1995 and 2005, during the presidency of Benjamin Mkapa, civil servants could not only rent government houses below the market price, they were also able, while living in them, to buy those properties cheaper than everyone else. Large parts of the population, especially government challengers, perceived the selling of those government-owned buildings as a scandal since they were sold for very low prices, to the benefit of the civil servants.[118] Some houses were also kept and resold for a much higher amount somewhat later, which caused even more critique from government opponents. At the time of the study, many of the government buildings were still inhabited by state employed people, former civil servants or family members of civil servants, who bought the houses between 1995 and 2005. Due to its past and similar to other civil servant areas, Ada Estate is still ill-reputed as an area where state profiteers stay.

The mtaa leader of Ada Estate described the inhabitants of the area as belonging to three different groups: "there are the low-income people, the middle income and the high-income people … but here there are not so many low-income people but many [with] middle income and some [with] high

[117] Most information on Ada Estate comes from several talks from June 2012 to February 2015 with my landlord, a former high government officer who has been living in the area for many years.

[118] According to Mzee Ngowi, the forty-one bachelor bungalows, for example, were sold for approximately TZS9 million shillings, a price that usually did not allow you to buy a plot. However, there was apparently the agreement that the owner had to leave the house unchanged as it was for twenty-five years, without changes and without any rights to the land. It is said that maybe once the leading political party of the government changes they could reclaim the houses.

income" (Mtaa leader 2013). The leader pointed out that an area they call *Kinondoni Shamba* borders Ada Estate, which, according to many voices, brings theft and crime to the area. What is termed Kinondoni Shamba in the vernacular is an informal settlement adjoining the Ada Estate (the administrative name of the settlement is Hanna Nassif). Even on the map the area shows a difference from Ada Estate and from the bird's eye view the disparity of the two areas is striking; while Ada Estate hosts a lot of open space between the houses, with a high number of trees and grass fields, the neighboring area has a much higher density of houses. Kinondoni shamba is described as a typical uswahilini place. Those places are usually perceived to be equipped with a rather poor infrastructure and to belong to a low socio-economic group of inhabitants.[119]

Although houses were sold to private owners between 1995 and 2005, Ada Estate remained an area known for state employed residents. The picture of the area might change, however, once the now retired state employed people (the research participants of this study) no longer occupy their houses.

REPERTOIRES OF OLD AGE

In the city of Dar es Salaam, older people, but also their social environment, draw on different frames of reference to describe or engage with an "old" person. These repertoires of old age[120] are situational and people refer to different definitions, not only depending on their counterpart in a particular situation but also depending on their intentions. While this study departed from a definition of old age starting with sixty years of age, I feel it is important to emphasize that this artificially set benchmark does not mean the same for all the participants of this study. Some older study participants were heavily confronted with their legal age, for example, when employed by the state and forced to retire at the age of sixty. Compulsory retirement at the age of sixty was a marked change from being middle aged and employed to being old and unemployed. For those older people, turning sixty years meant the end of a particular stage in life and the start of a new one, as a retired older person. Many of the state employed older city dwellers thus had to prepare for their retirement at some point; some continued with another income earning activity after retirement (for example, Mzee Mohamad who kept cows to sell milk or Mzee Buni, a retired soldier, who worked in the security company of a relative since his pension was too small to live on it). Others, however, with no formal employment usually worked until their body became too weak to continue. They related more to their social age. For them, turning sixty did not constitute a turning point. Rather, becoming an older person was experienced as a slow process and

---

[119] As mentioned earlier being denominated as Swahili does mean different things in different contexts. Moyer (2003: 44) describes *Uswahilini* areas as "characterized by an unplanned, almost willy-nilly arrangement of houses, limited access to electricity and clean water, and incredibly dense populations."

[120] I came to call these frames of reference "repertoires" after a discussion with Till Förster in his research group on political transformation.

was usually linked to the older person's health condition. Their condition thus played a major role in how they presented themselves to others (i.e., as a frail older person or as a healthy and active older person). Older city dwellers' link to legal age is distinctly higher in the urban environment. However, when the older participants of this study lamented about the difficulties of older people in the urban space, they were referring more to social age and the linked discrimination of older people in the city, as will be shown later.

LEGAL AGE: DAR ES SALAAM'S INSTITUTIONAL LANDSCAPES

With 3.5 percent the metropolitan city of Dar es Salaam has one of the lowest proportion of people aged sixty years and above (URT National Bureau of Statistics 2013, 47). However, with a growth rate in Dar es Salaam of 5.6 percent over the last years, an impressive population growth can be observed. During the censi of 1988, 2002, and 2012 the proportion of the population aged sixty years and above has remained constant; this accounts for a massive absolute growth of older people in the city (URT National Bureau of Statistics 2013, 49). While these numbers should call for state interventions in order to support the growing number of people getting older, international NGOs and policy documents describe the current social protection scheme of older people in Tanzania as inadequate (amongst others, Spitzer, Rwegoshora, and Mabeyo 2009). An estimated 96 percent of people over sixty in the whole of Tanzania do not have a secure income, while 73 percent of older people remain economically active (HelpAge International 2013). Most of them are not entitled to a pension in old age, and those who are cannot live from it and thus they are forced to generate some form of income.

Some major development policies acknowledge the vulnerable position of older people,[121] such as the National Strategy for Growth and the Reduction of Poverty (NSGRP II or in Swahili MKUKUTA II) which considers older people among the "vulnerable and needy." The document is seen as a "vehicle for realizing Tanzania's Development Vision 2025, the Millennium Development Goals (MDGs) and the aspirations of the ruling Party's Election Manifesto" and aims at increasing the "proportion of eligible elderly people reached with minimum social pension" (URT Ministry of Finance and Economic Affairs 2010, 81). The strategy thereby also acknowledges the role of older people as care providers of orphans and vulnerable children.

The Health Sector Strategic Plan (HSSP III) as a guiding reference plan to achieve the millennium development goals emphasizes the strengthening of services amongst others provided to the

[121] In his master's thesis Büsch provides an overview on the policy framework existing for older people in Tanzania. The following paragraphs on the available policy documents are therefore based on Büsch's attentive compilation of these legal texts (Büsch 2014, 21-25).

"chronically ill and the elderly"[122] (URT Ministry of Health and Social Welfare 2008, 21).

HelpAge International, an international NGO, estimates that in some areas of Tanzania nearly 60 percent of deaths among people over sixty are due to non-communicable diseases (HelpAge International 2013). Access to health care can make a difference, they claim. The National Health Policy of Tanzania (URT Ministry of Health 2003) guides access of older people to health care. Apart from pregnant women and children under five and people with particular diseases, the policy recognizes that there are people over sixty who do not have the capabilities to pay for their treatment (URT Wizara ya Afya na Ustawi wa Jamii 2007, 32) and should be exempted from paying user fees. According to the health policy, regulations in form of a law should be adopted soon to strengthen the policy. The National Aging Policy of Tanzania also states that "health services are not easily accessible for the majority of older people and in most cases [they] are expensive" despite of the exemption for people above sixty years since "the existing procedure of providing free health services to older people has some shortcomings" (URT Ministry of Labour 2003, 9). Especially in rural areas, older people face problems in providing proof of their legal age in order to get free treatment. In the city of Dar es Salaam, it seems to be slightly easier to acquire the document of proof. In the *mtaa*[123] of Manzese Mnazi Mmoja, for example, Bibi Ruth had to go to the mtaa office, fill in a form and provide a passport photograph in order to get the exemption document.[124] According to a member of the mtaa office, the process of issuing the document should be quick and easy in theory. Since the exemption is not executed in the same way in different areas of Tanzania, the Department of Social Welfare was at the time developing guidelines for its implementation.[125] In the Primary Health Services Development Programme 2007-2017 (PHSDP) older people are not addressed (Büsch 2014, 22).

In September 2003, the Tanzanian ministry of Labor, Youth Development and Sports adopted the above-mentioned Aging Policy. With this act, Tanzania was the second country on the African continent (after Mauritius) to adopt an aging policy. "This commitment is a clear demonstration of government resolve to put ageing issues into the development agenda of the nation" (Preface, URT Ministry of Labour 2003). The process of elaborating the policy started after the celebrations of the International Year of Older People in 1999. Although the policy recognizes that only government

[122] The exact wording says: "Provision of services to the chronically ill and the elderly; this includes catering for life long treatment like hypertension, diabetes, AIDS patients on ARVs, renal conditions, Cancer and any other chronic conditions" (URT Ministry of Health and Social Welfare 2008, 21).

[123] As mentioned above, the Swahili word *mtaa* can be translated as quarter or neighborhood.

[124] For many older people, obtaining a passport picture constitutes the first obstacle to receiving an exemption document. As an intervention after the finalization of the field research, therefore, Elisha and I supported some older participants of this study in obtaining a passport picture.

[125] Information derived from a telephone conversation with the acting assistant commissioner for social welfare in the Ministry of Health and Social Welfare (13.02.2015).

employees retire at the age of sixty and all others "stop working only due to limited energy" (URT Ministry of Labour 2003, 2), the policy nevertheless defines old age as starting at sixty years of age: "For the purpose of this policy, an older person is an individual who is 60 years and above" (URT Ministry of Labour 2003, 3). This definition of old age guides the country's conception of the legal age of an older person.

An important figure in the fight for social protection of older people is the above mentioned HelpAge International which has been working in Tanzania since 1993. The NGO collaborates with local partners to "support the development of social protection policies that recognise a universal social pension as a right of all older people" (HelpAge International 2013, 2). Furthermore, as stated on their website, it searches to "improve access to free, age-friendly health services for older men and women and prevent and manage chronic illnesses" (HelpAge International 2017).

Despite the commitment of HelpAge International and the existing above-mentioned policies, the implementation of social protection for older people—especially in Dar es Salaam—is rather poor. While in other areas of the country, initiatives began to improve the situation of older people, not much can be observed in the city of Dar es Salaam itself.[126] This might be due to the fact that at present still a higher number of older people (80 percent) live in rural areas (HelpAge International 2013), and (geographical) access to health care is expected to be less complicated in the urban space. In fact, the landscape of health facilities in Dar es Salaam is quite rich: According to the Health Facility Registry Website of the Ministry of Health, there are thirty-seven hospitals (nine of them private), thirty-two health centers, five hundred and seventy dispensaries (URT Ministry of Health 2017). Consequently, one could think that geographical access to a health facility should not be problematic for older people. While some of the health facilities mentioned above are state-owned, others belong to faith-based or private institutions. Normally, the governmental health facilities are less expensive and therefore more often frequented than the privately owned ones. Some faith-based institutions have special funds for particular treatments. For older people who are entitled to a health insurance, only a part of the health facilities—usually the government institutions—can be frequented. The National Health Insurance Fund (NHIF) usually covers public servants and their dependents. It is a compulsory health insurance scheme introduced by the Act of Parliament No. 8 of 1999: "The National Health Insurance Fund is the first and largest Social Health insurance scheme in Tanzania to provide medical care services in accordance with internationally recognized Social Health Insurance Principles and Standards" (URT

[126] There are local initiatives in Zanzibar for example that together with the HelpAge International succeeded in the implementation of a universal pension in 2016 (cf. Gillam 2016), while Tanzania Mainland, and especially Dar es Salaam was still far from such an implementation during the time of this study. When looking at interventions of HelpAge International it is significant that not much of their work targets the city of Dar es Salaam.

Dar es Salaam City Council 2004).[127] Paradoxically, however, once retired, people were, until 2009, no longer covered by the NHIF. But according to the website of the insurance fund, since 2009, the coverage continues, also when retired. As a result, people who retired after 2009 are now covered by a health insurance, whereas those who retired before, remain uncovered. After retirement people were only covered by the insurance fund if a child was a public servant and able to cover his or her parents as a dependent on his or her card. According to the website of the National Health Insurance Fund, since 2009 the coverage also continues after retirement, however, in that case it only covers the retired government employee and his wife or her husband, but no dependents (URT National Health Insurance Fund 2017). As most of the participants of this study that were state employed retired before 2009, they were not covered by a health insurance after retirement.

Compulsory retirement age for government employees in Tanzania is sixty years: "… an officer who attains the age of fifty-five years may at any time thereafter opt to retire but an officer who does not so opt shall continue in office in the Service on pensionable terms until he attains the age of sixty years which is the age of compulsory retirement" (URT 1999, Section 17, Subsection 2). In Dar es Salaam the number of people benefiting from a pension from a former employer after retirement amounts to at least 8 percent, 14.6 percent of them older men (Mboghoina and Olsberg 2010, 5).[128] This number is higher compared to other regions of the country (4.4 percent for all of Tanzania).[129]

While government employees profit from a pension and those who retired after 2009 also from health insurance coverage, the majority of older people are left with very little governmental support. The only assistance provided on paper is the exemption from health costs at the age of sixty. Otherwise, also the National Aging Policy of Tanzania states: "… the family will remain the basic institution of care and support for older people. Institutional care of older people will be the last resort" (URT Ministry of Labour 2003, 10).

---

[127] Apart from the NHIF, there are other funds targeting health insurance, such as the Community Health Fund (CHF) that is a "voluntary community based financing scheme whereby households pay contributions to finance part of their basic health care services to complement the Government health care financing efforts" (URT 2001, 5). The act passed in 2001, however until today the coverage of CHFs is very fragmented and mainly targets rural areas.

[128] The presented numbers are based on the Views of the People (VoP) survey that was conducted by REPOA in 2007. Two-thirds (66 percent) of the older people interviewed in the survey were depending in some way on their children. Interestingly, the report found that among the older people who were not depending on their children, those residing outside of Dar es Salaam mostly depended on full-time work while among those in Dar es Salaam, a minority of men depended on pensions (Mboghoina and Olsberg 2010, 5).

[129] The largest pension scheme in Tanzania is the National Social Security Fund (NSSF) (cf. URT National Social Security Fund 2017a).

When it comes to encounters with the health care system, the exemption policy at the age of sixty only partially relieves older people from investing in their health care. As the following extract from an interview with Mzee Amani from Manzese Mnazi Mmoja shows:

> Andrea: And do you get the free treatment because you are already sixty?
>
> Mzee Amani: I get free treatment, but in the hospital once they realize you are above sixty, they cannot give you all the medicine you need. You will only be given some of them. For example, if you were supposed to be given six kinds of medicine, they will only give you two kinds and the rest they will tell you to go and buy at the pharmacy and at the pharmacy they need money.[130]
>
> (Mzee Amani 2012)

Also, Bibi Khadija from Azimio Kichangani explains how the exemption policy worked for her: She was able to go to see the doctor for free, however, since she needed hypertension medication, and this medication was not available at the hospital, she was sent to buy it at her own cost. She explained to Neema and me that one pill costs TZS600 to 700 (about 20 to 30 cents)—and she had to take these pills daily—which was, a lot of money for her. Most of the study participants pointed out that they received free consultations at health facilities due to their advanced age, however, after the diagnosis, treatment with medication became challenging because they had to pay for the medication themselves. If there is not enough financial support available, many older people struggle to comply with the instructions from medical doctors and sooner or later stop or pause treatment. In spite of the lack of medical care at the age of sixty, most of the older study participants from all sub-wards were aware of the exemption policy and therefore familiar with this artificially set benchmark of sixty years.[131]

Especially the elderly members of the former civil servants' milieu in Ada Estate experienced this drastic change in life when retiring at the age of sixty. Many former civil servants of this study or their family members also retired before reaching the age of sixty which in some cases decreased the likelihood of receiving a monthly pension. Nevertheless, sixty years served as a fixed benchmark for many. The aspect of numerical aging becoming important for former employees was also emphasized by Gerold (2017, 153). Other older people were less confronted with the artificially set age differences and thus rather related to what I here call social age.

---

[130] Elisha (translating Andrea's question): "Je unapata matibabu bure kwa sababu tayari una miaka sixty?" Mzee Amani: "Napata bure lakini wale wakishaona tu kwamba hapa msamaha baadhi ya dawa utapata dawa mbili kwa mfano umeandikiwa mfululizo wa dawa labda sita pale utapata dawa mbili zingine zote unaambiwa kanunue sasa na kule kwenye kununua hawajui msamaha wanahitaji pesa."

[131] Aulino's "demographic imaginary" reflects nicely the legal age that is put forward by government plans and international NGOs and that shapes people's experiences of becoming old. The demographic imaginary of older people in Thailand "reflects a relation between traditional ideals and neoliberal biopolitics, as the elder population is increasingly defined, reified, regulated, and made self-reliant via government plans and practices" (Aulino 2017, 8).

SOCIAL AGE: SEMA SHIKAMOO

Although the above-mentioned institutional landscape has to agree on a marker to make their policies applicable, aging has to be seen as a process that does not only start when people turn sixty. In the paradigmatic literature of Social Gerontology, aging is understood as "a process whereby people accumulate years and progressively experience changes to their biological, social and psychological functioning as they move through different phases of the life course" (Phillips, Ajrouch, and Hillcoat-Nallétamby 2010, 12). But, taking this process into account, when does old age start? While some gerontologists talk of a third and fourth phase in life, meaning old age, others again differentiate more specifically within the aged—since the phase of being old has extended in recent years.[132] The German sociologist Thieme (2008, 37) for example, differentiates young old people (from sixty to seventy years), old people (from seventy to eighty or eighty-five), and the oldest old people (from eighty or eighty-five). Also, some participants of this study distinguished between different phases in old age. For example Mzee Mbujuni, who was in his mid-sixties when we met, answered when asked about whether he expected help from his children: "The children have to assist you if you are at the age of Mandela; like when you are totally finished …" (Mzee Mbujuni 2013).

In order to define the "start" of old age we could follow the legislative authorities that set the age of retirement, which in the case of Dar es Salaam would be sixty years, as mentioned above when referring to the legal age. However, this determination is set arbitrarily since individual aging experiences can differ from person to person. In a country like Tanzania where only a small number of Tanzanians above the age of sixty benefit from a pension from a former employer, such a definition seems even more arbitrary. People in Dar es Salaam are thus confronted with the official benchmark of sixty years if they are (state) employed and retired. The legislative authorities' determination of retirement age at sixty thus does pertain to all older people in Tanzania to the same degree. How individuals define and experience old age varies according to how much they are confronted with these artificially set benchmarks (i.e., if they go to hospital and get free health care because they have reached sixty). We consequently have to look for other frames of reference that mark the entry into old age for them today, for several of those repertoires may exist concurrently and are taken into account depending on the situation and social environment. As the answer of Bibi Helen from Kinondoni Ada Estate shows (when talking to me):

> Andrea: Would you consider yourself old or *bado* [not yet]?

[132] Höpflinger, for example distinguishes a third age which is the "healthy retirement age" (*gesundes Rentenalter*) and a fourth age which is termed "fragile age, oldest old age" (fragiles Alter, Hochaltrigkeit) (cf. Höpflinger 2014).

> Bibi Helen: Ooh old according to my age, well I am above sixty; around seventy but myself I don't see myself as someone who is old and desperate [who] cannot do this and this… I just find myself I am fit I can move and do anything—I could even work in the office!
>
> (Bibi Helen 2013)

In this PhD thesis, I go from the assumption that older people draw on different frames of reference at once. Gerontologist Makoni, for example, points to the fact that researchers often use chronological age as a marker; however, it is much more important in his eyes, to give the older people a setting in which they can express their own views about aging. The author further explains that especially governments rely on "classifying and counting people and things," and thus chronological age is used for bureaucratic purposes. But he adds his concern that "…people who qualify as old may depend not only on chronological age, but rather on a whole host of other factors such as marital status, wealth and traditional position/function" (Makoni 2008, 201).

In addition, using chronological age is often connected with negative associations; loss of strength and increasing dependencies. In her PhD thesis, de Klerk rightly emphasizes that old age in Tanzania is not so much about dependence but about shifting interdependencies (Klerk 2011, 9). Also Makoni puts forward that "aging, like other categories such as ethnicity is not pre-given, but rather, socially constructed, fluid, performed from one moment and situation to another" (Makoni 2008, 203). A newer body of (gerontological) literature on aging therefore argues against a positivist modernization theory and is much more interested in how identity in old age is intersubjectively constructed within a social environment (cf. Makoni and Stroeken 2002; Aboderin 2004). Also, when it comes to this study's participants, they act differently towards others when negotiating care in old age. To receive care, they have to present themselves as an old (and frail) person. However, at the same time, they might claim that they are still strong compared to other people in their social network (cf. Part III).

De Klerk brings in the dimension of time and states that there are three different notions of time in the concept of aging: "Physical changes as older people grow older, the historical time period an older person grew up in, and time spent with others in everyday activities of living together" (Klerk 2011, 9). Similarly the authors Featherstone and Hepworth confirm that aging has to be taken as a process which cannot be explained in biological and medical terms, but as an "interactive process involving social and cultural factors" (Featherstone and Hepworth 2009, 135). In this connection, Sokolovsky rightly points out that in every corner of the world, due to globalizing contexts that intersect with culture, "new realities of what elderhood means" emerge (Sokolovsky 2009, xviii). In Part III, I will discuss new concepts about successful or active aging that circulate in urban spaces; these concepts are also likely to shape people's imagination on being and becoming old. Based on the literature cited above, I understand old age as a process that is shaped by various aspects.

I agree with the scholars cited above who emphasize the importance of social age. However, especially in urban environments we have to be aware of legal age definitions that shape the older person's perception. In the following part I would like to carve out what aging and therefore (social) old age means for the older people in daily encounters within different areas of Dar es Salaam. While doing so I feel it is important to keep in mind that in the city, the legal and social repertoires both shape how people perceive their old age.

How are older people in Dar es Salaam perceived or addressed as older people by other urban dwellers? The Swahili language uses different terms to express respect towards an older person: When greeting an older person, the address of welcome commonly used is *Shikamoo*. The respectful greeting is a particular greeting to someone who is older (or of higher rank) than the person who offers the address. In Swahili, an old person is usually described as a *mzee* or a *mtu mzima*. Mzee refers to a respectful address of an older man, and in some contexts, it may also be used for a woman that is already advanced in age. The plural *wazee* is commonly used for older people in the plural, deriving from the word *uzee,* which means old age. If somebody is not feeling well and has, like Bibi Hilda from Kinondoni Ada Estate, back pains she would tell me (in English) "you know, it's just uzee" (Bibi Hilda 2012), meaning it is (just) because of old age. A *mtu mzima* can be an adult or grown-up, mature person in general but it can also be used for somebody who is old. While *mtu* stands for person, *mzima* refers to being adult but also being complete, whole or healthy. In daily welcome addresses, the question *wote wazima?* is also used to ask if everybody in the family is well. Here *uzima* also refers to being well or healthy. Furthermore, somebody is addressed as a grandmother, *bibi*, or grandfather, *babu,* if the person has grandchildren or is at least expected to be in the age of having such.

How do older urban dwellers describe the old age of themselves and others? The older participants of this study often experienced becoming old in physical terms. This was the same in de Klerk's study on older people of the Kagera region of Tanzania (Klerk 2011, 62). Old age was often brought together with the ability of the own physical body that older people described, based on their own experiences, such as having problems in getting up early in the morning or being easily exhausted. These physical abilities and wellbeing also impact on the person's capacity to invest in social relations (Klerk 2011, 63).[133] Many older study participants also emphasized that becoming old strongly depended on how a person had grown up. Others further suggested that it depended on the means of looking after one's health whether somebody appeared old or not. If elderly people are worried about their health, they will also age more rapidly, they suggested. In the Christian environment of Ada Estate, being worried about health, the future as an old person or about the (not) received care and support of children was

[133] This aspect of physicality will be treated in more detail in Part III.

usually connected to (Christian) religion: it was explained that if an older person relied on God, he or she would not have to worry about anything.

When asked about (visual) signs that show that somebody is old (*dalili za mtu kuwa mzee*), the older study participants usually mentioned as a first marker the inability to walk upright and fast. Furthermore, one can find out whether a person is young or old by looking into his or her face. If the skin is no longer soft– even if that person uses creams to avoid wrinkles or make up to cover the face—one can see that the face appears old. Sinking eyes or an old voice were also mentioned. Mzee Dunford, who was in his early seventies when we met, described these signs of old age as follows: "There are many signs [of old age] like skin and hair destruction, lack of strength… you cannot work as in the past… you cannot stand, walk or run as in the past because of your age"[134] (Mzee Dunford 2013).

Grey hair was not used as a common marker for old age. The research participants pointed to the fact that getting a grey head is very individual. In addition, women can plait non-grey hair into their natural hair so that it is difficult to see the grey parts, or hair can be colored. Plaiting in artificial hair or using facial creams to avoid wrinkles can be related to the urban environment where such things are accessible.

How does aging differ between urban women and men? Older study participants mentioned gendered aspects of becoming old. Women were described to age more rapidly than men, when it comes to physical appearance. Apparently, they also become weaker in old age than men. This circumstance was mainly explained by the fact that women give birth to (a high number of) children which contributes to exhausting their bodies more rapidly.[135] However, especially women stated that if men did not take care of their own health as, for example, when consuming too much alcohol, they age earlier.

Older people's descriptions of old age very much depended on particular situations. Being old was, for example, suggested by some older people that when traveling in the city, they expected respectful greetings by others and certain amenities (as for example, when using public transport). In this connection, the city was often blamed for the missing respect that some of its inhabitants demonstrated towards the older people (that could also be described as agism), as described later in this part. According to many of the study participants, discrimination of the aged (*ubaguzi wa umri*) was ubiquitous. Elisha therefore said: "They look at us as if we are a spent force." However, it is important to compare what people discursively claimed to be true for the city and what their single experiences

[134] Mzee Dunford: "…[dalili] ziko nyingi, moja wapo ni ngozi kuharibika nywele kunyonyoka kipara kukosa nguvu huwezi kufanya kazi kama zamani ukasimama ukatembea ukakimbia ukiwa mzee huwezi ziko nyingi."

[135] A young man therefore always wants to marry a younger wife so that in old age, the woman does not appear much older than he does.

looked like. When being accompanied by myself or someone from the research team while navigating through a market and using public transport, the same older people that complained about missing respect, were provided with a free seat in a *daladala*[136] or greeted with shikamoo everywhere they passed. It therefore becomes even more important to mirror their discourse on the city with the actually observed interactions that take place in the public sphere, but also privately among relatives. Towards the research team, but also within the close social network, being old and frail can be used as a resource by the older people when bargaining for care.[137] Furthermore, the received care much depends on how caregivers perceive the older people's age. As will be described in Part III, whether a person is perceived to be sick or "just old" impacts on the care that this person is likely to receive.

Becoming Old in Dar es Salaam

While this project started from the assumption that aging differs according to geographical spaces in Dar es Salaam, I soon realized that it was not solely the built environment, but the multiple aspects which together constitute social milieus that create differences in urban aging. The older people's aging experiences are shaped by encounters with the city that differ markedly, depending on the milieu they belong to. Encounters can be quite positive as, for example, when an older person receives free treatment at a health facility because he or she is over the age of sixty, but also rather negative when an older person is, for example, involved in a car accident when crossing a busy street on his or her own. Aging in the city can be experienced as a tension between challenges and opportunities. In the course of an older person's age in the city, there can be both; experiences of hardship and opportunity. These experiences change over time and especially when the health of older people deteriorates, they can become more pronounced. A healthy older person normally follows his or her *shughuli,*[138] but as soon as health becomes a problem, the city can be either perceived as a place that increases the problem, or as a place that provides health care and enables therefore a good (and healthy) aging.

[136] According to Lugalla, the *daladala* buses (sometimes also dalla-dalla) were legalized in 1983 and "represent the most informal means of transportation which has existed for decades in Tanzania" (Lugalla 1995, 114). The name daladala derives from the bus fare which amounted, in the 1980s, to five Tanzanian shillings and the five shilling coin resembles the American dollar (Lugalla 1995, 114).

[137] While negotiations imply a frame within which these negotiations take place, bargaining is broader and therefore circumscribes more accurately discussions around care in old age (observation based on a personal conversation with Carole Ammann).

[138] The Swahili word *shughuli* can be translated as activity or business.

AGING URBANITES

In the following text, three different types of geographies of support networks in the city will be discussed. They are illustrated by stories of older city dwellers, and followed by subchapters that highlight different aspects of these support networks by also pointing out the similarities and differences with regard to the heterogenous experience of the older participants encountered in this study. In order to approach aging ethnographically as a social process, it is crucial to include these support networks, when it comes to how older people experience old age in the city and how they engage with others in order to shape it.

UNAJUA, MAISHA YA MJINI—YOU KNOW, CITY LIFE

I would like to start this chapter by describing our visits to Bibi Ruth. Her case is important in my view, as it contrasts the non-poor older people who are usually rather well supported by others. Bibi Ruth came to the city while still young and now experiences the harsh side of the urban life (i.e., the limiting power of the urban) while not being physically able to earn a living, let alone to pay for medical treatment.

I met Bibi Ruth for the first time at the beginning of September 2012 when Neema and I came to Manzese Mnazi Mmoja to conduct transsect walks in order to randomly sample people above sixty years of age. When we counted every tenth house together with Mama Zamira who was the Ten-cell Unit (TCU) leader of the area, we came to her house. It is situated on the border of the mtaa, close to an open wastewater canal with a lot of garbage that is dumped there. When we arrived, some women were busy preparing food on the veranda of the house, while children were playing next to them. We were welcomed to the first room of the house, the living room. On the other side of the living room the house had a corridor with four rooms that Bibi Ruth as a house owner rented out.

Every time we arrived at her house—and that was in the course of this study many (around eight) times—Bibi Ruth was sitting on the sofa in the living room, sometimes with a charcoal stove next to her when preparing food. At that first encounter, when shaking hands with her for the greeting, I could already observe that her eye sight must be limited as she had difficulties to see where my hand was.

Bibi Ruth later told us that she was around seventy-six or seventy-seven years old. She was not sure about her age since she had lost her birth certificate. She was born and grew up in a village, west-central Tanzania. She only went to school for two years (up to standard two). She explained that it was not common for girls to go to school more than that, at that time. Two children of her six children had already passed away and she remained with another two in Dar es Salaam, while two children lived in west-central Tanzania. She told us that she came to Dar es Salaam around fifty years ago, when her husband died, with her children, the youngest only six years old. She came to stay with her mother who happened to be in Dar es Salaam at that time. Bibi Ruth started working at a textile factory and was

able to buy her own house from the money she got as a redundancy pay-off when she had to stop working in 1980. Because the money run out before construction on the house completed, some parts of the house were still in a preliminary condition. Although being formally employed, she never got a pension or health insurance.

Bibi Ruth shared her house with her two children, a son and a daughter. The son's girlfriend and their two children also lived in the house. The grandchildren were around four and six years old at that time (attending nursery school and standard one). In addition, a grandchild of her late sister stayed with them. In the house, she was responsible for cooking and cleaning the inside. She also washed her clothes and carried the salty water by herself to the house. For drinking water, she had to pay someone to carry the water for her because the pump was quite far away. When she needed help, her children and tenants supported her in the daily household tasks.

Through the money she earned from renting out the four rooms (if paid on a monthly base, each room cost about TZS15'000 or US$7 per month), she funded the school fees of her grandchildren, and provided money for the daily survival of the whole family. She explained that it was her task to do so because her daughter was sick (later we learned that she had HIV/AIDS and developed tuberculosis) and the son usually went out during the day to "look for life," which meant to apply for jobs, often without much success. Her younger sister stayed not very far from her place at Ubungo in Dar es Salaam, however she did not seem to have frequent contact with her. Her network of support was thus very much focused on her household, with random contacts to the village and to other parts of Dar es Salaam (her sister) in emergency situations.

When asked about her health, Bibi Ruth told us that particularly her eyes caused her a lot of problems. She had a vision impairment and the increased pressure of her eyes triggered frequent headaches. Apart from the eyes, she occasionally suffered from typhoid, and had pains in her legs and waist. Especially the impairment of her eyes and legs prevented her from going to a health facility to seek treatment. Because her daughter was sick, and her son was usually out every day, she did not have anybody to accompany her to the health facility. With her decreased eyesight, she did not feel comfortable to go out on her own, mainly due to the road traffic. In the city, there are too many cars, she explained. Furthermore, her legs prevented her from walking long distances and the bus fare was too expensive. For all these reasons, she normally remained in and around her sub-ward.

Bibi Ruth was a member of a church group and a priest visited her occasionally and once even gave her money to buy spectacles. However, because her child in the village died shortly after she got the money from the priest, she had to invest the money in the bus fare to travel to her home village. Unfortunately, the priest left again for Europe, and since then she has not received any more support from church.

When I came back to visit Bibi Ruth in 2013 her eyesight had deteriorated further and her daughter's health condition was worse (sadly, soon afterwards the daughter passed away). Meanwhile the TCU leader had heard about an eye screening in a church close by, we got involved in organizing a trip for her to that church some weeks after I left again for Switzerland. However, on the day of the screening the person that should have accompanied Bibi Ruth to the treatment was delayed and Bibi Ruth began the trip on her own. To avoid costs, she climbed on a *bodaboda*[139] that would take her to the church. However, due to the dense traffic the driver had to sidestep another vehicle and Bibi Ruth fell off the motorbike. Because of her injuries, she was taken to the police station where she got a certificate that granted her free treatment at the hospital. She was transferred from one hospital to the other and in the end, she had increased costs to treat her shoulder, head, and rib and remained without eye treatment as she missed the church screening—and she was even more afraid to move around the city because of the heavy traffic.

Bibi Ruth's story reveals experiences of challenging situations in the city of Dar es Salaam. Especially with her deteriorating health, she had difficulties to move around the city due to the heavy traffic and the lack of people that would accompany her. However, for Bibi Ruth the urban space also creates opportunities, like that she is able to own a house and earn an income through the rents.

Older People as House Owners

When starting with my research, I was impressed by the fact that many of the older study participants owned houses, as did Bibi Ruth. Most of them were able to buy land and build houses shortly after they arrived in town. Almost all older people that I encountered (thirty-nine out of fifty-one) were house owners; men as well as women (nineteen of twenty-five women owned houses). The six women, who did not own a house, stayed in houses of family members while a small number of older men rented rooms. When they came to Dar es Salaam during the 1960s and 70s, most of the older study participants were able to buy plots of land. Particularly older widows made their living from their properties that they did not inherit from their husbands, but normally built themselves from their own means while still young.

As mentioned earlier, the typical Swahili house has six rooms. Depending on the size of the family, rooms can be rented out to other urban dwellers. Most of the elderly house owners currently reside in central areas of the city, where rooms are easily let for rent. Being a house owner enables older people to earn a small monthly income, amounting to around US$5-10 per room per month (usually, however, rents are paid on a yearly base which causes problems especially at the end of the year, when money is

[139] The Swahili word *bodaboda* is a colloquial word for motorbike taxi, reflecting its speed in crossing roads and in traffic. The word is derived from the English word border.

short).[140] The little income can help the older person to meet basic needs and to claim certain support or rights within a family, as the example of seventy year-old Bibi Annette goes to show who told me during an interview: "… I am the final decision maker, because I have the money … I don't have the money as money but since I have the property which has the worth of money everybody has to listen to me …" (Bibi Annette 2012).

Being a house owner provides an older person with some freedom of choice. Many older people therefore emphasized the importance of staying in their own property; preferably by sharing it with their children. Not only men but also women pointed to the fact that it makes a big difference for them whether they stay in a property they own or in a house that belongs to one of their children. Since the person who owns the house is also the one who has the power to make decisions. In this context, many older study participants pointed out that they needed a certain degree of *uhuru*[141] in old age. Hence, it makes a huge difference, if children provide money for an older person while the older person then can decide by himself/herself to buy the food he or she likes. Consequently, if there is no owned property, older people have less power to bargain for their daily needs. Bibi Helen who does not have own children, lived in a house of her sister for some years that she held with her young niece who went to school in the city. However, when the sister herself decided to move to the house, Bibi Helen was sent to stay with her brother and his family on the outskirts of Dar es Salaam (cf. Part III).[142]

Also van der Geest describes for Kwahu-Tafo, a rural town in the Eastern Region of Ghana, the importance of owning a house. In his article he emphasizes that money or wealth can be stolen and is not remembered after death, whereas a house cannot be stolen and will help to remember the owner also after his or her death (Geest 1998, 334). The author concludes for the study participants in Kwahu-Tafo that "a house stands for a successful life, for respect, love, happiness and security in old age, it is a thing of beauty and it provides a sense of belonging, of 'home,' both physically and symbolically" (Geest 1998, 336).[143] A house is a sign of respect since it fulfills two requirements, so the author: visibility and sociability. Owning a house shows a successful life (financially as well as socially)—and in

[140] In Kinondoni Ada Estate rents were much higher, however, also in Ada Estate fewer people rented out rooms of their houses because they were not in need for additional income.

[141] The importance of "freedom" or "independence" in old age will be discussed in more detail in Part III as it impacts on the care provision for and by older people.

[142] In the city of Zanzibar, staying with children at the children's property seemed very common. Often older people's houses were taken over by a child or sold so that the older person did not remain in the house but moved to one of the children, while being moved from time to time from one child to the other (observation based on a personal communication with Sandra Staudacher). When talking to the older participants of this study about the Zanzibar case, they usually emphasized that they could not imagine living in the same way with their children in the children's house. Most older people underlined, that this would only be an option, if they fail to stay in their own house.

[143] Van der Geest concludes that a house is, among other things, also a sign of success, which drives migrants to go abroad and build a house back home. Building a house while staying abroad will be touched upon in Part IV.

the Ghanaian case, a successful funeral. In Ghana, women seem to build fewer houses than men, contrary to Dar es Salaam.

A house is also said to bring security in old age, however van der Geest shows that the wish for security is not always fulfilled in old age by owning a house. Older people may be neglected in their own house too. Owning a house is described as one aspect of a good old age.[144] Different from the discussions around houses in Dar es Salaam, was the fact that in the Ghanaian case, building a house in one's hometown was considered to be much more important than somewhere else. This aspect was also closely linked to the funerals that take place in the hometown and are influenced by whether the person who passed away was a respected house owner or not. The aspect of mobility of a dead body will be taken up later, when discussing rural-urban connections. In Dar es Salaam, some older people underlined that one has to own a house in the home village, while others rather seemed to consider Dar es Salaam as their "home" and did not opt as much for another house elsewhere.

Living Arrangements

When looking at the living arrangements (i.e., who is staying with whom), it seems to make a difference depending on the owner of the house. If older people stay with their own children in the children's house, gendered norms and values based on kinship concerning who is entitled to stay with whom play an important role. A grandmother would only be able to stay with a son and a daughter-in-law, while it is not common for her to move in with a daughter. If the daughter is married, she then belongs—"traditionally"—to the family of the husband. For older men, it seems even more complicated to stay with children. It was interesting to observe, that especially abroad in the USA, these norms seemed to be loosened, and an older woman was able to stay with her daughter for some time (cf. Part IV).

Within a house owned by the elderly person, preferred living arrangements involved children of the older people (cf. Figure 1). In the study, we were able to observe that most older men stayed with their wives and with their children, but only two older women stayed with their husbands (in total eighteen men with wives, two women with husbands). This could be explained by the fact that most of the older women's husbands had died already. Some, however, were also divorced. While a small number of the older men without wives lived on their own, this was only the case for one older woman (who stayed alone with tenants because her only son had passed away). Most older women shared houses with their grown-up children in multi-generational households. In general, the majority of thirty-nine out of fifty-one older people stayed with grown-up children and other relatives. Those who did not stay with

[144] However, as van der Geest points out, more security than by investing in a house is reached by investing in a good education for the children—as, if they are well educated, they can contribute financially to fulfil the second important aspect, that of building a house (Geest 1998, 350). This aspect will be taken up later in the text, when I will present the particularities of the former civil servants' milieu Ada Estate.

grown-up children, either because children that already passed away, or because they were staying in another part of the country. For example, Mzee Chumbuni from Manzese Mnazi Mmoja rented a room on his own in order to work as a tailor in the city, while his wife and children lived in northern Tanzania.

	MNM m/f	ILM m/f	ADE m/f	KIC m/f	*TOTAL* m/f
Mzee with wife	-	-	1/0	-	*1/0*
Mzee with wife and other family members	4/0	4/0	4/0	5/0	***17**/0*
Bibi with husband and other family members	-	-	0/1	0/1	*0/2*
Son	1/0	1/0	-	0/1	*2/1*
Daughter	0/1	0/1	0/1	-	*0/3*
Son and/or daughters and/or in-laws and/or grandchildren	0/5	0/3	1/2	1/4	*2/**14***
Grandchildren without son/daughter	0/1	0/1	-	-	*0/2*
Alone	1/0	1/0	1/0	0/1	*3/1*
Household helper	-	0/1	-	-	*0/1*
Sister	-	-	0/1	-	*0/1*
Niece	-	-	0/1	-	*0/1*

FIGURE 1 LIVING ARRANGEMENTS OF OLDER STUDY PARTICIPANTS

The older participants of this study perceived staying with children as the ideal living arrangement for a good old age, however, it did not always create supportive environments for the older people. Similar to the example of Bibi Ruth, some older people can be burdensome for their own children in old age. Especially in less privileged areas of Dar es Salaam, where young adults had difficulty to find employment, they struggled to live up to their responsibility as caregivers for their aging parents. They remained dependent on their parents, relying solely on the income of the older people provided through renting out rooms of the house. In this connection, Roth talks of "inverted intergenerational relations" (cf. Roth 2008), where expected rules of reciprocity cannot be fulfilled. This aspect will be taken up and critically reflected in Part III.

The Youth of Today

Some older study participants claimed that it is not financial shortfalls which made children fail to support their parents, but because they have other priorities in life and consequently do not invest the money they have in their parents. At this stage, many older study participants emphasized the importance of educating one's own children well to teach them values so that they are in a position to

set what are, in their eyes, the "right" priorities. With reference to this thought, many older people blamed the *watoto wa siku hizi*[145] in the city, who no longer respect the elderly urban dwellers, including their own parents. Bibi Annette called them the "dot.com" generation, which has other priorities than looking after parents. The older study participants usually stereotyped this younger generation by describing their "unhealthy" lifestyle with a high alcohol consumption and no work. The older people's descriptions were linked to the experienced disappointment with their own children or grandchildren who were not taking care in the way an older person would expect. These images of the city's youth are thus linked to normative requests made by the older people on how they wish their children and others of the children's generation to be. As, for example, Bibi Maimuna from Manzese Mnazi Mmoja who generalizes from her son who stays with her, but, according to her, does not do enough for his mother: "Nowadays it is not a guarantee that if you have children that you will have support from them, and sometimes I get support from other people who are not even my relatives"[146] (Bibi Maimuna 2012).

The lacking respect that older people experience in the city was often mentioned in connection with public transport. Older people lamented that they do not get free seats in the daladala. Mzee Mohamad who lived in the UK for a year in connection with a training for his job as a civil servant, compared the two transportation systems: while in the UK older people and also pregnant women are entitled to a seat in the public transport, in Dar es Salaam this is not the case and young people are not willing to provide seats for older urban residents, so the Mzee. According to Mzee Mohamad this has to do with "bad manners" of (selfish) people in town, whereas, according to Mzee Mohamad's view, in the village people would care for others. Older participants of this study often blamed the city for its selfish and unfriendly people who do not respect older people enough.

The "Guilty City"

The title of this section points to the circumstance, that many of the older study participants liked to blame the city, similar to Bibi Maimuna in the initial quote of this part. The fact that their own children but also other young people on the street were not able to fulfill expected norms of respect and reciprocity, made many of them complain. Furthermore, moving around without help became more difficult for them due to the heavy traffic, vast distances, and inaccessible public transport. Public transport was not only too expensive for some of the study participants, but—by referring back to the age-friendly cities report of the WHO—age-unfriendly, due to steep entrances, the rough style of driving, and the lacking number of empty seats. As Bibi Ruth's example demonstrates, many study participants became at one point rather immobile, due to the city's infrastructure.

[145] The youth or children of today.

[146] Bibi Maimuna: "Wala usitegemee useme nimezaa mtoto wangu atanisaidia siku nyingine huwa nasaidiwa tu na watu wengine wanaotoa msaada."

The above-mentioned blaming discourse on the city was very prominent when I started to conduct research in the sub-ward of Manzese Mnazi Mmoja, where Bibi Ruth lives. The area of Manzese was not very friendly for older people and I learned that already many NGO's had conducted research in the area. As mentioned in the research site description, people were therefore used to being paid for filling in questionnaires which, of course, impacted on our interview situations. The area is commonly known as an area in Dar es Salaam that is rather crowded and more deprived than others. Open waste-water canals and uneven small mud roads, where sometimes not even a *bajaj*[147] can pass, made moving around challenging for older people. Interestingly enough, when talking to many study participants in the better off areas, when they commented on intra-urban comparisons Manzese was usually referred to as a negative example compared to the Ada Estate area of living. Hence, all the negative stereotypes about "the city" were associated with this ward, as the extract of my field notes from an informal conversation with Bibi Hilda from Ada Estate reveals:

> We talked about people in Manzese and Bibi Hilda said that these urban dwellers are not putting so much effort in what they do. She said that her community is different because children are usually tough to fight for things. She said that the sons will receive a plot but they have to put in an effort to build a house before they get married. They grow up like this. And others they do not. For her, this explains why many people in Manzese do not work, they just hang around. She also said that there are a lot of thieves in the Manzese area. And she explained that there are many guesthouses because people who travel from upcountry would like to stay close to the major bus station in Ubungo. Another reason for the high number of guesthouses, Bibi Hilda emphasized, is that many women sell their bodies for money in Manzese. I probed that it is difficult for some of the older people in the area because they do not get much support from their children. Bibi Hilda agreed and said that she cannot imagine how an elderly person who is not able to work anymore can survive in Manzese. She also said that a lot of people are just sitting around because they are ashamed of selling fruits in the streets or do other "inferior" jobs. (Informal conversation with Bibi Hilda 2013)

The extract from the conversation with Bibi Maimuna, who resided in Manzese Mnazi Mmoja, at the beginning shows her experiences of Manzese as a place where you cannot make friends and where neighbors do not help each other. Bibi Maimuna owned a house consisting of two provisional rooms without doors leading to a courtyard that is open to the next building. She shared her torn mattress with two grandchildren while her son stayed in the other room with another child. Although her daughter sold fish close to her house, she did not have the feeling that she was getting much support from her children. Her joints were sore which might be due to lack of vitamins (according to Elisha), and she complained about the harsh city life. As for many other research participants from the same neighborhood, also for Bibi Maimuna talking about the city goes along with a discourse on poverty and

---

[147] A *bajaj* is a mototaxi with three wheels that is used to transport passengers. The name seems to derive from the Indian company that produces such trycicles. Using a bajaj is more expensive than the public buses; however, they are faster since they are able to drive around traffic jams. During this research project, they were banned from the inner city because they had been increasingly involved in criminal acts.

bad health. This discourse was less obviously dominant in the former civil servants' milieu who have a rather privileged position but would not necessarily see themselves as such.

On a methodological note, when visiting older people in different urban milieus many older people formulated their claims towards Neema and Elisha who not only worked for the research project but also sometimes implicitly presented themselves as NGO representatives (i.e., by wearing a particular T-shirt). Many of the questions that we asked about care in interviews tended towards a "complaint discourse" and thus concealed some of the questions about who is doing what for them. Obviously, this example sheds a light on the epistemological limits of interviews. When spending more time with the older study participants during continuous visits over the years and by participating in their daily lives, we gained deeper insight into their actual daily practices and visits.

Remaining the main financial and care provider until death, like Bibi Ruth and Bibi Maimuna, constitutes a burden for many of the older study participants. It is likely to increase their perception on the hardship that they face while staying in the city and was often subject to the complaint discourse that also shines through the initial quote of Bibi Maimuna at the beginning of this part. The burden increases even more when older people face disease or the death of their children. As the case of Bibi Ruth shows. Bibi Amira, who lived in the same neighborhood as Bibi Ruth, had a similar story. Her son, who was a lorry driver for some time, contracted tuberculosis. Although married, he came back to stay with his mother who then physically took care of him until he passed away.

At the same time, others have well-educated children in Tanzania or abroad who provide financial means for their parents' old age. Of course, to care for ones' parents or older relatives implies much more than simply giving money. Nevertheless, if treatment is involved, costs arise that need to be covered. This can be a burden for children who would like to support their parents financially, as the extract from an interview with eighty-eight-year-old Mzee Juma from Ilala Mafuriko and his daughter Mariamu shows, who suffered from a prostate problem and needed regular treatment as well as an operation:

> Elisha: Why don't you help your father?
>
> Mariamu: We help as much according to what we have, and now we do not have money anymore it has finished. Every treatment at the health facility cost not less than how many thousands? For every treatment, no less than TZS20'000.
>
> Elisha: Mmh…

> Mariamu: He used a lot of money only for treatment at the health facility ... We have reached our limit; we want someone to help us.[148]
>
> (Mzee Juma and Daugter Mariamu 2012)

Others are not necessarily in need of regular support since they have enough sources of income to make their own living, such as Bibi Lea who has her own stationary shop in Ilala Mafuriko which she bought from the lump sum she received at her retirement. She states, "Yes, I get financial help from my children especially when I am in need of help, but not necessary because I cannot support myself. But my children, they always help me … but it is not necessary"[149] (Bibi Lea 2012). Of course, the described dynamics does not apply only to children but also to other relatives. Among the participants of this study, the tensions, however, seemed to be more pronounced when the own children, who are expected to care for their parents, are involved. While health problems of children increase the burden for the older people to provide for the family, illness of the older person may result because the older person faces difficulties in ensuring the daily and regular support due to the loss of physical strength. A great deal of the articulated struggles of the older study participants to live the city are linked to the (perceived lack of) care they receive from their children. How the children are actually involved in caring for their parents in different areas of this study, will be looked at in more detail in Part III. The story of Bibi Ruth pointed to the rather negative discourse on the city, of some of the older study participants who have to struggle for daily survival. They perceive the city as an anonymous place where reliable relationships become rare. The city is, at the same time, a physically challenging place and rather leads to (health) problems instead of enabling older people to live more easily. Through the older people's complaint discourse, the urban is constructed as a "guilty city" in the sense that remaining in the urban space leads to hardship for the older people.

The City Makes You Sick But Also Cures You

Again, I would like to introduce this second subchapter with a story. This time it is Mzee Dunford's story who belongs to the former civil servants' milieu and lives in Ada Estate and has means (financial, but also social and educational) to invest in health care in old age.[150]

---

[148] Elisha: "Sasa na nyie watoto ndo hamsaidii tena?" Mariamu: "Ndio hivo tumemsaidia lakini tumekwamia huko unaona eeh kwa sababu hela zote zinaishia huko, yaani kliniki peke yake anatumia sio chini yaa elfu ngapi? elfu ishirini na ngapi ulikuwa unatumia kliniki" Elisha: "Mmh…" Mariamu: "Anatumia hela nyingi sana kliniki peke yake! …Yaani hapa ndio tume kwama, kiasi kwamba tunashindwa mtu wa kutusaidia."

[149] Bibi Lea: "Naweza kusema napata ninapokuwa nina shida wananisaidia lakini mostly [zaidi] najitegemea ila watoto hawakosi kunisaidia lakini sio ile misaada kusema kwamba lazima lakini wananisaidia."

[150] Mzee Dunford's story is also presented in a publication on "Transfigurations of Aging" (cf. Kaiser-Grolimund 2020).

When we first met Mzee Dunford, he was seventy years old. When he moved to open the door for Elisha and me, he moved slowly and insecurely. Each time we talked, he sat on the same part of the sofa. He always left his slippers at the edge of the carpet that covered the space below the sofa corner, before sitting down. Mzee Dunford was usually calm during our talks. I was therefore surprised to learn that he was a Jehovah Witness who went from door to door every week for a couple of hours to convince others to join his religion.

Mzee Dunford came to the city in 1976 (when he was thirty-four years old). Only two years later, he moved to the apartment in which he has lived since then. He grew up in a village in the southwestern part of Tanzania. He came to Dar es Salaam where he studied economics at the University and worked in the tourist sector until he retired in 1993. Thereafter, he worked in the garden around the house and kept poultry. Since his retirement, he has benefited from a small monthly pension of TZS50'000 (about US$25) and he also receives the pension of his late wife. Because one of his three children worked for the government, he is covered by the child's health insurance.

His late wife worked for the government, too, and they were able to rent and later buy the apartment he was living in. The apartment has two bedrooms and a living room and when we met in 2012, Mzee Dunford was sharing it with two grandchildren (at that time eleven and ten years old) of his late daughter, his two sons, one daughter, and a household helper (*dada*[151]). The children in the house shared the costs for food and electricity, while the already married daughter came to visit from time to time.

When we met Mzee Dunford again some months later at the beginning of 2013, his living arrangement had changed. His daughter had married and moved out. Also, one of the sons had married and left the apartment. The other son moved to the servant's house belonging to the apartment of Mzee Dunford in the same neighborhood. Mzee Dunford remained in the apartment with his two grandchildren and the dada. A year later again, the two grandchildren had left. They went to stay with Mzee Dunford's oldest daughter. One of the boys died only shortly after having moved to the new place due to severe malaria. When we last met in 2015, his children were still involved in providing for the daily needs of Mzee Dunford, although not sharing the apartment with him anymore.

Mzee Dunford was renting out a *banda*[152] and another room next to his apartment and got some income through the rents. Mzee Dunford supported his two sisters in the village in the west of Tanzania, by sending money from time to time. Once while visiting Mzee Dunford, he was hosting one of his sisters

---

[151] Directly translated, the Swahili word *dada* means "sister" in English. In my research context, the word is used for a female household helper who usually lives with a family and performs different activities around the house such as cleaning, washing, cooking, buying food, but also takes care of the children (but rarely older people).

[152] The Swahili word *banda* describes a shed or hut where people usually sell food on the street, it can also be used to describe a construction used for living.

for some days in his apartment who had come to town for an x-ray. However, since the x-ray machine was broken, she left again for the village before being screened. According to Mzee Dunford, she did not wish to stay in the city and missed home. She preferred cultivating her *shamba*[153]*,* while in the city she was "just" sitting around bored. When talking to Mzee Dunford and his sister about city life, Mzee Dunford pointed out that food would be much healthier at home—in the village. In the city, you therefore have to be very careful about what you eat, because there are too many chemicals, he said.

Mzee Dunford had been a diabetic patient for many years. His household helper prepared special meals for him and the old man visited the diabetes unit at the district hospital on a monthly base. His visits were covered by his health insurance. Apart from treating his disease with insulin pills he also used what he calls a "traditional way" by drinking a special juice made from leaves. His relatives in his home village sent the ingredients for the juice by bus to Dar es Salaam. Because of his illness, he went for physical exercise on a regular base which consisted of walking for almost two hours. When Frank and I joined him for the first time, we were amazed how this fragile old man who moved very insecurely and slowly inside his apartment, suddenly started to walk upright and with speed while doing his exercises. During the exercises, he had to avoid cars, bajajs and motorbikes that were using the same small lane along the main road due to heavy traffic. When Mzee Dunford did his exercises, he was very attentive and therefore did not bump into any car while I was struggling.

In the summer of 2013, the doctors decided to change the diabetes medication of Mzee Dunford from pills to injections. In a conversation, Mzee Dunford explained that he had been given a short introduction on how to use the injections at the hospital and then sent home. At home, due to his poor vision, he did not see the amount of the insulin he was supposed to put into the injection pump. He injected far too much and nearly died. While close to a shock he went to the hospital on his own where they gave him glucose. When asked about why he did not go with somebody to the hospital, he said that nobody was around at that time and he did not want to bother anyone by calling.

Also in the summer of 2013, Mzee Dunford started doing yoga. He told me that he had once attended a yoga class in the early 1990s when he was in the northern part of Tanzania for some time. In the summer of 2013, he found an American book on Yoga from 1975 in one of the Indian book stores close to his place. With the help of the book, he was exercising yoga in his bedroom. He described doing yoga and walking exercises as a modern way of getting old.[154]

[153] A *shamba* can be translated as field or farm.

[154] Unfortunately, in December 2015 he had a minor stroke and was afterwards recovering while not being able to continue with his exercises for the moment. Sadly, in 2017 he passed away after having suffered from a severe malaria infection and receiving a treatment that was contraindicated for diabetes patients.

Mzee Dunford's' ambivalent experience with the urban is illustrated by the title of this subchapter, the city can be at the same time a place that makes you sick but also a place where you could find a cure. This ambivalence was also experienced by other older study participants, one important aspect thereby was accessing the health care facilities that the city offers.

Accessing Health Care

In terms of geography, access to health care in the city is theoretically given, but practically not all wazee are entitled to receive treatment for their various health problems. While Mzee Dunford is enrolled in the diabetes clinic and gets his insulin pills on a monthly basis without paying for them (due to his health insurance), others like Bibi Asha from Manzese Mnazi Mmoja had already lost two toes because of the same chronic disease. Even though her daughter is involved in small-scale business and invests in her mother's treatment, it was not enough to prevent Bibi Asha from loosing her toes. Neema translates Bibi Asha explanation, "she says, that after all she made the daughter bankrupt because the daughter was using a lot of money to treat her diabetes… about five million… So they were about to cut this leg here at Muhimbili [hospital] but the daughter gave a lot of money and now she is gone bankrupt because of her"[155] (Bibi Asha 2012).

The older people who were able to access it, usually appreciated the existence of biomedical health care in the form of hospitals and other health facilities within the city. While sometimes combining biomedical treatment with so-called "traditional" medicine (as Mzee Dunford), as urban dwellers the usual way was to seek treatment at the government health facilities. Only when no relieve resulted from the biomedical treatment, the participants of this study searched for new ways of treating an illness. As for example Mzee Bariki, who suffered from the pains of the scars resulting from herpes zoster. Because both biomedical treatment as well as herbal medicine did not give him the relieve, he wished for, he tried Korean medicine. The environment of biomedical health facilities in the city also seemed to influence how older people describe their health condition. When Frank and I for example asked Mzee Mohamad to describe somebody who is healthy in old age, he answered as follows: "During the past, we described somebody who is healthy by looking at the physical appearance if she or he is fat we see that this person has health but for now a person can be fat and still have many health problems so the best way to describe a person who is healthy is by going to the hospital to do a checkup"[156] (Mzee Mohamad 2013).

---

[155] In Bibi Asha's own words: "…lakini ni juzijuzi kweli, sasa hivi kasimama biashara kisukari, aah! Kilichukua karibu milioni tano hivi muulize hapa hela teketeke sumu kilipanda mpaka kisukari kina sumu, ilipanda huku nilimwambia Jeni kakate, wakaniambia hapana utapona tu bibi … ukubwa tu wa kidonda."

[156] Mzee Mohamad: "Zamani tulikuwa tunamtambua mtu mwenye afya nzuri kwa kumuangalia kama amenenepa lakini kwa sasa hivi hiyo haisaidiii kwa sababu unaweza kuona mtu amenenepa lakini ana matatizo yake kwa hiyo kumtambua mtu mwenye afya nzuri ni kupima na kucheki afya hospitali."

The "Un-Healthy City" versus the "Healthy City"

While access to health care provides one reason for older people to remain in the city (cf. the story of Bibi Veronica later in the text), the city is at the same time perceived as a place that makes people sick. One aspect mentioned in this context was contaminated food that people were forced to eat in the city. Bibi Hilda from Kinondoni Ada Estate therefore claimed that people do not get as old as they did *zamani*[157]. She emphasized that this is, amongst other reasons, also linked to the food that people eat in the city.

> There is a big change because those wazee of days' past, they were bigger, you knew they were having a longer life; yah like my uncle he died, he was hundred years except two month he could have reached a hundred, yah even my mother she died, she was a hundred and five, so in the village [discursively like in the past] but not nowadays [discursively like the city]. Those who are born in the nineteen thirties, nineteen twenties they used to live longer. I don't know why but here [in the city] I think the food which we are having, like this, you don't know, [because of] chemicals we die… we die very young; [at the age of] sixty, fifty people can die. (Bibi Hilda 2013)

Bibi Veronica from the same area as Bibi Hilda avoided buying *chapati*[158] on the streets for the same reason. Chapati is a very common side dish that people usually buy as it is laborious to cook at home. However, Bibi Veronica thinks that the cooking oil that is used to bake them is not good for her health. As will be explained in more detail in Part III, she prefers to buy the more expensive sunflower oil at the supermarket, in order to prepare her own chapati.

Not only the food was perceived to be more harmful in the urban environment, but also what the participants of this study called the "lifestyle of the city." Many older people believed the urban lifestyle to be unhealthy. Especially in the former civil servants' milieu where, according to my impression, awareness of chronic conditions was higher, the inhabitants maintained that the urban lifestyle could lead to diabetes, hypertension or heart diseases, not only in old age but already before. Another aspect of the city lifestyle articulated by civil servants, but also by members of the other milieus, was the lack of physical movement in the urban space. At this point, comparisons with the countryside and cultivation were made and mirrored against the work in the city with less bodily involvement. As described in the portrait of Mzee Dunford, whose sister came to visit him from the village: Mzee Dunford emphasized his sister's discontent in the city because she could do her farming activities. Mzee Dunford, who was from the same village, had to find new ways of physical activity, and replaced the missing farming activities with walking exercises and yoga.

---

[157] The Swahili word *zamani* means in the past, earlier. Older participants of this study normally used the word to describe something that happened a long time ago (i.e., when they were young).

[158] *Chapati* are locally made flatbreads that are eaten for breakfast, but also to accompany other dishes.

Furthermore, not being able to farm also increased food insecurity for some older people and their families, because in the city, more cash is needed to buy food. For a diabetic patient like Mzee Dunford, food can be even more expensive due to the special needs. Mzee Alpha from Manzese Mnazi Mmjoa, who is also a diabetic patient, therefore emphasized the difference between purchasing "normal" bread for toasting that is available at every local shop, and the wholemeal toast, as recommended by the medical doctor, which is only available in bigger supermarkets and costs approximately three times as much as the regular toast.

While some older people started to exercise, to physically move, others built their own garden around the house. For example, the elderly couple Mzee and Bibi Bariki seasonally cultivated corn in order to prepare their own *ugali*[159] and started each day at 7 am with two hours of garden work. Urban farming, however, needs space. In the four sub-wards of this study, only in the better-off area of Kinondoni Ada Estate older people had enough open space around their houses to cultivate their own crops. Another solution was to have a shamba somewhere on the outskirts of the city. However, many research participants who had such a space for cultivation struggled to get there on a regular basis due to the problem of using public transport.

I found it interesting to observe that articulated health problems differed in the different sub-wards of this study. Sadly, eighty plus Mzee Hussein from Ilala Mafuriko died in 2014 of malaria, while those deaths were usually—but not always—prevented in the better off area. On the other hand, in the better off area, chronic conditions such as hypertension or diabetes seemed more common, or at least more diagnosed. Numbers of the Tanzania diabetes association reflect this fact: in 2015, for example, the number of diabetic patients was estimated at 1,7 million cases, while almost 1,3 million cases remain undiagnosed (International Diabetes Federation 2014, 28).[160] One study participant from Kinondoni Ada Estate, Mzee Mbujuni, again used the area of Manzese to contrast people from Masaki, which is an area in the north of Dar es Salaam where mostly high government officers and NGO employees reside, in order to point to diverse health problems in old age:

> So, there is the difference of food they [older people] eat and these people of Masaki, they suffer from kidney [problems] because of what they eat, like eggs and meat. But those people of Manzese they do not have any other sicknesses than malaria and they will die of malaria and cholera. And these people of Masaki are dying of strokes and many more problems because of their overeating… so that is it. (Mzee Mbujuni 2013)

---

[159] *Ugali* is Tanzania's main dish. The mash is usually made of corn flour, depending on the quality of flour, the prize can vary. The preparation of ugali is tiring as it takes some time to stir the gooey mash for it to reach the right consistency.

[160] The numbers displayed in the report by the International Diabetes Federation include only adults between twenty to seventy-nine years.

Despite the different health problems that people in different milieus of the city struggle with, it is important to mention that improved geographical access to health care in the city does not necessarily mean that older people get that care. Also, the portrait of Bibi Ruth showed how difficult it was for her to get an eye screening, as, in the end, she had the motorbike accident and felt even worse than before. Likewise, Mzee Nassor, who is in his late seventies and from Azimio Kichangani, underlined his difficulties in booking a consultation with the appropriate doctor when talking to Elisha and me in front of his house. He usually sat in front of his house on his *baraza*[161], because he was no longer able to move on his own, and complained about each and everything, so his neighbors.

> Elisha: When you go there yourself, they don't receive you?
>
> Mzee Nassor: …they will start predicting where you are sick like the head, the legs and tell you to go and buy some medicines…and when I can say this is the third year, please allow me to see the professor, no one will direct you.
>
> Elisha: And in this, how will you advise the government on these problems?
>
> Mzee Nassor: What I really want is to see the professor who is specialized in bones so that he can tell me why I am failing to walk, but I can't see him I don't have that capacity…for going, my children might take a car and take me there but I won't see him, I am a very small person nobody can direct me.
>
> Elisha: From your children, nobody can direct you?
>
> Mzee Nassor: They don't have anything, I only have one boy and a girl, and even the boy cannot reach at him. He doesn't have that capacity, even when we are going to the hospital, I am the one who brings the documents and talks to the doctors that boy of mine cannot, he can only manage up to district hospital but not Muhimbili [the National Referral Hospital] … At Muhimbili, we small people, nobody cares for us.[162]
>
> (Mzee Nassor 2012)

What became evident when listening to these stories of older people's struggles to access biomedical health care is the fact that they needed somebody skilled to guide them. This aspect will be taken up again in Part III when talking about (relational) care for older people. Due to their legal age, however, most of the participants of this study were entitled to free medical care by being sixty plus. However,

---

[161] The Swahili word *baraza* describes a patio or veranda in front of a house where people sit and talk to neighbors.

[162] Elisha: "Ukienda peke yako hawakusikilizi?" Mzee Nassor: "Aaah wapi watakuambia tu wale…, unaumwa miguu een, unaumwa kichwani een, haya kanunue vidonge mzee basi unaondoka.... Basi useme huu mwaka wa tatu nimuone professor au ... hakuna atayekuongoza umuone docta mkuu au professor huwezi kumuona" Elisha: "Katika hili wee ungesemaje kushauri serikali... katika matatizo haya unependekeza iweje?" Mzee Nassor: "Mapendekezo yangu sindio kuonana na professor anayeshughulika na mifupa aniambie tatizo ni nini kwanini nashindwa kutembea lakini siwezi kumuona uwezo huo sina mimi...wa kwenda watoto wanaweza kunichukua hata na gari lakini wakumuona siwezi kumuona professor mimi mtu mdogo wa kuniongoza hakuna hapo." Elisha: "Katika watoto wako hawa hakuna anayeweza kukuongoza?" Mzee Nassor: "Aaa mtu hawana chochote watoto wangu tu mii nnae mmoja wa kiume na wa kike...kwanza wa kiume huyo hana upeo huo wa kuweza kufika mpaka kwake hajui... huyo motto wangu wa kiume hapati na mtu … mii ndo nikienda naenda kupeleka ile naniii yeemwenyewe peke yake hana uwezo, uwezo wake mwisho hospitali ya wilaya hapa ndio hapahapa anaweza lakini sio muhimbili…muhimbili si watu wadogo hatudhaminiwi bwana."

as mentioned earlier, an examination at a health facility after several hours of standing in a queue does not mean that these older people gain access to the treatment they need. Although they may have received a diagnosis, they still have to purchase medication by themselves, which is usually much more expensive than the examination.

When focusing on health aspects, therefore, many study participants perceived the city as a rather ambivalent place. On the one hand, the city and its "lifestyle" is said to make people sick, because they cannot move and eat as they would in the countryside. The city becomes an "un-healthy city" that challenges older people and their health. However, on the other hand, the city can also enable people to stay healthy and to treat illnesses because of the geographical proximity to biomedical health care and the new social spaces that allow them to exercise. For older people, whose access to biomedical health care is given, therefore the city can be perceived as a "healthy city."[163]

LIVING OR LEAVING THE CITY

Many other older study participants in the former civil servants' milieu lived links to their rural "home town" but decided to reside in the urban space. In order to live these links, financial means are crucial for traveling. Bibi Veronica's story will illustrate some of these lived links through the connection to her children in the USA, allowing her to build on a far-reaching support network.[164]

When I first met her in 2012 in the former civil servants' milieu in Ada Estate, Bibi Veronica was sixty-three years old. She had lost her husband some months before we met and appeared rawboned and sad. Her husband died of cancer and had been transferred to India for treatment while already very sick– he did not come back alive. Bibi Veronica was born in the northern Kilimanjaro region of Tanzania and went to a mission school of the German Sisters. She came to the city in 1968, and nine years later moved with her husband to the house that she was staying in when I visited her. The house belonged to the government but Bibi Veronica and her husband were able to buy it. Bibi Veronica had been a teacher at a nursery school and also taught women classes at the Tanzanian railway company. She retired in 2000. Then Bibi Veronica started to keep poultry at her house, but stopped when her husband felt sick. It took her some time to mentally recover from the loss of her husband, but during the four years that I visited her, I observed how she became more active and involved again. More than one year after her husband had passed away, she started to keep poultry again.

---

[163] Also, Gerold describes the city as a space which functioned as constraining and enabling place at the same time for her older study participants in Mbagala, Dar es Salaam (Gerold 2013, 167).

[164] We will encounter Bibi Veronica again later in the text, and her story is also shared in a publication entitled "Healthy Aging, Middle-Classness, and Transnational Care between Tanzania and the United States" (cf. Kaiser-Grolimund 2018).

During the last three years, Bibi Veronica shared her house with her oldest son Eric. Her son Eric came back from the USA to stay with her when her husband (Eric's father) died. Eric came back to organize for the funeral—taking over his responsibilities as an oldest son—while he was in the process of getting the green card in the USA. Because he had left so suddenly, he did not have a legal permission to go back—although his wife and the two children were in the USA. Apart from her son, Bibi Veronica shared her house with a son of her late younger brother and two grandchildren, who helped her in the household. She cultivated vegetables around the house and kept poultry. Every time I was there, she was very busy preparing food for anyone who might pass by at her house. For preparing food, she used a fire and charcoal stove outside which the children had built especially for her. In the built-in kitchen, she only used the microwave to warm up food.

Bibi Veronica had strong connections to her village in the northern part of Tanzania, because one of her sons and also four of her siblings lived there. During the four years that I visited her, she went to her home village for visits several times; for funerals but also during holidays, as for example at Christmas or Easter. Her late husband's grave was also at their home in the North. Usually, her children drove her in a private car, but once she also took the plane to get there in time for a funeral. When we met in 2012, three of her children were living in the USA. Her youngest son came back after he had finished his medical degree. When we last met in February 2015, four of her seven children were staying in Dar es Salaam and visited her on a regular basis. Together with the children in the USA, they actively communicated with each other in order to decide what was best for their mother. In 2014 and again in 2015, Bibi Veronica traveled to the USA in order to stay with her children for almost three months. In the USA, the children took her for medical checkups in order to improve her hypertension regulation and treat her eyes. In August 2013, the wedding of her son in Dar es Salaam was a reason for all sisters and brothers to reunite in Tanzania. Bibi Veronica's network of support and care was vast, incorporating not only Dar es Salaam, but also the North of the country, and the USA.

Bibi Veronica was embedded in a neighborhood church group. Every Saturday they visited somebody of the group and prayed for those in need of prayers. On Sundays, usually her son took her to church by car. Many of her friends from church or from the neighboring houses belonged to the same ethnic group as Bibi Veronica. She strongly identified with the northern region and being *Mchagga*[165]. She also often talked positively about the region in the north, where the climate was much more convenient for an older person like her.

Like Bibi Veronika, many other study participants emphasized their links to a home village somewhere in Tanzania. However not all had the same possibilities to live these links. Often it was mentioned by

---

[165] Somebody who belongs to the *Wachagga,* or *Chagga* is called *Mchagga*.

the older people that medical treatment is much better in the city which was usually described as reason for staying in the urban space. Furthermore, also the fact that most adult children of most of the participants encountered in this study resided in Dar es Salaam, this was usually described as another reason to stay. However, as Bibi Veronika's story revealed there are also many reasons to leave the city.

Reasons to Go

As mentioned earlier, during Ujamaa, the country's socialist period, people were told to only remain in the urban space when "productively" contributing to society. Although the country's politics of today are no longer influenced by the ideology, the idea of going back to one's home village in old age seems to have remained in people's heads. The same applies when it comes to people who go abroad. In the older study participants' view, those who do not come back after having finished their degrees abroad do not contribute to the country's development. In my landlord Mzee Ngowi's eyes, they are "hooligans." Of course, it would be too simple to claim that the decision of going back to the home village in old age is only based on former ideologies. However, it seems worth reconsidering the ideology as one out of many aspects influencing people's decision to remain in or leave the city. As, for example, the talk with a brother of Bibi Sara shows, who replied to my question about going back to his home village in southwestern Tanzania:

> Medical facilities are not there…the hospitals. Here at every corner, there is at least a medical something, in [place of origin] there is only one district hospital and it's not the best, say if you get sick somehow…. So things are like that. We would like to go there but then think about it and say: is it a question of being patriotic, is it a question of being seen by other people, 'oh yes he is going back home!' or is it a question of life, going on. (Mzee Baden 2013)

While the idea of "going back where you came from" and aspects such as better food and better climate outside the city would "pull" people back to the countryside, there are also many reasons that hold people back in the urban space. Among the ones most mentioned are the improved access to health care as well as the fact that one's own children reside in Dar es Salaam. These aspects are also mirrored in Bibi Hilda's expression of her wish to go back to her home village in the North:

> In fact, I wish to go to the village, if I can't support myself [in the city]. But my kids they say, oooh if you go to the village, you will become very old, you will become very poor and this and that. But in the village, I think I will be [more] comfortable than here, because if I go to the village and my daughter has shifted, I will rent out the house and get something. (Bibi Hilda 2012)

Also Bibi Ngowi, who comes from a neighboring village of Bibi Hilda, emphasized that for people from the north who reside in Dar es Salaam: "Moshi is like the Jerusalem of Africa, everybody goes back!" (Bibi Hilda 2012). On a methodological note, my visits to the Kilimanjaro region, but also to the Western Highlands where a considerable number of the older study participants came from, let me realize what it meant for the older study participants to stay in Dar es Salaam, with its heat, traffic, dirt and (malaria infected) mosquitoes, while in the northern or western region, the climate is less humid

and hot, there are mountains and farming possibilities and no malaria (however lesser access to health care). By sharing those experiences we thus reached a certain intersubjectivity,[166] which "is the basis for attendance to what is relevant in study participants' lifeworlds—for *recognizing* an element of our stock of knowledge that we have acquired as part of our engagement with the world and with our informants' lives" (emphasis in original, Kesselring 2015, 19).

It was also Bibi Ngowi's plan, to go back to her home village, but she remained in Dar es Salaam due to her health problems and the need to be supported by her children. All of her five children lived in and around Dar es Salaam. Two children who were not married stayed in the same house as Bibi Ngowi. The children did not consider moving to the village with their parents and, therefore, Bibi Ngowi decided to stay. Others, however, such as Bibi Maimuna from the initial quote of this chapter, do not have relatives in their home village anymore. Either contact had broken off or close relatives in the village had already passed away or moved to other regions.

Burials and Belonging

Older peoples' decisions to live or leave the city were strongly connected with feelings of belonging. Most of the participants of this study were born and raised in a rural area and came to the city when they were young and then spent most of their life in the urban area. Their children, in turn, were born and raised in the city and their work was situated in the city. Owning a house in one's village seemed to reinforce the longing to re-migrate to the countryside. Study participants, who were still mobile, were able to move between their house in Dar es Salaam and their home village. Though, only a few study participants were mobile enough to move back and forth. Travels to the north or west were usually linked with long bus journeys, which were not only exhausting but also too expensive for most older people. Consequently, I observed more of these home visits on the part of elderly urban dwellers from the former civil servants' milieu.

Whether older participants of this study identified with the city or the village is not easy to answer. When talking to them about the place where they grew up, usually rather nostalgic feelings shaped their descriptions of their home villages. These were then contrasted to city life. Most of the study participants, however, underlined that they had spent a longer period of their life in the city and had therefore got used to it.

Stronger feelings of belonging, either to the city or the countryside, became more observable when listening to the older people's imaginations about burials. For many, being buried at their home village

[166] "Intersubjectivity means that two or more people share a judgment of aspects of the world they inhabit and that they understand this as a given in their interaction, but also as part of their world." (Kesselring 2015, 17) However, Kesselring calls attention to the fact that through habituation that gives us "unique access to the lifeworlds of others" we risk to "lose attention" (Kesselring 2015, 10).

seemed the preferred way of resting. This extract from an informal conversation with Mzee Mohamad raises the question whether burial practices also changed over time, from one generation to the next:

> We were supposed to meet Mzee Mohamad already before, but shortly before our planned visit, he called and canceled it. He informed us that he could not receive us at his place because one of his neighbors had just passed away. He told us that it was the young daughter of his neighbor, who stayed in the neighboring apartment block. Since Mzee Mohamad was the representative of the neighborhood, he was extensively occupied with the funeral. There seems to be a strong community of neighbors in these blocks. Mzee Mohamad represented all blocks during the funeral. He was the one collecting condolences and the money and put flowers on the grave representing the neighborhood at the ceremony. The girl was buried at the *Makaburi*[167] of Kinondoni. During the same week, an elderly woman from the neighborhood passed away as well and her body was transferred back to the village.
>
> After these two incidents, Mzee Mohamad, Frank and I discussed about places where people are buried. Mzee Mohamad emphasized that in any case it is better to be buried in the home village and only if somebody cannot afford to transfer the body to the rural area, he or she will be buried in the city. According to Mzee Mohamad, it is always a preference to be transferred "home." However, it costs a lot of money. Mzee Mohamad explained that the girl who passed away was a special case because her parents do not come from the same region. Her father originated from Malawi and thus, the girl did not have a "home village." In addition, her parents both lived in Dar es Salaam and the girl was born in the city. Thus, for Mzee Mohamad it made sense to bury her in the city. According to Frank, youth in town nowadays did not care much about the place where they will be buried, but they generally preferred to not spend too much money on it. (Informal conversation with Mzee Mohamad 2013)

Being very much attached to their home villages where they grew up and where their own parents were buried, many older people preferred to "go home," at least after death. The first president Julius Nyerere, too, was buried in his village of origin, Butiame, after having died in a hospital in London, UK (Hashim 1999, 516). Nyerere might serve as an inspiration for older Tanzanians (Gerold 2013, 165). Others, however, explained that they would not want their children to spend money on the transport of the body, and claimed that they would agree to be buried anywhere. In the following field notes, my landlord Mzee Ngowi explained the rules and regulations of being buried, either at home or in the city:

> Mzee Ngowi pointed to a very practical aspect: when you would like to be buried at your home village you have to possess land where you are allowed to bury. In his home village in the northern Kilimanjaro region there was a cemetery before. However, as it started to become full, they decided to close it so that everybody would bury family members on the own land. Traditionally, according to his ethnic group the wife is usually buried on the husband's land. Also children who die while still young are buried on their father's land. It is therefore simple according to Mzee Ngowi; if you do not possess any land in your home village, you cannot be buried there. Since burials on one's own land are forbidden in the city of Dar es Salaam, people who do not possess land outside the city, are forced to bury at the city's cemeteries.[168] According to Mzee Ngowi, nowadays some people bought land at the outskirts of Dar es Salaam, since it is allowed to bury the dead there. (Informal conversation with Mzee Ngowi 2013)

---

[167] The Swahili word *makaburi* means graves in English, while makaburini refers to the graveyard.

[168] Although being buried in Dar es Salaam can be costly, too, especially since the development of burial places has become a business. For example, at Kinondoni Makaburini, people buy empty spaces and resell them at a higher price in order to make money (according to Mzee Mohamad).

Apart from owning a plot where a person can be buried, the high costs involved in transporting a dead body to a rural area also play a role. According to Mzee Mohamad, transporting his body back to his home village in central Tanzania would cost his family around TZS3 million shillings (around US$1'450). For some older people of this study, being buried either in the countryside or in the city made no big difference. They explained that, from a spiritual point of view "all land belongs to God" and thus it does not matter where the body is buried, but it is rather important to where the soul goes. Bibi Annette replied to my question whether people should be buried in the village or in the city as follows: "It depends on your decision. I personally, I don't care where they will bury me. Any place is ok for me even in [place of origin] or Dar es Salaam but traditionally I am supposed to be buried at [place of origin] in my compound" (Bibi Annette 2013).

While in former times it was common to be buried on one's own land, the city challenges this idea. As mentioned above, in Dar es Salaam burials at private places is not allowed. It is thus permitted to either bury in a cemetery or on the outskirts of the city. Furthermore, while city inhabitants who are at the age of the participants of this study were mostly born in rural areas and moved to the city, many young people were born in the city. They would consider the city as their home where they want to be buried. For the older people of this study, it was common to bury their age mates in their rural places of origin. However, some of the older city dwellers use religious reasons to legitimate their wish to be buried in the city. They claim that, as a religious person, their soul will get to the right place irrespective of where their body is.

Gerold furthermore addresses the gender aspect she found with regard to her older study participants' imagination of their own funeral. Elderly men usually emphasized the importance of being transferred to the countryside for the funeral since they did not want to be buried in the "city sand," where they feared exhumation due to changes in the infrastructure. In addition, they seemed to fear that land changes ownership rapidly which could lead to a disrespectful treatment of a burial site (Gerold 2013, 164). Women, on the other hand, rather claimed that they did not want to be a burden to their children or those organizing the funeral and therefore had a more pragmatic approach to their funeral site, so the author (Gerold 2013, 165).

The "Enabling City"

Reasons of the older participants of this study to remain in the city were various and also depended on the current available connections to the home village. The ability to maintain connections seemed to be closely linked to the older person's mobility. And, depending on the milieu they belonged to, being mobile was either more common or not. The city is thus an "enabling city" that makes people cultivate networks that span across rural areas, even across other countries. The aspect of being mobile will be taken up again when describing the former civil servants' milieu in Ada Estate in more depth.

ZAMANI VERSUS *LEO*—VILLAGE VERSUS CITY

When examining urban aging experiences of older inhabitants in Dar es Salaam, we cannot but take into account their perception of the city as a place of "modernity," as opposed to what they see as "traditional" village life.[169] Dilger's quote below reflects in my view well the anxiety between what older urban dwellers perceive as "traditional" and "modern" ways of aging, respectively. By basing his argument on Comaroff's concept on "Afromodernity," Dilger writes: "modernity in Africa (and elsewhere) is essentially about the tensions and dilemmas that result from often unsolvable conflicts between various oppositional forces that coexist in social actors and institutions as either 'modern' or 'traditional'" (Dilger 2009, 112). Especially urban spaces seem to increase those conflicts by providing a platform for co-existing antinomies. According to Comaroff and Comaroff therefore, Afromodernity which is not seen as a "late-arriving derivative" of European modernity (Comaroff and Comaroff 2004, 330), is experienced as a series of contradictions:

> … between continuity with the past and a radical alienation from it, between the freedom to choose among futures and an absence of the wherewithal to exercise that choice, between a sense of transparency provided by new ways of knowing the world and the kind of opacity that arises from the perception that nothing is quite what it appears, between desire and a gnawing feeling that nothing can ever be brought to fulfillment, between a growing obsession with the law and epidemic lawlessness, between … possibility and impossibility. (Comaroff and Comaroff 2004, 345)

Although modernity is often associated with the young, older people seem to be much more torn between tensions and dilemmas that come along with what they call modernity in the urban space. The older study participants in Dar es Salaam used these oppositional forces of what they called "modern city life" and "traditional village life" in order to make sense of their own city experiences and to cope with the above in my opinion accurately described contradictions spelled out by Comaroff and Comaroff.

I will focus more on the "modern" part of the above-mentioned contradictions between what can be called "tradition" and "modernity." Lamb found that practices and reflections of her older study participants reveal a complex interplay and dialectic between two different views of modernity (Lamb 2009, 9). One of them is mainly prominent in popular discourses and social theory, and describes modernity as "a uniform, culture-neutral destination to which all paths of development lead," whereas the past is differentiated as "traditional" from the future that will lead into modernity (Lamb 2009, 9).

A second view understands modernit*ies* to be multiple. Goankar who writes about "Alternative Modernities" describes two aspects of modernity; convergence and divergence (Goankar 2001, 23).

---

[169] According to Robinson opposing "tradition" to modernity is "the first and largest error of existing accounts of the modern" (Robinson 2006, 7). Being aware of the deficiencies in theoretically opposing "tradition" to "modernity" I use these terms solely in an emic way, to point to the struggles the older study participants articulated when being torn between what they call (in English) traditional and modern.

The former points to a modernity that is Western in origin and globally oriented, while the latter leads to a way of "negotiating and fashioning of particular forms and appropriations of modernity" (Lamb 2009, 10). Lamb, who takes up Goankar's concept, notes that although most of Lamb's research participants belonged to transnational families where aspects of the "modern West" circulate among family members, the author claims that more important for the older residents was to "make sense of them, to critique and evaluate them, to contend with them—embracing some, rejecting others, reshaping and interpreting yet others, and, when possible and desirable, integrating the more 'Western' forms with certain more 'Indian' (often presented as 'traditional' or 'older') principles, institutions, lifeways, and conceptualizations of personhood, family, and the life course" (Lamb 2009, 11).

I decided to quote the above description by Lamb here as it corresponds quite well with what I was able to observe in the former civil servants' milieu. The older participants of this study tried to make sense of different aspects of old age which are coming together in the city. In Dar es Salaam, different "modernities" are coming together and shape the creation of new social spaces for older people. Older urbanites are not only torn between what they see as a "traditional" village way of becoming old and a "modern" city way, but between several ideas on how to age well that co-exist in the urban space. Robinson understands urban modernity as "the cultural experience of contemporary city life and the associated cultural valorisation and celebration of innovation and novelty" (Robinson 2006, 4).

Especially when complaining about "the unhealthy city," the wazee in this study made a difference in how people get old *zamani* and *leo* or *ya kisasa*[170]. The aging of today was linked to a "modern" or urban way of aging, while it was compared to aging in former times which was equated with "traditional" or "village" ways of aging. The fact that many older study participants used the term zamani synonymous with village and ya kisasa synonymous with city can be explained by the circumstance that for most of the older people of the study, there are no persons for reference that had grown old in the city before. The older study participants' parents usually grew old in the villages, even if they came to the city for work. Older people interviewed on the topic in Kinondoni Ada Estate had diverging explanations about how aging differs in former times and today. In the following two extracts from interviews with two older men from the former civil servants' milieu in Ada Estate, different ideas on where people age faster or better are highlighted: While Mzee Buni explained that, according to his perception, people are aging faster today if compared to former times due to unhealthy food, Mzee Dunford stated that because of improved medical treatment people are likely to live longer nowadays.

> Frank: Do you think may be the elderly in the past and the elderly of today are getting old differently or the same?

---

[170] While *zamani* is used to describe something that happened earlier, some time ago, in contrast, *leo* or *ya kisasa* points to something that is current, from today, the present time (leo) or new, modern, up-to-date (kisasa).

> Mzee Buni: I think they are getting old differently. Nowadays people are getting old faster than the people of past years, I think because of the food we eat, most of the food we eat today has many chemicals, for example if you take a meat broiler chicken and indigenous chicken meat their taste is different and the youth of today is the same as broiler chicken.[171]
>
> (Mzee Buni 2013)
>
> Andrea: Do you see changes on how people aged today and how like long time ago when you were young people, how did people get old?
>
> Mzee Dunford: I think there is some difference, people were getting older faster in the past than now I think because of changes in the environment, food and medicine, in the past medicine treatment was very difficult to get and many diseases did not have medicine, but nowadays many diseases have medicine, so if you care about your health, medicines are available, different from past.[172]
>
> (Mzee Dunford 2013)

A topic that came up when discussing the aging process of the body with the older urban residents was products and strategies aimed to hide the signs of aging. They described dyeing the hair or using special creams for the face (with bleaching effects) as part of a "modern" fashion of aging in the city. As the example of Mzee Mbujuni illustrates who dyes his hair in order to be taken more seriously as a pastor. Others, however, argued against putting color on their own hair to appear younger. As Mzee Mohamad explained to Frank and me, at a certain age you have to sacrifice certain things, such as black hair. He told us that he would not only embarrass himself but also his wife if pretending to be younger than he is. Others also underlined their reservation to use certain beauty products that are available in the city and that make older people appear to be younger:

> … there is this fashion of using strong creams. If you use strong creams on your skin, you will end up having a funny skin; when you get old the skin will change and the color of the skin changes. There are several women—but not women of my age—because when we were growing up, we never had things like cosmetics; we were simple and natural skin. But of this late year, they have been living on the cosmetics. You see a woman who is forty to fifty, if you see her face, you will just sympathize [with her] because of the side effects of the creams because they say there is a lot of mercury in the cream and most of the people, they did not know the side effects of the cream that may affect even the kidney. (Bibi Annette, 2013)

[171] Frank: "Unahisi wazee wa zamani na wazee wa sasa hivi wanazeeka tofauti au sawa?" Mzee Buni: "Wanazeeka tofauti sasa hivi wanazeeka haraka zaidi kuliko zamani nadhani ni kutokana na vyakula tunavyokula vina kemikali nyingi sana ndio maana ukimchukua kuku yule ambaye umemfuga mwenyewe ukamchinja halafu ukamchukua kuku hawa wa kisasa aliyefugwa kwa madawa nyama na ladha zao zitakuwa tofauti kwa hiyo na hwa vijana wa siku hizi wanakuwa kama kuku wa kisasa."

[172] Andrea (translated by Frank): "Unaona kuna mabadiliko yoyote siku hizi jinsi watu wanavyozeeka ukilinganisha na zamani?" Mzee Dunford: "Naona kama kuna tofauti kidogo walikuwa wanazeeka haraka zaidi zamani kuliko sasa nahisi kwa sababu ya mabadiliko katika mazingira na vyakula na matibabu zamani matibabu yalikuwa magumu sana kupata magonjwa mengi yalikuwa hayana dawa lakini siku hizi magonjwa mengi yana dawa kama mtu ni mwangalifu huwezi kuugua ukakosa dawa zamani hata uwe mwangalifu ulikuwa unaugua lakini dawa hakuna siku hizi dawa ziko."

As listening to Bibi Annette suggests, not all aspects of a "modern" aging in the city are perceived as positive. Many of the older study participants' comparisons about zamani versus leo were linked to their struggles within the city. The village as an "imagined place" (Förster 2018, 415), as they remembered from their youth, was nostalgically praised by the older study participants.[173] There exists a considerable amount of literature on complaints raised by the older generation claiming that life that was much better when they were young (Reynolds Whyte, Alber, and Geest 2008, 9). With these complaints, they do not only utter their discontent with their current situation in the city towards the anthropologist, but also point to unfulfilled expectations with regard to social relations. While some anthropologists have argued that the "complaint discourse" is an effective means to ensure respect and assistance from the younger generation (cf. Cattell 1997; Rosenberg 2009), Reynolds Whyte, et al., emphasize that complaining can also be counterproductive and rather lead to a loss in respect and recognition (Reynolds Whyte, Alber, and Geest 2008, 10; cf. also Geest 2007). Bibi Maimuna in the initial quote to this part—who claimed that zamani and everything in the village would be better for her, while she was forced to stay in the urban space without friends and enough support—therefore not only hints at a perceived difference of aging in an urban space, but when she complains about the loosened social relations in the city, she also makes a claim towards others for more care. These negotiations will be taken up again when discussing relational care since it greatly depends on the older person's agency when negotiating for care. How the older study participants bargain for care will be subject of the next part of this thesis. Before, though, I will now describe one particular milieu of Dar es Salaam's "middle class" which I focused on during my research.

Aging in the Former Civil Servants' Milieu

When others talked about older people in the Ada Estate, they used an expression that referred to their abilities. They called them *wazee ambao wanajiweza*, meaning "older people who are themselves able, well off." This was opposed to others who are *wazee ambao wasiojiweza*; "older people who are themselves not able, less well off."[174] When conducting research in different sub-wards of Dar es Salaam, these wazee ambao wanajiweza and their ideas of old age caught my interest. In a second phase of field research, I therefore decided to focus on this particular area of the city, in order to find out, why aging

[173] In her book chapter, Gerold emphasizes the village as an ideal that is remembered by the older city dwellers (Gerold 2013, 166).

[174] In Swahili the reflexive "*-ji-*" can be added to a verb, as is the case with *wanajiweza*. Wanaweza means "they are able to" and with the reflexive prefix a direct translation leads to "they are themselves able to." Colloquially, the verb form is used to describe people who are well off financially. In the case of the members of the former civil servants' milieu in Ada Estate, both, the direct translation and the colloquial meaning apply.

practices seemed to differ from those of older people living in the other sub-wards of this study. Instead of the complaints about the city, mentioned earlier, the older study participants in Ada Estate preferably pointed to the amenities that they had learned to utilize in the urban space. I started to wonder whether their aging practices differed only because they had more financial means, because they belonged to an "urban middle class," but exploring this through the concept of social milieu may reveal other dimensions too. The French word *milieu* can be translated literally as "between places" and thus points to a connection between place and social structure (translated from German, Frey 2012, 503). Apart from the social milieu approach as it is used in this PhD thesis that focuses on socio-cultural aspects that become relevant for people's belonging to a social milieu, there is a rather location-centered understanding of milieu that is discussed in urban sociology. These differing approaches use a different assumption regarding their reference to space (*Raum*) (Frey 2012, 513). The Chicago School developed a milieu-based approach that explored the connection between urban ways of life and urban places and neighborhoods (Frey 2012, 507). Frey describes the introduction of what he calls a meso-level when looking at local communities or wards (in German *Quartiere*) and neighborhoods in order to study urban milieus. Neighborhoods gained new attention in urban sociology while Schnur emphasizes different theoretical approaches to the spatial dimension of them (Schnur 2012, 452). While I consider it important to describe the spatial environment of the sub-ward Ada Estate and to take into account the city's infrastructure, as it helps to economically situate older people in Dar es Salaams middle-income strata, a location-centered approach to milieu would, in my view, miss important aspects, such as the older people's lived rural connections as well as the aspect of civil servant-ness that constitutes an important element of the milieu and which is not bound to a specific locality but to a particular occupation. Hence, I met other former civil servants in Ilala Mafuriko who belong to the same former civils servants' milieu but lived in another locality. By using the concept of social milieu, I point to the particularities of how older people in different milieus of the city grow old, while the former civil servants' milieu will be explored in more detail.[175] The agency lens of this PhD thesis allows us to further explore people's enabling and constraining environments that may be shared among members from the same urban milieu. However, such an approach can also be criticized as it can render us blind to the hard and cruel sides of city life, for instance, if we over-romanticize urban life as particularly creative (with regard to urban margins, see also Aceska, Heer, and Kaiser-Grolimund 2019, 4).

Conducting research on "the non-poor" compelled me to defend my decision several times, as many people from the applied research fields in Tanzania and Switzerland claimed that, ethically, it would be wiser to investigate the poor in order to "help" them. This is a valid point, however I would like to argue that particularly by looking at these slightly better off older people, we can learn about current

---

[175] The milieu dimensions that will be further explored below, concentrate only on people above the age of sixty years. Further research would be needed to find out whether the similar conclusions could be drawn for other age groups.

trends of urban aging in Tanzania and the new social spaces that open up for older people: with the help of financial means and access to information, these "middle class elderly urban dwellers" followed creative ways of becoming old in the city of Dar es Salaam. Also, Neubert and Stoll write: "Because of their better socio-economic position, members of the middle class have more freedom of choice with regard to planning their future and consumption preferences. They are able to put different values into practice which makes socio-cultural differences clearer" (Neubert and Stoll 2015, 14).

Although Ada Estate is a sub-ward of Dar es Salaam and, thus, a geographical area, I would like to show in this chapter the particularities of the milieu of former civil servants, while pointing out that older people from other sub-wards may also create "Ada Estate-like" social spaces. The milieu stands out by its members who have more monetary means than the average urban inhabitants. I call the milieu "former civil servants' milieu"[176] to point to the "civil servant-ness" of its inhabitants. As a former civil servants' area owned by the government, it does not only have a certain shape as a physical area, but still hosts many state-employed people, or people who are in some way related to those state-employed people. The mentioned two aspects, belonging to a middle-income group and being (related to) former state employee tell us more about the socio-economic position of the milieu. However, "people in the same socio-economic position do not share necessarily the same values and lifestyles" (Neubert and Stoll 2015, 3). It is therefore important to look at what earlier on was called the subjective conditions (cf. chapter on Social Differentiation in Africa: The Concept of Social Milieu) and explore which values and lifestyles are shared among a group. I will do so in a second sub-chapter when looking at the socio-cultural dimensions that can be described as particular for the former civil servants' milieu. The discussed socio-cultural aspects are interlinked and not all of them have the same importance for each of the older person belonging to the milieu.[177] I use the milieu concept here as an analytical tool, it is clearly not an emic concept.

Socio-Economic Dimensions: "Middle Class" Civil Servants

A milieu is always shaped by the "objective" conditions of life. The fact of belonging to a certain socio-economic group shapes the system of values that are shared in a milieu. Therefore, I first look at the socio-economic aspects. I will situate the members of the former civil servants' milieu in Ada Estate

---

[176] The name "former civil servants in Ada Estate" developed when discussing this chapter with Florian Stoll.

[177] Also, Neubert and Stoll, who work on middle class milieus in Nairobi, call for a "comprehensive analysis which distinguishes certain milieu cores, around the borders of which are people who only partly share or live the basic values and practices of the milieu in question. This results in clear overlapping areas between milieus, and a large group of people who belong simultaneously to very different milieus or small lifeworlds" (Neubert and Stoll 2015, 14).

economically within the wider population of Dar es Salaam, and argue that, from a historical viewpoint, they economically belong to the Tanzanian "middle class."

BELONGING TO DAR ES SALAAM'S MIDDLE-INCOME GROUP

Especially, with the growth of a middle class only recently, the term "class" became prominent again, not only on a global scale, but also on the African continent (Mercer 2014, 228; Lentz 2016, 25), despite its deficiencies of the term, which was developed for a "highly specific economic and industrial context" (Quénot-Suarez 2012, 8).[178]Although, in many recently published articles on the African continent, the growth of a middle income group does not yet seems a prominent issue (Mercer 2014, 231). Banerjee and Duflo depart from an "absolute approach" and define "middle class" households as "households whose daily per capita expenditures valued at purchasing power parity are between $2 and $4 and those households between $6 and $10" (Banerjee and Duflo 2008, 2). Including the therefore so-called "floating class" (US$2 to US$4 per capital daily expenditure), which is just above the "developing-world poverty line" and what Ncube, Lufumpa, and Kayizzi-Mugerwa (2011) call the "upper middle class" (US$10 to US$20 per capita consumption level per day), one third of the African continent (34.3 percent in 2010), the authors claim, belong to a middle class (Ncube, Lufumpa, and Kayizzi-Mugerwa 2011, 2-3).[179] This number is expected to rise to 42 percent by 2060 (Ncube 2015, 1). The size of such a socio-economically defined (homogenous) "middle class" looking at expenditures may obviously change, depending on its definition (Neubert 2014, 25).

From a development economy point of view, the generalized "African middle class"[180] is described by using income as a first criteria, while acknowledging the importance of "a set of assumed universal middle class traits" (Mercer 2014, 228), including choices concerning "aspirations and lifestyle" such as smaller families, emphasis on education and nutrition, salaried jobs or entrepreneurship, and consumption patterns that include refrigerators, internet, mobile phones, and cars (Ncube, Lufumpa, and Kayizzi-Mugerwa 2011, 6). With such a definition, "middle classes" may be presented as "drivers of economic and political change" (Neubert 2014, 23). Neubert and Stoll emphasize that features

---

[178] Quénot-Suarez points out that the terminology of middle classes is ill-suited for a non-Western context and cautions that "a society 'with' a middle class is not necessarily a society made up 'of' middle classes," since, especially in the development discourse, this would be misleading (Quénot-Suarez 2012, 8). I use "class" here not in Bourdieu's sense but to define the economic position within society.

[179] The authors emphasize the growth of the middle class in the recent years; while in 1980, 26.2 percent belonged to a middle class in Africa, in 1990 this number increased to 27 percent, and 27.2 percent in 2000 (Ncube, Lufumpa, and Kayizzi-Mugerwa 2011, 3). It is important to note that the "floating class" constitutes more than half of Africa's middle classes; members of the floating class are therefore in a vulnerable position since they are "facing the possibility of dropping back into the poor category …" The group below a per capita expenditure level of US$2 is the biggest, with 61 percent (Ncube, Lufumpa, and Kayizzi-Mugerwa 2011, 4).

[180] Mercer (2014, 228) rightly points out that on other continents scholars prefer to talk of a national i.e. "Indian" or "Chinese" middle class.

usually attributed to an "African middle class" could be applied to a larger group of African societies. In this connection they argue that "[t]he main difference between the middle class and the other groups is a socio-economic one based on the better position of the middle class with regard to consumption opportunities" (Neubert and Stoll 2015, 2). Despite the criticism of the use of the term "middle class," especially also in development economics, I use the term in this PhD thesis to refer to texts that describe the middle-income milieu that I would like to further describe based on local empirical findings.

In Tanzania, the group that is called "middle class" in the literature grew since the economic and political liberalization in the mid 1980s (Mercer 2014, 230). Tanzania's middle income class in 2010 amounted to 2.9 percent; when including the floating class of 12.1 percent (Ncube, Lufumpa, and Kayizzi-Mugerwa 2011, 5). However social difference started much earlier and during Tanzania's Ujamaa period, being a government employee was "the most reliable route to middle classness, particularly in rural areas" (Mercer 2014, 230).[181] In the post-socialist period apart from the public sector, both the civil society sector and the private sector also experienced growth (World Bank 2014; Mercer 2014, 230). In the post-Ujamaa period, as described by Mercer, a new middle class emerged where "there is now more opportunity for, and less opprobrium attached to, the visible pursuit of individual distinction through lifestyle and consumption choices centered on the house, the car, the nuclear family and the body" (Mercer 2014, 231).

Taking into account the change in values, following Moyer we can distinguish two different middle classes or middle income groups in Dar es Salaam that have developed differently since independence: there is what she calls the "petty bourgeoisie" of educated civil servants, professionals, and intellectuals as well as their children (Moyer 2003, 49). Without having conducted a survey that quantifies their income or assets, the Ada Estate study participants seem to fit the description fairly well; according to Moyer they did not gain significantly after Ujamaa. The members of what can be called "older middle class" are "those still inclined to embrace the ideological claims that made Ujamaa so persuasive to begin with" (Moyer 2003, 50). The "older middle class" can be distinguished from a "new middle class," the *wakubwa*.[182] Rather than putting emphasis on education and the position within society, the newly rich base their status on money and success in business (Moyer 2003, 59). Thus a newly emerged "competitive consumerism" allowed also poorer people to "fashion themselves in a middle class style" (Brennan and Burton 2007, 63). According to Moyer (2003, 41), the new middle class has emerged since the 1980s. Moyer points to the fact that there is no vernacular term for the petty bourgeoisie and

[181] It may be important to emphasize that the emergence of an old middle class of civil servants is particular to Tanzania's development of the society. It would be interesting to compare the group of aging civil servants with Tanzania's neighboring countries Kenya or Uganda, however this goes beyond the scope of this PhD thesis.

[182] The *wakubwa* can be translated as "the big ones," meaning those with financial means and power.

suggests that the reason for that might be that they are considered as the "unmarked carriers of the moral status quo" (Moyer 2003, 61). Mercer shows the importance of "work, leisure, consumption and the home to what makes the middle class across Africa" and points at the importance of Tanzania's history of socialism and the "changing moral values through which accumulation and consumption are perceived" by different groups (Mercer 2014, 232).

Since this PhD thesis focuses on older people, who are typically no longer formally employed and usually share their home with family members from other generations, it was not possible to assess their daily income or expenditures. I content myself therefore with the historical explanation and a description of assets (in their houses) in order to economically situate them in the middle-income strata. When it comes to housing, the study participants in Ada Estate were, at the time of fieldwork, usually well equipped with electricity, tap water, and a built-in kitchen. Usually, they had a courtyard around the house protected by a wall. At first, I was told that especially the wall would restrict me from accessing these older people (in contrast to older people of other areas where houses are not protected by a wall), which luckily did not hold true. Furthermore, cars were also more common among the Ada Estate study participants.

While these assets and the reference to the above-mentioned debate on the development of Tanzanian "middle classes" thus helps to describe the middle-income milieu in economic terms, much more emphasis should be laid on the local characteristics that shape this milieu. As Stoll puts forward, such an approach may focus rather on horizontally differentiated groups than trying to describe in this case Dar es Salaam with a vertical concept of class (Stoll 2018, para. 11).

Civil Servant-ness and Legal Age

As shown above, the old generation of civil servants in Tanzania historically developed into an "older middle class," whose members are well educated (relative to the time and development of the country), and profit from certain privileges such as health insurances (while employed) and pensions (when retired). Being a civil servant entitles the inhabitants of Ada Estate to certain houses in specified areas of the city. There are several of these former civil servants' areas in Dar es Salaam (amongst others in Upanga, Kinondoni) and these areas are usually in a favorable location (similar to Ada Estate), which eases the access to city facilities such as hospital or other health facilities. Also Brennan and Burton describe these so-called quarters, the government-built housing, that was "favoured by 'better-off' Africans 'in the more responsible, the clerical, and the artisan classes of job,' who were also more likely of upcountry origin" (Brennan and Burton 2007, 45). Mzee Mohamad, a former civil servant residing in Ada Estate, pointed out that until today many younger people residing in Ada Estate belong to the group of civil servants:

> Andrea: What would you say; what kind of people live in Ada Estate? …because formerly there were state employed people who got houses here.

> Mzee Mohamad: Still the same people because even if there are people who are renting these houses they are just employed by the government or state organizations because an ordinary man from the street cannot afford to meet the rent for example like this one [his own apartment] rent is about TZS2 million shillings per month.
>
> (Mzee Mohamad 2013)

For the older participants of this study being part of the civil servants' milieu means that many of them are benefiting from a pension because they were themselves state employed. Some also benefited from a family member who was state employed and therefore entitled to buy or rent a house or flat in this area. Through formally employed children, many of the older people also benefit from a health insurance, as is the case with Mzee Dunford portrayed earlier. By being formally employed, most of the study participants experienced the legal age definition on their own body when being forced to retire at the age of sixty years (however some also retired earlier). The fact of experiencing compulsory retirement that comes along with a small pension payment in some of the cases, shaped the older people's view of old age. This legal age definition was also observable with civil servants in other sub-wards of this study. I mention this aspect here, as it seems representative of a "civil servant-ness" of the old and historically developed generation of civil servants living in Ada Estate and other civil servant areas.

Being a civil servant after independence strongly shapes one's relation to the state. Eckert describes the time after independence in the 1960s and early 1970s as "the 'golden age' of civil service in Tanzania" (linked to training, social security as well as social prestige), while thereafter the situation changed (Eckert 2014, 217). Although the relationship of politics and civil servants seems to have changed in the years after independence, Eckert describes them—taking into account the context of the national building in a one-party system—as having worked for the nation and supporting the political party with the implementation of their priorities (Eckert 2014, 216). Listening to the older study participants, I got the impression that many of them were politically in favor of the ruling party (CCM) because they had helped to build up the nation after independence. In old age, the older study participants still seem to be interested and well informed about political issues. Mzee Mohamad, for example, reads the Uhuru newspaper, which is the paper of the ruling party and listens to the government radio channel TBC (Tanzania Broadcasting Corporation). When discussing with him the access to newspapers, after observing that mostly better off older people could afford newspapers while most of the other study participants did not, Mzee Mohamad told me that everybody could afford to buy a newspaper. He said the newspaper he buys costs TZS800 and he claimed that if somebody could not earn at least a dollar a day, he or she should go back to the village and cultivate the land; this person should not stay in the

city. In Mzee Mohamad's view, everybody can do something to get money (Field notes 24.04.2013).[183] Since many of the older study participants are provided with a state pension, the idea of serving the state seems to stick in their minds, although also some critical voices were heard.

SOCIO-CULTURAL DIMENSIONS: CARING FOR HEALTH

A social milieu does not only share ideals and mentalities, but also the way members of a group see and shape their relations towards others and the environment (my translation, Hradil 2001, 45). In this sub-chapter, the socio-cultural aspects of the former civil servants' milieu will be described.

As indicated earlier, in order to describe a milieu, we have to go further than only defining the social position (*Soziale Lage*), as was done by describing the middle class-ness of the older study participants above (and their civil servant-ness). Rather, we also have to look at the aims in life (*Lebensziele*) as well as the ways of life (*Lebensweise*) (Hradil 2001, 427).[184]

FUTURE PREPARATIONS FOR A "GOOD" OLD AGE

When it comes to the older people's aims in life, their preparations for becoming an old person seemed prominent and will be therefore treated here. While other older people of this study had to struggle for daily survival, the older people belonging to the former civil servants' milieu in Ada Estate uttered many concerns about their future as older people. At the age of sixty and over, most of them still felt strong and expected to live for a many more years yet. The statistics mentioned earlier show an increase in the life expectancy of older people in Tanzania. While in former times, civil servants might not have lived until their retirement, nowadays they can expect to go on for some more years, triggering a new process in which people have to reflect on their life after retirement.

Preparation for old age was perceived as an important aspect of care. Mzee Bariki also mentioned this aspect when Frank and I talked with him about *kuzeeka vizuri*[185]: He told us that he sees his "success" in aging in the fact that he was able to educate his children. All of them had completed form four (secondary education); three of them went to university. He said although his education was low, he invested a lot in the education of his children and for him this meant successful aging. As, if you

---

[183] By saying this, Mzee Mohamad's opinion seems to mirror the idea of the former Ujamaa politics when "non-productive" inhabitants are asked to leave the city. His attitude towards work also clearly mirrors his privilege as a (high ranking) civil servant.

[184] Hadril (2001, 427) mentions three variables to empirically identify a social milieu: while the aims in life (*Lebensziele*) is an "active" variable, the way of life (*Lebensweise*) and the social position (*Soziale Lage*) can be described as "passive" variables that serve to describe the members of the milieu.

[185] As mentioned earlier, the expression *kuzeeka vizuri* is a main focus of this PhD thesis, as it describes a good way of getting old. It can be directly translated as aging well.

managed to educate your children well, you will "earn" what you invested later. Those who did not make an effort to educate their children well, should not be astonished if they are not well cared for afterwards. Hence, by not providing a better future for your children means you are transferring your problems to the next generation. To educate them well does not mean only schooling but also values and respect; to love one another and to care for each other (Field notes 03.05.2013). Mzee Ngowi, who is in his mid-seventies, also supported this view by mentioning: "If you are blessed with children and they are educated and they are working, then you have at least some security …" (Mzee Ngowi 2012). Also, my conversation with Mzee Mohamad, a high-ranking government officer before he retired at the age of sixty years, reveals the importance of preparing for old age:

> Mzee Mohamad: There is no specific way of getting old because everybody will get old. The only thing is how do you prepare yourself for your future.
>
> Andrea: And did you prepare yourself?
>
> Mzee Mohamad: Myself as a civil servant I have prepared although it was very difficult as a middle class civil servant because actually the salary was very low with children because most of my children have studied in private schools where I had to pay their education expenses from the salary but with all problems I have managed at least to arrange for my future to a certain extent for example now I am staying at this house I bought myself and I have bought some other properties which I actually used my salary to get them so those properties and the little pension I am getting if I add them together the same which I use to help myself to continue with my life …
>
> Andrea: And would you say you prepared your children?
>
> Mzee Mohamad: The preparation made to my children is to educate them what else can I prepare? The only preparation is to educate them because if you educate them, you make two things—you help themselves at the same time in the long run they can assist you in case you cannot manage to support yourself.
>
> (Mzee Mohamad 2013)

This small extract from an interview with Mzee Mohamad shows his thoughts about preparing old age while reflecting on his financial abilities linked to his job as a civil servant. However not all interviewed older people confirmed what Mzee Mohamad said, as, for example, Mzee Mbujuni's statement in an interview shows:

> Mzee Mbujuni: No, I never educated my children so that they can come to take care of me it's good to prepare your children for their own … and what am telling you is the truth I never thought of my children that will come and assist me I was just do it because is the part of my obligation so it is better take good care of them for their own life …
>
> Andrea: And you mentioned that they are not comfortable now to support you?
>
> Mzee Mbujuni: Yaah … they think I am rich why because they saw me driving this expensive car if you put a diesel for the day is US$100 to go around town so why did I drive these big cars so the way I compose myself I do not compose as a poor man so they think I have money.
>
> (Mzee Mbujuni 2013)

In the second quote, Mzee Mbujuni did not claim that he prepared his children so that they can care for him in old age, he rather invested in other assets, such as his house and some stores that he rents out. Although being married to a civil servant (Mzee Mbujuni's wife is a teacher) and therefore entitled to the house in the sub-ward Ada Estate, Mzee Mbujuni was an entrepreneur who could be part of another milieu of "older wakubwa" that make different investment decisions for old age. What became evident when talking to the participants of this study was the fact that most of them started to prepare for old age before being (legally defined) old and retired. Some also stopped working as civil servants before the age of sixty years and used the lump sum they received upon (early) retirement to invest in a business that would sustain them later on. Of course, not all of them invested in their future to the same extent. However, it was striking to see how members of the former civil servants' milieu as well as successful entrepreneurs like Mzee Mbujuni, articulated these reflections about their future much more than the older people I met in the milieu of the "working poor."

CONDUCTING A HEALTHY WAY OF LIFE

Most of the former civil servants were quite concerned about their health and a healthy way of living. As this topic of health in old age was one important aspect of this study, my research team and I probably also triggered these conversations. An important aspect when it comes to a healthy way of living was food and food preparation. As Bibi Veronica mentioned earlier, many elderly women preferred preparing food on the charcoal oven outside the house (or on the balcony) although their houses or apartments were all equipped with built-in kitchens,[186] simply because they are used to cooking with charcoal. However, some also combine outside cooking with the use of the gas cooker inside, as in the case of Bibi Veronica, who cooks the fresh food outside and warms it up inside on her gas cooker or in her microwave. Her children especially built a cooking place outside the house for her, with a roof and partly open walls, a paved floor, and an installed water tap. Bibi Veronica cooked large quantities of meat at the same time and then stored it in the deep-freeze inside her kitchen.

Mzee Dunford emphasized the importance of doing *mazoezi*[187] for a healthy living. I recall the quote that I already presented at the onset of this PhD thesis, from an interview with Mzee Dunford where he explained this aspect of exercises as in his eyes essential part of a good old age:

> Andrea: And which is the good way of aging that makes you look happier or more comfortable?
>
> Mzee Dunford: A good way of getting old is when you are able to control your body like when you are doing physical exercise [like] that you are getting old in the best way, because instead of dying today you will die tomorrow instead of dying this week you will die next week. You are adding the hours of living

---

[186] Most of the houses and apartments were built by the British during colonial rule, or by the Swedish development cooperation. I assume that some of the house owners renovated the houses and took over the design with the built-in kitchen.

[187] As mentioned earlier, the Swahili word *mazoezi* can be translated as physical exercises.

> although you will die anyway, and you can still say something if you want to say may be to your children you want to tell them they should not do a certain thing.[188]
>
> (Mzee Dunford 2013)

Also, as part of a healthy lifestyle, the possibility of going to a health facility was mentioned. Mzee Mohamad told us a story to show Frank and me how important having money for health care was:

> … two years ago, my second daughter, the one who came here and said good evening, was sick. I took her to Mwananyamala hospital because she had no insurance. First I took her to a private hospital at Namanga here, there they told me … to be referred to a government hospital and at Mwananyamala hospital they send us to Muhimbili hospital—then I took her to Muhimbili hospital and at Muhimbili they told me this [needs] to be operated so they gave her some medicine so as to reduce the pain until she gets stable so that they can conduct the operation—It cost me over TZS5 million shillings and I thank God, I had the money because if I had no money I would have lost her. (Mzee Mohamad 2013)

This extract raises another issue, namely, who can frequent which hospital in the city of Dar es Salaam. For members of the former civil servants' milieu, much depended on whether they possessed an insurance card or not. If they do so, the number of hospitals they can visit becomes limited. The usual places are the governmental hospitals and a few private ones where they get free treatment; however, especially in the government hospitals waiting queues are long and unpredictable. Therefore, those who can afford it do not use their insurance card but go directly to a private hospital where they can get treatment within a short time, but where they pay more. Through connections while still employed, some have the telephone number of a doctor in a (private) hospital whom they can call and arrange an appointment in order to skip the queue. Like my landlord, Mzee Ngowi, who, when sick, called his personal doctor who told him at what time he should come to the private hospital so that he could be examined right away. As mentioned earlier on in this part, especially their improved access to health care made the older people of this milieu appreciate their residence in the city.

While still working, Mzee Mohamad had to travel to India and he therefore took the opportunity to visit the Apollo hospital[189] where they found out about his hypertension. However, he told me that he would not have managed to visit the hospital at his own expenses. As mentioned earlier, Bibi Veronica's husband also died in India while traveling there for treatment. Trips to India were common among

---

[188] Frank (translating Andrea's question): "Ipi ni njia nzuri ya kufanya uzeeke ukiwa na furaha na ukiwa umerelax?" Mzee Dunford: "Kuzeeka vizuri ni kule ambako unajicontrol mwili wako kama kufanya mazoezi ndiko kuzeeka vizuri kwa sababu badala ya kufa leo unakufa kesho, badala ya kufa wiki hii unakufa wiki ijayo. Unakuwa umeongeza masaa ya kuishi ingawa utakufa lakini umesogeza siku kama kuna jambo ulitakiwa uliseme kabla hujafa unakuwa una nafasi ya kulisema kumwambia mwanangu usifanye hivi, unapata nafasi ya kuliongea."

[189] The Apollo Hospitals Group has six hospitals in different Indian cities. The group seems specialized on international patient care and, according to their website, supports international patients in planning their trip (cf. Apollo Hospitals Group 2017).

economically better-situated older people, as for some treatments Tanzanian hospitals were not skilled and sufficiently equipped.

Most older people of the Ada Estate sample were provided for with regard to health through their children, since many of them were state employed too, and thus had a health insurance where they could choose to secure four dependents. An exceptional case is Bibi Helen who did not have children of her own. She received a small pension since she had been a state employed secretary before. Her younger sister, who was still working, included her as a dependent in her health insurance, so that Bibi Helen was covered after retirement. However, while conducting this field research, her sister retired which meant that she could no longer take Bibi Helen on her health insurance card. Before her sister retired, Bibi Helen therefore did as many checkups as possible before she had to give back the card.

In addition, most members of the milieu in Ada Estate employed household helpers. Several times when I was there, a household helper had left and it took several weeks or months to find a new help who was acceptable and fitted in the household. Once a new household helper was employed some of the wazee told me that they first took her to a medical checkup to make sure that she was de-wormed before sharing their house with the person.

Access to health information also seems to be different according to milieus. Through their access to health care, more information from medical doctors was generated. Furthermore, understanding English also provided a wider range of TV channels and literature for the study participants. From our conversation on our visit to Bibi Annette at her second house in the village in the northern part of Tanzania, I noted the following:

> When asked about how Bibi Annette would know what is good for her health, she replied that it was through experience and observation. When she traveled, she was in France for example and invited for food sometimes and she observed what people eat. She said that she did not learn from her parents. And for the food supplements her husband uses at the moment she said that she was the "guinea pig" because she was once very sick and tried this medicine. And from one day to the next she felt ok again. It is a product from South Africa; a powder full of vitamins, you can put it into your tea (it is like vanilla powder). To buy it you have to be member because otherwise it is too expensive. It costs around TZS75'000 for the box … (Field notes 17.04.2013)

Like Bibi Annette, many of the former civil servants traveled during their employment. Bibi Annette was a sports teacher and was able to travel to different places for further education, for example, to Australia and different places in Europe. My landlord Mzee Ngowi was sent to Israel to study law. Through their travels, they were exposed to new contexts and ideas concerning health and old age, which is likely to have shaped their ways of living old age. The aspect of living a healthy way of life will be treated in more detail when looking at the self-care practices of the older study participants in Part III.

Living a Socially Embedded Old Age

Another important dimension of the milieu is the (ethnic) belonging while living a socially embedded old age. Neubert cautions the use of ethnic belonging as a single explanation for social differentiation (Neubert 2005). I do not want to do that. However, the older study participants identified much through belonging to a certain group and a certain "home village," which was also mirrored in the visits between the city and the countryside (as mentioned earlier when talking about funeral preferences). Through their means and connectedness, most older people of the former civil servants' milieu seemed more mobile with regard to traveling to their village of origin. Of course, their health condition also impacted on their ability to travel back and forth.

Many of the Ada Estate inhabitants belonged to the same ethnic group (Chagga) and originally came from the northern Kilimanjaro region. As mentioned in the historical overview, many people from upcountry arrived in the city after independence, many also worked as civil servants. Some study participants put forward that they grew up with certain values, namely working hard and saving money. Many also owned property in their home village in the northern part of the country. Owning property in the village increases mobility, due to the need of maintaining the houses and lands. There were also saving systems in the city that had ethnic belonging as a membership criterion to which some of the older study participants belonged. If they have to raise money for a funeral of a family member or a wedding, they can access a larger sum through the saving group.[190]

However, not only belonging to a particular ethnic group and cultivating links to "home" were emphasized as being important for the members of the milieu, but also their embeddedness in a church community.[191] As a mainly Christian milieu, religion and corresponding church visits seemed crucial for older people. Many older study participants were able to invest a huge amount of their time in church activities after they stopped working. Some traveled far to other areas of the city in order to attend a particular church service, others even slept in the church in order to be ready for Saturday and Sunday. Some church groups also had saving pots and those groups were active with regard to supporting the ward members—without consideration of ethnic belonging. Some groups circulate in forms of prayer groups and meet to pray each week at another house in the ward. Others get together to visit or help a sick member. Like the church of Bibi Veronica, whose members reside in the sub-

---

[190] In their study on middle class milieus in Nairobi, Kenya Neubert and Stoll present urban milieus of different age groups. They describe a "Neo-traditional milieu" who's member focus much on maintaining ethnic traditions and customs and who's aim in life is amongst others the burial in the home village, while they put forward local family values and gender roles (Neubert and Stoll 2015, 12). Some of these strong lived ties between the city and the home village can also be observed among the former civil servants.

[191] Here I see parallels to an urban middle class "Christian milieu" described by Neubert and Stoll (2015) for Nairobi. Members of this milieu lead their life according to Christian values and socialize with other members of the church group (Neubert and Stoll 2015, 12).

ward Ada Estate and who meet every Saturday morning to visit one of the groups and pray together for him or her. When she lost her husband, the church group provided her with much needed psychosocial support.

Being socially engaged was correlated to the older person's available time and means to cultivate these connections. They invested in cultivating contacts to the rural area or to neighbors, friends or church members in the city. Especially, because most of the milieu members were retired civil servants who were no longer preoccupied with an income generating activity, they seemed to have more time in order to engage in these relations. I recall here the initial quote of this chapter by Bibi Maimuna, who claimed that in cities there are no friends and it was difficult for her to rely on neighbors.

Conclusion: Urban Aging Between Challenges and Opportunities

This part was inspired by the many conversations with older inhabitants of four different sub-wards of Dar es Salaam. While talking with them, mainly about care, and participating in and observing their daily practices, many study participants themselves highlighted that living in an urban space impacted on their old age. Furthermore, conducting research in the four different sub-wards made me realize that, depending on whose setting I was looking at, experiences of "the urban" changed. City does not mean the same for older people in different milieus.

This part highlighted at the outset the importance of looking at aging in the city by noting the growing number of older people in urban space. Owing to national politics, in the last decades, not many older people were to be found in the city, as they were taught to leave the busy city when growing old and no longer able to work. Therefore, in this project, a first generation of older people becoming old in the city was studied. Remaining in the city, these older people are confronted with different repertoires of old age. Depending on their work and health, they are confronted with the issue of legal age when retiring or wanting to make use of the exemption policy at health facilities. However, not all older people are confronted with this legal age definition and many are more significantly shaped by their own definition of social age where aging is more an advancing process. By moving around the city, especially encounters with others shaped their perceptions of being an old person or not. Also, their bodily experience of health and illness impacted on presenting themselves as an old person or not. Furthermore, especially physical problems of moving within the built environment of the city, that cannot be described "age-friendly," shape the older people's perception of and experience with the city.

The experiences of the urban were presented as a tension field between challenges and opportunities. While some older people blamed the city for not being able to live the old age they envisioned. They especially emphasized the lack of reliable social relations in the urban space, and thus created the image

of a “guilty city” that is blamed for struggles and hardship they experienced. Linked to the fact that the older participants of this study belonged to the first generation of people to grow old in the city, as they arrived soon after independence and witnessed the changing politics of the country, I emphasized their being torn between the city and their village. The tensions they described were also mirrored in their discourse on the city as their present reality as opposed to the village as a nostalgic past.

What became evident when accompanying the study participants over several years is that old age especially became a concern for older people when their health deteriorated. Not being able to provide for themselves anymore (while in some cases also children and other relatives are not able to take over the tasks), made them experience the city as a place of hardship. They described the “unhealthy city” which they made responsible for making their health even worse, due to the contaminated food or restrictions in moving around. However, the same as their health had ups and downs, their perception of the urban as a place of struggle or a place that enables also changes over time. Others therefore underlined the importance of being geographically close to quality health care. Rather, they foregrounded the “healthy city” that allows an older person to remain healthy in old age. They profited from the city’s landscape of different medical treatments and explored, for example, Chinese diagnostic centers when they did not find relief in the biomedical treatments offered at hospitals. The stories thus showed that not all older study participants were able to profit from the offered health supply to a same extend.

Especially some older people from the former civil servants’ milieu highly praised their life as urban dwellers and rather pointed to an “enabling city.” Focusing on this milieu in Ada Estate, I sought to find out more about new social spaces for older people that open up in the urban environment. Older people in Ada Estate seemed to profit more from residing in the urban space, and practice new and innovative ways of aging in the city. Belonging to Dar es Salaam’s “older middle class,” they not only seemed to have more means to do so, but also had the means to follow a particular healthy way of living for a good old age.

Depending on how the older participants of this study lived, the city also impacted on how they were able to act towards others, for example, when bargaining for care. Therefore, in a next part care provided by others but also practices of self-care will be looked at in more detail.

PART III CARE DYNAMICS

OLD AGE CARE

Tronto emphasizes that "the activity of caring is largely defined culturally, and will vary among different cultures" (Tronto 1993, 103). Due to its dependence on the local context, I used the concept of care described in the literature as a leading sensitizing concept,[192] guiding my research while not predefining my categories. Since anthropological literature on care in aging in sub-Saharan Africa is rather scarce, the understandings of "care" presented in this part is based on countless conversations and observations in the field. In this first chapter, they will be mirrored with existing reflections in the literature about care in different contexts that I consider relevant for the discussion and analysis of care in Dar es Salaam, especially in the former civil servants' milieu of Ada Estate.

Dilger describes for the HIV/AIDS context in Tanzania that care is embedded in "complex relationships between power, experience and practice" (Dilger 2012, 83). Although care for HIV-positive relatives differs from old age care under discussion here, some aspects that Dilger describes when it comes to how the Tanzanian state draws back and assigns the families the responsibility for care also applies for the aging context. In the context of old age care, assigned with the responsibility for the elders by the national aging policy (cf. Part II), the family is the main provider of care.[193] As we will see later in this text, not all families engage to the same degree in old age care for several reasons, many of them financial. Care for older people is very much embedded in the social relations that are guided by values based on kinship,[194] with some scope of flexibility. I perceive the state but also kinship as contexts of action that may guide how actors organize older people's care.

Especially in the urban context, international discourses on how to age successfully (cf. Rowe and Kahn 1997) also play an important role in organizing old age (self-) care. For the older persons themselves, care is very much an embodied experience shaped by these contexts of action while, at the same time,

[192] As mentioned in Part I by drawing on (Blumer 1954), Charmaz notes that sensitizing concepts help to sharpen the researcher to ask particular questions about a topic (Charmaz 2006, 16).

[193] The Aging Policy of Tanzania uses the term "family" in their text. Although the term might be misleading when only taking into account the "nuclear" family, I will use it in the following text based on the emic use in my research context. Many study participants talked about family when referring to somebody from their kin group. Especially when older people in the former civil servants' milieu communicated in English (and not in their native language), they used the term family in English when talking about relatives. Also, in Swahili, *familia* (family) and *jamaa* (relatives) were sometimes used interchangeably by the older study participants and their relatives. Therefore, in this PhD thesis I will not make any categorical difference between family, relatives, and kin. In line with the new kinship studies, the lived relatedness will be in the focus.

[194] In the following text, I will use the word "kinship" when I point to the structural and relational contexts of action, that may guide people's actions.

shaping them. In addition, the cultural embedding of care, mentioned by Tronto at the beginning of this chapter becomes even more evident when looking at a transnational care context, namely the care and its (cultural) concepts that "flow" between children in the USA and their parents in Tanzania (cf. Part IV).

How do people talk about care? In Dar es Salaam, the research team and the study participants used different Swahili expressions to circumscribe forms of care in old age. Most often the term *kusaidia* was used in our talks with older people, many times this was the most obvious translation for the Tanzanian assistants of this study to talk about care in the interviews. Kusaidia is one of the broadest terms to describe care, used not only for relatives but also for neighbors or household helpers who help the older person with something. As, for example, Bibi Bariki from Kinondoni Ada Estate, who uses the term for general help of the family: "The family *helps* us so that we can age well"[195] (Bibi Bariki 2013). However, kusaidia, which is literally translated as to help, assist, protect and support, sometimes pointed more to the economic aspects of care.[196] Therefore, when we asked the older people in interviews or informal talks how others cared for them or how they cared for others, by using the term kusaidia, we often triggered answers related to financial support which they received or provided to others. An option was then to use the term but to specify that it is not only about financial support (*sio pesa tu*). This came closer to our understanding of the meaning of the English term "care."

Another term that older people and their relatives, but also the research team, used frequently was *kuangalia*, which literally means to watch, check, look, and observe. The term kuangalia is often used to circumscribe the task of looking after children. The same practice of babysitting is then referred to older people by using kuangalia; to watch over them, to be there for them, or as Simon writes "to keep an eye on somebody" (Simon 2015, 136). In this way kuangalia seems slightly broader, encompassing different aspects of care, such as financial as well as physical aspects. The term kuangalia was used, for example, by Bibi Mercy who currently lives in the USA in a conversation we had about her mother, living in Northern Tanzania:

> Andrea: Does she [the mother] stay alone in her house?
>
> Bibi Mercy: There are people who are staying with her, our last born and his wife are staying there so they are looking after her as you know in our tradition the last born remains in the house of the family and he has

---

[195] Bibi Bariki: "Familia *inasaidia* sana ili tuzeeke vizuri."

[196] All translations of Swahili terms in this chapter are conducted by the help of the online dictionary (cf. African Languages 2017) and in discussion with native Swahili speakers.

> the children, even my other brother and his wife stay there so *there are people around/they are watching her*. [197]
>
> (Bibi Mercy 2014)

Furthermore, if care is translated literally, the term *kutunza* can be used. The term is also used in policy documents, such as the aging policy of Tanzania (URT Ministry of Labour 2003). Kutunza means to care for, to provide for, to protect, and to maintain. According to Simon, it can also be used to describe the provision of health care (Simon 2015, 136). In this research project, kutunza was used more when generally speaking about who should care for older people in Tanzania, including the state. Hence kutunza seemed an all-embracing concept of care in the research context. Apart from the broader use of the term, it was also applied in a reflexive manner to describe what somebody does for his or her own health (*kujitunza*). As, for example, in an interview with Mzee Bariki, an eighty plus year old man from the former civil servants' milieu, who was asked about what he is doing for his own health:

> Andrea: What are the things that you are doing to care for your health?
>
> Mzee Bariki: We are taking good *care of ourselves*, we are not drinking alcohol, we do not smoke, we are doing farming activities which are part of physical exercises, it helps us a lot because sometimes if you stay without anything you will be tired fast and that is why we walk from here to there so as to keep the body active and we eat good food and the people nowadays are getting older than the people from the past time this is because they are not careful with their lifestyle.[198] (Mzee Bariki 2013)

At the same time, *kuhudumia*, pointed more to care in the form of services provided in the hospital context or when care activities of a (hired) household helper were mentioned. For example, when Monica asked Bibi Veronica about accepting a household helper to take over some care tasks: "There is an older man who has his own house but he is not cared for by his children because maybe they are staying abroad and a household helper comes *to care for him*"[199] (Interview with Bibi Veronica 2013).

Bibi Veronica replied that she would accept such a help if one of her children lived with her and came home after work in the evening to look after her. Literally translated, kuhudumia means to assist, help, serve. Dilger describes the use of kutunza and kuhudumia to refer to the actual care provided by family

---

[197] Bibi Erica: "Kuna mtu anakaa nae last born wetu ambaye yuko pale nyumbani na ana mke mtoto wa mwisho kwetu anabaki nyumbani na ana mke kwa hiyo ndio anasaidia nyumba na ana watoto hata kaka yangu mwingine nae mke wake yupo pale nyumbani kwa hiyo *wanamuangalia*."

[198] Frank (translating Andrea's question): "Vitu gani ambavyo nyinyi mnavifanya kwa ajili ya kuitunza afya yenu?" Mzee Bariki: "Sisi *tunajitunza* hatunywi pombe hatuvuti sigara tunafanya na kazi za shamba ambazo zinatusaidia kwa sababu ukikaa hivi hivi bila kufanya kazi lazima utachoka haraka na ndio maana tunatembea kila siku kwa ajili ya mazoezi na kujitunza na kuzingatia chakula na ndio maana mtu wa sasa hivi unaweza ukazeeka haraka sana kuliko mtu aliyezaliwa miaka ilyopita kwa sababu wa sasa hivi si waangalifu kwenye maisha."

[199] Monica: "…Unakuta mzee labda yuko pale pale nyumbani kwake katika nyumba yake pale pale alipoijenga yeye mwenyewe lakini *hahudumiwi* na watoto wake labda mtu wa nje mfanyakazi anakuja *kumhudumia."*

members for their HIV positive relatives (Dilger 2010, 108). Simon also describes the use of kuhudumia when it comes to the provision of services, including in a hospital setting (Simon 2015, 136).

Different Swahili terms point to different semantics of care. Mzee Simon, for example, makes a difference between kutunza and kusaidia:

> Andrea: Do you have to care for the parents of your wife?
>
> Mzee Simon: Eeh maybe I would say I don't care for them like *care*, do you understand, in our culture I should care for my parents, there (at the wife's family's side) I only *give care/help* that is needed (meaning money) and I am glad that the grandfather (the wife's father) has luck because he has his own children outside in the USA.[200] (Mzee Simon 2012)

While some verbs are used to make claims (such as kusaidia), others point to a close relationship between family members (kuangalia), to self-care activities (kujitunza), or a service provided by the state (kuhudumia). Some are more attached to emotions and moral obligations than others. Some of the verbs can also be used in combination, as mentioned by Simon who emphasizes that, for his research context (Rufiji, Tanzania), he used a combination of helping (kusaidia) somebody to care (kuhudumia, kuangalia, kutunza) (Simon 2015, 136).

The above-mentioned Swahili terms cannot be fully separated from each other and may encompass different activities for different study participants. Also, the list of Swahili terms does not claim to be complete, there are other definitions which were, however, less relevant in the context of this study.[201] Dilger for example, also discusses another verb, *kujali*, which points more to the quality of care that people receive in his research context (Dilger 2010). Kujali was not much used in my research context. Simon also mentions a further expression, *kusindikiza*, which can be translated as to accompany somebody (Simon 2015, 136); also to accompany or escort somebody when getting out of the house.

Also, the English term "care" has different semantics, and some of the literature prefers the use of "nurturing" (Robbins 2013b) or "nursing" (Dilger 2010) to attain a more detailed description of specific activities. The term care, however, encompasses much more, which in German would be circumscribed, amongst others, as *Zuwendung*, *Anteilnahme*, *Versorgung*, *Mitmenschlichkeit, Verantwortung*, *Hausarbeit*, *Pflege* (Schnabl 2005, 16). In German, care is most commonly translated into *Fürsorge*. The term Fürsorge points to two meanings of *Sorge*, namely "sorgen für;" to care for somebody or something and "sich sorgen um;" to care about somebody or something. In Latin, these two

---

[200] Elisha (translating Andrea's question): "Anauliza unawatunza wazazi wa mkeo?" Mzee Simon: "Eee labda niseme simtunzi kama kutunza hiyo, nisiseme unafahamu tamaduni za kweetu inatakiwa mimi nitunze upande wa wazee wa kwangu huko nitoe tu msaada unapohitajika ee na nashukuru Babu huyo anabaraka moja ni kwamba ana watoto wake wako nje huko wapo umarekani…"

[201] A search within my interview transcripts in MAXQDA is nevertheless telling since the verb kusaidia gets more than 600 hits, while kuangalia gets around 200 hits, followed by kutunza with 70 hits and kuhudumia with 30 hits.

dimensions can be described by "cura" (care) and "sollicitudo" (solicitude, worry) (Schnabl 2005, 16-17).

Although it is important to analyze the different meanings of the term care, my aim is to approach these terms rather empirically in this part, without presuming particular care categories. While the care that older study participants in this study received or gave to others and themselves was sometimes financial, physical, emotional, material, and so forth, I deliberately do not use predefined categories when describing care practices. I do so because care usually has several dimensions simultaneously (for example, providing financial means for an older person can, at the same time, be a gesture of emotional attachment), and thus categorizing them would be misleading. Nevertheless, when possible, I try to be precise by describing different "forms" of care that I encountered.

As mirrored in the Swahili semantics above, Kleinman and van der Geest point out: care has multiple meanings (Kleinman and Geest 2009, 159). The authors nevertheless distinguish between two elements of it, namely an emotional and technical or practical element.[202] While the practical side of care is about executing activities for others who cannot do them on their own, the emotional side of care is about "concern, dedication, and attachment" (Kleinman and Geest 2009, 159). Pointing to an emotional aspect of care, for Tronto, "[s]emantically, care derives from an association with the notion of burden" (Tronto 1993, 103). Care is thus linked to accepting a burden. However, linking care to a burden leads us to the question about when care starts. Does it start with the "clinical ethical act of acknowledging the situation of the sufferer …" (Kleinman and Geest 2009, 163), meaning the burden? Or is it rather a subtle transition, particularly in contexts where only few people have a clinical diagnosis. Especially when looking at aging as a process, frailty does not set in from one day to the next and may require increasing support, which may at some point become what would be call care here. We will see later in this part that care has much to do with physicality; who provides care for whom, and from which moment in time care is needed depends much on the (aging) body.[203]

Furthermore, some of the activities involved may not be circumscribed by using "care" (when talking about them) but seem rather self-evident actions that are done for the older person in the household—already before they turn sixty. When we asked (by using the homecare tool described earlier) about who cooks or cleans the floor, these activities were not always perceived as being part of the care giving "package" and could also be performed by paid household helpers. It is therefore clear that the

[202] While their thoughts mainly target care in hospital settings, in my view, their ideas can also be applied to home care in private settings.

[203] Following Mol, I do not strictly distinguish between care and cure, since both may overlap. Or, in Mol's words: "In practice, after all, the activities categorised as 'care' and 'cure' overlap. (Caring) food and (curing) drugs may have similar effects on a body" (Mol 2008, 1).

analytical concept of care does not always conform with the emic perceptions of it. Coming back to Kleinman and van der Geest's distinction between emotional and technical, or practical, elements of care, while emotional parts usually cannot easily be transferred to others, technical aspects may also be conducted by household helpers (for example, cooking, cleaning, buying food). However, there are also some technical parts that necessitate emotional attachment, for example, when it comes to intimate care (such as accompanying a parent to the health facility or to visit somebody, or helping with bathing or going to the toilet). Talking with older people about care by use of the above-mentioned Swahili terms opened my eyes, to more critically reflect on what care means, for whom, and which expectations are linked with it, while then mirroring these conversations again with my observations during the days we spent with the research participants.

Care can be provided and received in different settings. While much work focused on care provided in hospital settings (cf. Kleinman and Geest 2009; Mol, Moser, and Pols 2010), in this study, I focus mainly on care that older people receive or provide in their private homes.[204] It is a form of "informal care" described by van der Geest as being "carried out in the context of family life" where "emotions, concern and personalized reciprocity" form an important part as opposed to care in a medical setting (Geest 2010, 6).[205]

Tronto developed four interconnected phases of care, namely "caring about," "taking care of," "care-giving," and "care-receiving" (Tronto 1993, 106). These interconnected phases necessitate different people and activities. The person who is caring about somebody is not necessarily the same who is involved in the actual care giving. In this connection, gender, race, or class dimensions of care also become visible. As Tronto claims "I think we come closer to the reality when we say: caring about, and taking care of, are the duties of the powerful. Care-giving and care-receiving are left to the less powerful" (Tronto 1993, 114).[206] Hence, the (emotional) parts of caring about or taking care might

[204] Although some forms of institutional care can be found in Tanzania in forms of clubs, associations, self-help groups, non-government organizations, and particular (faith-based) care institutions (cf. Eeuwijk 2014, 45-46), in my research settings I did not come across such groups particularly designed for older people.

[205] In his article van der Geest points to what he calls a "gulf between technical skill and 'true care,'" whereas in medical settings "true care" seems to be missing. He rightly asks if then, "good care" should always involve emotional care and points out that professional health care should not be compared to family-based care with the same quality requirements (Geest 2010, 6).

[206] Although Tronto has been criticized for simplifying much about power relations (and gender) in care giving and care receiving, I cite her here to point to the fact that care for an older person may involve more than one caregiver, especially when family members are scattered across different localities. Tronto uses a moral psychological approach to care and developed a four-stage concept of care which was a ground-breaking contribution to care several years ago (Critical reflections about Tronto derive from a personal conversation with Peter van Eeuwijk).

involve sending money for somebody to conduct practical tasks of care giving.[207] Especially, when those providing financial means for care do not live in the same locality (as for example children in the USA) as the ones involved in the practicalities of care, care can be provided within a complex network of caregivers and care receivers, where also communication about care becomes crucial (cf. Part IV).

In this PhD thesis, two spaces of care will be distinguished analytically; the (related) others[208] and the self. As mentioned at the beginning, not only the state or international discourses provide guiding structures for care giving in old age, norms and values based on kinship are also involved. Ideas about relational care can thus be colored normatively, by who is supposed to do what. While this will be addressed briefly in an initial chapter, I am much more concerned with describing and analyzing what actually happens on the ground when relational care is needed, drawing on information gathered through participating and observing. The stories of older study participants presented later in this part will reveal that much of the relational care is very much shaped by bodily experiences related to becoming or being old and provided with a considerable amount of flexibility. Unlike the international gerontological discourse (that promote autonomy and independence in old age), the self-care that will be described in more details below, is more about taking others into account in order to take decisions on how to best care for oneself. Hence, relational care and the self-care are both strongly shaped by how the older person perceives his or her own body and needs and how others perceive the older person's aging body and needs. Through the many stories of older study participants, I hope to show the additional value when looking at how care is actually enacted—with all the flexibility and constant adaptations it needs over time.[209]

Relational care that happens in the private setting in old age is usually provided by a younger and/or healthier person (an adult child, a spouse, a member of the extended family) to the (older) person in need. Kleinman and van der Geest describe this form of care giving as "an interpersonal experience; it is concern and compassion, and, in a large sense, love" (Kleinman and Geest 2009, 161). It is thus a relational form of care that is exchanged between two or more people as opposed to care that is provided for oneself. Similar to de Klerk I will speak of "relational care" when pointing to "care in and for social relations" (Klerk 2011, 11). For de Klerk, "[c]are is both the object and the subject of social

---

[207] Van der Geest describes the "monetisation of life" (Geest 2002, 18) as a development that he witnessed in his research context. He points out that remitting money can be seen as a form of emotional care: "Material provisions and money are emotional expressions, proof of loving care" (Geest 2002, 28).

[208] In this PhD thesis, I talk about relational care, as to distinguish care that is provided by others from care for oneself. Relational not only implies care through relatives but, in a wider sense, care that is provided within social relations. Thus, in my understanding, also a neighbor can provide relational care to an older person.

[209] In his article on "respect and reciprocity" van der Geest distinguishes four questions about care that also influence reflections of this chapter: 1) the kind of care that people receive, 2) who is/are the person/s providing care, 3) on what basis is care provided, and 4) how care provision changed over time (Geest 2002).

relations; through social relations care is provided, while at the same time through care social relations are intrinsically produced" (Klerk 2011, 164). The engagements in building care relations do not stop in old age, but have to be actively shaped by both, the care receiver and the caregiver.[210]

De Klerk's remarks come close to what is termed "new kinship studies," which put relatedness forward, namely, that it is rather about the "lived experience of relatedness" than taking kinship for granted (Carsten 2000, 1). In this sense, the new kinship debate replaces kinship with relatedness, that can be understood as "[t]he ways in which people create similarity or difference between themselves and others" (Carsten 2004, 82). Based on Carsten's concept of relatedness, Howell emphasizes that relatedness is the result of the practice of kinning, while nurture (care) is seen as one possible practice of kinning (Howell 2006, 9). Hence, social relations are formed or reinforced through bodily practices of care, as, for example, by a son who helps his father to shower or a daughter who supports her mother in washing her clothes—and, very importantly by the older person's agency in shaping these care relations. It is important, however, to emphasize that "[t]he *web of kinship*, of which Meyer Fortes spoke so vividly, consists of a great number of possible relationships" (emphasis in original, Alber, Häberlein, and Martin 2010, 45). Alber et al. also underline the importance of not perceiving kinship as a "system," but to observe the structuring principles of kinship in daily practices (Alber, Häberlein, and Martin 2010, 46). In doing so, the authors do not make a difference in terminology between kin group and family, as they claim it is much more important to look at concrete practices "without implying any categorical difference between family and kin group" (Alber, Häberlein, and Martin 2010, 46).[211] As mentioned above, I will follow their example.

I am aware of the criticism regarding the understanding of a "kinship system" that is considered as a "structural principle that endures for generations" (Alber, Häberlein, and Martin 2010, 46). In my understanding of agency, however, moral values such as reciprocity that are based on kinship are part of the structural or relational context of action of an elderly person, and thus likely to guide their actions—while, in turn, the actions may shape these contexts. Also Schnegg et al. emphasize that "every

---

[210] In this way, care can be seen as a social practice that shapes social relations, while at the same time it is based on cultural norms that structure these practices and thus form a context in which care takes place (see also, Eeuwijk 2014, 33-34).

[211] Many of these discussions lead back to earlier debates in the anthropology of kinship where, for example, Meyer Fortes (1969), as part of the group of British structural functionalists, pointed to the moral force of kinship, or Rodney Needham (1971), described as a "kinship skeptic," when criticizing kinship studies in anthropology for their lacking acknowledgment of heterogeneity and complexity, among other things (cf. Sousa 2003, 268-270).

nenegotiation and every creation of kinship takes place within the context of existing kin structures that can be confirmed or questioned through practices" (my translation, Schnegg et al. 2010, 13).[212]

I will show in this part of the PhD thesis that these contexts are usually referred to in the older people's narratives about who is supposed to care for them; however, at a later stage I will then show that, obviously, these rules are twisted and, in each case, applied to the current situation and abilities of the older person and the caregivers. When looking at these values from different angle, it becomes clear that care can also be used to invest in relations (i.e., when parents care for children when they are young in order to "get back" care when the parents become old and frail).

When care relations are not maintained, they run the risk rupturing in a process of de-kinning (Schnegg et al. 2010, 24). Also, a care burden that becomes too heavy may lead to and break apart social relations. "([N]on-) compliance with care obligations," depends therefore "on the quality of social, cultural, emotional and psychological relations between the members of each generation" (Eeuwijk 2014, 36). While for most of the study participants at least some amount of care (mostly intergenerational) seemed to be provided by applying a certain amount of flexibility, it is important to emphasize here that there are also neglected older people who cannot base their needs on relationships to negotiate care (cf. for example, Klerk 2016).

Almost universally, the central social actors involved in old age care are adult children.[213] Van der Geest confirms the importance of care-giving children in his study in rural Ghana: "Children have by now become the only solid basis for social security in old age. Children are the only ones from whom one may expect continuous care" (Geest 2002, 20). In Tanzania, too, adult children are expected to care in fulfilment of their reciprocal duties. Or, as van Eeuwijk describes for the Tanzanian and Indonesian context; "[t]his image and imagination is a distinct expression of complying with the normative cultural requirements of filial piety" (Eeuwijk 2014, 48). The National Aging Policy of Tanzania (URT Ministry of Labour 2003) is based on the premise that it is the children's duty to care for older parents. While in the rural areas, studies have shown that at least some of the children usually lived far from their parents, and were thus less involved in the physical aspects of care (cf. Büsch 2014; Simon 2015), the city often represents quite a luxury context for older people in that many have the possibility residing

---

[212] "Jedes Aushandeln und jede Schaffung von Verwandtschaft finden vor dem Hintergrund bestehender verwandtschaftlicher Strukturen statt, die durch die Praxis bestätigt oder in Frage gestellt werden" (Schnegg et al. 2010, 13).

[213] When speaking of adult "children," I always mean biological children as well as others that are described as children (i.e., grandchildren, nieces, nephews but also adopted or fostered children). Hence, I use the term children in a broad sense, as was done by the study participants, depending on the lived relationships of older people and these "children."

(geographically) close to their children. However, van der Geest rightly also highlights that there is no certainty that children will provide care (Geest 2002, 20) and fulfill their reciprocal duties.

Van der Geest emphasizes that, in the Ghanaian context, respect for and care of older people depends on reciprocity (Geest 2002, 26). Reynolds Whyte et al. term reciprocity as the "most important quality of intergenerational relationships" (Reynolds Whyte, Alber, and Geest 2008, 6). Reciprocity can be described as the "mutual dependence expressed in give and take over time," often these exchanges are not direct but "indirect or generalized" (Reynolds Whyte, Alber, and Geest 2008, 6). In their introductory chapter, Reynolds Whyte et al. point out two characteristics of reciprocity, namely the "transmission of resources" and its connection to "assumptions about morality" (Reynolds Whyte, Alber, and Geest 2008, 6).

The "intergenerational contract" can be described on a normative level as "the implicit expectation that parents will care for their children until they can care for themselves, and that children will support their parents when they can no longer support themselves" (Reynolds Whyte, Alber, and Geest 2008, 7). Hence it is about what is culturally and morally acceptable between generations. I will discuss later in this part that although some children may be responsible for parental care, they might not be in the position to provide it (financially but also physically) and some may thus "invert" the generational contract by remaining dependent on their parents (cf. Roth 2008). While departing from generational contracts leads to a rather static grasp of care relations, I opt for an approach that analyzes these rather normative kinship obligations, but also takes into account the very flexible and fluid ways of how people actually cope with those "rules" in their daily lives (cf. Miller 2007). Hence, older people draw on past experiences and existing norms and values when describing how things should be with regard to care obligations, at the same time, however, due to changing situations regarding their health condition but also owing to the context of the city, they sometimes have to pragmatically adapt these "rules."

Although in this research context, adult children are perceived as the ideal caregiver (according to local kinship norms and the national policy), often those who take care of an older person are those who happen to be around and capable of doing so; these are not necessarily children, but usually other relatives or even neighbors, friends, and members of church groups. Emerging church groups as support systems for sick persons were especially looked at in connection to HIV/AIDS and home-based care services provided by those institutions. Through the new communities, new forms of relatedness and belonging emerge (Schnegg et al. 2010, 35). In a comparative study on religion and old age care in Indonesia and Tanzania, van Eeuwijk also describes that "… faith-based organizations, having their own tight networks on different societal levels, provide their members with direct support, whether by material, financial, emotional, medical, or care assistance" (Eeuwijk 2017, 97). Those caregivers are usually part of a "generalized asymmetrical reciprocity" (Baldassar and Merla 2014a, 8-9), involving more actors than only parents and children (cf. Part IV).

Van der Geest rightly observes that "[c]are is often managed on a day-to-day basis, with considerable improvisation" (Geest 2002, 24). Especially when children live in other parts of Tanzania or abroad, physical care tasks are left to the family members (and/or household helpers) who happen to be around. However, it is important to point out that care for older people, although flexibly adapted, is at the same time very much gendered and cannot be provided by just anyone, but in accordance with some basic cultural and social norms.

We will see later in this PhD thesis that for certain care activities gender may become important. But gender not only plays a role in concrete care activities, also when it comes to claiming care. As mentioned above, not only older men owned houses but also most of the elderly women. Although many elderly men stayed with their spouses and were thus cared for, elderly women used their strong financial position to formulate claims about care (cf. Part II).

Spouses have a greater field of possibilities in caring for their husband or wife by performing care tasks that cannot be performed between mixed genders (as for example intimate tasks such as bathing). The mentioned care provided by spouses can be described as an "intra-generational" form of care, provided by and for members within the same generation. According to van Eeuwijk, these care relations are very much marked by the "'caregiving wife—care receiving husband' arrangement," but can also be observed between elderly siblings (Eeuwijk 2014, 36).[214]

Especially when we focus on intimate care in the Tanzanian context, this form of care can only be provided by close kin (as for example, from spouse to spouse, from daughter to mother, from son to father). Therefore, depending on the older person's health condition that necessitates support in performing intimate care tasks, close ties to related others become even more important. Much of the literature on care misses out on these intimate aspects of care. Care is something that is experienced through the body. It is also the body that is used to formulate claims about care. In their chapter on "Becoming Old and Frail in Coastal Tanzania," Obrist and van Eeuwijk emphasized that older people expressed their becoming frail by the term *nguvu*[215]. Also, when it comes to older people in Dar es Salaam, they refer to no longer having sufficient strength (*sina nguvu*) to cope with their daily activities.

[214] Not many of the older study participants lived as couples. Most of the older women of this sample had lost their husbands due to advanced age and/or illness. In van der Geest's study on older people's care in Ghana, he observed that many older people were divorced when becoming old and frail (Geest 2002, 22); also in the city of Zanzibar, divorce in old age seemed common (according to a personal conversation with Sandra Staudacher), a phenomenon that did not seem to be very prominent in my research area.

[215] The Swahili word *nguvu* can be translated as strength, power, and also energy. As will be shown later in the text, older people often referred to their strength in connection with old age and their abilities in connection with their physical conditions.

In her study on old age care in the Kagera region of Tanzania, de Klerk found that emotional struggles are usually also expressed by talking about bodily weakness (Klerk 2011, 4). The author furthermore claims that "the body as a site for *experiences* of old age is relatively under-examined" in studies on aging in Africa (emphasis in original, Klerk 2011, 9). The body is important in care giving and receiving, since "[c]are is about spaces for touching, presence and closeness" (Klerk 2011, 11). By using an embodiment perspective, Obrist also points out that especially older people experiencing a "critical health moment," when old age, illness, and disability restrain them from following their daily routine, become aware of their loss of strength (Obrist 2016, 96).

The discussion around physicality reveals that care is not so much a concern of the caregiver but much more of the care receiver. This PhD thesis therefore also focuses mainly on the perspective of the older people themselves. Mol et al., focusing on a hospital setting, bring in this aspect of care by saying: "Far from just 'receiving' care, patients actively attend to their symptoms, swallow their pills, follow their diets, and so on" (Mol, Moser, and Pols 2010, 9). Therefore, the authors emphasize that the term "patient" is rather misleading as it gives the care receiver a rather passive role. Also, older people, when cared for in public and private settings, are much more than passive "objects" of care. By articulating their concerns and wishes about the care they ought be receiving as well as through their practices, they actively engage in and shape the care relationship.

Care is not only provided by others but also for oneself. While most studies focusing on old age care in Africa point to social relations that enable or constrain care giving and receiving, they often miss out the care that is provided for oneself. At the same time, gerontological studies on aging in the Global North, focus more on self-care and autonomy. With the discourse on "active aging" or "successful aging," WHO and others promote looking after oneself in old age. While remaining healthy until the end of your life, you will be able to remain independent and able to care for yourself, without being a burden to your children. And if you need social interactions, you can also enjoy them with your peers—best when doing physical or mental exercises together. In what follows I will discuss these gerontological concepts connected to self-care in old age and later introduce the concept of "everyday self-care."

Together with national policies in Tanzania, these international discourses on aging that "flow" globally, form a complex context in which the participants of this study are asked to take decisions on how they wish to become old. In his article on HIV/AIDS in the era of globalization in Tanzania, Dilger nicely describes the different national and international concepts and practices at stake. The structural adjustment policies of the late 1970s led to a "growing fragmentation and privatization of Tanzania's health care system" (Dilger 2012, 65). What Dilger then describes for the context of HIV/AIDS also holds true for other international NGOs forwarding empowerment approaches. These empowerment

approaches expect people to apply what Dilger calls "technologies of the self," basing his conceptual framing on Foucault (1988).[216]

Dilger then points out that especially in the rural area where he worked, these self-care aspects became less relevant, but behaviors towards health "were also rooted in the logics of community and kinship politics and in the moral, cultural, and religious priorities that people had with regard to the persistence of social relationships in and beyond the context of death and suffering" (Dilger 2012, 83). Therefore, "there may be significant gaps between the ways in which the 'empowered individuals' of transnationally designed health programs …, on the one hand, and people who perceive of themselves mainly as members of kinship- and other community-based networks, on the other, conceive of illness and well-being …" (Dilger 2012, 82). One of my aims in the following text is therefore to discuss to what extent older people engage in everyday self-care, as promoted by international discourses and medical doctors, while at the same time engage in forms of relational care, as members of a social network.

At first, however, I will describe the prevalent international discourses concerning aging noticeable in the Tanzanian urban context: Trying to mitigate the megatrends of global aging, international gerontologists opt for concepts such as "successful aging" (Rowe and Kahn 1997), "active aging" (WHO 2002), or "healthy aging" (WHO 2005) in order to bring in health promotion and illness prevention in old age. Since the 1990s, perceptions on aging are less closely linked to death, but to what the authors of a book called "Generation Ageless," Clurman and Smith, describe as the "continuing, emphatic engagement with life" (Clurman and Smith 2007)[217]. The active aging campaign of the WHO contributed to this shift as did the Action Plan EU 2007 "Ageing Well in the Information Society" (Sokolovsky 2009, xvii). With the term "successful aging" (American) core values of activity, future orientation, and autonomy were brought together with aging (Rowe and Kahn 1997). Rowe and Kahn base their book on a study carried out by the MacArthur Foundation in order to "develop the conceptual basis of a 'new gerontology'" (Rowe and Kahn 1997, xii). With their book, they contributed to a shift in focus from "treating disease to preventing disease" and distinguished between "usual" and

[216] Foucault describes technologies of the self "… which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault 1988, 18). Foucault was interested in the technologies of the self in order to study sexuality, and he distinguished four different technologies (technologies of production, of sign systems, of power and of the self). His main focus, however, was on the technologies of the self, in which he studied sources focusing on pagan and early Christian practice (c.f., Foucault 1988). Although used in another context, Foucault's description of the technologies of the self seems useful here to emphasize an empowerment approach to self-care.

[217] The electronic book by Clurman and Smith, who lead a company providing marketing consulting services in the USA, is unpaginated, the quotation comes from the introduction to the book.

"successful" aging, by underlining "the potential empowerment of the individuals" (Bülow and Söderqvist 2014, 141).

In the introduction to a book on "Successful Aging as a Contemporary Obsession," Lamb, et al. distinguish four common themes relevant to the successful aging discourse, namely individual agency and control, independence, productive activity, and permanent personhood (cf. Lamb, Robbins-Ruszkowski, and Corwin 2017) and call for a critical reflection on the pressure they put on older people. Others, such as the philosopher Moody, also caution against this "individualistic, activity-oriented and future-oriented approach of successful aging" which in his eyes becomes an "uncritical kind of cultural blindness" (Moody 2009, 70). While especially in the United States, the discussion is centered on successful aging, on a global scale the WHO (2002) came up with their policy framework on "active aging." For them "active ageing is the process of optimizing opportunities for health, participation and security in order to enhance quality of life as people age" (WHO 2002, 12). Thus, apart from general well-being (physical, social, and mental), protection, security, and care are also important components for a good way of getting old. In addition, autonomy and independence, but at the same time interdependence and intergenerational solidarity, make up the framework.

The term self-care, which forms an important part of these aging discourses, is to a great extent coined by the policy discourse of the WHO. Their oldest definition of self-care dates back to 1983 and describes self-care as follows:

> Self-care in health refers to the activities individuals, families and communities undertake with the intention of enhancing health, preventing disease, limiting illness, and restoring health. These activities are derived from knowledge and skills from the pool of both professional and lay experience. They are undertaken by lay people on their own behalf, either separately or in participative collaboration with professionals. (WHO 1983, 2)

Also, in their revised definition of 2009, WHO promotes self-care as the "key strategy for health promotion and disease prevention" (WHO 2009, 1).[218] At the same time they emphasize self-care at various levels; national and subnational, community, family and individuals, and institutions for self-care promotion (WHO 2009, 18). In the WHO definitions of self-care,[219] the concept has an

---

[218] The exact wording of the revised definition reads as follows: "Self-care is the ability of individuals, families and communities to promote health, prevent disease, and maintain health and to cope with illness and disability with or without the support of a health-care provider" (WHO 2009, 18).

[219] According to Webber et al. (2013, 102) there are three relevant definitions of WHO. While the earliest definition from 1983 and the latest definition from 2009 are already mentioned in the text, the third definition from 1998 is the most specific: "Self-care is what people do for themselves to establish and maintain health, prevent and deal with illness. It is a broad concept encompassing: hygiene (general and personal); nutrition (type and quality of food eaten); lifestyle (sporting activities, leisure etc.); environmental factors (living conditions, social habits, etc.); socioeconomic factors (income level, cultural beliefs, etc.); self-medication" (WHO 1998, 2).

educational and empowering component (WHO 2009, 2) and mostly targets healthy people (Webber, Guo, and Mann 2013, 103).

Self-care is often used synonymously with self-medication, and much linked to self-reliance, as it outlined in the WHO policy on Primary Health Care (Geest 1987, 294). Hence, if access to medical care becomes difficult, self-medication might be one of the first strategies for people to get better.[220] Thus, self-care points more to a kind of "do-it-yourself" phenomenon (Levin 1977, 116). Furthermore, the above-mentioned definitions of self-care by the WHO indicate a rather narrow understanding of medically oriented self-care as they seem to fade out the fact that, for some older people, self-care might just be the only option they have as no one is there to take over their care (Hickey, Dean, and Holstein 1986, 1368).

Especially anthropologists call for a critical reflection on how culture and ideology silently coin the above described international gerontological discourse on aging and self-care (Lamb 2014, 42). It is therefore important to question what, for example, "success" means to different disciplines (Bülow and Söderqvist 2014, 148) but also to different people in different contexts. In the following section, I will explore how older study participants themselves perceive a "successful" or "good" way of getting old when engaging in practices of self-care. Lamb, for example, describes in her article how Indian gerontologists promote the care of the "individual self" as a form of social security or self-reliance for people in old age, because the support provided by relatives and the government is perceived to be insufficient (Lamb 2013, 76).

In this PhD thesis, I do not speak of "self-care" in the narrow sense of the term, since, in order to care for one's own health, the older study participants do not only listen to medical doctors, but also to relatives, neighbors, friends, and other sources such as radio broadcasts or newspaper articles. As described above, self-care very much targets empowered individuals who autonomously take action in the hope of preventing disease and death. Furthermore, the definitions around self-care are more focused on a rather narrow understanding of health, while I would like to look at it in a much broader sense.

The understanding of what people do for themselves in old age derives from the emic use of the Swahili verb *kujitunza*. As mentioned earlier, kutunza can be translated as to care, to provide for, to protect, and to maintain. The reflexive *-ji-* prefix adds the dimension for oneself.[221] Starting from the use of the

---

[220] See van der Geest's text on "Self-care and the informal sale of drugs in South Cameroon" where he looks at self-medication with Western pharmaceuticals in South Cameroon (Geest 1987).

[221] See also Kaiser (2020) where the discussion of the emic use of the verb kujitunza was also taken up, as well as Mzee Dunfords' story that will be discussed later in this text with regard to everyday self-care.

word by the participants of this research project, my take on self-care is broader than the WHO definitions. In this PhD thesis, not only activities targeting directly an improvement of physical health are looked at but also other practices that are beneficial to an older person's wellbeing and thus to a way of aging well (in Swahili, kuzeeka vizuri). In order to relate to the WHO definitions but also to point to a broader understanding of the term, I will consequently call the practices "everyday self-care."[222] Nevertheless, with a focus on the middle-income milieu, these practices mainly look towards the future, while they imply certain possibilities of caring for oneself, not out of pure necessity but as an investment in future health and well-being.

On this broader level, subjectivity is shaped by cultural formations. Later in the text, ethnographic insights will reveal that especially in Dar es Salaam's "middle class," older people engage in health promoting activities in order to remain healthy in old age. They are thus oriented towards the future and wish to retain with a certain degree of *uhuru*[223], also in old age. For India, Lamb writes that older people live and shape new forms of aging. They do so by facing processes of "global" or "modern" living and aging while belonging to transnational families with members in the USA (Lamb 2009, 419). Comparably, in Tanzania, older people take up ideas that derive from exchanges with their children abroad. They tried to make sense of what they were told and integrated aspects of it into their daily aging practices. At the same time, information received from other sources (i.e., medical doctors, media, or social and church environment in Tanzania) played a role too.

Self-care practices of the former civil servants will be addressed later in this part. We will see that caring for oneself does not preclude relational care. Nevertheless, it is important to look at how it changes relational care provision; do they go hand in hand or do children pull back when an older person is taking care of himself or herself? Together they may form part of what is perceived by the older people as "good care." Mol et al. also refer to "good care" which for them means the "persistent tinkering in a world full of complex ambivalence and shifting tensions" (Mol, Moser, and Pols 2010, 14). Of course there are always different "goods" and care thus "implies a negotiation about how different goods might coexist in a given, specific, local practice" (Mol, Moser, and Pols 2010, 13)—while in some cases care is lacking and good care remains wishful thinking.

[222] I use the word everyday not to point to the past and to monotony (Lefebvre and Levich 1987, 9) but rather to everyday practices that are sometimes unspectacular and unquestioned in the everyday life of older people.

[223] The Swahili word *uhuru* can be translated as freedom but also as independence. The word is used in several instances in connection with Tanzania's independence from colonial rule. Independence Day is locally called "uhuru day" and the "uhuru torch" is one of the national symbols of Tanzania.

On Relational Care

In the following sub-chapters, relational care will be explored. By calling it relational care I point to care that is provided by others within the web of social relations. Relational care can at the same time result from cultivated social relations (i.e., between parents and children), but can also be created or formed by new social relations developed through lived care practices. First, I will present some of the older people's narratives about how care is supposed to be provided and by whom. Older people and their relatives base their perceptions hereby on normative ideas about kinship, gender, religion, and ethnic belonging. These highly normative ideas on how care is supposed to be provided can be understood as contexts of action that may guide how older people act.

In a following chapter, the nguvu of older people is addressed, since the older person's physical condition proved to be important for the provision of care by others. The condition of an older person but also how this condition was interpreted triggered the willingness to provide and accept care in old age. The two chapters following serve as an introduction to a discussion of different care practices and arrangements and their dynamic adaptation over time shaped by older peoples' health conditions.

Findings from this section on relational care draw not only on data gathered in the former civil servants' milieu of Ada Estate but also on results from the base-line study that included the other three sub-wards (Ilala Mafurko, Azimio Kichangani and Manzese Mnazi Mmoja).

Older People's Narratives About "Good Care"

> Mzee Rajani: *Bima ya afya* [health insurance], is… we are covered by our children
>
> Elisha: Ah you are using the children's bima ya afya?
>
> Mzee Rajani: Haha no I call them bima ya afya because they support me
>
> Andrea: Like a pension!
>
> Mzee Rajani: Hahaha… they are my pension, [my] bima ya afya...
>
> (Mzee Rajani 2012)

As mentioned in the introductory chapter to old age care, in the older study participants' view, adult children are supposed to care for parents in old age. However, they base their explanations of why this is so on different contexts of action.[224] In most cases it seemed very naïve for me to ask the question,

---

[224] As mentioned in the introduction, Emirbayer and Goodwin distinguish three structural or relational contexts of action: a cultural, a social-structural and a social-psychological context of action. Human agency is then defined as "the *engagement* by actors of their different contexts of action, an engagement that both reproduces and transforms those structures in interactive response to the problems posed by changing historical situations" (emphasis in original,

why specifically adult children are supposed to care for their parents, as for the older study participants this was a self-evident fact, so that speaking about it led to different explanations with regard to answering my question. This chapter is concerned with the normative ideas of the older study participants and their caregivers about who is (theoretically) supposed to care for older people. Although, this is not the main focus of this part, I think it is important to capture their narratives about how they envision good care in old age and look at their frames of references they base their expectations on.

Some older study participants explained that receiving care in old age depends on the "heart" of the adult children. After raising them and making sure that they get a good education, in the end it depends on the willingness of the children whether you as a parent will be supported in old age. Mzee Rajani, who illuminated this fact further at the start of this chapter, elaborated that he was lucky since his children agreed to care of him and his wife. However, he claimed that he knew cases of older people in his social environment who did not receive the expected support since the children were much more interested in improving their own livelihoods by investing in cars and houses while neglecting their parents. De Klerk also discusses the neglect of older people in Kagera, Tanzania, when older people would call a caregiver who does not provide the expected care as a person with a *roho mbaya*[225] (Klerk 2016, 138). Mzee Rajani claimed that as a parent you can build the basis, however, the actual relational care you will receive depends on many other aspects.[226]

Especially in the former civil servants' milieu of Ada Estate, some older study participants told their children that they can still rely on themselves and hence do not need much support from their children. Some mentioned that they do so in order not to burden the children. These older people were usually rather young old people (between sixty and seventy) and still able not only to support themselves financially, but they are also in a relatively good shape healthwise, so that they do not depend on any help when conducting their daily activities, and are thus in a rather privileged position in terms of self-care. Mzee Mohamad from Ada Estate, for example, claimed that in the future he does not expect to become frail so that he would need physical support from his children or his wife. Furthermore, he explained that with his pension (which was rather high in comparison to what other study participants earned), his small income generating activity (selling milk from his three cows) and the income through rents, he would be able to sustain himself also in the future. Former entrepreneur Mzee Mbujuni from

---

Emirbayer and Goodwin 1996, 371). I will use their language and consequently call the different structuring environments that people draw on "contexts of action."

[225] In English, a bad heart or soul.

[226] The Mzee's explanation reminds of van der Geest's descriptions about care in old age that is based on respect (cf. Geest 2002).

Ada Estate believed that his children were currently not supporting him financially because they thought their father was rich. In addition, Mzee Mbujuni who has his own church, invested a lot of money in his religious activities—to the dislike of his children. However, he was sure that once he needed their support, they would be there for him. He explained this expectation by saying that they were all well-educated and earned enough money to support their parents, at least financially.

As mentioned above, many of the study participants in Ada Estate were still in good health and did not need more practical elements of care. Therefore, in the sub-ward, questions around care by children mainly concerned financial support. However, when talking to the study participants about their future as eventually frail older people, most of them uttered expectations towards their children: the children would take care of them once they were in need of practical care and technical support.

Talking to the participants of this study about expected care in different milieus revealed that older people from different milieus greatly valued financial support in old age. The financial support was usually directly connected to emotional forms of care because older people considered giving money as a way for children to show their concern about their parents. When, for example, we asked them about their (three) most important care givers, they usually considered those children or relatives that providing them with regular financial support to be more important than those at home taking over the practical tasks that I would (analytically) describe as care work, too. Yet, there might have been a bias when using the Swahili translation for the word care or caregiver as this usually leads to answers that mainly target financial forms of help (in the sense of kusaidia). A rather exceptional answer came from Mzee Dunford, who pointed to the importance of his household helper instead of mentioning his children, who provided for him financially:

> Andrea: In your old age, who would you consider the two or three most important people in your surrounding who help you in old age?
>
> Mzee Dunford (translated by Elisha): For now, it is the household helper because she is cooking for me and does the cleaning of the house and other activities around, but my clothes I wash himself. The household helper is very important because she is cooking and does all activities around the house and even to go to buy some stuff.
>
> Elisha: Does she know the kind of food which you are eating?
>
> Mzee Dunford: She knows what kind of food I am eating. She goes to buy maize and wheat and mix together so as to get flour she knows what I need.[227]
>
> (Mzee Dunford 2013)

[227] Elisha: "Katika maisha yako ya uzeeni ni mtu gani ambae yuko karibu na wewe na wamuhimu kukusaidia katika maisha yako ya sasa, wanaweza kuwa wawili au watatu?" Mzee Dunford: "Kwa sasa hivi ni mfanyakazi wa kupika na usafi hapa ndani kufua nguo zangu nafua mwenyewe. Huyo mfanyakazi ni muhimu sana kwa mapishi na kumtuma kununua vitu flani." Elisha: "Anavijua vyakuala unavyotumia?" Mzee Dunford: "Anajua ninavyokula. Hwenda kununua mahindi na ngano na kusaga na anajua kuchanganya ambacho mimi nahitaji."

Accounts of lack of care were common especially in the less well-off sub-wards of this study. Older people explained that they based their expectations towards their children or grandchildren on reciprocal duties. Thus, they emphasized that they have raised their children and, as aging parents, they now expected to "get something back." Bibi Khadija from Kichangani, for example, raised ten grandchildren because her only son died early. Being ninety-five years old and slightly frail, she expected her grandchildren to "remember her," but they did not seem to care for her the way she imagined. They just gave her money for the Muslim festivities which was not enough in her view. She claimed: "The new generation of children, you just have to raise them [and once they grow older they do not really take care of you]"[228] (Bibi Khadija 2012). With her statement, she does not only refer to the reciprocal duty based on kinship, but also to the "new generation" that grew old in the urban environment, where in the view of many older people less respect is given to older people in general (cf. Part II). The conversation with Mzee Baraka from Manzese Mnazi Moja also revealed the expectations of reciprocal support between parents and children, triggered by the question whether Mzee Baraka supported his children:

> Andrea. And does he [Mzee Baraka] help them [the children] sometimes?
>
> Mzee Baraka. Where would they be today if I hadn't helped them?
>
> Elisha. Aaa so you helped them earlier and now you don't?
>
> Mzee Baraka. How should I help them, I don't have anything for myself.[229]
>
> (Mzee Baraka 2012)

Other older study participants, who did not get the support as imagined, did not complain but justified the lacking support by the difficult financial situation of their children.

As described above, the underlying ideas and ideals of care for older people were to a great extend based on kinship. As mentioned in the introductory chapter of this part, van der Geest described the same phenomenon when it comes to the parents' expectations towards their children in eastern Ghana: based on reciprocity, children are expected to provide continuous care in old age (Geest 2002, 20). I recall the mentioned "intergenerational contract" (cf. Roth 2008) that—on a normative level—describes the moral duties between children and parents. As mentioned above, of course these expectations do not only involve biological children but also, for example, foster children, where the same expectations towards a reciprocal care arrangement may exist. Bibi Helen from the former civil

---

[228] Bibi Khadija: "Watoto wa siku hizi si ndio maaana ulee tu."

[229] Andrea (translated by Elisha): "Eti wewe kuna wakati unaweza ukawasaidia wao?" Mzee Baraka: "Sasa walikuwaje kama sikuwasaidia mimi?" Elisha. "Aaa uliwasaidia zamani, kwa wakati huu hapana?" Mzee Baraka: "Nitawasaidia nini, mwenyewe sina."

servants' milieu in Ada Estate did not have children of her own but took care of her niece, while the niece's parents were away working in another region of Tanzania. By raising the child, she can later expect support from her niece. Hence, care in old age can be described as an "outcome of relations that had been built in a good manner over the course of a lifetime" (Klerk 2016, 145).

Some of the older study participants also emphasized that they could not expect support from all their children to the same extent. Bibi Hilda, for example, who had three daughters, explained that sons would support her more, but since her daughters did not earn much and had to make sure that their own families got enough support, she could not expect much financial help from them. However, at the same time, the quote from a conversation with Bibi Annette from the former civil servants' milieu in Ada Estate shows the increasing importance of daughters when it comes to parental care:

> …I think that is the tradition and customs in Africa that is how it is supposed to be and the word of God says: "Take care of your father and your mother so that you can have many years to live in this world!" So for someone who believes in that word he or she will take care of the parents to get that blessing but they can live somewhere else but still take care of you. It is not necessary to stay in the same house, but nowadays the daughters are taking better care of the house than boys. I don't know why because in the past we were thinking that male children were wealthier than girls but now things have changed. (Bibi Annette 2013)

Bibi Annette is thus pointing out that the way care is gendered has changed. Especially in the urban context, many young women earn their own money and thus become involved differently in caring for their parents. This aspect will be taken up again in Part IV when I discuss the involvement of children in the USA who provide transnational care for their parents.

Apart from the reciprocal duties among relatives, some of the older study participants also explained the support that should be provided to older people on the basis of religion. As my data mainly derives from the former civil servants' milieu, which is a mainly Christian milieu, I refer here primarily to Christian religious values that shape the expectations about care.[230] Here is an extract from a conversation with Bibi Veronica about old age homes and her feeling about older people living in these institutions. She emphasized that she did not consider old age homes a good solution for older people since it was the religious duty of children to look after their parents—instead of admitting them to institutions:

> What you are asking is good, as myself I do not agree to leave my parents to another place for care and I am here. Even if I do not have any food here inside, I will carry my parents, I watch them how they walk, even if it is to the toilet, I will take them … Eeh you see, and if I am at work another day … and yes, the word of God says respect your father and your mother … no other person can take care of your

[230] My colleague Sandra Staudacher, who conducted a similar study in Zanzibar city, found that many of her older study participants based their arguments on Muslim principles when it comes to the care of older people. In her text she describes the discursive formation that mothers have to be cared for three times more than fathers (Staudacher 2019a).

> father and mother, *jamani* no! Here you lose all the blessings. How would you know how your father left? Maybe I am at work, for example she [Andrea] is here and her father is there, this is another story, but I can't be there and come home and go to bed and eat and my father is cared for by somebody else at another place, no no no.[231] (Bibi Veronica 2013)

In Bibi Veronica's view, based on religious values, children have to respect their parents and are responsible for their care. Mzee Rajani from Ilala Mafuriko addressed respect as an important religious principle: "Because I supported my family, my parents … now God is paying me through my children. That is what the Bible says: Respect your parents as kids should respect their mother and father. Which means if you respect them also God will make your children supporting you" (Mzee Rajani 2012). Likewise, van Eeuwijk states that "among other bodies of conventions, religious norms, rules, and values also frame care relations" (Eeuwijk 2017, 83). The author also emphasizes that these religious norms, rules, and values "have an impact on the normative expectations of who should provide which care activities in elder care relations (and who should not do so)" (Eeuwijk 2017, 83). Therefore, again based on religious values, particular care activities might be expected to be provided by a particular person.

The religious values not only shaped expectations of older study participants about receiving care from their children, but were also used to explain why some care is lacking. And thus, some older people based their reasoning on religion when explaining that they were happy with what they got although it probably did not conform with ideas based on kinship. Bibi Ruth who was the main financial provider for her family, also used religious values to accept her situation and not ask for more. Bibi Ruth would then usually say *nipo tu*; meaning that she is "just here" and thus, God decides what he does with her. Van Eeuwijk found that older people in Tanzania and Indonesia perceived God and Allah as "explanatory model" for their destiny in old age. Religion can thus be described as "rich sources for the elderly … for giving meaning and reason to physical and mental conditions with uncertain outcomes and unclear expectations" in old age (Eeuwijk 2017, 96). Not only the lack of care can be explained by "God's will," but also ill-health and death.

As already emphasized in Part II, many of the older study participants belonged to the ethnic group of the *Wachagga*.[232] Traditionally the ethnic group was structured in a patrilineal way and inheritance was

---

[231] Bibi Veronica: "Hiyo kitu umeuliza kitu kizuri kabisa kama mimi sitakubali kumwacha mzee wangu apelekwe akalelewe kwingine na mimi nipo hata kama sina chakula humo ndani nitambeba mzee wangu nimwone anatembeaje hata kama ni chooni nampeleka nimpeleke ajisaidie amalize nimnawishe vizuri eeh, unaona eeh, kama niko kazini siku nyingine, na ndiyo maana … neno la Mungu linasema waheshimu baba yako na mama yako … uweze kuishi kama ni kufa wanifie mikononi mwangu siyo wafie kwa mtu … mtu mwengine atawezaje kunilelea baba yangu na mama yangu jamani no! Hapo ndiyo unakosa baraka zote. Ntajuaje baba yangu aliondokaje? Labda niko kazini, kwa mfano huyu yuko huku baba yake yuko kule hilo ni jambo jingine, lakini siyo niko pale pale narudi kitandani nalala chali eti baba yangu anahudumiwa na mtu mwingine kule, no no no."

[232] In Swahili *Wa*-chagga describes the group of Chagga people. In the following text, I will use the English denomination "Chagga" to describe members of the ethnic group, as was done by the research participants. The Chagga ethnic group only began to develop a common identity during colonial time, before it was a rather loose

only possible over the male family line (Jensen 1998, 188). Many of the study participants often pointed to the "Chagga care arrangement" when talking about who is supposed to provide care. This arrangement will be used here as an example for a particular arrangement of elder care, although it seems to have lost some of its relevance in the city. The "traditional way" of caring for parents described by the study participants obligates the last-born son of a family to remain in the parents' home and care for them until the moment he inherits the house and buries the parents on their land. As mentioned above, while older children move out of the parental home once they get married, the youngest son brings his wife to the parent's home in order to support them later on.

Yacinta, whom I met in the USA, explained the idea of the youngest son taking over responsibility of parental care:

> … For our culture the most [important] thing I see is like for example we are six [children] right and we have one brother so my brother will be more responsible to take care of my parents because he is a man so he has to be close to the parents because he is going to inherit everything like the house, cattle and everything so he had to take care of them. So most I don't know about now days or even if my parents they are still thinking about it but what I know in case I am not taking care of them, still my young brother will be responsible so they will influence him to get married and keep the wife home to my parents' home so that she can take care of my parents. (Yacinta 2014)

In her explanation, Yacinta addressed the important fact of inheritance that influences this parental care arrangement. In a conversation with my landlord Mzee Ngowi the topic of inheritance also came up when he explained how care for parents was organized (see field notes below). Furthermore, he illuminated that in the city these ways of caring were less prominent today which also seems due to the practicalities of inheritance. The fact that these particular care arrangements are changing was confirmed by most other study participants from the same ethnic group.

> Mzee Ngowi explained that earlier on it was the last-born son who was responsible for the parents but now this "tradition" is not very strong anymore. However, when talking about his family or the one of his wife, the tradition seems to be intact. Traditionally, every father divides his plot among the sons, or if he has a daughter who is not getting married, she will also get a small plot. If the father has not enough land to distribute to all sons, only the last-born son will get the plot of the parents. Otherwise, if more land is needed for the distribution, the father can also buy land somewhere else for his sons. For example, in Mzee Ngowi's family, he and his younger brother divided the family plot, while his two elder brothers got plots outside the family home.[233]

---

grouping of people in the south and southeast of the Kilimanjaro mountain in Northern Tanzania (Jensen 1998, 186). The Chagga in the northern region around Kilimanjaro were famous for "one of Africa's most impressive systems of water management" (Grove 1993, 431). Furthermore, the area southwards of the mountain is well suited for the production of export crops such as natural rubber, cotton or coffee (Jensen 1998, 187). In Tanzania, certain prejudice exists concerning Chagga people, they are said to be good business people, usually well-educated and "greedy". Many people from the Chagga ethnic group can be found in government positions.

[233] Mzee Ngowi's parents had cultivated coffee on the land that he inherited. During the time he was working in Dar es Salaam and his parents were still alive, the parents cultivated the coffee for him on the inherited land. They worked with a coffee union, but never collected the money for the coffee they produced. They did this for almost ten years,

> Mzee Ngowi explained further that also in his wife's family, the youngest brother of Bibi Ngowi remained in the house of the parents (and cared for them when they were still alive) and her sister who did not marry was able to live in the annex of the house. The whole land of the family was divided among the two brothers.
>
> Mzee Ngowi said that this "system" of inheritance and care does not work in the city. He has given his sons Daniel and Alex the possibility to build their houses on his land. However, he explicated that this is not the same than it would be in the countryside because the land is registered in his name for 99 years (apparently, only after ninety-nine years, the name of the owner of the land can be changed). Therefore, in the city Mzee Ngowi's sons can only build their houses while the land still belongs to their father. In Moshi, where Mzee Ngowi comes from, it is different. Mzee Ngowi also referred to the example of Mzee Mbujuni who's last-born son built his house in the courtyard of his father in Dar es Salaam. Mzee Ngowi emphasized that this is not the same as the traditional partition of land in the village.
>
> (Informal conversation with Mzee Ngowi 2014)[234]

While the older city dwellers' own parents were usually cared for by their younger brothers in the countryside, in many cases the older people's own care arrangements in the city no longer mirrored this concept. In Mzee Ngowi's case, his oldest son, Alex, took over much of the parental care and stayed part time in the house of his parents. Alex was not married, while his younger brother Daniel lived with his own family on the outskirts of Dar es Salaam.

In the city, as was explained, the "traditional values" get lost or cannot be maintained due to regulations when it comes to the purchase of land. Although the "traditional system" of elder care, that was referred to by many research participants coming from the northern part of the country, still seems to prevail in the older peoples' narratives about good care in old age in the city, children or other caregivers clearly pointed out that this ideal form of care arrangement in old age did not correspond to their urban lives. In the city, the idea of the nuclear family was prevalent and wives did not necessarily agree to move to their husband's parents in order to care for them, since they were already involved in caring for their own parents. In a quote by Bibi Veronica's son, Eric, who came back from the USA to care for his mother, he explained that all children in his family felt equally responsible for their mother's care:

> Nowadays people think it [care] will be divided equally among all children. And myself, my view, I share it with my brothers … we said we will do this equal; we will distribute. Everybody has the same share, but if you don't contribute, if you don't do it, I will do it for you. It does not matter. But if you can do it, do it but if you don't do it, I will do my best to do it. That is why I am here with mother because if everybody else wants to do that, I won't have to do it but I am giving them [my brothers] freedom, they

and Mzee Ngowi's father collected all the receipts he received when delivering the coffee and stored them in his bible. When Mzee Ngowi retired, he received the receipts and was able to go and get a lot of money from the union. At the time of our conversation, Mzee Ngowi did not grow coffee anymore because nobody took care of the land. Mzee Ngowi plans to grow coffee again and he is looking for somebody to stay there.

[234] The inheritance of land is described by Baily (1968) and Howard (1994) in a similar way as in my field notes on the conversation with Mzee Ngowi.

> can do whatever they gonna do. So I feel responsible but also the society wants you to feel responsible for that… (Eric 2013)

Following Eric's quote, I would now like to turn to the narratives of those people caring for the older study participants: Why do caregivers in Dar es Salaam feel responsible for the care of older people? Interviews and informal conversations with children or other relatives identified as the most important caregivers by the older people, or who were usually around an older person in order to take over practical support stated that most of them cared for the older parents or relatives because they felt responsible for it. In his study on old age care in rural Ghana, van der Geest's conversations with those providing care revealed similar feelings of responsibility; many of the caregivers thus based their explanations on reciprocal duties (cf. Geest 2002).

When talking to younger study participants about the normative ideas about the care of older parents or relatives, their narratives mirrored much what their parents said, namely that they felt responsible for their older relatives because the older people had raised them or supported them earlier in life. Hence, they very much based on reciprocal duties.[235] Also the conversation with the son of Mzee Dunford, Christian, who lived in the neighborhood of his father, shows the importance of children taking over care responsibilities when compared with external help:

> Andrea: Is it acceptable that somebody else is taking care of the old person generally like for example the household helper?
>
> Christian: It is not good if the children are available because they will take good care of their father with all their heart and love, they can wash his clothes, himself take him to the hospital but if you take someone else, he or she will do it as other job and not with love so even myself when I get old, I wish my children to take care of me.
>
> Andrea: But for Mzee Dunford in twenty years if his health becomes worse will you do that?
>
> Christian: We have to come back ourselves as children and it would be very important that someone else from outside may do special activities like cooking and cleaning the house but to wash him, his clothes and take him to the hospital we have to do by ourselves that's why we pray to God so that he can live many years with strength.[236]
>
> (Christian 2013)

---

[235] Interestingly, in a study on the negotiation of care for older people in South Africa, Hoffman presents a difference in how different generations perceive their role in care giving and receiving. While the older people referred to care as a duty "that overrides capacity and context" the younger generation rather argued "from the departure point of capacity and hierarchy of needs" (Hoffman 2016, 169).

[236] Andrea (translated by Frank): "Inakubalika mtu mwingine yoyote kumtunza mzee kwa mfano mfanyakazi wa ndani?" Christian: "Sio nzuri kama watoto wapo ni vizuri watoto wakamsaidia wenyewe kama amepoteza nguvu kama kumfulia, kumlisha au hata kumpeleka hospitali kuliko mtu mwingine, kwa sababu mtoto wake mwenyewe atakuwa na huruma na upendo zaidi, kwa sababu mtu mwingine atafanya kama anafanya kazi ya kawaida lakini mtoto mwenyewe atafanya kwa moyo wote." Andrea (translated by Frank): "Kwa Mzee Dunford miaka labda 20 ijayo na afya yake ikawa sio nzuri utafanya hivyo." Christian: "Sasa itabidi turudi sisi wenyewe ili kumsaidia hayo yote itabidi tufanye hivyo na itakuwa muhimu sana mtu wa nje atakuwa kwa ajili ya kazi flani, kama kupika au usafi, ila kwa ajili ya yeye kama yeye itabidi turudi kumsaidia na ndio maana tunaomba mungu aishi muda mrefu akiwa na nguvu."

The fact that children would prefer to take up more practical care work themselves was also mirrored in the interviews with children living abroad in the USA. In Part IV of this PhD thesis, their view will be discussed. Like Christian, many potential caregivers imagined themselves taking over practical care work once it was needed in the near future.

Not only adult children but also other relatives were engaged in the provision of care for the older study participants. In the case of Bibi Helen, who never married and did not have her own children, her brother, Mzee Baden, assured that once she needed more support, everyone in his family would be ready to contribute:

> [This is how] it works in our communities here in Tanzania and Africa in general: we take care of each other…so if my sister would be old and not able to cook for herself and things like that, the homes of each one of us would be open for her, she can come to me she can go to Victoria [her sister], she can go to Robert that is the younger brother… you know it's not even discussed—it's known and everybody expects that the family members will take care and if you don't care everybody is like "ah, what kind of family is this?!", you know—So we have not even spoken about what will happen because we know automatically the doors are open, she can come to me she can go to Victoria she can go to Honorata [other sister], you know …it's like the way we are taking care of our parents: first my mom was staying with Victoria, and Helen [the Bibi], Helen was still working then and Victoria was here in Dar es Salaam, she was working. So our mom was staying with them [for a] long long time—she died of cancer and later on when our father was also … he died at 91 … he was still strong you know walking, tall, reading newspapers at 91 … We thank God for that but when he became really sick the last few months, he was staying with me, and he stayed with our elder brother, you saw him he was there, so it's like that …. It's the way it is going to happen with Helen or any other member of the family who is not able to support himself or herself. (Mzee Baden 2013)

When listening to the older study participants' narratives about good care, it became clear that they based their arguments largely on kinship to formulate their expectations towards others (especially adult children). When bargaining for care based on these expectations, they oriented themselves toward what Emirbayer and Mische would call iterational or habitual aspects of agency: "… the selective reactivation by actors of past patterns of thought and action, as routinely incorporated in practical activity, thereby giving stability and order to social universes and helping to sustain identities, interactions, and institutions over time" (Emirbayer and Mische 1998, 971). Hence, the older study participants go from their own experiences when caring for their parents or grandparents when formulating their expectations towards their children or other relatives. Hereby older people's actions are shaped by a cultural context of action that "encompasses those symbolic configurations or formations that constrain and enable action by structuring actors' normative commitments and their understandings of the world and of their own possibilities within it" (Emirbayer and Goodwin 1996, 365). In an iterational moment of agency they reproduce some of these structures in order to bargain for care.

Later in the text, I will show that some of the older study participants nevertheless also invest considerably in future care arrangements by, for example, preparing their children for the task of care

in old age. In addition, they save money.[237] Others, however, hand over the decision about their own future and care completely to their adult children or other relatives. Bibi Buni belongs to the latter group and explains that she expects her children to decide about her care arrangement in the future:

> Andrea: And how is it like in your tradition, do you stay with a particular child I mean may be the first born or the last born, maybe girl or boy, or it can be any of the children?
>
> Bibi Buni (Frank's translation): She says it depends you can stay with anyone it doesn't matter on who you are going to stay with according to the tradition, but also it depends from them the children themselves who they chose among themselves who are you going to stay with and because you older you have to obey whatever they decide and she say you became like a flag you are following the direction of wind if the wind goes this way and also you are going the same way and if the children decide that you are going to stay with this one you agree with them.[238]
>
> (Bibi Buni 2013)

After having briefly sketched the older person's and children's articulated expectations towards care, in the next chapter the topic of (bodily) strength will be addressed, as the perceived strength of an older person very much shapes the actual care that is then provided. Care practices are part of a dynamic process that needs to operate with great flexibility, as will become clear in the following chapters.

Nguvu as a Point of Departure for Care

> My health … there are two kind of health problems, there is one health problem which is caused by disease and the second is caused by becoming older. For me, I am not suffering because of disease but I have the problem due to my age as I am too old now.[239] (Bibi Amina 2012)

I open this chapter with the quote by Bibi Amina from Manzese Mnazi Moja who emphasizes an important point in her description of her own health. She differentiates between aging problems and health problems, and attributes her own ailments rather to aging than to being ill. When it comes to

---

[237] In Part II, the future preparation of older people was described as one dimension of the former civil servants' milieu in Ada Estate.

[238] Andrea (Frank's translation): "Kwa mfano kwa taratibu zenu labda ni lazima ukae na mtoto flani labda wa kwanza, wa mwisho, wa kike, wa kiume au yoyote yule?" Bibi Buni: "Inafuatana unaweza ukakaa labda na mtoto wako, lakini wote ni watoto wako kwa sababu mtoto wa kwanza lazima atakuwa anajitegemea inawezekana hata wa pili wa tatu wote wanajitegemea sasa inafuatana au naenda kukaa kwa mtoto yupi unaweza ukakaa kwa mtoto wako wa kiume au wa kike na baadae ukakaa na mtoto mwingine itakavyokuwa ukiwa katika himaya yao ya kukutunza wao watajua kwa mama au wazee wakakae wapi watachagua wao sasa unakuwa sawa na bendera kufuata upepo."

[239] Bibi Amina: "Mimi afya yangu kutokuwa na afya, mimi mwenyewe kwa kifupi maanake kuna afya ya aina hizi mbili kuna kudhoofika kwa kuumwa kuna kudhoofika kwa utu uzima, mimi sidhoofiki kwa kuumwa nadhoofika kwa kuzeeka sasa."

discussions around care that older people are entitled to from others, their own perception of their aging body seemed crucial.[240]

My conversations with relatives involved in caring for the older study participants also revealed that their assessment of the older person's health condition very much influenced the care they were ready to provide. As in the case of Bibi Amina, some would differentiate between the fact that their parent or older relative had an acute health problem or was "just" becoming old and frail. How they perceived the older person's condition shaped their care provision. Eighty-year-old Bibi Selma from Manzese Mnazi Moja explained that her daughter would take her to the hospital if she fell ill. The daughter, who was her main care provider and assisted her in taking a shower or using the bathroom would however not take her to the hospital because of her legs that were paralyzed (Bibi Selma was not able to walk anymore). The leg problem, she explained, was due to her old age. Sadly, Bibi Selma died of pneumonia only a few months after we had met. The daughter had taken her to hospital to treat her pneumonia, but Bibi Selma died a few days after hospitalization.

In both cases, when falling ill or when growing old, the study participants became more aware of their own body. In the majority of cases, they would then refer to their (lacking) strength (nguvu). Men sometimes referred to strength by explaining how much kilograms they could still lift. As, for example, Mzee Juma when asked by Elisha whether he could still lift water[241]:

> Elisha: Can you still conduct small work?
>
> Mzee Juma: Aaaaaah!
>
> Elisha: Or can you still carry some water?
>
> Mzee Juma: Aaa bucket!
>
> Elisha: Au eeeh, you cannot even carry 5 or 10 liters?
>
> Mzee Juma: Five liters we can do, small things but not with much strength.[242]
>
> (Mzee Juma 2012)

[240] Freeman, who researched on care of older people in Malawi, made similar experiences and emphasizes that how people talk about care differs whether they have age related or non-age related health problems. Interestingly enough, the author found that people would call it "care" and talk about it when it was illness related but less so when it was age related (Freeman 2016, 116). I did not come across such a distinction in my field research.

[241] It was interesting for me to observe how the research team approached the question of feeling healthy/having strength in different ways. Especially Elisha, who is himself over sixty years old, often referred to the marker of how much weight a person was still able to carry.

[242] Elisha: "Unaweza kufanya kazi ndogo ndogo?" Mzee Juma: "Aaaaaah!" Elisha: "Au kubeba maji kidogo?" Mzee Juma: "Aa ndoo!" Elisha: "Au eeeh, huwezi hata lita 5 au 10?" Mzee Juma: "Lita 5 tunashika, ah kile kidude lakini sio sana kwa nguvu."

Many older women I met referred to their daily activities of preparing food and explained that they could only prepare small portions of *ugali*[243] because they did not feel strong enough to do more. Also, fetching water was often mentioned as a problem when one's strength had gone. A further point of reference was how many acres of land an older person was still be able to cultivate. Here the number of acres usually remained an estimation since most older people in the city were not heavily involved in garden work. Although some older people cultivated crops around their houses, a few older people owned garden plots outside the city and traveled to their plots from time to time to cultivate. Mzee Dunford replied to my question whether he was still involved in garden work also by pointing to the problem of physical strength: "I failed to cultivate because I have no *strength*"[244] (Mzee Dunford 2013). Others again referred to the distance a person was still able to walk.

As mentioned in the introductory chapter of this part, Eeuwijk and Obrist (2016) systematically analyzed the use of strength as a description for older people's health condition in Tanzania. They distinguish older people who refer to themselves as having strength (nina nguvu), not having strength (sina nguvu) and sometimes having strength (baadhi ya wakati or wakati mwingine sina). Furthermore, they add another category of being without strength today (leo sina nguvu) when referring to those older people who mitigate their being frail and expect to improve their health (cf. Eeuwijk and Obrist 2016). Of course, an older person's own description of being with or without strength very much depends on his or her subjective perception of abilities. Thus, placing this analysis of strength in the urban context may also highlight the earlier mentioned exhaustion of living in the city without much support from others (cf. Part II) that makes people emphasize their lack of strength—although I would have attributed them with strength on the basis their performance in daily activities that I observed. Spending days with our study participants provided important insights in this regard. If people considered living in the city to be harmful to their health (cf. the guilty city, the unhealthy city), they tended to estimated their health as worse as a way to articulate their discomfort. Talking about strength thus seems to have a physical as well as a psychological component. Furthermore, strength or not having strength might also have been used to claim for more care towards their relatives but maybe also towards the research team. Hence, what was mentioned or also deliberately not mentioned may reveal some insight into the field of tension when aging in the city.

Listening to the older study participants when describing their own health,[245] their conditions ranged from feeling healthy to feeling frail (corresponding to having strength and no longer having strength).

---

[243] As mentioned earlier, Tanzania's main dish *ugali* is mash made of corn flour.

[244] Mzee Dunford: "Sasa mimi nimeshindwa kulima *nguvu* zimeisha."

[245] In the earlier mentioned base-line study, the project team in Dar es Salaam and Zanzibar asked the older people of this study about their assessment of their own health condition if they could choose between having strength (*nina*

Their position on the continuum between healthy and frail depended on different aspects and dynamically changed over the period of time that I accompanied them. Usually, conditions changed from feeling healthy to feeling frail, due to the natural course of old age. However, some older study participants also managed to reverse from a frail to a healthier condition (for example, when an older person recovers from malaria or manages to stabilize a hypertension). The three stories, that will follow this chapter, reveal three different health conditions on the continuum between healthy and frail, and highlight different aspects of relational care that become important in particular health conditions. They may be based on the above-described reciprocal duties among family members or on religious values, but also on "traditional" rules inherent to a particular ethnic group.

Connecting bodily experiences to the above-mentioned normative ideas about who is supposed to care, de Klerk writes, "[a]s physical strength declines, the state of older people's relations becomes visible in the way care is organised" (Klerk 2016, 141). Especially when health deteriorates, and care needs to be adapted to a new condition, people may be able to bargain for care based on their investments in social relations in the past.

"Critical health moments," as described by Obrist (2016, 96), although usually connected to difficulties and pains, provide important insights in which people articulate ideas and ideals about care that are habitual and thus not easily described before. I recall Obrist's quote from the introduction, where she states, "[f]rom a methodological point of view, it is especially during these critical health moments that older people, and those with whom they interact, articulate their experiences of health and care through discursive and enacted practice" (Obrist 2016, 96).

These moments of crisis often triggered changes in care provision of older people. Usually, these critical moments are rather attributed to a health problem and not to age, since the aging process is, in contrast, a more subtle decline of health over time. In these health-related crises, care givers usually react faster than they would with problems due to age. Sixty-year-old Mzee Tenga from Kinondoni Ada Estate started to suffer from a severe infection on one of his legs that nearly made him loose the leg in order to survive. Due to his health problem, he lost his job and, some months later, his wife died. As a consequence, his two sisters took over the responsibility for Mzee Tenga's children at school and paid for his rent while providing his daily meals at their house. At the same time, his friend and former neighbor, Mzee Duni, paid for his medical treatment. Old and frail Mzee Baraka from Manzese Mnazi Moja fell down the stairs of his house and thereafter suffered from problems with his legs, making him completely dependent on his wife and children. He had to stop his income generating activity and needed physical support to move around the house. Bibi Sharifa from Azimio Kichangani worked as a

---

nguvu), having strength sometimes (*nina nguvu baadhi ya wakati*) and not having strength (*sina nguvu*). It was interesting to observe how the assessment of their own health sometimes differed with my outsider view.

street cleaner to financially support her niece and the grandchildren staying with her. However, due to unbearable pains in her hands, she had to stop the work. Because her daughter did not earn any income, they had to sell Bibi Sharifa's house and move to another area within Dar es Salaam.

The above-presented examples show that in a crisis situations care has to be quickly adapted to new circumstances. For a short time, people may step in as caregivers that would not do so otherwise. After some time, the care arrangement slumps again. Freeman therefore distinguishes care givers in times of crises when older people could expect help from extended family, friends, and community groups, from longer-term care relations where care was mainly provided by adult children or spouses (Freeman 2016, 119-120).

The above-mentioned examples with occurring (health) crises reveal that, especially in these critical moments, relational care becomes important for many of the older study participants and the bargaining for it visible. At the same time, the assessment of older people's strength (by themselves and by others) shapes different care involvements by different people at different moments in time. On a methodological note, spending substantial amounts of time with the older study participants and staying in contact with them for almost four years revealed many such ups and downs.

CARE FOR OLDER PEOPLE

As announced before, in what follows, three different health conditions and care arrangements with a focus on relational care will be presented. They reveal different health conditions as well as the ups and downs that sometimes imply daily adaptions to relational care. Again, it draws on ethnographic material to illustrate some of these variations that are shaped by the older people's own ideas about how "good" care for them should look like.

CARE WHEN FRAIL AND DEPENDENT

This chapter starts with Mzee Juma's story to show a contrast to the relatively young and healthy older people of the former civil servants' milieu. Due to his troubles with his urine tube, his constant unpleasant companion, his mobility is restricted and he depends heavily on others to support him in conducting daily tasks such as carrying the warm water to the bathroom for bathing or preparing food. Mzee Juma's health condition is not good. This is not only due to his advanced age but also due to his rather deprived living conditions and his lacking financial means for health care. Mzee Juma described himself therefore as not having strength anymore.

Especially in advanced age, untreated health problems burden older people, and some study participants died from malaria in the course of this study. A disease that would be treatable in Tanzania. In contrast to older people who are confronted with a sudden health crisis, frailty rather seemed to be a slow process, gradually leading to more need for relational care. However, due to advanced age and

health problems, the older people's ability to bargain for their care decreases and they very much rely on relationships in which they invested earlier on or on assets such as houses which made them able to claim something from others. In addition, when older people become frail, financial means and property become important to be able to afford medical care when no other health care insurance is available. Furthermore, normative rules influence the provision of care by relatives, but also forms of non-kin care.

Mzee Juma was eighty-eight years old when we met for the first time at his house in the neighborhood of Ilala Mafuriko.[246] The entrance to the house is located on the tarmac road that also constitutes one of the borders of the sub-ward. Due to a sewage drain, in order to get to the house, one has to step over a small instable bridge made of wooden boards. The typical Swahili house consisted of a long and dark corridor, with a few rooms, that led to the backyard where Mzee Juma usually sat on a slightly broken plastic chair. Bordering the courtyard, there were other rooms as well as the place of the pit latrine. Not only the corridor but also the backyard was dingy, with lots of broken material lying around.

Mzee Juma belonged to the ethnic group of the *Wazaramo* who are said to be native to the area of Dar es Salaam. He was born near Dar es Salaam and moved to the city seventy years ago. In 1974, he was able to buy the house in Ilala. Mzee Juma never went to school and engaged in petty trade in order to generate an income. When his prostate problem started some years ago, he had to give up his business. Since then he has experienced a long journey of health facility visits and spent a lot of money on examinations and treatments. When we met in 2012, he was living with a urine tube and explained that his children had already spent all their money on his treatment so that now there was nothing left for the needed operation. Mzee Juma's first-born daughter, who was present during the first interview, explained to Elisha and me that at the Muhimbili National hospital they were told that once they were able to raise the necessary money, they should come back with Mzee Juma for the needed operation. Since then they have been waiting.

Mzee Juma did not receive regular financial support from his children, but explained that when they did have something, they would bring food and they would eat together. Mzee Juma had eight children but four of them have died already. One of the four children went abroad but the family did not know where he was and whether he was still alive. Another son was schooling and thus still too small to support, Mzee Juma explained. So, the main financial support came from two of his daughters. His first-born daughter, who was already married, came back to stay with him for several weeks because Mzee Juma did not feel well. Furthermore, when we met in 2012, a son and some grandchildren shared

---

[246] Mzee Juma was part of the base-line study of this research project and I visited him less frequently than the older people in Ada Estate. However, due to our and especially Elisha's involvement in his health problem (more information below), we happened to visit him more often than others from the same sub-ward.

the house with Mzee Juma and his wife. Mzee Juma had two tenants who each paid TZS15'000 (approximately US$7) per month for the room. The house had a shop in front, which was run by a family relative. The wife of Mzee Juma, who was in her mid-sixties, sold *chai*[247] in front of the house to gain a little income.

Mzee Juma had a *shamba*[248] where he cultivated food, however, due to his health condition he was no longer able to go there. The shamba was about 150 km away from Dar es Salaam. Usually, Mzee Juma did not leave the house. The only distance he managed to walk was to see his friend Mzee Hussein (also a participant of this study), who lived some houses away. Mzee Juma had to stop going to the mosque for prayers due to his urine tube, and when his daughters took him to hospital, they had to borrow a car from relatives as he was no longer able to use the public transport. Also due to his health condition, Mzee Juma was not able to conduct any activities in and around the house. In the morning, the daughter normally brought water for Mzee Juma to the bathroom, so that he could shower. In case he felt pain, Mzee Juma used Panadol to get some relief. Although in 2013 Mzee Juma was finally operated on, he died only some months later.[249]

Mzee Juma's rather sad story shows his struggles with being frail in old age, with not much financial support for treating his health problems. When I met the Mzee Juma in 2012, he was not able to conduct any activities in or around the house and was fully dependent on others. His wife took over much of the couple's responsibilities through her income generating activity of selling tea along with the daily household chores, for example, preparing food for themselves. Furthermore, in the case of Mzee Juma, especially his first-born daughter played an important part in his care arrangement. Only in very few cases of this study, children came back to stay with their parents in order to care for them. Very often, those children staying with the parents jumped in to provide the needed care while non-resident children tended to contribute financial means. Another case was Mzee Omari whose daughter came back with her children to stay with him and his wife after a divorce. The daughter opened a small *genge*[250] at the house and the family lived from the income of the shop.

[247] The Swahili word *chai* means tea in English. The tea is usually black tea produced in western Tanzania. Many people use a lot of sugar to drink the tea, those with more financial means afford milk powder.

[248] As mentioned in Part II, the Swahili word *shamba* can be translated as field or farm.

[249] With the help of my grandmother in Switzerland, Elisha and I got involved to pay the US$200 for the prostate operation. Also, when he had the money, and in company of Elisha, he went to Muhimbili three times without being attended to, before in a fourth attempt he was examined again which detracted already some money from the amount he had for the operation. Although the doctors then disadvised him from an operation due to his advanced age, some weeks later he was able to undergo the operation in another hospital which at least led to some relief.

[250] As mentioned in Part II, a *genge* is a food stall or shop where apart from food, and mainly vegetables, also detergent or soap is sold.

Struggling for Support

In many families that became part of this study, adult children and other relatives were at least able to support their parents with some practical tasks, which are included in the broad definition of care used in this PhD thesis. However, in some cases, older study participants were left with not much support. Reasons mentioned for the lack of support were children that were still too young to support financially because they were schooling, like the younger son of Mzee Juma. However, these grandchildren or young children were usually able to engage at least in practical support in and around the house when not at school. Other children were not in good health themselves to care for their parents; on the contrary, they needed their parents' care. The story of Bibi Ruth in Part II was such a case, where Bibi Ruth was involved in caring for her HIV-positive daughter, while her son was absent during the day in search of income. Also, in Bibi Ruth's case, her children were jobless and thus not able to support themselves financially. They failed in providing care for their parents as would be expected according to the principle of reciprocity. This lack of care can also be observed when spending time with the older study participants as it is reflected not only in their health issues but also in the quality and state of their personal items such as clothes and shoes. As mentioned in Bibi Ruth's case, when talking to her about her situation, she did not blame her children for this lack of support but rather blame the circumstances of the city life. Due to these situations, the normative rules sometimes had to be extended. Also, in the case of Mzee Juma, normally not the married daughter was supposed to return and take care of her father, but a son instead; but Mzee Juma's only son seemed to have moved away, without looking back.

Caregivers in and Outside the Family

When talking to older people about care, it became clear that many expected their adult children's care on the basis of reciprocity and struggled with accepting situations of "inverted intergenerational contracts" (cf. Roth 2008). Especially when talking with study participants about who was caring for them by using the Swahili expression *kusaidia*, financial support was clearly more emphasized than additional practical involvement. While in many cases, children who provided financial means for the daily life of their parents were living away from the parents' house, those at home were deeply involved in supporting their parents in daily household activities. Those daily activities were less the subject of conversation and only mentioned when we asked about them or were able to observe them. Non-kin, for example an employed household help, could also perform some of these tasks in and around the house. Still, the children present seemed very important in case of emergencies, as in most of the study participants' households, once the older person needed more care, the children who were already present took over particular care tasks.

Most of the study participants lived at least with one adult child. Apart from these children, also nieces, nephews, grandchildren, and sometimes in-laws were present. When no household helper was

employed, household tasks were usually shared among the women in the house. In many cases, especially nieces or female grandchildren took over many of the chores (i.e., fetching water, buying food at the small shop, cleaning the compound), which was rather seen to be self-evident but perceived by myself as part of a care arrangement for an older person. Such self-evident practices of care were usually not mentioned in conversations; however, they could be observed when spending time together. Often these children benefit from growing up in the city and being able to go to school, while supporting their grandparents, aunts or uncles. Bibi Veronica from Kinondoni Ada Estate also received such support from her granddaughter who helped her with preparing food or cleaning after school. At the same time, Bibi Veronica's son, who lived with them, drove the elderly woman to the shopping mall with his car when she wanted to do her monthly grocery shopping.

When caring for frail and dependent older people, intimate care can become an important part of a care arrangement. Especially when it comes to performing intimate care, certain tasks have to be taken over by a particular person. My landlord Mzee Ngowi, for example, lived in his house with his wife and three of his adult children, who were not yet married. While they employed two household helpers for the daily cleaning and preparation of food, especially assuring the parents' medicine intake was an important part of the children's involvement in parental care. While Alex, the son, was responsible for his father's medicaments, the two daughters took care of the mother's daily medication. When their mother's health condition became worse, the daughters assisted her on "bad" days with bathing and dressing.

In a few cases, present adult children failed to care for their parents' daily needs, and non-kin forms of care became important for the older person. Although in the discourse on the (guilty) city it showed that neighbors and tenants barely know each other and therefore do not assist each other, this study also observed some minor care activities provided by non-kin. An example for non-kin care is Bibi Elizabeth from Ilala Mafuriko, who lived in her own house and rented out rooms to tenants. Her only son resided in a neighboring sub-ward but did not care for his mother other than financially. Bibi Elizabeth had broken her leg several years ago and suffered from the consequences of the fracture. Due to her overweight and the problems with her leg, she was almost completely immobile and only able to move on her own when pushing a small chair in front of her. She had a household helper who supported her in buying and preparing food. Her main care provider, however, was a female tenant who watched over her (*kuangalia*) and also went to the pharmacy for her when she needed medication. According to Bibi Elizabeth, the tenant even paid the salary of the household helper for her.

Bibi Ruth from Manzese Mnazi Moja also sometimes asked her tenants to buy food for her at the market when she did not feel well enough to go shopping herself. Other houses had cleaning schedules that obliged tenants to clean the house and the compound. Hence, although usually of different origin and age, tenants seemed to be important players for older people as they were often around and could

lend a helping hand in times of need. However, of course not all tenants were supportive, and ninety-five-year-old Bibi Khadija complained about her tenants, who would leave the house for work in the morning and come back late in the evening and did not partake in any cleaning activity in and around the house.[251]

In the above-presented case of Mzee Juma, his neighbor and friend Mzee Hussein played an important role. However, Mzee Juma emphasized that they just visited without supporting each other (financially), as in the city everybody depends on himself. When they sat together, they exchanged political information on the sub-ward. Other older people without a TV also mentioned that they sometimes went to watch TV at a neighbor's place. As in Mzee Juma and Mzee Hussein's cases, often particular neighborhood contacts such as people from the same political party or church/mosque became important. Due to regular meetings and like interests, some neighbors thus became more important than others. In most cases, the role of neighbors limited itself to greetings while others became friends and got involved when visiting each other. Only few neighborhoods were organized in official neighborhood groups as was the case with Mzee Mohamad from Kinondoni Ada Estate who was responsible for the neighborhood group involved in organizing funerals within the neighborhood (cf. Part II). Other neighbors would get together to service the sewage system or the water supply of a particular sub-ward.

Advanced Stages of Frailty

Loss of strength due to advanced age and illness, as in the case of Mzee Juma, often coincided with becoming more and more immobile and thus dependent on the help of others. As mentioned above, in these situations care was very much influenced by the older people's and the care provider's perception of the older person's health condition. The dependent older people usually suffered advanced age and a multi-morbidity issue due to their age and untreated health problems. In this case, adult children as well as spouses usually became more responsible for the increased needs of (practical) care for the older person, while the quality of care often depended on the financial means at their disposal.

Older people at an advanced stage of frailty and ill-health needed much more medical care, which necessitated substantial amounts of money. Although medical treatment is supposed to be cost free for people above the age of sixty (cf. the legal age definition in Part II), medical care usually involved substantial costs, especially when medication was needed over a longer period of time. In addition to the financial side of treatment, medical care of frail older people also required a person who took over the task of organizing hospital visits or of medication intake. These caregivers were involved in

[251] Tenants were less relevant in care arrangements in the former civil servants' milieu in Ada Estate as only few older people rented out rooms of their house to others.

organizing transport to the health facility and accompanied the older person to the treatment, while also doing all the talking with the health staff.

The ability of elderly people to bargain their own care although being old and frail seemed very connected with their position as an older person within the family as well as their investments in relationships in the past. In de Klerks words, "care in advanced old age was the outcome of relations that had been built in a good manner over the course of a lifetime" (Klerk 2016, 145). As mentioned earlier, also the fact of being a house owner seemed to influence to a great extent an older persons' position in negotiating their needs and can be perceived as part of the older people's preparing for old age. "[P]reparing for old age by retaining land, a house and assets remains one of the ways in which older people try to manage the uncertainties of declining bodily strength" (Klerk 2016, 149). The following quote by Mzee Baraka, the elderly man with the broken leg, also shows the importance of having at least some means at hand when bargaining for care:

> Andrea. And about your health, have you ever discussed this with your wife or the family, do you discuss these problems?
>
> Mzee Baraka. I only say, we never have talked about this issue.
>
> Elisha. There was no discussion?
>
> Mzee Baraka (translated by Elisha): The decision is based on how much you have, if you have some money then you can discuss what you want to do, so they have not been able to do any discussions any plans because they have no income.[252]
>
> (Mzee Baraka 2012)

When becoming mentally affected, older people seem to lack agency to bargain their care. As a consequence, their vulnerability increases. Bibi Mariam from Ilala Mafuriko was suffering from a tumor in her stomach and was slightly confused. Due to her condition, her son decided not to treat her cancer at the health facility but to just wait for her time to pass.[253] Bibi Salum from Azimio Kichangani was described by her granddaughter as being over a hundred years old and her confusion was explained by her advanced age. Because she had already hurt herself by trying to climbing a wall when nobody was around, the caregivers started to lock her in her room. The very aged woman had already run away

---

[252] Elisha: "Je umewahi kuzungumza matatizo haya pamoja na mama au na watoto au kuhusu matatizo yako kwamba tuyatatueje?" Mzee Baraka: "Amm acha niseme tu hatujawahi kuzungumza haya mambo." Elisha: "Hamja discuss?" Mzee Baraka: "Unajua kitu chochote kile mnafanya mipango hiyo ili muweze kufanya kama capital mnayo."

[253] Her pains due to the tumor were nearly unbearable for Bibi Mariam, and Neema and I had difficulties in bearing the misery of this elderly woman. She was very confused while talking, and the room smelt from the dried urine in her clothes. We refrained from asking our prepared questions and left, shocked and sad. Some days later, Elisha and I brought her oil to massage away some of the pains, and some weeks later we learned that she had passed away. Although she was the initial owner of the house, her son and nephew decided not to invest money in her ailing health and she was not in a condition to do anything about it.

several times and failed to find her way back. Her confusion led to many problems so that the daughter and granddaughter caring for her decided to move to another place with her. In this research project, only these few very old and very ill exceptional cases of older people were unable to shape the care they received. Freeman writes that older people who were getting frail in her study were described as becoming child-like again, especially when living in somebody else's house and being dependent on others for care, this was described to be difficult because you just have to wait for care but are not allowed to ask for much (Freeman 2016, 126).

Especially among the frail and dependent older people who would often describe their existence by nipo tu, I often observed that care arrangements remained more or less similar over a long period of time. Often the visited frail older people received an increased amount of care by those people who were already around and involved in care. Also de Klerk described that the care of older people in northwestern Tanzania not only depended on belonging (to a certain family or group of kin) but also on what she calls circumstance, since the provision of care very much depended on who was present at a particular moment (Klerk 2016, 142). Only when the amount of care became too much, somebody else, as for example Mzee Juma's daughter came in to support. When it came to the question, why a particular child was more responsible than his or her siblings in order to do so, van der Geest claims that it is a question about who has "the best arguments to say no" (Geest 2002, 24). Also, in this study, parental care was organized according to the children's ability and availability, while neglecting some normative rules. Caregivers become caregivers due to situational circumstances; in many cases this reflected the values of kinship, in others it did not.

Care with Daily Adaptations

Caregiving is very dynamic as it has to adapt to the daily changing health condition of the older care receivers. This will be illustrated by the story of Mzee Bariki who suffers from chronic pains, with ups and downs. Some days he feels strong and even cultivates his food crops in the garden around the house, on other days he remains in bed, not capable of doing anything because of his pains. Due to the changing health condition of the older man, the care provided by his wife, his daughters, and the household helpers had to be adapted each day.

The case of Mzee Bariki shows how especially within a household, caregivers are more or less involved in caregiving tasks depending on an older person's changing health condition. These ups and downs were especially observable in the case of chronic diseases (i.e., in this study mainly with diabetes or hypertension), when older people's conditions varied from day to day. These dynamics were usually absorbed by those already involved in care, thus they did not result in changing caregivers but burdened those caregivers who were already involved. Mzee Bariki's case also shows how intimate care is organized within a couple relationship, as a form of intra-generational care.

Mzee Bariki, who was in his mid-eighties when we met, was the oldest study participant of the Ada Estate sample. Although he was slightly frail due to his age and his health problem, being part of the former civil servants' milieu and his access to biomedical care and other treatments seemed to improve his chronic condition (in contrast to Mzee Juma).

At the beginning, it was not easy to get to know Mzee Bariki better because every time I arrived at his place, often together with Elisha and later together with Frank,[254] his wife, who was six years younger than Mzee Bariki, did the talking while he listened to the conversation quietly. When we met for the first time in September 2012, they had only recently moved to the house that my assistants and I had chosen randomly by following our transsect sample strategy. As their son worked for *TAZARA*[255] railways, he was entitled to stay in the house, and, at that time, he was in the process of buying it from the company. And since his parents had to move out of their home in the national housing blocks in Magomeni, another sub-ward of the Kinondoni district (the area was cleared for new constructions), the son offered to his parents to move to his place. When we met, the elderly couple had already built another house somewhere on the outskirts of the city, but although it was finished, they still favored to remain in the son's house because they cherished the proximity to the hospital and church in the city. Nevertheless, they said that once their son was married, they would move to their own house. However, they expected this to happen only after some time, because their son first wanted to do a PhD. Mzee and Bibi Bariki both came from a place far away from Dar es Salaam on Lake Malawi in the southwestern part of Tanzania. Before coming to Dar es Salaam in 1965, Mzee Bariki had worked in the mining industry in South Africa for some time. His last employment in the city was then at the marine port where he retired in 1991. He got TZS52'000 (approximately US$23) as a lump sum and until the time we met, together with other former employees they had a case before the East African court to claim for the monthly pension that they were supposed to receive.

[254] It was actually the favorite family of Frank, who very much felt at home at their place since they came more or less from the same region.

[255] The Tanzania-Zambia Railway Authority (TAZARA) was established in 1968. The TAZARA project, the construction of a railway connecting the two countries, Tanzania and Zambia, started in 1970 and was funded by China (cf. TAZARA Tanzania-Zambia Railway Authority 2016).

Mzee Bariki told us that he had suffered from *BP*[256] for more than ten years, which also started causing some heart problems. In 2010, he contracted herpes zoster[257]. Unfortunately, it was treated only late—only the second hospital found out what it actually was—which is why, from then on, Mzee Bariki suffered from the scars of the wounds across his upper part of the body. Some days he woke up and felt ok, but other days he did not even manage to wear a t-shirt as his scars were too painful. His conditions changed on a daily basis, and after several days of not feeling well, his wife usually described him as thin and unhappy. While after several days of feeling well he seemed stronger and happier.

Although medical treatment for older people is supposed to be free of charge, the family spent a considerable amount of money on Mzee Bariki's medical care. Mzee Bariki had to collect his hypertension medication on a monthly basis. Usually, his adult children drove him to the hospital by car, sometimes the children simply went to collect the medication from the hospital. During the time Frank and I visited the family, we constantly experienced new ailments that made Mzee and Bibi Bariki go to the hospital or to the pharmacy to buy medication: back pains, eye problems, teeth problems, malaria. For his chronic pains, one of his sons took Mzee Bariki to different hospitals in town, one of them a Korean hospital where they hoped to get a different kind of treatment. For the elderly couple, a good old age was linked to being able to go to hospital and search for treatment.

The couple had five children. Apart from the son, the house owner, two daughters were also living in the house. A further son and another daughter also lived in Dar es Salaam, but on the outskirts of the city. While the owner of the house went to work every day of the week, the two daughters were responsible for the practical (and physical) care of their parents. They prepared food, made sure that both took their medication, and accompanied them to church on Sundays (Bibi and Mzee Bariki went to different churches in town). The family had household helpers that changed from time to time, which meant that sometimes they were weeks or months on end without help. During that time the two daughters took over the responsibility of cleaning the house and the compound. The daughters normally also went to buy the food. Sometimes Bibi Bariki went to the inner-city market Kariakoo after church on Sunday. When somebody of the family started feeling unwell because of malaria, which happened surprisingly often in this family, it was usually one of the daughters that went to the shop to

---

[256] The abbreviation *BP* was used when talking in Swahili as well as in English and derives from the English expression "blood pressure." It does not specify if high or low blood pressure is meant, however in most cases it was used to circumscribe a chronic condition of hypertension. Looking at chronicity and control in Uganda, Reynolds Whyte describes the spread of biomedical disease categories when it comes to what her study participants called "the new sicknesses." Also in Tanzania, hypertension is usually referred to as "BP" or *presha*, which imply the biomedical English terms (Reynolds Whyte 2012, 66). Strahl who conducted research on hypertension in Dar es Salaam emphasizes further that "'BP' is a somatic expression of emotional distress that links the body with the lived experience in this urban setting" (Strahl 2003, 309).

[257] Apparently, the disease targets especially people with a weak immune system. The Mzee was also tested for HIV but was negative.

buy medicine. Mzee Bariki's laundry was frequently done by his wife. Also, in case Mzee Bariki needed physical care, for example bathing or a massage against the painful scars, it was Bibi Bariki who took over the responsibility. Since Mzee Bariki was not mobile anymore, most visitors came to their place if they wanted to meet. The children, grandchildren, and great grandchildren usually passed by on weekends. The financial support mainly derived from the two sons and the daughter in Tegeta, as they were working and had an income. The sons were educated abroad: the house owner in Russia and the other son in the UK, both on government scholarships. The daughter from Tegeta also provided her father with a liquid of vitamins which she purchased from a colleague at work who bought it in the US. A bottle costed no less than TZS80'000 (approximately US$35) and lasted for almost a month.

As the elderly couple grew up in the village, they enjoyed farming activities. So, in the compound of the house they began growing maize in order to prepare their own ugali. Apart from maize, they also cultivated other crops such as manioc. When their health allowed, they got up in the morning at five a.m. and started working on their field at seven a.m. When the sun got too hot, around 9 a.m., they went to the house where they had tea and whole-grain toast with butter and eggs for breakfast, prepared by the daughters or household helpers. Sometimes they resumed garden work again in the evening at around 5 p.m. On some days Mzee Bariki was able to join in, while on other days he remained in bed the whole day due to his pains. His weekly church visits often also had to be canceled, since he did not feel strong enough to attend the service. In 2015, the family initiated a *kuku*[258] project. The son financed the construction of a stable where they started to keep chicken for egg production. They produced slightly more than 500 eggs a day and sold them to people they knew. After that, Bibi Bariki and one of the daughters were mainly occupied with the chicken, while Mzee Bariki remained indoors or relaxed in the shade of the house.

The example of Mzee Bariki shows the difference of care activities that can be performed by a household helper and care that can only be provided by particular relatives. On his "bad" days, Mzee Bariki needed intimate care, which will be now discussed in more detail.

Intimate Care

While most of the study participants told me that they were still able to use the bathroom on their own as well as to shower, some very frail and old study participants needed assistance especially for these activities. Bibi Salum from Azimio Kichangani who was believed to be over a hundred years old, was very weak and confused and thus not able to find her way to the bathroom in the courtyard of the house. The same goes for Bibi Selma from Manzese Mnazi Moja, who had paralyzed legs and only one eye with poor vision and thus needed help. In both cases, daughters and granddaughters living in the

[258] The Swahili word *kuku* means chicken in English. It refers to both, the animal and the cooked form of it.

same house with the elderly women were responsible for their assistance. In the case of Mzee Nassor from Azimio Kichangani, who was no longer able to walk, his son who stayed with him usually poured water over Mzee Nassor when taking his daily bath. Furthermore, in Bibi Mariam's case, a resident of Ilala Mafuriko, her nephew would carry the very weak cancer patient to the bathroom, while there her granddaughter would take over the bathing.

Others, for example Mzee Juma portrayed above, were able to shower by themselves if somebody carried the water for them to the bathroom. Also in van der Geest's research in Ghana, bathing was one of the main care activities mentioned by older people, and the author describes that carrying the warm water to the shower is seen as a sign of respect and should not be done by the older person, although he or she might still be capable of doing it (Geest 2002, 11). Some of the study participants also struggled to use the usual Tanzanian toilet (without bowl). Usually in typical Swahili houses, several families share one toilet that is situated in the house's backyard. These pit latrines were challenging for older people. Ninety-five-year-old Bibi Khadija told us about her fall in the toilet due to its unstable construction. A few of the study participants, however, had the means to build a toilet with a seat so that they were able to use it on their own. As, for example, Bibi Elizabeth whom I mentioned earlier, who was overweight and unable to walk. Thanks to the seat in her toilet, close to the place in the corridor of the house where she normally sits during the day, she is able to use it independently without having to wait for somebody to assist her[259]:

> Andrea: Who is actually helping, like if you have to take a shower, for example? Who is helping you with these things?
>
> Bibi Elizabeth: Fortunately, bathroom and toilet are just here inside. I can go alone. I go and have a shower, I put a toilet with a seat. When I am there, I sit and shower and there is the tap inside there for water.[260]
>
> (Bibi Elizabeth 2012)

With regard to intimate care activities, we mainly had to rely on conversations as they concerned quite private spheres of life where thick participation was hardly possible or appropriate and people might also have decided to not talk about certain aspects in the context of our conversations. This, of course also revealed some of the epistemological limitations of the spoken words as mentioned in the earlier methodology section when pointing to the performative character of interviews and conversations

[259] The challenge of using the toilet was not a subject of conversations in the former civil servants' milieu in Ada Estate, where many older people had flush toilets in their houses.

[260] Neema (translating Andrea's question): "Anasemaje huyo ndio anayekusaidia kwa mfano unahitaji kuoga au nani anakusaidia katika hilo?" Bibi Elizabeth: "Kwa bahati choo changu hicho hapo kwa hiyo kiko hapahapa ndani najisindikiza mwenyewe nakwenda kuoga halafu nimeweka kile choo cha kukaa nikifika nakaa naoga na bomba liko hapohapo ndani."

(Förster 2011b, 5). Nevertheless, it was helpful to spend time with the older people in their homes and to be able to see the sanitary constructions they were referring to.

As mentioned in the initial chapter of this part, intimate care activities, such as assisting an older person to shower or to go to the toilet, are gendered. Often, for older men, spouses play an important role in the provision of these activities. Van Eeuwijk also describes that "[i]ntra-generational care relations—i.e., providing care to members of the same generation—are strongly marked by the 'caregiving wife–care receiving husband' arrangement" (Eeuwijk 2014, 36). Often in these arrangements, the elderly women were younger than their husbands and in a better health condition. I only encountered one elderly couple living on their own without other family members, such as adult children or grandchildren, in the same house. When Mzee Mtoro had to undergo an operation, his wife took over the activities in and around the house as well as the care for her sick husband. Other elderly couples usually received assistance from other relatives within the same household. My landlord, Mzee Ngowi and his wife who stayed with three of their five children received much care from their adult children, however, they also performed small activities for each other. For example, Mzee Ngowi helped his wife to cut her toenails with a razor while sitting together in the courtyard.

The intimate care activities necessitate a certain closeness among relatives, and in our conversations, it became clear that none of the study participants could imagine an employed household helper taking over such tasks. Especially in Kinondoni Ada Estate, household helpers were very common in supporting older people in daily household activities. Activities such as cleaning the floor, preparing food, and cleaning dishes or doing the general laundry were not perceived as "care" by the older study participants; still, I include them in my review of care arrangements of older people. Bibi Annette, for example, employed a man for the outside of her house (i.e., cleaning the compound or cutting trees) and a woman for the inside who assisted her in preparing food and cleaning.

(Good) Food

Preparing food seemed to be a field that many elderly women preferred to control, by supervising household helpers or younger relatives. If no paid help was available, the preparation of food was one of the few tasks that many elderly women were still able to perform. Even Bibi Elizabeth, who was not able to walk anymore, made sure that somebody carried the pots to her chair in the corridor where she usually sat so that she was able to partake in preparing the food. Normally elderly men were not involved in food preparation. In van der Geest's research, preparing food for an older person was one of the most important care activities, described by the older participants of his research (Geest 2002, 10). Food is closely connected with daily survival, and especially frail older people struggled with the

preparation of their own food. Furthermore, in the Ghanaian case, most family members left the house during the day, leaving the older person alone and without anyone to buy or prepare their food.[261]

In my research context, older people mainly struggled to go to buy the food at the market due to the distance and their lack of strength to carry groceries. However, once the food was at their place, also the almost blind Bibi Ruth was able to prepare her own meals. However, what was often mentioned in the less privileged areas was the lacking financial means to buy "good" and enough food. Especially when particular diet requirements existed. Older people with chronic conditions such as diabetes or hypertension usually received special food with less salt or sugar. Some older people mentioned their struggle to follow a certain diet due to the increased costs, for example for whole-grain bread. However, in most cases when preparing food for themselves but also when others prepared for them, they managed to follow their doctor's instructions (i.e., to use less salt, not to eat red meat). Mzee Dunford followed a particular diet due to his diabetes. While his children, who did not live with him, usually bought food such as rice and beans in big quantities for him, his household helper was taught to prepare the diabetic food for him.[262]

Flexibility

Chronic health conditions such as the condition of Mzee Bariki need constant adaptation to the daily condition of the older person and a considerable amount of flexibility on the part of a household in order to handle the changing care needs. As mentioned, when introducing Mzee Bariki, in most cases of this study these changing needs were handled within a household without organizing somebody from the outside for care. Those older people with chronic conditions such as diabetes seemed more competent than their care providers in handling their condition on their own. Usually, they knew best about their diet and medicament intake, as well as the frequency of their visits at the diabetes unit. These aspects will be taken up later in this text when talking about the care for oneself.

Care After a Health-Related Crisis

Health-related crises do not necessarily only have to do with changing physical health conditions, but also with changes in their social environment, such as the loss of an important person that impacts on

---

[261] In my research context, bringing cooked food was not common and I encountered only one older person among the fifty people that I met, who received food from outside her house.

[262] Mzee Dunford was a special case with regard to his care arrangement. As mentioned in Part II, when I met him for the first time, he was sharing his apartment in Kinondoni Ada Estate with three of his adult children and two grandchildren. Two years later he remained alone in the apartment with a household helper. When talking to others about Mzee Dunford's arrangement, many would tell me that they do not think that it is acceptable for an elderly man to live alone with a female household helper. Many of the study participants emphasized that when a household helper is taking over certain care activities, another relative has to be present to make sure that he or she is performing his or her tasks well; without neglecting the older person who might not be able to defend himself or herself. When Mzee Dunford had a stroke in December 2015, his own children had to come in on a daily base in order to assist him with the intimate care aspects.

their psychological well-being. During such a critical moment, particular forms of care became more important and thus existing care arrangements need to be quickly adapted.

Let us start with Bibi Veronica's story to highlight the importance of visits to and from older people. For Bibi Veronica, after the loss of her husband, especially visits from her church group became important for her psychological wellbeing. However, not all older people were able to visit others as they wished. Here the "age-unfriendly" urban environment was one of the main reasons that hindered older people from visiting others in other wards or even sub-wards of the same city. These inner-city visits have to be distinguished from visits to and from other places within Tanzania and abroad.

Another form of care that became important for Bibi Veronica, but also for others, was the support of adult children in setting up their own income generating project, such as raising poultry. In Bibi Veronica's case, this project was meant to keep the elderly woman busy and thus help her recover from the crisis she was going through.

As mentioned in Part II, Bibi Veronica was born in the Kilimanjaro region and lost her husband only shortly before I met her for the first time.[263] Her daughter once described her as being "the perfect housewife," doing all for her husband while listening to his suggestions. According to the daughter it was even the husband who went to buy her clothes, once he decided that it is time for something new. She had been well cared for by her husband when it came to decisions concerning financial issues, and, at the same time, cared for him by preparing three meals a day and keeping the house and compound clean. During her husband's illness, Bibi Veronica was also heavily involved in the intimate aspects of care and gave up her kuku production in order to have more time for her husband. When he died, the whole "system" seemed to break apart, that is how her daughter described the situation. During our first conversations she could not hold back her tears when talking about her husband and the life they had. However, during the years we accompanied her, we saw her gradually recovering.

The life crisis that Bibi Veronica had to cope with did not directly concern her own physical health, but impacted much on her emotional well-being. This is also what her children realized when organizing the care around her. As mentioned in Part II, her oldest son, Eric, came back from the USA to help her with the funeral organizations for her late husband. Although he risked losing his permission to stay in the USA, he came back to Tanzania. And after the funeral, Eric decided to live with his mother as he explained to me that he did not feel it was right to leave his mother on her own during this moment of grief. Belonging to the ethnic group of the Chagga, the youngest son was actually supposed to take over the care of the parents (as exemplified earlier in this part). Yet Eric told me that his younger brother still had to finish his education and to find a wife and start a family, which would all be too

[263] As mentioned earlier, some aspects regarding Bibi Veronica's story can also be found in Kaiser-Grolimund (2018).

complicated if staying with his mother. Therefore, so the oldest son explained, he decided to take over this part for the time being.

After the death of her husband Bibi Veronica thus shared her house with Eric as well as a son of her late younger brother and two grandchildren. Since she had lost a lot of weight and become frail due to her grief, her children wanted to organize a household help for her. However, this proved difficult because Bibi Veronica had her own ideas about how things in the household should be done. Therefore, she preferred to do them herself. While the son of her younger brother mainly supported her in cultivating the compound (she grew different sorts of vegetables around her house) and also took over some cleaning responsibilities, the grandchildren went to school and just carried out small tasks such as quickly run to the shop close by if, for instance, salt was needed. For her grandchildren and for everyone that passed by at her house (actually, there were many: relatives, neighbors, church members—each time we visited somebody else was there) she cooked three meals daily. She had her particular system of using only little water when cleaning her pots and she always cleaned up right away, also when something dropped on the floor. When she prepared food she always made sure that it was balanced with vegetables, meat, and carbs. And for dessert usually fruits were served. Also, when a grandchild was sick, the parents usually took it to Bibi Veronica to stay there for some days until recovery.

Financial support came from her children on a regular base. New clothes were sent to her from the USA, while her youngest son, as a medical doctor, usually took over medical treatment or the escort to the hospital when needed. Being a hypertension patient, she was supposed to take regular medication—which she confessed she did not always do—and measured her blood pressure with the help of a monitor that her children sent her from the USA. Eric usually drove her by car to the supermarket or church so that she did not have to take the *daladala*[264]. In 2013, Bibi Veronica felt strong enough to take up her poultry production and the children provided her with the materials for it. Apart from being well embedded in her family, Bibi Veronica was very interested in religious activities. Her regular church visits seemed very important to her, and within the neighborhood group of the church they met regularly at each other's places for spiritual and emotional support.

What becomes evident in Bibi Veronica's case is that, apart from adult children who, in Bibi Veronica's case organize the care around her, other relatives also become important when it comes to care. Grandchildren as well as other relatives who got involved in small tasks in and around the house supported Bibi Veronica in her daily living. Also, in Bibi Veronica's case, "indirect" forms of care could be observed when her adult children supported her chicken project.

---

[264] As mentioned in Part II, *daladala* buses are used for public transport.

Projects for Older People

With such a project, children or other care givers usually intend to keep an older person busy and enable him or her to earn a small income. As mentioned above, Mzee and Bibi Bariki, too, engaged in egg production that kept them busy. I observed the establishment of these "occupations" for older people mainly in the former civil servants' milieu in Ada Estate, as it was costly to establish such a business and needed investment by others (mainly adult children) in order to get started. Also, when talking to Eric, he explained that he would like his mother to decide on a small business so that he could support her in building it up. The interview with Eric took place before the chicken project had been established:

> Eric: I think right now she wanted to do poultry. But the way she wanted to do is not life scale its small scale which is ok for her. So what we are thinking right now … we have people; Joseph [her nephew] is there … to train him; to become able enough to take care of this—because Joseph can do it and maybe two more people, to wake up in the morning, to go and feed the poultry, to get some young ones, to raise them and sell them—that would be good—but not for her to raise [the poultry] … no we don't want her to do that … Joseph can do that [and] we find a driver and the driver can go and do all the things and she [can] stay there and make sure [that] we have new ones, if they are sick, and stuff like that—because she did that before …
>
> Andrea: Ok, that would be good, so you are trying to organize that?
>
> Eric: Yeah we want her to pick up herself and then we can help her to make that happen, we don't want that it is coming from us "mommy do that do this!" No, that will not work very well because if it fails then it is you—because you came up with, but if she wants to do it, you need to support her—it's not hundred percent making profit, it could be "break nil" but at least she can have something to do and keep herself busy …
>
> (Eric 2013)

Apart from the chicken businesses, other study participants had plans to breed dogs or open a small shop where they could sell items. These occupations seemed to provide important daily structures for older people, and also helped Bibi Veronica to cope with her loss.

Visits

Another aspect that became important especially in health-related crises was home visits to older people. While not being very mobile anymore due to their own health condition, but also due to the conditions of the city, most of the study participants received visitors at their places rather than traveling to visit others. Mzee Juma, portrayed earlier, pointed to the importance of these visits: "Human beings do not live alone, people come and talk"[265] (Mzee Juma 2012).

Moving around Dar es Salaam in order to visit others was often perceived as tiresome (cf. Part II), so sometimes phone calls replaced these trips. Communication on the phone, however, was used in different ways by older people. Some of the study participants explained that they only communicated

[265] Mzee Juma: "Mwanadamu haishi peke yake anakuja mtu yoyote anaongea nae!"

with others through their phones when there was a problem. But others said that since they live far from each other, it is easier to communicate by phone than to meet in the city. Bibi Zulfa from Temeke Kichangani, for example, talked to her son (who resided in another sub-ward of Dar es Salaam) on a daily base, and Mzee Mohamad from Kinondoni Ada Estate even claimed to talk to his youngest brother in Dodoma twice a day.

At Bibi Veronica's house I was astonished that each time Monica and I visited her, other visitors came or just passed by to say hello. When she started her poultry business, even more visitors arrived at her compound to buy chicken. Apart from these passers-by also more long-term visitors were common when relatives were dispersed over different localities in Tanzania (or abroad). Due to the fact that we conducted long-term research in the former civil servants' milieu, I observed these visits mainly there. Many of the visits were related to health problems, so that people from the countryside came to stay with one of the older study participants in order to be treated in the city. I already mentioned Mzee Dunford's sister, who came to stay with her brother for some weeks because she had to undergo an x-ray. Also, Bibi and Mzee Bariki received relatives from their home village in southwestern Tanzania so that they could be treated in the city's hospitals.

On the other hand, some older people were busy themselves visiting others. As for example Bibi Hilda, who would visit her grandchild when sick, because her daughter was working and not able to take care of the child accordingly. Some of the study participants also visited older siblings who lived in other wards of the city and who were less mobile. Visits however necessitated the older person's ability to use public transport as well as the means to pay for it.

Especially funerals made older people travel longer distances to their villages of origin in order to attend the ceremonies. However, not all of the study participants had the means and health to travel long distances. Mzee Dunford, for example, once sent his son as a representative because he was unable to face the tiresome journey to his home village. Mzee Amani from Manzese Mnazi Moja could not attend the funeral of his son at his home village because the bus fare was unaffordable. Mzee Nelson from Manzese Mnazi Moja usually decided with his wife that only one of them would travel to a funeral, in order to safe costs.

When an older person was sick, usually more visitors arrived at his or her place. Visitors did not always belong to the family but also included non-kin, such as neighbors and friends who passed by in order to ask about the older person's *hali*[266]. In Bibi Veronica's case, the members of her church group seemed

[266] The Swahili word *hali* can be translated as (health) condition. It is used in colloquial speech to ask somebody how he or she is (for example, *vipi hali?*).

crucial for her mental recovery. They visited her on a regular base to provide psychosocial support.[267] Van der Geest notes for rural Ghana that older people, who are no longer able to engage in mutual visits, received less visits after some time. The author describes this as a vicious circle when the loss of social importance results in fewer and fewer people being interested in visiting the person (Geest 2002, 16; 2016, 24).[268] I did not come across older people who uttered this concern, however, I find it an important aspect to consider when trying to understand people's care in old age.

In the course of this research, many of the older study participants experienced health-related crises. Some of these crises were related to incidents in their families, such as Bibi Veronica's loss of her husband. Other crises directly concerned the older person's health. As the examples of Mzee Baraka, who fell down and broke his leg, or Mzee Tenga, who struggled with an infected wound on his leg. From a methodological point of view, these critical moments are present opportunities to observe and talk about relational care, since aspects of it are suddenly articulated and discussed that would otherwise be self-evident for older people and their relatives. In these situations, I observed a high degree of flexibility among relatives in coping with the increased burden of care, contrary to the above presented cases (of Mzee Juma and Mzee Bariki); often these crises necessitated changes in care arrangements because they could not easily be absorbed by the already existing arrangement.

ON *KUJITUNZA* OR EVERYDAY SELF-CARE

When it comes to relational care, as mentioned above, the older participants of this study referred to different structural contexts in order to negotiate the "right" care and oriented their agency mainly towards habitual practices. Very prominent thereby were reciprocal duties based on kinship that made older people expect care from their adult children in old age. While the older people looked after their children when they were still young, they now expected their children to "give back" some of the care. However, not all of the study participants fully depended on these reciprocal norms to the same extent. Some claimed that they did not want to be a burden to their children in old age which was one of the reasons why they cared for themselves.

[267] The aspect of religion and prayer groups will be taken up again in the following sub-chapters on self-care.

[268] Van der Geest mainly mentions younger people who would be expected to visit older people in order to listen to their stories, which is in the author's eyes an important aspect of care. Van der Geest describes these visits as "moral duty one would rather not do" (Geest 2016, 25). The daily visits that Bibi Veronica, for example, receives are often paid by other older people, who are not as busy as the younger generation during weekdays and find time to visit, in case their health condition allows. Children and grandchildren preferably visited at weekends.

In the following sub-chapters I will therefore explore the older people's engagements in what I came to call "everyday self-care."[269] To a great extent I concentrate on the older study participants of the former civil servants' milieu in Ada Estate because I especially focused on (health promoting) practices of everyday self-care in this milieu. In addition, as will be explored below, belonging to the urban middle-income milieu seemed conducive for a future oriented self-engagement in one's own care. Furthermore, these engagements also depended very much on the health condition of the older person. Older people who were frail and dependent were not able to care for themselves to the same extent with advancing age. Often, they accepted their frail condition by using the phrase "nipo tu." In contrast to the very active and younger study participants, who did not accept their condition but engaged in practices to improve it. Most of the project's study participants from the middle-income milieu were rather young older people (between sixty and seventy years) and had enough strength to engage in physical exercise, for example. By taking care of themselves many of them were able to cope well with chronic illnesses. The earlier mentioned approaches, as promoted by WHO, that search to empower the individual to take actions in order to live a healthy old age target rather healthy people who are able to engage in these actions.

In the following chapter, I will first address the paradigm of "successful aging" and ask whether aspects of the movement can be found among the articulations of the older participants of this study when engaging in everyday self-care. The aspects of individual agency and control, independence, productive activity and permanent personhood (Lamb, Robbins-Ruszkowski, and Corwin 2017, 7) will be discussed critically when reflecting on the ethnographic material presented later in the text.[270]

"SUCCESSFUL AGING" IN DAR ES SALAAM

When I talked to Mzee Mohamad, who was in his mid-sixties when we met, about his future as a frail older person, he explained that he did not intend to become a burden to others in old age:

> Andrea: And if you become weak who will take care of you, like to assist you to walk, maybe in the thirty or twenty years to come?
>
> Mzee Mohamad: I am not expecting to live up to those years. I do not expect to live more than five years from now.

---

[269] The idea to call these practices "everyday self-care" derives from a personal conversation with my colleague Sandra Staudacher. By calling it *everyday* self-care, my aim is to encompass a broad range of activities that an older person does for his or her wellbeing.

[270] I was inspired by Lamb's recent edited volume on "Successful Aging as a Contemporary Obsession" where she critically reflects about the paradigms around successful or active aging and asked contributors to look at the question what successful aging means for different people in different parts of the world (cf. Lamb 2017b). Some aspects of this discussion have also been highlighted in the book chapter "Healthy Aging, Middle-Classness, and Transnational Care between Tanzania and the United States" (c.f., Kaiser-Grolimund 2018).

> Andrea: So you don't expect to become very weak so that you need help?
>
> Mzee Mohamad: No no no! Because it will be like giving trouble to other people and there is no need of that.
>
> (Mzee Mohamad 2013)

With the intention to remain healthy in old age, many older study participants cared for themselves in different ways. One of them being physical and targeting directly their health condition (such as, conducting exercises or eating good food), the other being psychological and targeting a broader well-being (such as, engaging in prayer groups or caring for others such as grandchildren). These aspects are captured in the Swahili verb *kujitunza* which serves as a starting point to reflect about everyday self-care. As will be shown, the older people's self-care was very dynamic and changed according to their actual health condition, the support and care through their care network as well as health-related crises in their lives.

The paradigm of "successful aging," that can be described as foregrounded in the USA and the paradigm of "active aging," foregrounded in Europe, promote in the popular but also in the academic literature mainly four common themes: individual agency and control, independence, productive activity, and permanent personhood (Lamb, Robbins-Ruszkowski, and Corwin 2017, 7). The first theme around individual agency and control addresses the fact that how a person ages is up to him or her, aging is thus an individual project that everybody can design and control (Lamb, Robbins-Ruszkowski, and Corwin 2017, 8). Independence in old age is described as taking care of oneself by living in an own home and not being forced to share living arrangements with children or other relatives (Lamb, Robbins-Ruszkowski, and Corwin 2017, 9). While the goal of productive activity mirrors an active aging of busy older people who travel or engage in educational programs (Lamb, Robbins-Ruszkowski, and Corwin 2017, 10-11), the idea behind a permanent personhood can be depicted as an ageless aging or as Lamb et al. put it "[t]he aging self is, ideally, an ageless self" (Lamb, Robbins-Ruszkowski, and Corwin 2017, 12).

Successful or active aging can be described as a movement that does not want to relate becoming old with disability and decline but with activity and success, or as Lamb et al. describe, "[a]ging well becomes a vital personal and moral project, benefiting not only the individual but also one's broader family, society, and nation" (Lamb, Robbins-Ruszkowski, and Corwin 2017, 2). Older people do not become a burden to their families or the state by being dependent on others, but contribute productively to the society. When conducting research among well educated, middle or upper-middle class older people in the Boston area in the USA, Lamb found that many of her research participants engaged heavily in activities around successful aging, although some critical voices were uttered with regard to the pressure that this paradigm puts on individuals who are not physically or mentally able to follow it (cf. Lamb 2017a).

In the same edited volume by Lamb on "Successful Aging as a Contemporary Obsession. Global Perspectives," other chapters contributed to an alternative view from African countries. As mentioned in the introduction of this PhD thesis, Reynolds Whyte writes about the "African way" that she describes as "desired interdependence" as age advances (Reynolds Whyte 2017, 247). The author describes desired interdependence as "it makes a virtue of caring for relationships with those who will provide support when the time comes. The body is a means of social engagement and usefulness to others, not primarily something to be nurtured for its own sake" (Reynolds Whyte 2017, 245). The author mentions the "intergenerational contract" that, based on reciprocity, makes the children responsible for their parents as the parents cared for them when they were young.

The paradigm of successful aging mainly targets healthy people; this is also problematized by McIntosh who states that although her elder study participants on the Kenyan coast live longer today, they often have to cope with what she calls "diseases of modernity, including heart disease, stroke, diabetes, and cancer, as well as HIV/AIDS …" (McIntosh 2017, 192). The studies on successful aging based in the African context furthermore point to the inequality when it comes to the provision of state pensions and other forms of support in old age and emphasize that wealthy older people have more possibilities in investing in their children's education and thus in their future care when these children have salaried jobs and are able to care for their parents in old age (Reynolds Whyte 2017, 245-246).

While in the literature there seem to be an "American way" of aging that is opposed to an "African way," in the following sub-chapters I would like to explore how a "good" or "successful" old age is imagined by the older participants of this study. As presented above and labeled as the African way of aging successfully, relations and care that is provided for older people constitute an important part of kuzeeka vizuri. However, as will be highlighted in the following text, older people in Dar es Salaam also implement some of the activities that could be attributed more to an "American way" of getting old, although I find it problematic to call it so. In what follows below, I would like to emphasize people's engagements in everyday self-care and argue that when wanting to know more about how older people in Dar es Salaam articulate their way of aging well (kuzeeka vizuri), we should not only look at relational care but also take into account what they say they wish to do or do for themselves (what I call everyday self-care). While Bibi Helen's idea about accepting decline as God's wish does not come close to the concept of permanent personhood, Mzee Dunford's engagement in Yoga exercises reminds us of some of the discussions around activity, individual agency and control in old age.

The older study participants' subjectivities[271] were to a great extent shaped by their wish not to become a burden to others while being able to remain a decision maker with uhuru to decide—or even take

[271] Ortner describes that "… the idea of agency itself presupposes a complex subjectivity behind it, in which a subject partially internalizes and partially reflects upon … a set of circumstances in which she finds herself" (Ortner 2005, 45).

over care for others. Investing in health promotion in order not to become frail and dependent can be perceived as a projective aspect in the older person's agency (cf. Emirbayer and Mische 1998, 983-984), that is not only targeted to the present when mitigating health problems, but also to the future as a person in advanced old age. As mentioned in Part I, Emirbayer and Mische define the projective element as "the imaginative generation by actors of possible future trajectories of action, in which received structures of thought and action may be creatively reconfigured in relation to actors' hopes, fears, and desires for the future" (Emirbayer and Mische 1998, 971). Imagining can thus be described as the "creative … dimension of agency" (Emirbayer and Mische 1998, 984). Especially those older people who are confronted with the Legal Age (cf. Part II), such as the former civil servants, articulated concerns and ideas about their lives as older people. As life expectancy increases, a timespan in the life of the individual after retirement begins to open up.

Before illustrating some of the above-described practices around everyday self-care by drawing on ethnographic insights, I would like to reflect on a conducive environment for these activities. As will be shown below, especially the urban environment with its landscapes of information, but also the available (financial) support from children or relatives seemed important here.

A Conducive Environment for Self-Care

Being in rather good health, thus with a certain amount of strength, enabled older study participants to engage in practices of self-care. Lamb et al. criticize, amongst others the inequality at stake when it comes to investments in successful aging.[272] They claim that the "successful aging discourse assumes that people are already healthy, and the challenge is only to maintain this existing status" (Lamb, Robbins-Ruszkowski, and Corwin 2017, 15). Although older people need strength to engage in health promoting activities, the story of Mzee Dunford below will show that especially older people with a chronic illness were significantly more aware of their health and consequently engaged more than others in everyday self-care.

Furthermore, the health-promoting practices seemed to be prominent among urban elders looking for ways of staying healthy in the city. Many study participants underlined the difference between aging well in the countryside and in the city, as mentioned in Part II. In the rural environment, according to some study participants, older people automatically engage in practices of self-care by conducting bodily exercises through farming and by eating healthier food, which they produce themselves without

[272] Lamb et al. furthermore highlight that the successful aging paradigm is ageist, as it judges becoming old and frail as not being okay (Lamb, Robbins-Ruszkowski, and Corwin 2017, 13). In addition, they claim that the paradigm maintains gender stereotypes and is ethnocentric as it is tied to US values and visions of an ideal way of growing old. As a last point, the authors highlight the importance of incorporating more the voices of the older people themselves which does not seem to be done enough (Lamb, Robbins-Ruszkowski, and Corwin 2017, 16).

fertilizers and with clean water. While some older people in the city tried to engage in crop cultivation around their houses and invested in what they perceived as healthy food, others searched for alternatives in order to stay healthy in old age, for example, practicing walking exercises or yoga.

In the city, not only the possibilities to engage in physical activities differ much from the countryside but also the landscape of information on health promotion and disease prevention seems to differ from the rural environment.[273] Although information from newspapers that promote special diets in their health sections, TV channels that stream aerobic exercises, and NGO's that advertise screenings for particular diseases seem accessible independent of the place of residence, they seemed more prominent in the urban space. Especially the international discourse on health in old age is distinct from the values heralded by the Tanzanian state and the Aging Policy that describe the family and especially adult children as being responsible for the care of older people. At the same time, these international ideas promote an individual self-care of the empowered older person whose aims in old age are to remain independent from others—and healthy.

The older participants of this study are shaped by different contexts that inform their actions in some way or another. Their engagements in everyday self-care usually did not only start in old age. Some of the study participants underlined that they had already engaged in exercises when still young. Others, however, realized only with the onset of an illness that they needed to change their health behavior, and started to engage in particular activities. Additionally, belonging to a middle-income milieu, older people had more (financial, educational, for example) possibilities to make use of new forms of aging in the city.

While in the USA, successful aging seems to be an individual project, the engagement of older participants of this study in caring for themselves was facilitated by their adult children or other caring relatives. They did so by providing financial means, knowledge or practical support. These caregivers thus contributed to a conducive environment for the older people's self-care. As mentioned earlier, some caregivers provided financial means for older people to cultivate crops or raise chicken, with the aim of keeping their parents or relatives busy in old age. Also, regular health checkups, which became especially important for older people with chronic illnesses, needed some guidance as well as financial means that were usually provided by others, either directly in form of money or indirectly by contributing to a health insurance for an older person. Children living abroad furthermore seemed to influence some of the care that the older study participants provided for themselves, when sending medicaments or technologies targeting the improvement of health in old age (cf. Part IV). Moreover,

[273] As I did not conduct research in rural Tanzania, I base my argument here on observations of others (study participants, assistants, and other researchers of the overall project).

adult children, but also others such as medical doctors, were much involved in the older person's access to information.

Although some ("self-help") groups for older people seem to exist in the city, none of the older participants of this study belonged to such a group.[274] When we asked, the older study participants and their relatives did not know about any institutionalized form of (active) aging in groups in Dar es Salaam. When Mzee Dunford, conducted his exercises, he walked along the busy streets of Dar es Salaam on his own.

CARING OLDER PEOPLE

In the following text, different aspects of everyday self-care will be addressed. While they mirror in some ways the international discourse on successful or active aging, they reject others. Some practices are mainly oriented towards remain healthy in future old age, others targeted more a mental or spiritual wellbeing. Other practices again, focus more on dealing with a chronic condition while learning more about preventive practices to cope with a particular illness. Furthermore, a slightly different aspect will be included as well, namely, when older people become caregivers for others.

SPIRITUAL CARE AND "GOOD" FOOD

This chapter starts with the story of Bibi Helen to show how a healthy older person who does not have children of her own engages in everyday self-care in order to remain in good health in future. Bibi Helen also serves as a case to show the importance of faith when it comes to wellbeing in old age. Bibi Helen is one of many elderly women I met who was very engaged in her church. Many of them not only attended Sunday services at church but also spent a considerable amount of time there attending prayer groups during the week. In addition, being able to travel to church and attend services or prayers required strength, thus especially healthy older people engaged much in this kind of spiritual care.

Bibi Helen also noticeably invested in a healthy diet, a topic that was mainly discussed among the older study participants from the middle-income milieu as it premised the possibility of choosing between different kinds of food, which was not the case for all participants of this study.

Bibi Helen is one of the few older people of this study who always answered the question about her health condition in the same way: she was fine. When Monika and I asked her about the last time she went to the hospital she said that must have been around the year 1984. Although very skinny, I soon learned that Bibi Helen was very strong and able to look after herself. When we met for the first time

[274] Some of the older study participants were part of church groups, prayer groups, or saving groups, but those groups never only involved older people but also middle aged or younger people.

in 2012, she was sixty-seven years old and was living in her sister's house that was in the process of being renovated. The house was one of those so-called "servant's houses" belonging to one of the big apartment blocks on Ada Estate. Each apartment had a servant's house. Many people used these servant's houses for living while they rented out the main apartment. Bibi Helen's sister who was the actual owner of the apartment and the small house also decided to do so. However, in order to be comfortable in the servant's house, they undertook some major renovations. Since the sister lived in central Tanzania at the time and was employed at a university there, Bibi Helen was the one supervising the constructions. In 2012, Bibi Helen was living in the house together with her niece who profited from going to school in Dar es Salaam while her father remained in their home village in the southwestern part of the country.

Bibi Helen did not have any children of her own. But she raised two of her younger sister's children and looked after another niece. She had worked as a secretary for the government for several years before retiring early in 1997. It was in the same year that her sister was able to buy the house in Ada Estate. Apart from the little pension she received (around TZS21'000 every month[275]), her siblings supported her financially. In particular, one of her younger sisters and a younger brother, both in Dar es Salaam, supported her on a monthly base. Her younger brother had his own church in the city center and was married to a German. The siblings also had a family bank account to which they contributed money on a monthly base. Next to their house, Bibi Helen and her sister were able to let some *mabanda*[276], which gave them a little income. Furthermore, Bibi Helen also worked for her church to earn a rather symbolic amount of money. In 2013, Bibi Helen's sister who stayed in the central part of the country retired at the age of sixty and came to stay with Bibi Helen and her niece in the house in Dar es Salaam, together with her own daughter. Most of the household tasks were shared among the household members, only for the little garden in front of the house they employed a paid help from outside. Bibi Helen usually took over the preparation of food, since the girls were at school, while the nieces were responsible for cleaning the house.

Bibi Helen and her siblings came together at least four times a year to discuss family issues, most of the time related to their land in the home village. Each sibling had received a part of land from their parents and they were farming together. The siblings also purchased a tractor together so that the only brother who was left in the village was able to do the cultivation of crops for all of them.

The fact that she was so healthy and strong Bibi Helen explained by her Christian faith. She did not buy large amounts of food at once so that she did not have to carry too much, and she was not able to

[275] The amount of TZS 21'000 equals approximately US$9.

[276] In singular, *banda* can be translated as a shed or hut where people usually sell food on the street, it can also be used to describe a construction used for living.

do garden work as she had done in the past. However, otherwise she claimed that she did not feel restricted in her movements due to age. Only when knowing her better, she revealed that she was following a particular diet because of food allergies. A colleague from the bible study gave her a specific book on how to eat according to your blood group and your body. Since following these rules, which meant avoiding rice, wheat, and sugar, she said that she felt much better. She started her diet in 2009. And sometimes when she was fasting for religious reasons, she took a special *uji*[277] afterwards to increase her weight again. The doctor who advised her to take the porridge was based at Temeke hospital. Since this doctor was recommended to her (sharing the same faith as born-again Christians), Bibi Helen preferred to travel all the way to the South of the city for treatment. Furthermore, Bibi Helen took a specific kind of olive oil pills as a food supplement and during the time she was able to profit from the health insurance of her sister (before the sister retired), she regularly went to the dentist to have her teeth cleaned. Furthermore, for her appearance, she usually dyed her hair to look younger. She told me once that she thought elderly women with grey hair looked good, however not herself.

As a very religious person, the church and bible studies took up a big part of her week. We were able to join her on church visits on a Sunday morning and it took us a while to get to the northern end of the city, where her church was located. Some of the bible studies were late in the evening, starting at 11 p.m., so that Bibi Helen had to walk through the ward when it was already dark. She did not see a problem in doing this, because she claimed to be protected by her faith. Although at the same time, together with the neighbors, they paid for a *mlinzi*[278] to ensure security of their houses. At home, her belief was also prominent as she watched mainly one TV channel, that of "T.B. Joshua," the most famous Nigerian priest in Tanzania at that time with his own TV channel. Her sister and the sister's daughter even traveled to Nigeria to spend a week at the priest's church. When talking with Bibi Helen, she usually did not make long sentences, but when it came to religion, she could talk for hours it seemed.

When we met for the last time in 2015, she was just in the process of moving to her brother's house on the outskirts of Dar es Salaam because her other brother had come to Dar es Salaam with his children, so they moved family members to create space for everyone. She had also changed her church, maintaining that she had learned everything she could in the other church. Although I had the feeling that the church community in Kawe was crucial for her, it seemed that this familiarity with the church was not bringing her forward on her spiritual journey. In addition, she also started an NGO together

---

[277] The Swahili word *uji* can be translated as porridge.

[278] A *mlinzi* is a watchman.

with one of her sisters. They were busy starting an orphanage so that Bibi Helen could take care of orphans in her old age.

Apart from some health promoting self-care activities, many older study participants, like Bibi Helen, heavily involved in activities around their faith. When talking about aspects they considered beneficial to their own health, such church activities were often mentioned.

Importance of the Church

Especially in the former civil servants' milieu, where twelve of the thirteen randomly sampled study participants belonged to a Christian faith, religion constituted an important part of their lives. This is not to say that for the Muslim older study participants, religion was less important, however, since I mainly focused on churchgoers, what follows primarily concerns the Christian faith.

For many of my study participants, going to church (as well as going to the mosque) structured much of their daily life. Depending on their denomination, they attended church services on Saturdays (for example the seventh day Adventists) or on Sundays (for example, the RC or Lutheran as well as many Pentecostal churches) but also on particular weekdays (for example, the Jehovah Witnesses). Apart from the church services, many older people also attended Bible groups or prayer groups during the week. Bibi Rose, a former agronomist from Kinondoni Ada Estate, for example, attended morning prayers at her church every day. In my field notes I described her daily routine as I was impressed how the church structured her days:

> To be in church on time Bibi Rose gets up at 3 a.m. in the morning. At 10 a.m. she is back from church and takes her chai (breakfast). Then she rests a little and after having had lunch, Bibi Rose does some garden work and looks after her poultry that she keeps outside the apartment block. Sometimes she attends again the evening prayers of the church but sometimes she prefers to stay at home and to cook dinner for the family. In the evening the family prays again together, and depending on how tired she is Bibi Rose watches some news on TV or reads in her Bible or directly goes to bed, between 8 p.m. and 11 p.m. (Field notes 10.04.2013)

Of course, only those older people with enough strength (nguvu), like Bibi Rose or Bibi Helen, were able to attend church meetings regularly. For me it was particularly impressive to learn that these elderly women would walk through the city at night without fear to attend these early morning or late evening prayers. Especially Ada Estate, being a middle-income area, where the main street turned into a place known for street prostitution at night and where, during open air concerts, pickpocketing increased drastically,[279] was in my view not the safest environment for an elderly woman to walk alone in the

[279] As mentioned in Part II when describing the area, Ada Estate has a famous ground for open-air concerts ("Leaders club"). During concerts, residents usually did not go out because these events were known for attracting "criminals" from more deprived areas of the city (people would usually mention those arriving by foot from Manzese or even Mbagala). I only once attended such an event and was impressed by the fact that armed police officers escorted festival visitors from the festival ground to their cars. Nevertheless, I "lost" my phone out of my pocket on the way to the car.

dark. However especially the elderly women, who attended these prayers more than did the older men of this study, were convinced—as Bibi Helen—that nothing could happen to them because they believed in God. Though, not all the study participants were able to attend church services as they would have liked to due to their health condition. Mzee Ngowi explains:

> I couldn't go to church early in the morning. I used to pray in the morning, the early morning prayers at 7 a.m. but I cannot wake up at that moment… certainly I am advised by the doctor not to be in a congested group, you know, and therefore if I go to church, I prefer when I happen to go to church, I prefer to stay at the window you know—to stay at the window but not right within—If I stay in a congested place, I feel uncomfortable. (Mzee Ngowi 2012)

Attending church services can be very exhausting for older people. Bibi Bariki, whose husband was portrayed earlier, was very proud that she was still able to attend the early morning service of her church in the city center. She explained that usually older people have problems in getting up early in the morning and are mostly seen at the second service which only started around 10 a.m. Bibi Annette, who will be portrayed below, attended the church services of a church on the outskirts of Dar es Salaam. It took her a considerable amount of time to get there by public transport. Since services usually started on Saturday and did not end until late at night and started again on early Sunday morning she usually slept at the church with other churchgoers. Sleeping on her *khanga*[280] on the floor caused the seventy-year-old Bibi some troubles with her back. However, she once explained that she did not want to bring the sleeping bag that her daughter from the USA had sent her, because she did not want to distinguish herself from the others who just had a khanga to sleep on. Exhausting services or prayers were also a reason to stay at home for some of the Muslim study participants, as Bibi Khadija from Temeke Kichangani explains: "I can't go [to the mosque] because when they have to pray, they have to bend down and get up so I can't do that fast and that would interrupt the prayer so I decided to pray at home"[281] (Bibi Khadija 2012).

Not only the active services at church challenged the healthy older churchgoers but also the distance to church. Usually, the church was not close to the person's home and he or she had to manage a certain distance by public transport. Accompanying the older study participants to church revealed some of the access problems they faced in the city.[282] When going to church with Bibi Bariki, who attended Sunday services together with her daughter in a Lutheran church in the city center, it became

---

[280] A *khanga* is a traditional cloth that women wear as skirts, headscarves or use to carry children. Khanga are usually colorful and contain a saying in Swahili. They can be used to transfer messages, for example, when attending a funeral particular khanga are worn for funerals.

[281] Bibi Khadija: "Kwa hiyo inakuwa taabu kuinama uinuke na wenzako kwa hiyo hamuwezi kwenda sawa inakuwa kama unawaharibia swala yao."

[282] I already mentioned exhausting travels to health facilities.

evident to me that the public transport was a major difficulty for older people, since public transport was not at all "age-friendly" (cf. Part II):

> Once we arrived at the bus stop after walking for 15 minutes, we had to wait for the bus a long time until we found one that goes to Kariakoo. The bus was then very full and Bibi Bariki was at first hesitating to enter, but she decided, because we were already very late, that we should go. At first, she was standing, squeezed in like everybody else as well, but soon she found an empty seat and was even able to hold my bag on her legs. While waiting for the bus she already prepared the money for the bus fare, which she held in her hand during the travel. We got out of the bus near Kariakoo and had to walk for another 10 to 15 minutes until we reached the church. (Field notes 21.04.2013)

As the above-mentioned examples show, attending church services or "navigating" the city in general was heavily connected with a person's health condition. However, the church was not only associated with the exhausting experience of managing the city, but also with the positive effect on emotional well-being. The following statement of Bibi Annette confirms this effect: "I go to church very often because that is the only place I get psychological satisfaction…" (Bibi Annette 2013).

In Bibi Veronica's case, too, being embedded in a church network was very important to her after the loss of her husband; the neighborhood prayer group visited her at her place and they prayed together. This type of psychosocial support was highly valued by the study participants and many considered their spiritual engagement an important aspect of their self-care.[283] In this connection, most of the Christian participants of this study were very particular when choosing the church they frequented. Dar es Salaam's landscape of Christian denominations and churches is vast (cf. Dilger 2014, 53) and thus there is a huge selection to choose from. I was astonished that many older study participants chose their church without considering other family members' preferences, but went to the church they perceived to be best for their own spiritual well-being. Bibi Rose from Kinondoni Ada Estate, for example, chose a particular Pentecostal church that the rest of her family perceived to be a sect. When accompanying Bibi Rose to her church service, we were able to observe that everyone in this church was supposed to wear white clothes, and church members recognized each other's membership to the denomination through particular formula of greetings.

Bibi Rose, like many others, considered their spiritual engagement crucial not only for their mental health but also for physical ailments. Through prayers, they claimed to be healed from certain diseases without using biomedical treatment. Others built on their faith when explaining why they would rather not actively engage in fighting against a particular health problem as they accepted what God foresaw for them. Corwin, who writes about Catholic nuns and their alternative vision of successful aging, states that the nuns experience a successful old age mainly because they do not pursue these common themes

[283] Psychosocial support is also topic of Dilger's text on religious institutions engaging in medical care (cf. Dilger 2014). Churches Dilger looked at in Dar es Salaam engaged in psychosocial counselling and some paid for operations for members (Dilger 2014, 63).

of individual control or independence (Corwin 2017, 100). Rather "they seemed to understand illness and death as inevitable and met these … with acceptance, serenity, and a sense of peace rather than with a sense of failure, discouragement, or frustration …" (Corwin 2017, 102).[284] Furthermore, Corwin also states that the Catholic nuns that participated in her research did not seek to be independent but rather aspired interdependence "as a way to serve and to be served" (Corwin 2017, 104). In a religious sense, caring for others can thus contribute to one's own well-being. This aspect will be taken up later in this text when portraying Bibi Annette who was called to care for her sick ex-husband.

As mentioned above, especially some of the older women I met not only attended Sunday services at church but also engaged in prayer groups throughout the week. These engagements seemed to broadly structure their daily lives. Furthermore, many women considered their active participation during services (which usually also involved singing and dancing) as a form of physical exercises.

Researching in a Christian environment in Ada Estate, church visits became important means through which the research team was able to participate in the older study participants' daily activities. And as the older people started to consider us as part of their family, they wanted us to join them in their particular church. During the course of my fieldwork, I learned much about the different Christian denominations and their church services. I went to Lutheran, Catholic, and many different Pentecostal church services, usually together with either Frank or Monica. One of the older study participants was a pastor himself and had his own church.[285] While I could join the services out of curiosity, Monica and Frank had a more difficult task to distance themselves especially in the Pentecostal churches (usually they were very interested in new members). Getting up for church very early on Sundays and holding out for hours in a loud and stuffy building, usually after some time with an empty water bottle was physically challenging for me—but provided those precious moments of shared experience.

Kula Kizuri

As mentioned briefly in Part II, a very important aspect of everyday self-care was to eat well (*kula kizuri/vizuri*). Bibi Veronica and Bibi Rose, who both kept poultry, would never buy *chapati*[286] on the street because they claimed that you would never know how they were prepared. Their main concern was the oil that was used to prepare and fry them, as it was known that to save money, some food vendors would reuse cooking oil several times for different meals. Bibi Veronica, therefore, prepared

---

[284] Death was also accepted by the Catholic nuns in Corwin's research as they did not aspire permanent personhood as described in the US paradigms around successful aging, but rather saw death "as a transition from corporeality into another mode of being" (Corwin 2017, 106).

[285] This elderly man was actually a very successful economist with his own company, which expanded to the USA. When in the USA for business he had a "call" from God and stopped his company immediately to open his own church.

[286] As explained in Part II, *chapati* are locally made flatbreads.

her own chapati by using the much more expensive sunflower oil. Sunflower oil however cannot be purchased at the local shops but only in the big supermarkets. Both Bibi Veronica and also Bibi Rose, who was an agronomist, cultivated their own vegetables around the house. They said that the food you can buy at the market is sometimes grown with wastewater, so they too did not trust the vegetables sold at the markets (cf. Part II).

Another topic among the older study participants was the preparation a high quality ugali. Bibi Hilda, a diabetes patient, bought good quality maize and mixed it with other cereals to prepare a healthier ugali. She brought her own mix to the grinding machine which involved a walk through the neighborhood carrying the maize, we once joined her and helped carry the heavy packet of grained cereals. As mentioned earlier, while only some older people had enough space around their houses to cultivate their own food, others had a shamba on the outskirts or outside of Dar es Salaam (cf. Part II). Many had a piece of land in their home village; however, being far away, these pieces of land were not used for cultivating food.

When talking with the older participants of this study about what they considered aspects of kuzeeka vizuri, "good" food was frequently mentioned. However, I soon had to realize that good food does not necessarily mean healthy food from a biomedical point of view. Bibi Veronica, who used sunflower oil for her chapati, was very concerned with cooking healthy food for her grandchildren and children in the house. She told me that she learned to do so when she was still young; she assisted German sisters at a mission in caring for patients and was taught about their understanding of a healthy diet. As mentioned earlier in the portrait, when she prepared food she therefore made sure that there was always a vegetable side dish as well as fruits for dessert.

Mzee Dunford struggled hard to find out which kind of food was best for his health problem. During the years we met, he often changed his diet without really knowing what was good for him. When Elisha and I met him first in 2012, he ate beans, chapati made from soya flour, and *mboga za majani*[287] three times a day. A major problem for him was to access information about what diabetic patients should eat.

Good food is what an older person likes and accepts, in the words of Mzee Mohamad. It is food that is rather expensive and contains a lot of meat and oil. Van Eeuwijk describes for Indonesia that "[c]hanges in eating habits among better-off elderly people in particular have led to over-eating and the over-consumption of fat, oil, salt, sugar and starchy foods" (Eeuwijk 2007, 3). Good food therefore can increase the risk of so called diet-related lifestyle diseases, and "newly emerging chronic diseases such as obesity, diabetes, hypertension and cardiovascular problems" that come along with age-related

[287] The side dish *mboga za majani* can be translated as leafy vegetables.

impairments (Eeuwijk 2007, 3). While many of the former civil servants were aware of a difference between "good" and "healthy" food, some still preferred good food over a healthy and balanced diet, but then also complained about their weight, like Bibi Annette who had been trying to lose weight for several years already, but said about herself that she simply enjoyed her food too much.

An often-discussed aliment in this study was chai. Black tea was often consumed with a large amount of sugar, and especially for diabetic patients it was difficult to get used to chai without sugar. "Sugar for chai" is also a paraphrase used if a family member gives money to an older person. The person who gives the money would say that this is money to buy sugar for chai. Also, when an older person asks for money, he or she would ask for a contribution to buy sugar for chai. Many older people struggled to take chai without sugar. The milk powder that is added to the chai also contains a certain amount of sugar. Those who were able to afford it therefore bought the much more expensive fresh milk (which requires a fridge). For some older people it was also very common to drink sodas. Of course, Coca Cola or Sprite is not quite the right thing for diabetic patients, but many struggle to completely abstain from soft drinks.[288]

In the less economically well-off areas, especially patients with chronic conditions such as diabetes or hypertension struggled to access food that is good for their health. As mentioned in Part II, they were advised to take whole wheat toast bread instead of white bread, which was more expensive. For hypertension patients, another issue was to renounce salt. They were told by doctors that they should not eat food containing a lot of salt. However, depending on who prepared the food in a family, some had to negotiate about the amount of salt added, with either more or less success. Some older people with heart problems were told by the doctor to not consume oil. Mzee Rajani from Ilala Mafuriko, for example, received each dish prepared separately for him without oil.

On the one hand, food has much to do with the freedom of deciding what kind of food an older person wants to eat; this will be discussed below. On the other hand, it is also very much a concern of relational care when food is purchased or prepared by others. According to van Eeuwijk, food reveals power relations. For Indonesia, the author describes how a caregiver—care receiver relationship "is largely defined by the giving and receiving of food and nutrition which generates very powerful interpersonal relationships…" (Eeuwijk 2007, 2). Especially regards more deprived households, the author describes older people as "net consumers" and considered to be rather "weak, passive household members" (Eeuwijk 2007, 3). In contrast, being house owners, many of the older study participants in Dar es

[288] When conducting my field research in 2013, Cola zero was heavily promoted all over Dar es Salaam. Although less harmful, diabetic study participant Bibi Hilda still preferred the "normal" Coca Cola.

Salaam emphasized the importance of being able to choose the type of food they prepared or that was prepared for them.

As the advertisement in a health section of a local newspaper shows, information on how to eat healthily is shaped variously. However, access to the “right” information is not given to every older person. As mentioned earlier, study participants from the former civil servants’ milieu in Ada Estate above all raised the topic of eating well when I asked them what a good old age meant to them. Much advice on how to eat well came from medical doctors that the older study participants from the middle-income milieu met when going to the hospital for a checkup or treatment. The influence of adult children or other caregivers was described as rather marginal, as most study participants claimed that they knew better than their caregivers which food was best for them. Newspaper articles, such as an ad for apples, often revealed the international discourse—not much adapted to the local context.

When looking at church visits and good food, the older study participants seemed to know what is best for them and chose their food and church individually. While church services and prayer groups also provided some psychosocial support and thus contributed to a broader well-being, good food targeted healthy living, especially when coping with a chronic condition. Church was an important leisure activity for those who had enough time and strength to engage in it. At the same time, eating well needed sufficient financial means and knowledge that was mainly acquired when visiting medical doctors.

Care For One’s Own Chronic Conditions

In this PhD thesis I focus mainly on two chronic conditions, namely diabetes (type 2) and hypertension. I concentrate on these two chronic illnesses because they were the most frequent concern of my older study participants. Both conditions belong to the so-called chronic non-communicable diseases (CNCDs) (Daar et al. 2007, 494; Reynolds Whyte 2012, 65).

Below I present Mzee Dunford’s story as it stands for those older study participants who have a chronic impairment and engage in everyday self-care in an attempt to cope with it.[289] Especially the former civil servants’ milieu members suffering from hypertension or diabetes were very aware of their body and the disease, and thus much engaged in self-care. Due to their regular visits to the hospital for medication, they are exposed to information on how to live best with their chronic conditions. In Mzee Dunford’s view, however, the information he received at the hospital about how to live with diabetes was not enough. Therefore, he started to actively search for information about other forms of self-care (i.e., Yoga or walking exercises) in order to improve his condition.

[289] See also Kaiser-Grolimund (2020), where Mzee Dunford’s case is discussed with regard to transfigurations of aging.

Mzee Dunford was already portrayed in Part II of this PhD thesis. Well over seventy years of age, he lived alone with his female household helper in his apartment in Kinondoni Ada Estate. When I met him in 2012, I had the impression that his health condition was rather bad. He seemed quite frail, spoke slowly, and even told me that he was not sure whether, after my return to Switzerland, I would ever meet him again. He described himself as being with little strength (nguvu) due to his diabetes. Nevertheless, he was still able to perform minor tasks such as doing his own laundry or watering his plants in the garden. When we met again at the beginning of 2013, his condition had not changed much but the two grandchildren that had stayed with him in 2012, had to leave because it was too much effort for him to take care of them. He struggled with his diet and tried different foods in an attempt to feel better, while his fluctuating blood sugar level made him feel better or worse, day after day. Hence, while on some days our visits meant sitting on the sofa in his living room, chatting, on other days, when he was feeling much better, Frank and I would join him for exercises. When conducting his exercises, Mzee Dunford walked for almost two hours around the ward. Usually, he did this early in the morning around 6 a.m. because of the traffic and the heat which at that time is still more manageable.

As a big fan of the football club Manchester United, Mzee Dunford also went to watch several games of his team at the bar close by where we sometimes joined him. He explained that while earlier on he was still able to drink a beer, he does not consume anything now because of his illness. He found out about his diabetes in 2007 when he started to feel weak and a relative advised him to see a doctor for a checkup. Mzee Dunford was enrolled in a diabetic program of the diabetic unit at Mwanyamala hospital in Kinondoni. He was booked in for monthly appointments with the diabetic specialist at the hospital. During the monthly control of his blood sugar level, he also received a fresh dose of insulin pills that lasted for a month. Usually, he walked to the diabetes clinic as he considered walking there as a chance to do his exercises. In addition, in order not to wait too long at the diabetes clinic, he had to be there early in the morning (it opens at 8 a.m.), but at this time public transport is packed and this was another reason for walking.

While many other diabetic patients came to the clinic with a younger relative, Mzee Dunford usually went on his own. His children, who all lived in the city, bought his food for him on a monthly base and supported him financially, however, regarding his disease he seemed to know best about his visits at the clinic and his blood sugar level—although his daughter worked as a nurse at a hospital in Dar es Salaam. Furthermore, Mzee Dunford's relation to his son, who lived just some houses away, seemed difficult because the son had moved in with a former household helper of Mzee Dunford without being married to her. According to Mzee Dunford, this was a no-go. Still, this son explained to us that he passed by every day to check on his father, and other children also visited Mzee Dunford at the weekends. Hence, although his children seemed to make sure that all his domestic needs were seen to, he alone was responsible for his health. When he had a health emergency after injecting far too much

insulin, he did not call any of his children but went to the health facility on his own. When his phone was stolen in a daladala, his children did not buy him a new one, instead it was Frank, a member of the research team who felt close to Mzee Dunford, did so.

When I met Mzee Dunford again at the end of 2013, his health seemed to have improved substantially, after having explored different diets and forms of exercises. He told Frank and me that he had finally found a healthy diet that enabled him to stabilize his blood sugar level. In addition, he started doing Yoga exercises in his bedroom which also seemed to improve his wellbeing. His voice had become stronger again and he told us about his plans to raise chicken in his garden. Also, mentally he seemed to have improved as he found a way to cope well with his disease.

As Mzee Dunford's story illustrates, older study participants with a diagnosed chronic condition usually had a particular interest in self-care. Not only the diabetic study participants, others too explained that they went for regular checkups at the health facility.

Checkups and Hospital Visits

Usually, diabetic patients enrolled in a diabetes program at the diabetic unit of one of the district hospitals and were attending the clinic once a month in order to get their medication. Bibi Hilda, another diabetes patient in Ada Estate, occasionally missed her monthly appointments. She explained that she sometimes did not feel well enough to go (since the journey by public transport was too exhausting), and sometimes she was not able to leave the beauty store in front of her house that she tended to on a daily basis for her daughter. When she missed an appointment, she ran out of drugs and had to buy them at the nearby pharmacy, although she would get them for free at the hospital thanks to her health insurance. Sometimes she also decided to run out of drugs on purpose without purchasing new ones, because she was tired of taking the medication. However, usually she started feeling unwell soon afterwards so that she was forced to go and see the doctor at the hospital. In these situations, she explained, she was usually afraid to go because the doctor would scold her.

I was able to join Bibi Hilda as well as Mzee Dunford on their monthly appointments at the diabetic unit and the following extract from my field notes show how exhausting the monthly visit could be for them, walking in the sun for more than an hour—without breakfast—to the diabetes clinic for blood sugar testing. These health facility visits were usually very tiresome, also for me as a researcher, being out in the sun for some time without having many possibilities of sitting down or having something to eat or drink while waiting. Hence, I can image how exhausting they must be for a much older body, impaired with a disease. As described by Kesselring, such "moments of dislocation" allow us to access cognitively "knowledge that was previously in the realm of the habitual or non-predicated" (Kesselring 2015, 20).

Only with nguvu older people were thus able to appear for their appointments:

> Today, Frank and I joined Mzee Dunford to the diabetes unit. We met at 6 a.m. at Mzee Dunford's apartment in Ada Estate and Mzee Dunford proposed to walk to the clinic with us as he usually does. It took us a bit more than an hour to arrive. When arrived, we first went to a building right after the entry to the busy hospital ground to put down Mzee Dunford's card on the pile in front of a container that constituted the diabetic unit. The cards have to be put on the pile on a small wooden chair. A stone on the pile avoided that the wind carries them away. Everybody just added his or her file on the top and later on, from time to time a nurse passed and collected the files and the patients were called according to their position on the pile. At the moment when Mzee Dunford put his card, there was nobody from the staff around, but already maybe five people were waiting for them to open. The clinic opens at 8 a.m. We went to the building with the *bima*[290] counter which was a five minutes' walk. At the insurance building, some people were sitting on the bench waiting for their turn. Mzee Dunford sat down, to wait as well. Forty-five minutes later the counter opened and they took Mzee Dunford's health insurance card and started to fill in his form. After another ten minutes, we got the form and were able to go back to the container building. It was 8 a.m. We sat down, but soon Frank and I had to get up because people were constantly arriving and there was not enough space for all to sit. Therefore, the younger people who accompanied their diabetic patients got up to provide space. Then it took about one hour until Mzee Dunford's name was called and he was able to go for the blood sugar, blood pressure and weight test. The test cost TZS1'000 shillings, which is half of what is charged at local pharmacies. Afterwards he waited again to see the doctor in the next room. Then at around 9.30 a.m. we had to go back to the insurance building because at this building also the medicaments were provided. At the desk only one of the medicaments was available, and for the other Mzee Dunford was told to wait again in front of another room in order to see another doctor who was able to fill in a form so that Mzee Dunford can get the medication at the pharmacy. We waited another 20 minutes in order to get the form. We were ready to go to the pharmacy at around 10 a.m. The pharmacy was located at the street that goes along the hospital, so not very far. It was a special pharmacy where you can get medicaments with a health insurance. At the pharmacy Mzee Dunford realized that he forgot his bima card at the hospital where he was asking for the medicaments (he already forgot the card last time when he was with Frank). Frank went back to get it for him. Then he was able to get the medicaments and he had to sign the form for the insurance. He did not have to pay anything. On the way home Mzee Dunford told us that he did not yet eat or drink water and he planned to go home to get uji. They are told to come to the clinic sober, that is without breakfast. (Field notes 11.11.2013)

When joining Bibi Hilda to the clinic, she was so hungry after the long wait that we decided to have breakfast at a local restaurant just outside the hospital building. However, as in every local restaurant, they served *mandazi*[291] or chapati and grilled meat but no food that was convenient for Bibi Hilda, as a diabetic patient. She asked for milk, but they did not have any. Bibi Hilda finally had to make do with a bottle of water and a meat stick. When talking with Bibi Hilda about food convenient for diabetic patients, I realized that it required a huge effort to eat healthily according to their needs as a chronically ill older person. This effort was also described in the portrait of Mzee Dunford, who also struggled to find an appropriate diet for some years. Although the diabetes unit at the hospital offered a weekly information session for diabetic patients, Mzee Dunford still did not get the necessary directions regarding the appropriate food for his condition. At the information, they told him to not to overdo it

---

[290] The word *bima* can be translated as insurance.

[291] *Mandazi* can be described as small fried bread rolls that are usually eaten for breakfast together with black tea.

with particular aliments (when I attended the session the nurse mentioned beer, juices, soft drinks, fruits and eggs), however without defining more precisely what he should eat instead.

The same problem appeared for Mzee Dunford when it came to the advice concerning physical exercise. Mzee Dunford explained to Frank and me that it took him some years to find out that walking would be good for him. At the information, they just told him to go jogging but as a seventy-plus diabetic patient he did not feel strong enough to run. Initially he thought he would not be able not engage in exercises at all because of his advanced age. So, he was very happy to find out that walking exercises were sufficient. In addition, Mzee Dunford was keen to read books about diabetes in order to find out what was good for him. His English reading skills helped him to do so. Due to his eagerness to engage in self-care practices, he also discovered Yoga, which helped him to improve his condition.

Chronic Conditions

When it comes to chronic illnesses, Reynolds-White states that in Uganda "cosmopolitan people, especially members of the 'working class' (employees who earn regular salaries), are more likely to have received treatment for these sicknesses, and they are also more exposed to media and commercial products orientated to prevention and control" (Reynolds Whyte 2012, 66). This also holds true for the former civil servants' milieu in Ada Estate. Although I was astonished how many older people were diagnosed with diabetes or hypertension in general. However, being diagnosed did not guarantee treatment. This was also underlined by Reynolds-Whyte who, when looking at control, claims that "prevention and treatment of 'the new sicknesses' illuminates differences—between richer and poorer, urban and rural, more and less educated" (Reynolds Whyte 2012, 68).

As mirrored in Reynolds Whyte's statement above, not all of the diabetic older people of this study (six older people had a diagnosis), were able to cope as well as Mzee Dunford did with his illness. Bibi Asha from Manzese Mnazi Moja had already lost some toes, and Mzee Alpha who had his own tailor shop in the same sub-ward had a vision impairment due to diabetes that made him worry about his future as a tailor. The ability to take care of the self, also in terms of financial means to buy good food or going for regular medical treatment greatly influenced whether the older study participants were able to cope well with an illness.[292]

Older participants of this study suffering from diabetes or hypertension (eight people had a diagnosis) were normally provided with medication that did not last longer than one month. Hence, after the

[292] In the former civil servants' milieu, not only diabetic patients went for regular checkups; others, not suffering from chronic conditions, also told me about their regular visits to particular clinics or doctors for general health checks. Mzee and Bibi Mtoro went every six months for a screening. Others went to see a doctor on a less regular basis, as for example Bibi Mbujuni who explained that she checked her health every two years. At the same time, however, her husband, a pastor, did not go for regular checkups as he relied on God when it came to his health.

drugs were finished, they were forced to go back to the clinic for another checkup in order to get their medication. Mzee Mohamad from Kinondoni Ada Estate, who found out that his blood pressure was too high when he was in India for a checkup, usually went to measure his pressure at a nearby dispensary. Bibi Veronica had her own blood pressure machine that she received from her children in the USA. She was able to measure her "BP" at home, while her son, a medical doctor, supervised her condition. As will be described in Part IV, Bibi Veronica usually traveled to the US to visit her children and went for checkups there.

Bibi Veronica, but also others with hypertension were not convinced about taking their medication on a regular basis. While engaging heavily in spiritual self-care, Bibi Veronica explained that she did not really see the point of taking the drugs when she felt well. Therefore, she sometimes stopped taking them for some days until either one of her children found out, or she felt sick. The same practice also applied to food supplements that some of the study participants received from their children or bought on their own. Many claimed to take the pills once they felt weak but appreciated the positive effect it had on their body (this aspect will be taken up again in Part IV, as many children sent their parents vitamins from the USA as a preventive measure for a good health in old age).

Health Information and Exercises

Regular appointments at health facilities furthermore provided the older study participants with relevant information on their health condition and practices. When I asked them where they learned how to cope with their impairments study participants usually mentioned doctors as main persons of reference. Also, when children engaged in advising their parents concerning health issues, the older people seemed to prefer to trust the doctor's advice.

Going to the doctor or hospital for regular checkups mirrors aspects of the health discourse promoted internationally. People have to take over responsibility for their own health in old age, when old age becomes an individual project (as described in self-help books around successful aging). Lamb et al., who critically reflect on this notion of self-control, state that this vision of the individual as a project "resonates with individualist notions of personhood favored in the United States and with broader American myths of self-control" (Lamb, Robbins-Ruszkowski, and Corwin 2017, 8). NGO's in Dar es Salaam also promote the idea of health checks and offer free screenings for particular diseases, such as breast cancer or cataract.[293] Although Mzee Dunford and others take care of their own health and go for medical checkups on their own, they never emphasized their aim to do it independently from their children or other relatives.

[293] The free eye screening mentioned in Part II, for example, that Bibi Ruth in Manzese wanted to attend was organized by a Catholic church and was meant to detect and treat problems of cataract at an early stage.

I already briefly mentioned before that Mzee Dunford discovered walking as a helpful exercise. He emphasized that by doing exercises he hoped to add a few more years to his life which reflects some of the current aging discourses around active or successful aging. Not only when talking to Mzee Dunford, but also to other older study participants in the former civil servants' milieu in Ada Estate, the term *mazoezi*[294] became a topic of many of our talks. When asked what they think is good for their health in old age, exercises were usually mentioned next to eating well.

However, I soon realized that with some older study participants there was a gap between talking about exercises and actually conducting exercises. They mentioned in our conversations conducting mazoezi as an ideal way of living a healthy old age; but the knowledge alone did not inspire all of them to engage in the practice. Mzee Mbujuni, for example, admitted his own "failure" when it came to exercises:

> Frank: You said sometimes you walk, you go to the beach?
>
> Mzee Mbujuni: I used [to]… I say I do walk but not very much
>
> Frank: But do you think that helps you
>
> Mzee Mbujuni: It does so much but I do walk very rarely
>
> Andrea: Is it because of time?
>
> Mzee Mbujuni: Yaa because of time… not actually because of time [it] is because of carelessness—what is time in life by the way if I say because of time? It is the matter of planning so it is because of laziness, because of carelessness not that I don't know, I know but I am not careful
>
> (Mzee Mbujuni 2013)

Nevertheless, especially some of the older men of the former civil servants' milieu in Ada Estate, conducted exercises on a regular basis. Sixty-year young Mzee Buni, who had been a soldier before retirement, claimed to go jogging almost every morning for fifteen minutes before driving to work at a security company in his private car. Furthermore, he explained that he conducted karate exercises in his room. Mzee Mohamad was told by the doctor to walk 5 km every day in order to keep his hypertension in check. He therefore usually refused to use public transport, but walked to visit others or when going for an appointment in the city, instead.

As did Mzee Dunford or Mzee Buni, some of the elderly men deliberately left the house to do exercises. In contrast, none of elderly women we visited claimed to do so, but they too pointed to the importance of conducting mazoezi. However, most of the elderly women I met claimed to incorporate doing exercises into their daily activities. In this way, they identified a physical activity they pursued regularly as their mazoezi. Bibi Hilda, for example, explained that the regular walk to the grinding machine to

[294] As already mentioned in Part II, the Swahili word *mazoezi* means physical exercises.

grind her own ugali was her weekly exercise. In the other sub-wards, where water had to be carried home, this task, too, was seen as physical exercise that was good for one's health. Bibi Annette from Kinondoni Ada Estate explained that she wanted to lose weight and therefore engaged in exercises. Her way of doing exercises was to always walk very fast when going somewhere, "pretending to catch a plane." My landlord's wife, Bibi Ngowi, who was slightly frail, conducted stretching exercises on her bed which the doctor had shown her. Moreover, she perceived the daily walk around her house within her own compound as important for her health. Especially among the older participants of this study with a diagnosed chronic condition, their perception on the importance of conducting exercises was prominently mentioned in our conversations.

As Mzee Dunford's case shows, the city is a place where older people are exposed to different ideas about health, disease, and old age. Several daily newspapers include a health section with advice on how to stay healthy. In addition, television programs feature aerobic exercises and documentations on health. International NGOs advertise screenings. Not least, conducting exercises seemed to be a rather urban phenomenon. Many older study participants explained their engagement in exercises with the fact that they cannot engage in physical activities as in the countryside (for example, farming). Therefore, they search for alternatives, they claimed. The available discourse on chronic illnesses and old age shape the older people's subjectivities as older urban dwellers. As mentioned above, they wish to remain healthy and active with or without chronic conditions and therefore engage in everyday self-care. Their active engagement in exercises reflects productive activity. Although older people in this study usually also greatly appreciated having a rest after engaging in an activity for the improvement of their health.

Care for Oneself and Others

Oftentimes aspects of everyday self-care go hand in hand with care for others through older people. While, on the one hand, being healthy in old age helps older people to be able to care for others, the involvement in care for somebody else may hamper older people's everyday self-care practices. At the same time, caring for others can be perceived as a way to be productive and useful in old age. These entanglements will be the focus of this chapter.

Especially caring for grandchildren was an often-debated topic of older people in this study. While in first encounters most of the older people emphasized how great it is to watch their grandchildren, after getting to know them better some admitted that they would prefer not to take over that much responsibility for their grandchildren. Bibi Annette, portrayed below, cared for her husband, her mentally ill son as well as her grandchild. In doing so, she was concerned that she would not have enough time to take care of herself.

An aspect mentioned in relation to the care burden when taking care of others was the expectations of relatives or others surrounding an older person about who is supposed to care. This feeds back into what I discussed earlier regarding relational care. In Bibi Annette's story, she is not the older person in need of care, as depicted above, instead she is the healthy and active person expected to care for somebody else. As will be shown in Bibi Annette's story, being engaged in such care arrangements as a care giver may hamper the uhuru, the freedom to decide, that older people in the former civil servants' milieu associate with a good old age.[295]

When we met in 2012, Bibi Annette shared her house with two of her sons. One of her sons was married and came to stay with his wife and the newborn baby to get some support from Bibi Annette and the household helper they had. The younger son was causing her a lot of worries since he was suffering from a depression. He was diagnosed and was taking antidepressants. Bibi Annette organized that he could join a group of people with mental health problems at Muhimbili hospital. She believed that the dispute with her husband had affected her children in a negative way. She also regretted being a single mom; during the time her sons would have needed more financial support to access higher education, she explained. That is why she always very proudly talked about her daughter, the last-born child, who was about to study and work in the USA when we met. Bibi Annette lived from the rents she collected from the six shops in front of her house and she got no support from her children; rather, she sent some money for her daughter's school fees to the USA.

Being a former sports teacher, Bibi Annette was very knowledgeable about what was good for her health. She tried to walk to places instead of taking the public transport. She always complained about her body weight, which was too high, according to her. She was also very particular about food. Bibi Annette used a particular vitamin powder imported from South Africa and made sure that her diet was balanced. Furthermore, she made sure that she wore a warm nightdress to keep her chest warm, and, according to her, this was one reason why she never felt sick. She had slight hypertension and took medicaments for that. She said that she got malaria about once in a year.

When we met again in 2013, Bibi Annette was in a dilemma. Her ex-husband had fallen severely ill (because of kidney and liver problems) and his new wife refused to care for him once he came out of the hospital. Since Bibi Annette and her husband were only separated but still married "in front of God," both Bibi Annette's as well as the husband's family put pressure on her to take over the care work for her sick husband. Bibi Annette hesitated but then decided to travel to northern Tanzania where she took over the care for her husband in their common house in the village. Because she could not leave her mentally ill son in Dar es Salaam, she took him with her in order to be able to care for

[295] See also Staudacher and Kaiser-Grolimund (2020) where Bibi Annette's story is discussed.

both of them. She left the house in Dar es Salaam as well as her beloved dog to her son and his wife and the small grandchild. Slowly she managed to get the house in the village in shape, by putting new up curtains and purchasing a fridge and a rice cooker so as to make living more comfortable.

When I visited her in her house in the north in 2013, it already looked warm, but Bibi Annette still had some ideas of how to improve her living situation. She got the money to purchase the assets from a pot of a women's saving group she belonged to. They contribute to it each month and if a group member needs a larger amount of money, she can apply for it and pay it back bit by bit. Bibi Annette also employed a household helper who came to support her every second day. The lady assisted her in buying and preparing food, as well as with some cleaning tasks, since Bibi Annette was not able to do so anymore due to her back pains. However, she would never let somebody else do her laundry, she explained that it would not be clean enough for her. Once she had bought a microwave for her husband, she was able to travel back to Dar es Salaam for some days, and her husband could warm up the food that the household helper cooked for him. In the second half of 2013, she traveled back and forth between the city and the village.

In 2014, I met Bibi Annette's daughter Debora in New York and soon afterwards I got an email from the daughter, telling me that she traveled back to Tanzania because her father had died. After several weeks of hospitalization financed amongst others by the daughter in the USA, he was able to fall asleep when Bibi Annette was beside his bed - just one day before Debora arrived from the USA. When I met Bibi Annette a few months later, she was still in her house in the North, together with her daughter. When caring for her dying husband, she had overburdened her shoulder by carrying heavy things to the village. With the help of physiotherapy, she slowly recovered physically, while emphasizing that she also needed to recover mentally from the last couple of months.

Only by being healthy and active herself, Bibi Annette was able to cope with the care work that she was asked to provide for others; her son, her ex-husband and to some extent her grandson. However, as Bibi Annette's story reveals, in our conversations older people sometimes linked some aspects of care to a perceived burden.

The "Burden" of Grandchildren

Many of the older study participants were involved in providing care for others, according to their physical abilities. Much of this work was related to the care of grandchildren. While some of them shared their house with grandchildren and were thus involved in watching over them on a daily basis while providing a place to live for them, others received visits, especially at weekends. Bibi and Mzee Bariki, for example, sometimes looked after the grandchildren in their house when the parents went to church on Sunday morning. Others, like Bibi Veronica, lived with two of her grandchildren while their parents resided in the north of the country. She woke them up in the morning, got them ready for

school, and provided three meals a day for them. Especially the older people's children perceived the task of caring for grandchildren to be good for the older people, as it keeps them fit and at the same time, grandchildren were able to execute small tasks for them, for example, to quickly run to the shop when an ingredient for the kitchen was missing. Often, taking care of grandchildren was therefore seen as a leisure activity to keep oneself fit and active. Furthermore, it was believed to strengthen the family bonds, as emphasized by Mzee Mohamad:

> A grandfather or grandmother is always keen to stay with the grandchildren, they are giving me comfort at least after my retirement I just play with them around and keep me busy... [and] it strengthens the ties between grandparents and grandchildren and actually the parents of the children yeah because they strengthen the relationship. (Mzee Mohamad 2013)

In the literature on grand-parenting in African countries, social relations between grandparents and grandchildren are described to be of a "special quality" (Whyte, Alber, and Geissler 2004, 2). Geissler and Prince use the notion of sharing when describing lived practices between grandmothers and grandchildren in Western Kenya (cf. Geissler and Prince 2004). Often, grandparents are the ones that praise the "good old times" (amongst others, Ingstad 2004; Geissler and Prince 2004) when they were still respected by their grandchildren or grandchildren were given to them for care.

While in my view, grandchildren seem important when looking at the older people's care arrangements, I was astonished that some of the older study participants tended to complain about the additional (care) burden that grandchildren caused them. Mzee Mbujuni and his wife, for example, took care of two children under the age of five, one was the son of their working daughter who dropped the child off in the morning and collected it in the evening. The other child, who also stayed over nights, was the child of a former employee of the daughter who was not able to care of her child by herself. The elderly couple felt very exhausted by the burden of care and explained that they would prefer their grandchildren to visit them from time to time so that they could enjoy their company, however, having them around twenty-four hours was too much in their view.

Also, Mzee Mohamad, who emphasized the family bonds when caring for grandchildren, admitted that the grandchild he and his wife were taking care of was only with them while his daughter, the child's mother, finished her studies abroad in China. He said that he and his wife had become too tired now to look after the young boy. Mzee Mohamad told me that he appreciated visits of his grandchildren, but he did not see the point of taking over full responsibility for them, since he had raised his own children and now it felt strange to him that his own children were not able to do the same for their children. Other older study participants also spoke ambivalently about the care work of *kuangalia wajukuu*[296]. Of course, it made a difference how old the grandchildren were, how much they were in

[296] *Kuangalia wajukuu* can be translated as "watching grandchildren."

need of care, and how much they could be involved in supporting the grandparents instead. In his contribution to the special issue on "Lifetimes Intertwined: African Grandparents and Grandchildren," van der Geest argues that there is a difference in the lived relations of grandchildren at different ages. While younger children may be able to reciprocate towards their grandparents, older grandchildren simply showed respect. Van der Geest writes, "[r]espect, one could say, is a compromise, a strategy to deal with the disappearance of practical reciprocity" (Geest 2004, 59). Also de Klerk emphasizes the notion of time when looking at how "grandparents grow old and grandchildren grow up over time" (Klerk 2016, 147).

Bibi Miriam, an elderly mother of a study participant I met in the USA, who was sharing her house on the outskirts of Dar es Salaam with her retired husband and her last-born daughter who had recently had a baby out of wedlock, also emphasized the temporary situation of looking after the grandchild while her still quite young daughter tried to find a job. When I pointed out that the daughter and granddaughter might also support her while living together, Bibi Miriam replied that she had a household helper for those tasks. Another study participant also confirmed that grandparents like to have grandchildren for visits but they do not like to have grandchildren "dumped" at their place, because this is perceived more as as a burden, exhausting older people. Mzee Dunford, portrayed earlier, also had to change his living situation, since the two grandsons he raised were becoming too much work for him, so his children decided that they should go to stay with Mzee Dunford's daughter, the boys' aunt.

Other wazee however did not have much choice but to take care of grandchildren because their own children had died or were not able to. As, for example Bibi Ruth from Manzese Mnazi Moja, portrayed in the first part of this PhD thesis. She took care of the children of her sick daughter, who died during this research project of HIV/AIDS. Caring for children without parents in the context of HIV/AIDS was also the focus of de Klerk's book, where describing the importance of "both economic aspects such as material needs and inheritance, and emotional aspects such as joking, closeness and authority" (Klerk 2011, 136). The author talks about "suffering" for grandchildren, when being responsible for them (Klerk 2016, 147).

Bibi Ruth's frail body and decreasing eye sight theoretically did not allow her to perform care functions for her grandchildren, however, since there was nobody else around, she tried to do her best. Owning the house also helped frail older people to provide care for others, with much of this care being financial. In the case of Bibi Ruth, the money she earned from the rents was invested in the education of her grandchildren and medical treatment for her daughter, while nothing was left to pay for her eye treatment.

Many older study participants were involved in caring for grandchildren, while some elderly women also cared for their aging husbands and some husbands supported their wives, mainly when sick. Older study participants with substantial means contributed financially to their children's and grandchildren's lives. In cases of illness and death, too, financial aspects of care became more important, as for example in Mzee Mohamad's case who supported the family of his wife financially when the grandmother died.

The portrait of Bibi Annette reveals the expectations at stake when decisions about who is supposed to care for whom are taken. Although heavily disappointed and not at all supported by her husband when raising their common children, something made her care for her ex-husband. Being an independent elderly woman with very clear ideas about what is right and wrong, she struggled hard to take over the care task. During that time, she took some days to decide about what she should do, and when we met and talked about it, it seemed not at all clear, what her decision would be. However, in the end, she accepted the "care burden" due to the pressure from her relatives who also called upon her religious duty as a wife. Although it seems that Bibi Annette resigned from caring for herself in order to care for others, we may also see her performance of care as a religious way of self-fulfillment (cf. Corwin 2017).

Means to Care

What became evident, not only in Bibi Annette's portrait, but also when looking at Mzee Dunford and Bibi Helen's cases, care for one self or for others can be facilitated by financial means. As depicted in the first part of this PhD thesis, some wazee had a source of income from renting out houses, rooms, or mabanda. Mzee Ngowi, for example, was in the favorable position of inheriting a part of a coffee plantation from his father that gave him enough resources to start building houses which he rented out in Dar es Salaam (amongst others, to me). Since he mainly rented out to non-Tanzanians, rents were almost double from what he could expect from locals. Bibi Hilda from Kinondoni Ada Estate, too, let three self-contained rooms in her house and could collect high rents because of the favorable location of the house.[297]

Apart from collecting rents, most of the study participants were busy conducting some income generating activity as long as their health still allowed them to do so. Although they enjoyed resting from time to time, many of the study participants from the former civil servants' milieu were still in good shape and therefore wanted to engage in activities. Here again we find parallels to the successful aging paradigms that put forward productivity in old age. While the discourse of the former civil servants dealt with the aspect of engaging in activities rather as a leisure option to keep them busy,

[297] As mentioned in Part II, the sub-ward Ada Estate is located favorably between the city center and the northern peninsula. Living in this area of the city was not only desired by better situated Tanzanians but also by foreigners who were able to pay a higher rent.

more deprived older people were sometimes also forced to work to generate an income for their family which they not always perceived as a bad thing for their health.

Mzee Mohamad from Kinondoni Ada Estate kept three cows and sold the milk. With the milk he was able to earn up to TZS100'000 per month, just enough to cover his water bill. Mzee Buni from the same area, a former military officer, worked in a security company managed by his cousin after retirement. As mentioned earlier, Bibi Veronica and Mzee and Bibi Bariki kept kuku, while Bibi Helen worked a few hours a week at church. In the other sub-wards that made up part of this study, Bibi Zulfa from Azimio Kichangani sold ice cream from her door, while Bibi Asha from Manzese Mnazi Moja earned a little income from selling bottles of water. Bibi Sharifa, whom I met in Azimio Kichangani, had worked for some years as a street cleaner before she had to stop due to health reasons (eye problems from the dust, joint problem in her hand from dusting). Bibi Bahati in Azimio Kichangani sold firewood, and Mzee Alpha from Manzese Mnazi Moja had a small tailor shop. The wife of Mzee Juma from Ilala Mafuriko sold tea on the street, while Mzee Daudi from the same sub-ward sold cassava that he purchased at the big market in town (Kariakoo). Mzee Hassan from Azimio Kichangani worked as a DOBI, he ironed clothes to make a living while, at the same time, he kept an eye on his mentally ill son. Others as for example Mzee Mahir from Azimio Kichangani, did not have a fix job but went out day by day to look for job opportunities. This was also what many un-employed adult children of my older study participants did; they go out in the morning and come home in the evening, sometimes with "something," sometimes without (Bibi Annette once called these jobs in English "trial and error jobs").

Uhuru to Decide

Some of the above-mentioned (leisure) activities gave the older people some pocket money which increased their uhuru. However, contrary to the gerontological discourse that promote autonomy and independence in old age, the older study participants very much appreciated being cared for (and here I mean not only financially) by others. However, they sought some freedom when (as house owners, for example) being able to take certain decisions for themselves, as for example, when it comes to what they want to eat or whom they want to share their house with. Also, when staying with children or grandchildren the importance usually was that the children stay at *their* place and not the other way round.[298]

[298] Bibi Rose explained that as a grandmother she could go and stay for a while with her daughter (she did so when her daughter studied in the UK and got her third child), however as a mzee, you can only move to your children's place when sick. Bibi Hilda, who lived with her unmarried daughter in her own house, also emphasized that it is difficult for an elderly woman to move to her married son's house, as she has to cope with the daughter-in-law.

The portrait of Bibi Annette raises several aspects linked to everyday self-care but also highlights aspects of relational care. It reveals that caring for oneself can be facilitated by the older person's strength. A very frail older person is not able to engage to a similar extent in caring for himself or herself compared to a healthy older person. This fact is also mirrored in the international aging discourse that especially targets healthy older people. In addition, caring for others, for example for a spouse or grandchildren requires a certain amount of strength. As depicted above, some older participants of this study mentioned in this connection the perceived burden of kuangalia wajukuu while not feeling well enough to do so.

The story of Bibi Annette underlines some of the above-mentioned ideas about who is supposed to care for whom. Bibi Annette was very much torn between her subjective perception of what she thought best for her own health and well-being, and the cultural context of action that wanted her to care for her husband as a loving wife, while still being married in front of God. Having already surpassed seventy years of age, caring for her husband in their village in the North was exhausting and left bodily marks on her in form of shoulder problems and back pain. In addition, she had to resign some of her uhuru to decide for herself, as she was used to when living on her own (with her beloved dog) in Dar es Salaam.

Especially when talking to the older people from the former civil servants' milieu while disseminating the first results of my analysis, they underlined the aspect of a certain freedom to decide. This freedom was associated with the older people's perception of kuzeeka vizuri. Hence, in this sense the older study participants could be described as empowered individuals (cf. Dilger 2012, 65; Bülow and Söderqvist 2014, 141) who aimed at retaining a certain degree of freedom to decide, especially when it came to decisions that concerned their body and well-being. For them a "good" way of aging was to remain in one's own house which was linked to a certain degree of uhuru to decide for oneself. Furthermore, they engaged in activities they perceived to be good for their health, as, for example, Mzee Dunford who did mazoezi, or Bibi Helen with her special diet. They sought to remain independent subjects, embedded in and supported by their social network. Furthermore, the story of Bibi Annette points to the very dynamic developments that care for the self and others undergo in the lives of the older study participants. Thus, practices of self-care therefore may have multiple meanings and can either be oriented towards the future and usually linked to aspects of health promotion, they can rather have a mitigating purpose when struggling with a chronic condition, they can go in a more spiritual direction when targeting an older person's mental well-being but they can also be used as a means to survive when there is no one else to care. Of course, these diverse nuances can go hand in hand and be adapted to the daily dynamics of old age.

Conclusion: Dynamics of Care

After an introductory chapter on care concepts, this part discussed relational care and asked who is supposed to care for older people in Dar es Salaam. The answers to the *who* is supposed to care and the *why* led to rather normative ideas about how good care in older age should be organized. It became evident that older people base their ideas very much on existing reciprocal duties between parents and children which they had already observed when their parents cared for their grandparents in the village. Situations in which children were not able to fulfill these expectations based on reciprocity, or where children simply were not able to do so seemed challenging for older people. They were linked to disappointments that contributed to a complaint discourse about aging in the city, as discussed in Part II. Apart from kinship that structured ideas about old age care, older people also drew on religion or arrangements that were specific to a particular ethnic group. These contexts of action shape older people's agency when negotiating care.

In the text above, we saw that the relational care provided for older people very much depended on the nguvu or health condition of the latter—as perceived by the older person, but also by the caregiver. The chapter on "Nguvu as a Point of Departure for Care" therefore provides answers to the question of *when* older people need relational care, and it touches upon the question of who decides about it. Frail and dependent older people, like Mzee Juma already advanced in age, had more difficulties in bargaining for their own care arrangement. Rather, they extensively depended on their relatives who organized their care and usually used the phrase "nipo tu." What became evident in the portrait of Mzee Juma but also of Mzee Bariki is that very frail and old older people without strength are more in need of care. They do not only need more practical support (intimate care being one aspect of it), but also more financial means for medical treatment.

Older people with chronic illnesses such as Mzee Bariki experience ups and downs when it comes to their health condition. These ups and downs necessitate constant adaptations by the care providers. The care providers caring for older people with chronic ailments but also for the frail and dependent older people usually lived in the same house as the affected person. In this sense, the care arrangement corresponded with the living arrangement of the older person. Living under the same roof facilitated flexible adaptations to the actual health condition of the older person. Especially in a metropolitan city like Dar es Salaam, distances are too big for caregivers to come in on a daily basis. Especially in health-related crises, older people and their relatives articulated their ideas about good care in old age, and new arrangements had to be found to cope with a suddenly arising care need. The older people's role in shaping these arrangements differed, but seemed to very much depend on the health condition as well as the power to negotiate care. Being a house owner with at least some financial abilities seemed to help here.

Relational care in Dar es Salaam seemed mainly focused on adult children, spouses and other close relatives. Some activities can be taken over by household helpers, however, they are usually not necessarily perceived to be part of old age care by the older participants of this study. Moreover, neighbors, friends or church groups may engage in emotional support, especially when older people become ill. Particularly when it came to intimate care work, gender became important. However, older people emphasized that, for other forms of care, gender lost in significance in the city, compared to earlier days in the village.

Although it was very clear to the older study participants and their relatives who was supposed to care for older people, in practice flexibility to stretch certain normative rules was needed to cope with the ups and downs inherent to all the three portraits on relational care described above. In Gerold's words, "[c]are relations of the elderly … are inherently dynamic, undergo changes by displaying notions of mutual engagements and reciprocal tendencies—especially those relations involving kin and non-kin" (Gerold 2017, 150-151). That norms and values and articulations about it do not always correspond with what happens in reality is nothing new, especially for anthropologists. Looking at these disagreements, however, allows us to come to a closer understanding of how older people and their social environment cope with the dynamics of change that older people experience.

Innovative solutions to increased care needs in old age were also part of the focus of the sub-chapters on everyday self-care. I was struck by the lack of contributions about old age in Africa in the collection of articles to Lamb's book on successful aging. Only one contribution looked at the question of what successful aging means for older people on the African continent, in this case the Kenyan coast (cf. McIntosh 2017). The chapter by McIntosh as well as the epilogue by Reynolds-Whyte (cf. Reynolds Whyte 2017) depicted an image of African aging that they described as an "African way" that is solely based on the care by relatives while older people fulfill their role as knowledgeable elders who are appreciated in society as the guardians of traditional knowledge, but who, as a result of the current changes and urbanization rather lost their status and thus also their security in old age (cf. McIntosh 2017).

While I intended to show these aspects of aging and care based on what Reynolds-Whyte call "desired interdependence" (cf. Reynolds Whyte 2017) in the sub-chapters on relational care, I also found it important to show another side of aging, namely self-care. The older study participant who faced the legal age limitation when forced to retire at the age of sixty were exposed to new and innovative ideas and plans about how they wanted organize their time in life as an (official) older person.

In order to age successfully, I argued, older people from the former civil servants' milieu in Ada Estate make use of the urban space and its opportunities when profiting from the existing health facilities for checkups and provision of knowledge about how to care for an aging body. Although the city is

described here as a place with many possibilities for older people, this does not mean that they make use of it. However, the city seems to provide room for maneuver and thus enables them to engage in everyday self-care practices (cf. the "enabling city" described in Part II).

As argued in the previous chapters on relational care, specifically when it comes to self-care, older people's health condition and nguvu seems to make a difference. Especially healthy people had more abilities to engage in practices of (health promoting) self-care. However, as I hoped to show with the story of Mzee Dunford, people facing a chronic illness such as diabetes also managed to care for themselves. As they were usually embedded in a medical program with regular visits to the hospital, they were much aware of practices good for their health and well-being (as when investing in "good" food). Furthermore, technologies such as blood pressure monitors that some older people received from their relatives abroad (as will be looked at in more detail in the following Part on Transnational Care), shaped an older person's experiences of health in old age.

By calling it everyday self-care my aim was to not have a narrow take on medical self-care focusing on medication and treatment alone, but to look at it in a broader sense. Especially elderly women in Ada Estate engaged strongly in spiritual care, which contributed to their well-being in old age (cf. story of Bibi Helen). The older people whom I portrayed in this section tried to live a healthy old age in order to avoid becoming frail and dependent. Their actions revealed projectivity in their agentic orientation. Although according to the age threshold of this study and the legal age relevant for Tanzania, they can be described as older people (being above sixty), they did not content themselves in being old and frail but articulated innovative ideas about how they imagined to age well in the future. While their families usually supported them in doing so.

Practices of relational care and self-care often go hand in hand, therefore, none of the older study participants involved only in either relational care or self-care. As I hoped to show when mirroring the prevailing international discourse around successful or active aging with the observed discussions and practices of the participants of this study, older people who engage in everyday self-care are usually deeply embedded in a support network of relatives who enable their self-care by providing financial means or knowledge. They never imagined a successful old age as an independent older person, but perceived it to be important to invest in practices to improve their chronic condition, for example, by conducting Yoga. Their aim hereby often was to not become a burden to their adult children. However, once they became dependent as "Mandela-like" very old people, they made sure that their children were prepared to take over. Although I can imagine that everyday self-care can hamper relational care, as caregivers may not be seen as needed when an older person takes care of himself or herself, I did not come across such cases. Rather, these caregivers' support in an older person's self-care changed over time, from providing financial means to, later, offering a practical care when the older person is no longer able.

How adult children and other relatives living abroad organize the care of an older person in Tanzania will be topic of the next section of this PhD thesis. I hope to show that these relatives abroad invest in older people's self-care when providing them with vitamin pills or technical monitors and thus shape their visions about aging well. At the same time, they try to engage in relational care through phone calls or by employing somebody else who takes over what they perceive to be their duty as sons, daughters or relatives.

PART IV CARE IN TRANSNATIONAL TRIANGLES

Different parts of the world become increasingly interconnected through flows of people, goods, and ideas. We are therefore confronted today with what Appadurai calls "new global realities":

> What is new is that this is a world in which both points of departure and points of arrival are in cultural flux, and thus the search for steady points of reference, as critical life choices are made, can be very difficult. It is in this atmosphere that the invention of tradition (and of ethnicity, kinship, and other identity markers) can become slippery, as the search for certainties is regularly frustrated by the fluidities of transnational communication. (Appadurai 1996, 44)

The fourth part of this PhD thesis is concerned with care that is provided across national borders. Care "flows" between different localities, and its provision is very much connected to the attached ideas about how to best provide for care. By focusing on older people's children residing in the USA, the global realities of care giving over distance will be depicted.[299] I hope to show that this transnational aspect of care does not only occur between two localities but also between different and maybe multiple cultural, social, educational, and financial contexts. Care can thus be a useful lens to explore ideas about good aging that exist in different contexts and therefore shape the provision of care. A transnational social field perspective will be used to show how older people as well as their adult children in the USA are embedded in such a field that encompasses these multiple contexts.

In this part, first the concept of transnational care will be discussed by taking up what has already been described as old age care in Part III. I will argue that looking at care over a distance leads to a rethinking of old age care. The view from afar may encourage the study participants to explore new possibilities of care arrangements which have previously been out of the question or never thought of when all the people concerned lived in the same locality. Over two continents other forms of care become important, as for example virtual care. After the conceptual introduction to this part, the ability to provide certain forms of care will be discussed in relation to the migration status of Tanzanian migrants in the USA. The last chapter of this part will then discuss the circulation of care across national borders. By using the spatializing image of a triangle, I will argue that care does not only happen between two people, the older person in Tanzania and the adult child in the USA; instead, it also involves an

[299] In this part I have again a broad understanding of "children," including biological as well as others that are described as children. In most cases, I observed transnational care relations between adult children and aging parents, as the care for parents seemed more intensive than for other relatives.

important third actor, namely the "observing eye" in Tanzania who is responsible for the organization of the provided care on site, as well as the reporting back to the caregiver in the USA.[300]

TRANSNATIONAL CARE

Care has "various shades of meaning," this quote by Kleinman and van der Geest (2009, 159) was already presented earlier in this PhD thesis. When looking at care provided across national borders, other nuances of care become important. Adult children in the USA who are not able to fulfill practical care tasks for their parents have to find other ways to show their concern, or simply to finance the provision of the needed care by someone else in Tanzania. The focus in this part lies on the provision of relational care, that is, care provided for others. At the same time, however, it will be argued that the care provision across national borders is also likely to (re-)shape the everyday self-care of the older people in Tanzania.

To begin with, however, I will discuss my understanding of the concept of "transnational care." In the migration literature, the new connectedness mentioned by Appadurai led to a rethinking of earlier concepts of migration as "one-way" processes where migrants leave one country to settle and assimilate in another. Hereby, much of the debate is concerned with questions about how well the migrant is able to integrate into a new society. Transnationalism as a concept became important in migration studies in the 1990s to counter the prevalent idea of the 1970s and 1980s that migrants either assimilate completely in the receiving country or, if they fail to do so, return to their own country (Mazzucato 2008a, 201; Rouse 1995, 353).

By looking at migration within a globalizing economy, Levitt and Glick Schiller opt for a reappraisal of a methodological nationalism, which is "the tendency to accept the nation-state and its boundaries as a given in social analysis" (Levitt and Glick Schiller 2004, 1007). While the authors admit the importance of nation-states, they nonetheless emphasize that "social life is not confined by nation-state boundaries" (Levitt and Glick Schiller 2004, 1007). They propose therefore to see transnational migration as one of many indicators "that the nation-state container view of society does not capture … the complex interconnectedness of contemporary reality" (Levitt and Glick Schiller 2004, 1006).[301]

[300] See also Kaiser-Grolimund (2018) and Staudacher and Kaiser-Grolimund (2020) for a discussion and comparative analysis of some of the arguments made in this Part.

[301] In this regard, Glick Schiller et al. also point out that the prevalent links of migrants to their home societies differ from the connections in the past due to new circuits of capital: "The increase in density, multiplicity, and importance of the transnational interconnections of immigrants is certainly made possible and sustained by transformations in the technologies of transportation and communication" (Glick Schiller, Basch, and Blanc 1995, 52).

The term "transnational" is consequently used to describe and acknowledge the embeddedness in two or more countries or nation-states simultaneously. Transnational migration is defined by Glick Schiller, Basch and Szanton Blanc as "the process by which immigrants forge and sustain simultaneous multi-stranded social relations that link together their societies of origin and settlement," it is a process of "simultaneous embeddedness in more than one society" (Glick Schiller, Basch, and Blanc 1995, 48). By using the term transnational, I would therefore like to point to this embeddedness of Tanzanian migrants in the USA, who are providing care for their parents in Tanzania. I will argue that not only Tanzanian migrants in the USA, but also older people in Tanzania are embedded in both (cultural) contexts through the care that they receive from and give abroad. Care that flows across national borders can thus be described as transnational care that is shaped by both contexts, the Tanzanian as well as the US context. [302]

Yeates concludes that in contrast to internationalization, a transnational perspective underlines the "blurring of social space and geographic space, as migration implies less a rupture of relations … than ongoing and simultaneous relations" with both countries (Yeates 2011, 1113). In what follows I would like to point to these double engagements by children in the USA by focusing on their involvement in care. When conducting research with Tanzanians in the USA, I was impressed by their double engagement in two "worlds" simultaneously as described in the literature, although most of the study participants insisted emphatically that they consider themselves throughout as Tanzanians (despite having applied for an American passport) and therefore engage in elder care following Tanzanian ideas about reciprocity. At the same time, they witnessed their own children in schooling, growing up with an American accent. From them, many would not expect the same engagement in elder care they are providing or which they envision to provide for their aging parents in Tanzania. They describe their children as growing up with "Western values" where either older people take care of themselves or the state takes over particular care tasks and costs. This is also why most of the adult children interviewed in this study mentioned the importance of preparing for their own old age. The Tanzanian migrants are doubly engaged, on the one side in caring for their small children in the USA, while at the same time they are involved in providing care and support over a great distance for their parents in Tanzania.

Lamb writes about the simultaneous engagement of older Indians who migrated to the USA with their children: "Indian American take some values, practices, and categories from one nation or culture ("Indian") and some from the other ("American"), living simultaneously across the two now

[302] Other authors also criticize the use of the terms local, national, transnational, and global and emphasize that all connections are local since they "penetrate the daily lives of individuals lived within a locale" (Levitt and Glick Schiller 2004, 1010). While I agree with Levitt and Glick Schiller that the mentioned connections impact on the daily lives of older people and their relatives, I nevertheless use the term transnational to point to care practices that are shaped by their being provided across national borders while also distinguishing themselves from the old age care provided within Tanzania as described in Part III.

overlapping worlds, transforming each cultural system, and themselves, in the process" (Lamb 2009, 210). Although in Lamb's case, the focus lays on Indian older care receivers residing in the USA, what she describes also holds true for the Tanzanian migrants I met in the USA whose ideas and practices around old age care are influenced by both "worlds."[303]

In order to acknowledge the simultaneous engagement in two or more countries, Levitt and Glick Schiller call for a "transnational social field approach" (Levitt and Glick Schiller 2004, 1006). The authors base their social field approach on Bourdieu's definition of social field, as he emphasizes how power structures social relationships. Participants thus "are joined in struggle for social position" and create social fields (Levitt and Glick Schiller 2004, 1008). Furthermore, the Manchester School found that migrant networks stretched across two localities, rural and urban, while both belonged to the same social field "created by a network of networks" (Levitt and Glick Schiller 2004, 1009). The authors follow Basch, Glick Schiller, and Szanton Blanc (1994) and define social fields as "a set of multiple interlocking networks of social relationships through which ideas, practices, and resources are unequally exchanged, organized, and transformed" (Levitt and Schiller 2004: 1009). While research on migration focuses much on the migrants in the current country of residence, the social field approach allows for a broadening of the view not only to migrants abroad, but also to the "other end" of the field—in the case of this study, the older people in Tanzania. Migrants as well as their parents are thus embedded in transnational social fields that encompass "those who move and those who stay behind" (Levitt and Glick Schiller 2004, 1003). When focusing on the older people remaining in Tanzania, it is important to note that "a person may participate in personal networks or receive ideas and information that connect them to others in a nation-state, across the borders of a nation-state, or globally, without ever having migrated" (Levitt and Glick Schiller 2004, 1010).[304]

In the following text, I will make use of the transnational social field approach to show how not only adult children in the USA but also the older people in Dar es Salaam or other parts of Tanzania are involved in these social fields. Their connections to their children or relatives abroad influence their

---

[303] However, not all migrants remain doubly engaged over a long period of time and in her work Mazzucato describes those who decide to return to their country of origin, because of a lack of opportunities in the receiving country. The author calls this "acts of 'disengagements'" (Mazzucato 2008a, 210).

[304] Torres and Karl assess in their introduction to an edited volume on "Ageing in Context of Migration" two strands of literature, namely the study of old age and migration in Social Gerontology and the study of old age and migration in migration studies. Their literature review revealed that much of the existing gerontological work over the past fifteen years concentrated on older migrants (Torres and Karl 2016, 3) rather than care of older people through migrants which is at stake in this PhD thesis. The authors furthermore point to the fact that astonishingly few articles focused on the gerontological concept of "successful aging" (as well as "well-being" and "life-satisfaction") (Torres and Karl 2016, 4). In migration scholarship, Torres and Karl distinguish four different strands of literature. Their second strand, which focuses on transnational family care and transnational social support, is of interest to this PhD thesis, while their first strand (different types of older migrants), third strand (migrant care workers), and fourth strand (demographic perspective) are of less relevance here.

relational context of action; they are thus structured, at least partially, by being embedded in a transnational social field—although many of them might never have traveled to visit their children in the USA. Briefly, a transnational social field approach is looking at both migrants and associated care situation of the elder person in Tanzania (despite them not be involved in travel), and hence this approach is useful here as it allows for a broader perspective but at the same time focuses on different actors involved in transnational care circuits.

Being embedded in a transnational social field moreover means being rooted "in two or more legal and regulatory systems" (Levitt and Glick Schiller 2004, 1012). Like the study participants in the USA, "individuals are, therefore, embedded in multiple legal and political institutions that determine access and action and organize and legitimate gender, race, and class status" (Levitt and Glick Schiller 2004, 1013). As will be underlined later, especially the embeddedness in two legal systems proved crucial for the study participants in the USA. The quote by Levitt and Glick Schiller could be expanded by adding the aspect of care. As will be shown below, this study found that the organization and legitimization of care is greatly influenced by being more or less embedded in USA as well as Tanzanian legal and political institutions. We will see later in the text that the "well-established" Tanzanians, who have usually cleared legal documents in order to stay in the USA, have other possibilities to engage in transnational care practices than the "over stayers" who struggle with their existence in the USA.

This PhD thesis is mainly concerned with transactions between Tanzania and the USA in connection with elder care. According to van der Geest et al. (2004) there are not less than four ways in which old age and migration are linked. First, migration and old age are linked through people who migrate and grow old in a foreign country. Some of the study participants, for example, those who have been residing in the USA already for more than ten years and pay social security in the foreign country, are confronted with the decision to either stay or leave the USA in old age. Usually, they imagined their successful old age in Tanzania and are engaged in preparations for their future back "home."

Second, migration and old age can be linked through immigrant workers who are employed in caring for older people in institutions in the Global North. This second link applies to those study participants who are employed for care work in American institutions such as in nursing homes or in-home care for elderly people. As will be shown later, much of the literature so far has focused on this domestic labor migration, however not with a focus on elder care, but childcare.

Third, a link between migration and old age can be found when looking at the out-migration of young people who migrate for economic reasons and who leave behind their parents. Most of the study participants in the USA left their parents in Tanzania. This is mainly due to the sampling strategy of this study that particularly looked at adult children in the USA who have their aging parents in Tanzania.

Furthermore, the authors explore a fourth linkage, namely that of immigrant workers who are employed in private homes to care for older people in place of emigrated children. When looking at those who replace the emigrated children in Tanzania, a hired help from outside the family was very rare in the Tanzanian context. As mentioned in Part III, household helpers were employed to do household chores or of what I called technical aspects of care. I perceive these duties to be part of the care arrangement of an older person, however, they do not replace another family member who is around and checks on the older person's health condition and performs other forms of care such as intimate care. Hence, in this study, the fourth linkage described by van der Geest et al. (2004) can be used to point to those caregivers who are "there" in Tanzanian and take over the care for the parents. They are not "employed" by the emigrated children in the USA (by paying them a salary) but are rather "assigned" by the family (by providing them with the necessary means through the adult child in the USA) to take over the care for an elderly person and thereby substitute the emigrated child. Mostly, these caretakers are siblings, spouses or relatives that belong to the extended family.[305]

The above-mentioned connections between old age and migration sooner or later results in care that is provided for older people and organized over distance. In the literature on transnational care that focuses on care provided over a distance for a group of the older people is still growing. And, especially in the African context, such studies are few.[306] When analyzing the US academic and public discourse, Lamb stresses "that in such scholarly, media, and daily discourses on gender and care work, there is so much ambivalence and anxiety regarding locating child care outside the family, but very little concern regarding extra-family care arrangements for the elderly" (Lamb 2009, 21).[307] At the same time, in India and its diaspora, discussions and anxieties about care mainly focus on elder care, especially when locating it outside the family (Lamb 2009, 19). Here parallels can be drawn to discussions in Tanzania and Tanzanians in the USA as in our conversations most study participants claimed that they could not imagine outsourcing the care of their parents to someone outside the family. This was also markedly underlined by the Tanzanian National Aging Policy (cf. Part II), which emphasizes that the family remains the main provider of elder care (URT Ministry of Labour 2003).

In what follows I will discuss some of the literature on transnational care that focuses on childcare in order to draw some parallels to the transnational old age care that is of concern for this PhD thesis.

---

[305] As their second way, van der Geest et al. (2004) describe people who migrate in old age, often Europeans that travel southwards. This link is not relevant for this PhD thesis, I will consequently only present four of the five links that the authors present in their article.

[306] This chapter therefore draws on few examples available for comparison.

[307] Not only American children would not feel comfortable to be assigned intimate care provisions for their parents, also the parents would rather choose somebody outside the family for tasks (Lamb 2009, 22). Rather, both children and parents desire to live independently, which brings us back to the earlier discourse around successful aging that is currently prevalent in the USA.

The debate around transnational child care bases much of the argument on what Hochschild coined "global care chains" focusing on care provided in exchange for financial returns (cf. Hochschild 2000). These global care chains are seen as products of the emerging global care markets, caused by migration (Skornia 2015, 19). In her much cited work, Hochschild describes a global care chain as a "series of personal links between people across the globe based on the paid or unpaid work of caring" (Hochschild 2000, 2). From a feminist point of view, the chains describe the imbalances between women from the "Global North" and women from the "Global South." Hence, with her concept, Hochschild argues for a moral concern that should be applied to care chains in order to point out the emotional and psychological costs that globalization brings (Parreñas 2012, 270). Women from the Global South migrate in order to do the "women's work" of the North (Ehrenreich and Hochschild 2002, 3). At the same time, these women miss out on the care that they are supposed to provide for their own children in the Global South. They do so because they are employed for the care of children in the Global North, while the mothers of these children in the Global North hold a job. The debate then also points to the fact that the children left behind receive a poorer quality of care when other family members, usually grandmothers have to jump in.

The care chain literature looks at transnational motherhood as an undesirable form by pointing at its rather negative effects, when resources and power are unequally distributed. Apart from describing care as an uni-linear process, the care chain literature has been criticized for only focusing on mothers as victims of the chains, while neglecting various other actors involved in an exchange of care across national borders.[308] With a rather "black and white" view of those gaining from the chains and those loosing from them, aspects of agency of both the caregiver and the care receiver are missing; but precisely this would be important when looking at care as an interdependent relationship (Skornia 2015, 25). Therefore, in her research on care migration between Peru and Italy, Skornia underlines that the focus within care chains should be preferably laid on the "shifts in ways in which care is provided," without assuming that care is coming to an end through migration that separates people physically (Skornia 2015, 23). The above-mentioned aspects that criticize the care chain debate are very much in the focus of the "care circulation" approach that will be discussed below.

The care chain debate as described by Hochschild was not often applied to older people. However, Hochschild points at parallels of an elder-care version of the child care chain, where paid workers from the Global South care for older people in the Global North, while the workers' own parents in the global south are cared for by someone else (cf. Hochschild 2000), combining what was described by van der Geest et al. (2004) as the second and third links. With the term "care substitution," Scott

[308] The debate focuses mainly on women that migrate; however, similar issues could be raised when looking at fathers that migrate. What does a traveling father mean for a family and how does this impact on the image of masculinity?

proposes to replace Hochschild's "care deficits" that arise within care chains. By calling it substitution, Scott wants to point to—in her case—women who fill the gaps of care in the communities of origin. Within care substitution, the author claims that "gendered divisions of labor remain intact, but there is a generational shift in responsibility for doing care work at home" (Scott 2012, 144). The author talks about a generational shift, since mostly grandmothers are those that take over the care tasks within these care chains. This generational shift could also be observed in Tanzania in a reverse direction, when nieces or nephews jumped in to provide care for an older person left behind by an emigrated child.

By thinking through the concept of care substitution, I would like to shed light on how the care provided for older people in America shape the children's ideas on how to provide care for their parents in Tanzania.[309] The described care chains, which result in care deficits or substitution, could thus be observed in this study when it comes to institutionalized elder care in the American nursing sector, which would correspond to van der Geest et al.'s second link between aging and migration. Some of the Tanzanian adult children who leave their parents to be cared for by somebody else in Tanzania, are involved in nursing American elders in the USA, either in institutions or in home care. At the same time, someone else is caring for their own parents in Tanzania. However, in all cases of this study, other family members in Tanzania were able to jump in to "substitute" and provide the care that their relatives failed to give. Many times, these were siblings or, as mentioned earlier, nieces, nephews or more distant family members.[310]

As an alternative to the above-mentioned care chain literature, Baldassar and Merla propose the concept of "care circulations." While the care chain literature focuses "on the commodification and political economy of care in 'south-north' female domestic labour flows" the focus of the care circulation framework lays emphasis on "the asymmetrically reciprocal flows of caregiving located in kinship and moral economies of care" (Baldassar and Merla 2014a, 8). Hence, the interest lays much more in the private provision of relational care, when situated in two different localities; as in the case of Tanzanian migrants in the USA who are involved in elder care of their parents in Tanzania. When discussing relational care, kinship was described as part of the structural or relational context of action that guides

[309] An analysis of the involvement of the market and state in the care economy as emphasized in the literature on care chains and care substitution is of less relevance to this study, as it goes beyond of the scope of this PhD thesis. Domestic labor flows that make people travel from one country to another to provide care for someone else will be looked at in the third story later on, when nannies from Tanzania come to the USA to care for Tanzanian children (cf. temporarily employed).

[310] When more distant relatives took over the care for an older parent, the question remained open, whether the quality of care as perceived by the older person was the same. Interestingly enough, when looking at childcare, only in one case did parents leave their schooling children with grandparents in Tanzania. Most study participants either traveled to the USA with children, or the children were born in the USA.

how people care. By exploring the concept of care circulation, kinship and connected reciprocity remain important aspects that guide the provision of care over distance.

The framework of care circulations broadens the view to the whole "network of relationships around which care flows" as well as to different types of families and migration (Baldassar and Merla 2014a, 8). According to them, care circulates within family networks and is informed by what they call "generalized asymmetrical reciprocity" (Baldassar and Merla 2014a, 8-9). Consequently, care circulations are much more complex than unilinear care chains. For this study, the concept of care circulations seems more appropriate, as findings confirmed that transnational care is not only an exchange between the emigrated child in the USA as caregiver and the older parent in Tanzania as care receiver. Rather, care circulates among different members of a care network, while especially those relatives present in Tanzania and busy organizing financial and material transactions of care from abroad became crucial. Based on these findings, I will argue for a more detailed specification of the concept of care circulations by using the spatializing image of a transnational triangle of care.

As described above, care circulates within transnational social fields—and it does so in different forms. Mazzucato points to the transactions that take place within transnational networks in form of exchanges in communication, goods, and money (Mazzucato 2008a, 201). When taking into account all kinds of flows of transnational care, our understanding of care also has to be broadened accordingly. Transnational care inevitably encompasses more aspects of care than physical contact (which would correspond to what was earlier described with the Swahili terms *kuangalia, kuhudumia*).

One of the most common forms of transnational care provided by Tanzanians in the USA was financial and material support (in Swahili referred to by using the term *kusaidia*). Children in the USA sent their support either through cash transfers or through sending goods. Usually referred to as remittances,[311] these common transactions targeted rather practical or technical elements of care, by providing financial means for those assuming the practical care at the older person's home in Tanzania.

Sending medicines or (medical) equipment to improve the health and wellbeing of older parents was another way to become involved in care over distance. Kane states that "sending biomedicine home has become as common as sending money …" (Kane 2012, 191). Medicine that travels between two countries is described by Zanini et al. (2013) as "medical remittances." With the concept the authors "… indicate 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

[311] Monetary forms of remittances are often studied by economists who look at its connection to the alleviation of poverty and a country's economic growth (Mazzucato 2010, 454). In a broader way, remittances can encompass the "flow of money, goods, ideas, and communication from migrants to their home communities" (Mazzucato 2010, 454).

et al. 2013, 15).[312] As will be shown later, medical equipment such as blood pressure monitors, thermometers, walkers, or other equipment for care such as diapers but also medication, for example painkillers, are sent by Tanzanian migrants to their parents (and other family members). At the same time, people in Tanzania may send antibiotics or other medicine that is not easily available for migrants in the USA. Likewise, Krause describes how antibiotics and other pharmaceuticals are sent from Ghana to London. Especially migrants with an unlawful status may face difficulties in accessing particular medicine that is only available with a prescription from a medical doctor (Krause 2008, 243).[313] Kane points out that "medicine is part of the flows that characterize African transnational practices" (Kane 2012, 190). The author, who looks at flows of medicines between Senegal and France, emphasizes that not only biomedical medicine is remitted from abroad but also traditional medicine from Senegal is sent to France for particular health problems (Kane 2012, 190). I find the concept of medical remittances useful as it encompasses, next to medicine and medical appliances, also medical advice that flows from one country to another.

With Kleinman and van der Geest's distinction between technical or practical and emotional elements of care in mind (cf. Part III; Kleinman and Geest 2009), it is important to note that especially in transnational networks caregiving cannot be of the same physical kind as when providing practical support for an older person at the person's home (such as, preparing food for this person or helping him or her to shower). Over distance, other forms of care become important, as for example, emotional and moral support (Baldassar and Merla 2014b, 49). Tronto's (1993) earlier-mentioned distinction between caring for and caring about may 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 2014b). Therefore, if emigrated children do not have sufficient means to financially care for their parents, they can still care *about* their parents.

Baldassar and Merla advocate a broad definition of care that also encompasses virtual forms of "caring about" (Baldassar and Merla 2014b, 40). As will be emphasized later in this part, especially communication technologies can facilitate virtual forms of care giving. Through phone calls and the use of social media, Tanzanian migrants in the USA remain connected to their parents and other relatives in Tanzania.[314]

---

[312] Zanini et al. (2013) base their concept on its use by Kane (2012) who addresses the remittances of medicine and Pribilsky (2008) who uses the concept but rather as a descriptive notion without a closer definition of it.

[313] In her article, Krause furthermore highlights the flow of medicine that is sent by migrants within Europe (cf. Krause 2008).

[314] In a contribution to the Basel Papers on Political Transformations, Sandra Staudacher and I explore these connections over national borders in more depth, by focusing on the instant messenger WhatsApp and its usefulness in conducting ethnographic research (cf. Staudacher and Kaiser-Grolimund 2016).

As described in the previous part on care dynamics, this PhD thesis looks at two spaces of care, namely the care space encompassing the related others and the care space of the self. While much of the following part is concerned with relational aspects of care (in form of money, goods, medical remittances, and virtual aspects of care), it is important to emphasize that especially these transnational connections over national borders strongly impact on how everyday self-care is provided. As Huang et al. write, "when care travels, whether through professional, personal or other networks, new amalgams/notions of care may emerge through the encounters of people who provide and receive the care" (Huang, Thang, and Toyota 2012, 130). Hence, when observing transnational care practices, it becomes evident that care is not a universal concept. Rather, care always travels with ideas about what care should entail and who should provide it. Being embedded in a cultural context, care is very much shaped and reshaped by existing norms and values.

Yeates claims that we should not neglect ideational forms of care transnationalization when she says that "[l]iteratures on care worker migration have tended to neglect how transnational networks act as conduits through which orientations, ideas and ideologies of care are circulated and mediated within and across 'national' terrains" (Yeates 2011, 1126). Therefore, as initially mentioned by citing Appadurai, global flows between localities involve ideas about practices of care and health in old age. In this sense, not only those who travel abroad are exposed to new ideas but also "those who stay behind" (Levitt and Glick Schiller 2004, 1003). As will be shown in this study, being part of transnational social fields, older people in Tanzania seemed exposed more than others to new ideas on how to age well. The chapter on everyday self-care (cf. Part III) touched upon some of these influences, by looking at how the international gerontological discourse on "successful aging" is mirrored in older people's health care practices.

Due to the sampling of this study, much of the relational care presented in this part concerns intergenerational care, provided by adult children for their aging parents. At the same time, only migrants who were actively involved in care relations were interviewed which might lead to the false impression that all Tanzanian migrants care for their relatives at home.[315] What became evident when looking at possible forms of care over a distance, relations between parents and children cannot be formed or reinforced through bodily practices of caring, but have to use other practices to create closeness and cultivate relatedness. Engagements in different forms of care over distance were thus used to express solidarity and belonging (Baldassar and Merla 2014a, 11). Hence, despite the physical absence, a sense of "co-presence" within the kin network located in Tanzania and the USA can be maintained (Baldassar and Merla 2014a, 6), by fostering these relationships through care. However,

[315] As mentioned in the methodology section in Part I, I used a snowball sample strategy in the USA in order to meet Tanzanians who care for a parent or another older person over the age of sixty living in Tanzania.

similar to care relations when care receiver and caregiver are based in the same locality, not cultivating these relations over distance can lead to a process of de-kinning (Schnegg et al. 2010, 24).

The provision of care over distance is likely to lead to a reconfiguration of who is responsible for which forms of care. This may also affect gendered aspects of care. In the present study, gendered aspects became pronounced when observing the care provision of daughters over distance. In Tanzania, many daughters of older people were involved in practical aspects of care, when, for example, helping with household tasks. However, when residing in the USA, they took over much of the financial support of their parents that would otherwise preferably be covered by their brothers in Tanzania. Furthermore, especially during visits of older people to the USA, the support of mothers or fathers-in-law differed slightly from inside Tanzania, as, due to practical reasons, elderly women were for example able to stay with their daughters and their sons-in-law. Bibi Veronica, who visited her daughter in the USA every second summer, stayed with the daughter and her husband in the USA, as it would be too expensive to rent a separate place for her. In Tanzania, a *bibi*[316] would ideally stay with her son and a daughter-in-law but she would not reside with her daughter and son-in-law, as the daughter is perceived to be part of her husband's family and thus assigned to care for her mother-in-law rather than for her own mother.

Interestingly enough, the importance of certain forms of care changed, for example, when formally employed parents turned sixty and were suddenly no longer able to sustain themselves. Also, in health-related crises quick financial support for hospitalization can become crucial. As mentioned earlier, the health condition of an older person shapes the care need of that person. Therefore, care provision of children in the USA may vary over time, and one or the other aspect can become more important. Hence, transnational care provision is subject to dynamic processes.

During a health-related crises within the family, physically "being there" most likely becomes more valued than any virtual form of care (Baldassar, Baldock, and Wilding 2007, 161). Visits, which cost money, and valid travel documents enable the temporary exchange of personal care. Especially well-established "middle-class" families were usually able to afford such visits. As became evident in Part III on care dynamics within Tanzania, other forms of care are at stake when children or relatives who live elsewhere in Tanzania provide care. Their transactions might be facilitated by less expensive communication costs, easier money transactions (for example, through m-pesa), no time difference, and greater possibilities to visit each other.

Talking to both the Tanzanian elders and their adult children in the USA revealed that the actors involved valued different engagements of care differently: While children often lamented their inability to provide practical or physical forms of care, parents seemed to appreciate greatly their financial

[316] As mentioned earlier, *bibi* can be translated as grandmother.

support. What became evident, however, is that kin networks were kept alive and together through care giving over distance when care is "given and returned at different times and to varying degrees across the life course" and thus circulated within transnational networks of kin relations over distance and time (Baldassar and Merla 2014a, 7), while the exchanges were not always even and harmonious.

By further exploring the concept of care circulations, I will depart from the assumption that care flows over distance only in one direction, but that care can flow in both directions, not only from children in the USA to older people in Tanzania but also the other way around. Furthermore, I assume that these circulations and the provisioned care involved will change over time. I will argue that care circulates within a transnational triangle of care, involving emigrated children, their parents in Tanzania but also the much-valued care providers in Tanzania. Due to the available data, much emphasis will be laid on the migrants in the USA and their involvement in transnational care triangles. The care provided by Tanzanian elders for their children abroad will be explored to a lesser extent,[317] while the third strand of the triangle, between the parents and the caregivers in Tanzania was already treated in detail in Part III. Before describing the exchanges within the triangle however, three portraits of children in the USA will be presented by showing how their (legal) situation within the USA has influenced the care that they were able to provide for their parents in Tanzania.

Caregivers in the United States

I arrived in the USA with a few contacts for Tanzanian migrants I had received from older people in Tanzania and other Tanzanian friends and colleagues. Through these different "entry points" I was able to establish contact with various Tanzanian communities in different US states and, through a snowball system, I was able to meet more people from these communities during my field research. At the beginning of this chapter, I will therefore provide some contextual information on these communities as research sites.

When getting to know several Tanzanians who are involved in elder care over a distance, I realized that there is a difference in how people are able to shape this transnational care. In the second part of this chapter, I therefore argue that the legal status of Tanzanian migrants in the USA matters when it comes to the care, they are able to provide and consequently also receive across national borders. Three stories will reveal different ways of how people came to the USA, and how they live their everyday life as migrants which is closely linked to their way of caring. In addition, their ideas and motivations for care

[317] In the last chapter of this part, I will touch upon the care that older parents in Tanzania send to their children in the USA. Unfortunately, this point will be explored to a lesser extent, due to the lack of data on this aspect of care and not because it does not exist.

will be highlighted, as much depends on reciprocal duties which they want to fulfill as children of their aging parents back "home."

TANZANIAN COMMUNITIES AS RESEARCH SITES IN THE USA

Tanzanians do not belong to the largest African-born populations in the USA (such as Kenyans or Somalis from Eastern Africa),[318] and data from the 2008-2012 American Community Survey (ACS) five-year file estimates a number of 20,000 Tanzanians in the USA (Gambino, Trevelyan, and Fitzwater 2014, 3). Obviously, if we consider all undocumented Tanzanians the number must be much higher. About 75 percent of the African-born population in the USA moved to the continent only after 1990. Interestingly enough, more than 40 percent of the African-born immigrants in the USA completed a bachelor's degree or higher which is more than the number of the overall foreign-born population in the USA (almost 30%) (Gambino, Trevelyan, and Fitzwater 2014, 9). The USA constitutes only one of several destinations young Tanzanians chose to migrate to. This study found that the USA seemed to be a prominent destination for children of better-off older people residing in Dar es Salaam. However, other destinations such as the UK or Asian countries were much frequented as well. As mentioned in the methodology part, I chose the US research sites by building on existing contacts, but presenting the USA as the main destination for Tanzanian migrants would be misleading. According to a report by the International Organization for Migration (IOM) about Tanzania's first diaspora conference, Tanzanians living abroad remitted $75 million dollars in 2013, which compared to other African countries is rather low.[319]

Among the four sites that will be presented here, three sites are officially organized as Tanzanian communities (DMV, Ohio and NY) while one site did not have such a formally organized network (Massachusetts). Due to the fact that my multi-sited research approach made me follow links from Tanzania to the USA, I do not consider the cities or states as such as my research sites, but the Tanzanian networks of people spread across them. Consequently, in what follows I will briefly introduce the communities rather than the geographical locations.

THE "DMV" COMMUNITY IN WASHINGTON D.C., MARYLAND AND VIRGINIA

Since the Tanzanian community joins the states of Washington D.C., Maryland, and Virginia into a DMV community, the three states are taken here together as one "research site."

[318] The US census bureau understands foreign-born as "anyone who is not a U.S. citizen at birth, including those who become U.S. citizens through naturalization" (United States Census Bureau 2017a).

[319] See report on the website of the International Organization of Migration (2014).

Together with New York, Maryland (with 120,000 foreign-born residents from Africa) belongs to one of the four states in the USA that have more than 100,000 foreign-born residents from Africa (Gambino, Trevelyan, and Fitzwater 2014, 4). In addition, Maryland as well as Washington D.C. are among the highest percentages when it comes to the number of foreign-born residents from Africa in the foreign-born populations in general (Gambino, Trevelyan, and Fitzwater 2014, 5). These figures were also reflected in the description of some of the study participants who especially came to reside in this area because one can "keep a low profile," and unless people do not break the law, police will not control them randomly on the streets. It is thus an area that was recommended to many of the study participants residing in the USA without legal documents. This advantage was also brought forward by my host in the area, Yacinta who worked at a fast-food restaurant (where people without papers get paid US$8 an hour). Yacinta also introduced me to some of the places where Tanzanians of the DMV community meet:

> We then decided that we will go to a Swahili restaurant in [location]. When we arrived at the metro station, google maps showed that the next bus would only arrive in twenty minutes and Yacinta proposed to take a taxi … She did not know exactly where the restaurant was but was able to give directions to the taxi driver and then we were lucky to see it from far. The taxi cost US$13. When we arrived at the restaurant, a bit after 8 p.m., we met a friend of Yacinta. This friend was at the restaurant with a Tanzanian delegation who came for a World Bank meeting. They were sitting outside and ordered a big plate of food. The friend of Yacinta said that they have a lot of money so they could order that.
>
> After a delicious Tanzanian dish, we went to another place in [location] with two other friends of Yacinta that we met incidentally at the restaurant. The club looked pretty much like a Tanzanian club in Dar es Salaam. There was Tanzanian music and mixed with music from other African countries. In the club, I met several familiar faces of people I encountered already at the community house in [location]. It was very interesting to observe the little "Tanzanian world" abroad, and many told me that they feel like being at "home" for a short moment in time when they are in this club or at the Swahili restaurant.
>
> (Field notes 12.04.2014)

The Tanzanian community of DMV owns a community house which is much frequented, especially at the weekends by Tanzanians from different ethnic groups and religious affiliations. On their official website, the DMV community states their motto as "promoting Unity among Tanzanians in Washington DC, Maryland and Virginia regardless of peoples' religions, political affiliations or genders" (Watanzania DMV 2017). On their website, the community presents a list of benefits that entitle members who pay their monthly fees of US$10. Amongst others, members are supported financially in times of birth or marriages but also in bereavement, illness, and hospitalization (cf. Watanzania DMV 2017). The community furthermore owns a blog that posts all these events and keeps people up to date about news in Tanzania.

Tanzanian Migrants in Massachusetts

> I got Emanuel's telephone number from Susan. Susan is a friend of Maria from Ohio, whose mother I met in Dar es Salaam. Susan talked to Emanuel on the phone and told him already about my planned research. I called him on Tuesday right after Susan gave me his number and he was very welcoming. He

> told me that he is usually working until 5 p.m. and afterwards, ready to talk to me. Thus, we agreed to meet on Wednesday around 5.30 p.m. at his place … We agreed to talk again once I am on my way. At 5.10 p.m. Emanuel called me to ask where I am … I then managed to find the right bus stop … The bus took fifteen minutes to get to his place and then I had to call several times until Emanuel picked up the phone again. He told me to wait where I am and he came to pick me up so that he can show me the entry to the dark multistory building where his apartment was located.
>
> Emanuel and his wife Angela and their three and half year-old son stayed in a small apartment … The apartment has a wonderful view and the living room is full of sofas on two sides of the room. The living room is open to a small kitchen. Everything was rather small and slightly run down. When we were about to start our conversation about their parents in Tanzania, Emanuel called his neighbors and asked whether they could guard their son for an hour so that we could talk without being interrupted. The neighbors are Tanzanians too and live in the same block, just some floors further down.
>
> I found it interesting that Emanuel and Angela explained that in Massachusetts there is no organized community of Tanzanians while these groups exist in other places in the USA. As the area is big and people are scattered, it is difficult to meet regularly. Furthermore, Emanuel and Angela presumed that people are less interested in a community bringing together Tanzanians, since people from Zanzibar do not necessarily get together with people from the mainland. They told me about an attempt to create a Chagga group (bringing together people from the same ethnic group) however Emanuel refused to go there because he said he could not even bring his wife Angela who belongs to a different ethnic group.
>
> When I left almost three hours later, I accompanied them to pick up their son at the neighbor's apartment and it was interesting to observe that they communicated in Swahili with the neighboring family while they spoke English with their son. (Field notes 02.04.2014)

The state of Massachusetts has a population of approximately 6,5 million people, whereby almost 14 percent are above the age of 65 years (Census 2010, cf. United States Census Bureau 2017b). The number of the foreign-born population from Africa in Massachusetts is roughly 80,000 people (Gambino, Trevelyan, and Fitzwater 2014, 4).

Since living in the city (for example, in Boston) is expensive, many Tanzanian migrants also reside in the suburbs, while some travel to the inner city on a daily base for work. Others remained on the outskirts and only rarely traveled to the city center, as transport to the outskirts was rather challenging, due to high costs of the train and only a few available lines. For Susan, for example, it took me approximately forty minutes by train to reach her place. And from the train station you need a car to reach their house. Due to their remote location, Susan rarely traveled to the city. One additional reason was that she did not like to drive through the busy streets of the city center in her own car.

THE "NYTC" IN NEW YORK

The state New York is inhabited by a bit more than 19 million people, 13.5 percent of them with an age higher than 65 years (Census 2010, cf. United States Census Bureau 2017b). With 164,000 people, the state of New York has one of the highest numbers when it comes to foreign-born people from Africa (Gambino, Trevelyan, and Fitzwater 2014, 4). Below Debora tells us how she arrived at the area for the first time:

Debora: …The first apartment we found … wasn't that fancy—It is actually those like … I have a picture—I will show you—It's those like colonial buildings … we lived on the 5th floor and … there was no elevator and the person who owned it was an Indian guy, an Indian man who lived in New Jersey … for some reason he just decided to rent to us and we explained that we are going to be sharing, so we shared a bedroom and a half—the half is like a big closet that had a bed in it—I went on Craigslist and we found like another person who was looking for a room and we found this nice girl her name was Rehema so me and my friend shared the room and Rehema used the smaller part by herself. Haha

Andrea: So it was crowded!

Debora: Yeah it was crowded, haha! It's funny because our room was really spacious it was a living room in a way … at first I don't even know we had like an air mattress … and this girl actually—we went to high school in Tanzania together and we found ourselves here—together—so it was amazing she was from Tanzania …

Andrea: Sounds like an adventure!

Debora: Oh my god! I don't know what I was thinking, now that I would look back. I would never do this again, haha!

(Debora 2014)

New York has its own Tanzanian community which is called New York Tanzanian Community (NYTC). The community has its own website and celebrates Tanzanian festivities and organizes, according to its website amongst others, "health, wellness and immigration awareness" events (cf. New York Tanzanian Community 2017). The community is well connected with the neighboring DMV community and when the Tanzania Union Day celebrations took place in the DMV area, a delegation from the New York Community visited for the festivities.

The Tanzanian migrants I met in New York usually resided in the affordable neighborhoods. According to the president of the New York Community, many Tanzanian migrants arrive at first in New York before they move to other places within the USA. It seems something of a transit place where many Tanzanians live without legal documents before managing to legalize their status.

THE "TCCA" IN OHIO

I especially traveled to Ohio to be there for Easter. I arrived on Thursday before Easter and happened to be in church every day until Easter Sunday. My host family was among the funders of a Swahili church service in a Lutheran church in the area. The church offers Swahili worship services every first and third Sunday of the month at 4 p.m. by a Tanzanian priest located at Evangelical Lutheran church. For Easter Sunday, the Tanzanian community organized a special event at the church. The event was supposed to start at 3.30 p.m. but we arrived at around ten past three apart and from my host's brother and his wife and the priest and his wife nobody was around. As members of the church choir, the small group rehearsed the singing again and soon people started to enter. When the service started, maybe around thirty Tanzanians, and few Kenyans were present, some especially traveled from neighboring states in order to attend the service. During the service, I had to stand up as *mgeni*[320] and greet. I was grateful that my host's father was sitting next to me and he helped me to stand up at the right moment. During the

[320] *Mgeni* can be translated as guest or visitor. Mgeni can also be used as a name for a person.

> service the priest talked to the people in the diaspora, addressing them in this way. The service took longer than the regular church services but it followed the lines on the program. After approximately two hours the service was over and people moved to another room of the church where a buffet with Tanzanian food was waiting. There was *Pilau*[321], chicken, chapati and during that eating event, my host's brother welcomed the guests and introduced people who held a speech. When we left the church, it was already almost 10 p.m. (Field notes 20.04.2014)

The state of Ohio has a population of 11,536,504 inhabitants among which 14.1 percent are above the age of sixty-five years (Census 2010, cf. United States Census Bureau 2017b). In Ohio there is the Tanzanian Columbus Community Association (TCCA) with its own representation on Facebook (cf. Facebook Group TCCA 2017). The TCCA community is again linked to the church that conducts weekly church services in Swahili and which also held the Easter church service described in the field notes above. The church had an established contact with churches in different places in Tanzania, and there was an ongoing exchange, with frequent travels of priests in both directions.

As the public transport does not cover a larger area, people are very much dependent on cars, when living in the suburbs. The neighborhood where my host family lived did not have sidewalks for pedestrians, therefore moving around without my own means of transport became almost impossible. For grocery shopping, my hosts usually frequented huge supermarkets that were not accessible without a car. As will be discussed later, Ohio also was a challenging place for nannies who did not know the English language and were not used to driving cars.

WHY LEGAL STATUS MATTERS FOR CARE

> At around 10.30 p.m. Saleh picked me up to go to the evening event of the Union Day celebrations in the DMV area. The embassy was organizing this event and everybody was invited to join—also non-Tanzanians! When we arrived at the venue at around 11 p.m., already many people were sitting at round tables while the *Balozi*[322] and other important people were seated in front. We found a space at the table of Abasi who has been ready to be interviewed recently before in [location]. Furthermore, Zuleikha with whom I met for an interview in [location] showed up with her elderly mother. They were travelling with their own car … for the event and left the event at 4 a.m. to drive back to New York.
>
> Soon after we arrived, they started to welcome the guests from different Tanzanian communities all over the US: California, Texas, Minnesota, New York… More or less everybody knew everybody, at least this was my impression. And I found it interesting to observe, who is talking to whom. There were those "newcomers," mostly young men who were not very much affiliated to the older and "more established" Tanzanians.
>
> At one point, the minister of finance from Tanzania, who especially arrived for the event, held a speech. I did not understand his Swahili so well, but Saleh explained to me that he talked for a long time to show the importance of what he called the "Tanzanian diaspora." He asked people to remain patient with

---

[321] *Pilau* can be described as a cooked rice dish with meat and spices of Indian origin.

[322] *Balozi* is a Swahili word for ambassador, it can also be a name for a person.

their request for the installation of a dual citizenship, while not ceasing the support for their relatives back home (and for his political party).

Later Saleh told me that most politicians in Tanzania do not support the request for a dual citizenship. Saleh assumed that they are afraid that people who stay outside the country would question their political actions more. With a dual citizenship they would become able to settle and establish themselves in the USA (or somewhere else abroad) while remaining politically active in Tanzania simultaneously.

Later there was a buffet with Tanzanian food that was emptied soon after its opening. Then there was a fashion show and far after midnight, the dance floor was opened. Again, as in most Tanzanian events in the USA the same DJ put on the music and the event was streamed live on his Blog. Even Zuleikha's elderly mother was dancing when tarab music was played. At 4 a.m. the event closed and the remaining people went home. (Field notes 26.04.2014)

During the period of this study in spring 2014 there was a lively discussion within the Tanzanian communities in the USA about the topic of dual citizenship. While at the time, politicians in Tanzania were involved in discussing the country's new constitution, the communities abroad came together to claim that dual citizenship should be part of the new constitution. Countries that grant dual citizenship accord emigrants and their descendants full rights "when they return to the homeland, even if they also hold the passport of another country" while other countries grant dual citizenship also with rights while living abroad (Levitt and Glick Schiller 2004, 1020). Currently, when a Tanzanian emigrant takes on the American citizenship, he or she loses the Tanzanian passport and when visiting Tanzania this person needs a tourist visa valid for three months.

Especially at the Tanzanian Union Day celebrations[323] in April 2014, the topic was lively debated as you could read from my field notes about the event. The event went on for two days and started with festivities at the Tanzanian Embassy. After the evening reception, the next day the DMV community organized a more informal barbeque with a football game between a team representing Tanganyika and a team representing Zanzibar.[324]

Tanzanians living in the USA opt for dual citizenship because they want to claim more rights in Tanzania as US citizens. They emphasize the huge amount of remittances they send home every year and would therefore like to be able to take part in the country's decision-making. Also, many are formally employed in the USA and pay taxes that would give them some social security later. Only as citizens of both countries, they could follow their dream of returning to Tanzania in old age and profit from the social security they worked hard for while living in the USA. The field notes presented above show how the minister "cares" for the group of Tanzanians residing in the USA by visiting them for

[323] The Union Day celebrates the unification of Tanganyika and the People's Republic of Zanzibar that took place in 1964.

[324] Since the two teams did not come to an agreement about the score, they finally decided that both teams had won and celebrated together.

the festivities. According to some study participants, politicians do so because they are aware of the power of migrant groups. Levitt and Glick Schiller also point to the power of migrants when they get involved in their home countries' affairs and hence they are impacting on the internal performing of states (Levitt and Glick Schiller 2004, 2014). And as the "second hat" mentioned by the minister above as a member of a political party shows, not only states themselves are "political actors that define their constituencies transnationally or that carry out activities across borders," political parties may also be active abroad (Levitt and Glick Schiller 2004: 1022).[325]

The Union Day celebrations nicely showed the diversity of Tanzanian migrants with different biographies and aims that came together for the festivities. Tanzanians who just arrived in the USA and try to make ends meet, Tanzanians who are well connected within the communities and settled in the foreign country, Tanzanians who are married to Americans, and Tanzanians who employ a Tanzanian nanny in order to ensure that their children learn how to speak Swahili. In what follows I will focus on different groups of Tanzanian migrants residing in the USA who are (to a larger or lesser extent) involved in caring for their elderly relatives back home. Conversations and interviews in the USA revealed that Tanzanian children's transnational care for their aging relatives strongly depended on their legal status in the country.

Tanzanian migrants interviewed for this study belonged mostly to the first generation of migrants, most of them arriving in the USA in their twenties or thirties. Some traveled to the USA with small children, but many started building their families only after arrival. Since my research was focused on Tanzanians who care for parents or older relatives over the age of sixty in Tanzania, I did not come across many second-generation migrants. I only met one Tanzanian who traveled abroad because her father was ambassador in the USA.

While in earlier days, Tanzanians traveled abroad for further education to socialist countries or trainings as civil servants, many study participants I met in the USA belonged more to the group of economic migrants (cf. van der Geest's third link between old age and migration) or came to the USA as students. Due to the tough migration regime of the US government, many of the study participants held at some point in time an "illegal" status, and not all managed to legalize it during their stay. While living in the USA without papers, they could neither make use of the American welfare state nor adequately care for their relatives back home.

[325] Levitt and Glick Schiller distinguish three categories of migrant-sending states: 1) transnational nation-states that grant dual-citizenship and treat migrants as long-term, long-distance members; 2) strategically selective states that never grand legal rights of citizenship or nationality but try to obtain support from migrants abroad (where Tanzania might be placed); 3) disinterested and denouncing states that treat migrants as no longer belonging to the state (Levitt and Glick Schiller 2004, 1023-1024).

While the above-presented figures take the group of Tanzanian immigrants as an entity, it is important to look closer at the diverse backgrounds of these people residing in the USA. Vertovec argues that it is not enough to look at ethnic diversity meaning people belonging to the Tanzanian community in the USA, but we also have to consider "additional variables" that complement what the author then calls "super-diversity" (Vertovec 2007). Tanzanian migrants in the USA can be differentiated along what Vertovec calls "socio-cultural axes of differentiation" such as ethnicity, language, and religion (Vertovec 2007, 1035).[326] When it comes to the provision of care for older people in Tanzania, the variable that became important in this study is the immigration status which Vertovec describes as an "additional, indeed, fundamental, dimension of today's patterns and dynamics of super-diversity" (Vertovec 2007, 1036). The immigration status can vary "within groups of the same ethnic or national origin" (Vertovec 2007, 1039). Furthermore, according to Vertovec the "immigration status is not just a crucial factor in determining an individual's relation to the state, its resources and legal system, the labour market and other structures. It is an important catalyst in the formation of social capital and a potential barrier to the formation of cross-cutting socio-economic and ethnic ties" (Vertovec 2007, 1040). When talking to Tanzanian migrants in the USA, they connected their ability to care for their aging parents to their possibilities of working in the USA and traveling to and from the USA as well as to their entitlement to benefit from the American social security system—all aspects that are linked to a cleared immigration status.

In the migration literature, a distinction is made between "class"[327] and migration status of migrants; there are migrants that belong to the cosmopolitan elite and others that are refugees or economic migrants. Between the two extremes are "middle class" migrants and their families; however, they have been largely unexamined so far. Most of the study participants I will later present, fall within the group of "well-established" Tanzanian migrants in the USA and belong to middle-income milieus in Tanzania. They have "access to enough economic, social and cultural capital within their extended networks to have a relative degree of control over their mobilities and transnational relationships" (Baldassar and Merla 2014a, 10).

What makes these differences between socio-economic positions even more extensive are "processes of deskilling and downward social mobility in host societies, further compounded by the current global economic crisis" (Baldassar and Merla 2014a). In this study, I will also focus partially on "middle class" migrants, although they might not perceive themselves as belonging to a "middle class" in the USA.

[326] Vertovec mentions next to ethnicity, language and religion also country of origin. The author describes these socio-cultural axes of differentiation as important for the migrants' identities and ways they interact, as well as for their access to diverse services and jobs (Vertovec 2007, 1035).

[327] As mentioned in Part II, I use the description "middle class" here to refer to the socio-economic position, in this case a middle-income group without implying any other markers to the concept of class.

Migrants sometimes "occupy different gender, racial, and class positions within different states at the same time" (Levitt and Glick Schiller 2004, 1015). Hence, "migrants who are laborers, home health aides, or domestic workers in countries of immigration may also be educated and middle-class homeowners or business people in their homelands" (Levitt and Glick Schiller 2004, 1015-1016). To cope with these differences and downward social mobilities, I will consequently talk about migrants belonging to Tanzanian middle-income families.

Despite the often-experienced downgrading, the fact that somebody emigrates from a better-off family from Dar es Salaam, seems to provide him or her a different initial position in the USA than somebody who grew up in a rural part of Tanzania and struggled to economically survive in Dar es Salaam, before traveling abroad. Hence, for children from former civil servants' milieus such as Ada Estate, going abroad for studies was much more common, and they were also not perceived to be something special when visiting back home, since most of their friends have a similar pathway of leaving Tanzania (and coming back).

Many Tanzanians traveled to the USA with a visitors' or students' visa and overstayed. For these "overstayers" to acquire means to send back regular support was difficult due to their non-legal status and 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 for Tanzanians who traveled to the USA with a scholarship or green card, or who were able to turn their initially illegal status into a legal permission to stay—the so-called "well-established"—supporting the parents on a regular base was more common. In addition, due to their immigration status—some also became naturalized during their stays—and with a more stable financial situation, they were (legally) able to invite their parents for health checkups to the USA, and traveled back home regularly.[328] Other Tanzanian migrants can be described as "temporarily employed." They usually travel to the USA with a visitor's visa, for example as nannies. Other nannies, however, are regularly employed with a work permit and thus receive the minimum wage. Since their stay is short, they focused more on accumulating money, for example, to pay for their children's education in Tanzania, than on sending it home on a regular base.

[328] Vertovec distinguishes for the UK six different possible immigration statuses: workers, students, spouses and family members, asylum-seekers and refugees, irregular, illegal or undocumented migrants, and new citizens (Vertovec 2007, 1036-1039). I will rather simplify his enumeration by looking at three groups (elaborated later in the text) since these three groups seem to make a difference when it comes to the care they provided to their parents back in Tanzania. The group of the "well-established" incorporates Vertovec's workers, students, spouses and family members, and new citizens, the group of the "overstayers" are more or less consistent with Vertovecs group of the irregular, illegal or undocumented migrants, while the group of the "temporarily employed" are on the one hand workers but also undocumented migrants.

In the following text I hope to show how the immigration status of the participants of this study in the USA impacts on their being more or less transnationally involved when caring for their older relatives in Tanzania. Vertovec also says that the level of transnational engagement is amongst others "largely conditioned by a range of factors including migration channel and legal status," and thus, undocumented migrants might struggle more to maintain ties with their relatives in their country of origin or elsewhere (Vertovec 2007, 1043), and consequently they might struggle more in providing care.

MIGRANTS WHO CARE

This chapter is organized according to the legal permission to stay in order to describe different care practices. Because the legal status and thus the ability to care are dynamic, and since legal positions can change over time (e.g. when a Tanzanian man without papers marries an American woman) along with care giving abilities, I use the subdivision into the three groups as my analytical categories, however, only partially informed by the own perceptions of the study participants.[329] Nevertheless, many participants themselves uttered their wish to have a clear migration status, as it would facilitate many aspects of their lives, amongst them also their ability to be able to face the various care demands coming from Tanzania.[330] Immigration status is one way of grouping the study participants in support of my argument about care. It is thus one of several aspects shaping parental care over a distance, while other aspects such as the lived relationship between caregivers and care receivers, the health condition and need for care of the older person in Tanzania as well as gender played a role too.

"OVERSTAYERS"

Yacinta's story stands for those Tanzanian migrants who travel to the USA with a temporary visa (students, visitors, tourists) and do not leave again after their visa expired. Their initial illegal position as foreign immigrants in the USA brings about many daily struggles concerning, amongst others, work, housing, and health care. Due to their undocumented status, they faced many difficulties in sending remittances back home or engaging in other material forms of care.

---

[329] In her article, Mazzucato distinguishes four groups of migrants or ways of how migrants involve in caring for their parents back home. Those who invest in houses in Ghana, those who set up a source of income in form of a small business, those who support occasionally, and those who do not care at all (Mazzucato 2008b). While Mazzucato's description of the four types seems more static, I decided to group the study participants differently in order to point to the dynamic process of moving between different migration statuses and groups. Furthermore, the analytical categories stem from the analysis of my data that was conducted in an inductive way.

[330] While this study focuses on transnational elderly care, the study participants I met did not only receive requests for care for older people but also diverse inquiries for support from a wider social network in Tanzania.

Not being able to travel back to Tanzania for important events complicates relationships that have to be cultivated over distance. Long working hours in exhausting jobs and no financial means while receiving many requests for support from Tanzania make engagements in care challenging. These challenges often result in Tanzanian migrants being less connected with Tanzania when, for example, compared to the group of the well-established that will be presented later.

Yacinta was my host in the DMV area and twenty-nine years old when we met. She had been in the USA already for four years. She studied languages in Tanzania and came to the USA for further studies and to teach Swahili. For her studies, she received a scholarship including the permission to stay in the USA. After having completed her studies, she continued to stay in the USA. She explained to me that around the DMV area there were many people without a passport, as the police did not control people arbitrarily on the streets as long as they did not misbehave. Yacinta shared a small room in an (again shared) apartment with a friend of hers from Tanzania, with whom she went to school. When I met her for the first time, Yacinta worked at a fast-food chain. Another Tanzanian friend who worked for the same employer introduced her to this job.

Since payment was low and the risk of being exploited high, Yacinta started a further education in nursing. She explained that working in the nursing sector was much more remunerative and, in addition, she did not have to pay for the training. She had received the suggestion to work in the nursing sector from another Tanzanian colleague who already worked there. When I met her some months later, Yacinta had quit her job in the fast-food company and was working in a nursing home for physically disabled people. She had also moved to a new apartment closer to work where she was able to rent one room on her own.

Yacinta's parents lived in northern Tanzania. They were in good health, although her mother suffered from asthma. Yacinta's youngest sister lived with her parents from time to time while visiting a boarding school. Furthermore, they shared their house with a grandchild as well as a household helper. Yacinta explained that her parents usually had many visiting relatives in their house. Due to the dynamics of these visits, it was hard for Yacinta to know who was around when I asked her.

Yacinta had five siblings and she was the only one of her nuclear family who had traveled abroad. She told me that she concentrated on sending money to her family in times of need—that is, if she had money available. The family had a chat group on WhatsApp and Yacinta also engaged in a separate chat with her sisters. Upon request, she sent goods or money, depending on what was asked for by her relatives. She had sent her parents and siblings phones and laptops from the USA in order to communicate with them more easily by using WhatsApp, Skype or Viber.

Apart from supporting her family, she used the money she earned to accumulate savings but also to buy things like the latest iPhone or a bike. Others would call her a "newcomer" who (still) invests a

large amount of money in fancy technical devices and other "unnecessary" things, while only putting little money aside for the future,[331] although Yacinta had already opened two bank accounts in Tanzania as well as in the USA. Her idea is to hold her money in different accounts as she was afraid of losing her savings in case one day her illegal status became a problem. She also bought a plot of land in Tanzania, her investment for the future; however, she did not yet know what she will to do with it later.

Ever since she left home for studying in the USA, she never managed to go back to Tanzania. Instead, she hoped to be able to bring her parents and her siblings to the USA one day, as she thought that caring for them in the USA would be easier because of the good health care system. Like Yacinta, many of the study participants residing in the USA came to the continent in order to study and continued to stay after they finished their studies. Others traveled to America as visitors invited by other Tanzanians, often (extended) family members.

Journeys to the USA

According the US department of homeland security, in 2013 a number of 7,635 Tanzanian citizens received nonimmigrant admissions (1-94) to enter the USA on a temporary base.[332] After entering legally with such a visa, many of the study participants did not leave again when the visa expired.[333] Utman explained how Tanzanians come to the USA as followed: "[They come] to visit somebody else like [with an] invitation—I send a letter to my cousin and say hey you can come and visit—I know that she isn't going back so they come here … I would say the majority comes as students and some come as visitors not really tourists [but] as visitors yah so … we have a lot of Tanzanians; we have a lot of Tanzanians here…" (Uthman 2014).

Many study participants I met in the USA traveled to the continent with educational ambitions; however, especially financial reasons contributed to their dropping out, when they were not entitled to a full scholarship like Yacinta. Godfrey, for example, who was in his late thirties when we met also came to the USA for higher education studies. After he finished high school in Tanzania, he was able to join his brother who was already living in the USA. He started with a Bachelor degree course at a university but struggled to finish his studies because of his unstable financial situation. Later, he married

[331] Mazzucato describes the group of migrants that are starting to make ends meet in the receiving country, and thus can afford more than mere subsistence, "play-it-by-ear" migrants (Mazzucato 2008a, 207).

[332] Nonimmigrant admissions are for "temporary visits for business or pleasure, academic or vocational study, temporary employment, and to act as a representative of a foreign government or international organization" (Teke and Navarro 2016, 1).

[333] Due to the fact that I encountered Tanzanians in the USA and not those who went back after their visits in the USA, I cannot say much about the experience of those people who decided to go back to Tanzania after some time. Many "overstayers" I met explained that they would stay in the USA as long as they were not caught with the aim of legalizing their status at some point in time. I did not come across people who traveled to the USA without a legal permission more than once.

an America woman. Ali also came to the USA with the intention to study. However, because his application for university that he had sent when still in Tanzania took time, a friend with whom he had gone to school as a child invited him to the USA as a visitor instead. Ali came as a visitor, with the idea that it would be easier from him to apply for a school when already in the country. He then decided to start working first as it was impossible for him to pay for the studies while not working. It was only afterwards that he started to take classes in Information Technology in the USA. Zuleikha came to the USA because of her brother, who was already there. She then started school in the USA and got married to an American shortly after her graduation in Computer Information System. A student visa is a way to legally enter the USA. The student visa allows you to stay and study in the USA for 120 days.

The decisions to leave their own country for the USA varied. Rashid, for example, who was in his early forties when we met, had finished his high school in Tanzania but did not have enough money to continue education. His father died early and when he did not find a job, the family sat together and decided that two of his brothers would try to go to the UK while his little sister would leave for the USA. Rashid went to South Africa. After working for six months in South Africa, he came back to Tanzania in order to try again to find a job. After two years without success, he decided to join his sister in the USA. Rashid was not the only one of the group of (male) study participants who went to South Africa before coming to the USA. Saleh also went to South Africa for work when he was sixteen years old. He finished his school in engineering and worked for a company. He lived in South Africa for twenty-three years before he applied for a job in the USA. He now lives in the USA on his own while his partner and their three children are still in South Africa.

Saad grew up in Zanzibar and went to Kenya before coming to the USA. Saad has an adventurous story about how he came to the USA. Like many others, it took Saad several months and struggles to obtain a passport and a visa, as well as enough money for the flight. Saad started his journey from Zanzibar with two friends and US$300 in his pocket. Because the customs officer at the airport in Tanzania claimed that his passport was fake, he had to use US$200 to “convince” the person at the customs in order to get on the airplane. With what was left of the money he arrived in the USA where he and his friends struggled with only little knowledge of English. They were received by other friends who had initially invited them to come to the USA. With an invitation, visitors are allowed to enter the USA in order to visit family members or friends for ninety days. Saad shared a flat and beds with others in a small apartment for three months. He worked nightshifts at a post office and stayed for four years “without any rights,” so his own words (Saad 2014).[334]

[334] Thanks to the social network of Tanzanians in these cities and suburbs, jobs were accessible for many of the participants of this study.

When talking to the study participants in 2014, some had managed to turn their initially illegal stay in the USA into a legal permission. Often this was a question of time and serendipity. Some were clearing their status through marriage to an US citizen. With a marriage, they were able to apply for a green card, which then allowed them to apply for a permanent residence in the USA. Other study participants were able to get a green card through work. This seemed to be a long process in which the employer had to submit the application for permanent residence. Otherwise, again through an employer, different kinds of work permits are obtainable (H visas).[335]

As Saad's story shows, the first years after arrival in the USA come with diverse (financial, linguistic, etc.) struggles. During this time of settling down, sending support back was difficult for most of the study participants who came to the USA on a temporary visa and had to first establish themselves in a lengthy process before being able to send remittances or other material support to their parents and other relatives.

The Tanzanian Community

Especially for overstayers, the Tanzanian communities that exist in many states[336] seemed to be of great importance. The DMV community owned a house that served as a meeting point for the group each Sunday. The house has a living room were men usually sit and talk or watch soccer.[337] There is a kitchen that is used to prepare food. On the upper floor there are rooms for Tanzanians who do not (yet) have their own place to stay. When a Tanzanian newly arrives in this part of the USA, the community helps him or her. Jobs are often organized within the group; there is, for example, one fast food chain that employs a large number of Tanzanians without papers (where also Yacinta worked). As Rashid explained, the community supports its members in finding jobs: "… let's say find one of a member he doesn't have job you take him there and say ok look there is this job do you wanna work—that's how it helps … it helps to be connected" (Rashid 2014).

Festivities such as Union Day or Independence Day celebrations usually take place within the community. For the official celebration of the Union Day, described at the outset of this chapter, the DMV community gets together with other communities as well as the Tanzanian embassy. A blog was

---

[335] The visa application process seems difficult to grasp. There are many different visa categories (from A to T) and sub-categories. To understand for which visa one has to apply already needs certain (English and Administrative) language skills (cf. U.S. Department of State 2017).

[336] While DMV is the largest community of Tanzanians in the USA, the second largest official group is in Texas. The third largest group is in Massachusetts, followed by Ohio. Then comes Minnesota and California (Information derives from an Interview with a member of the DMV community, 6th April 2014). According to an estimate by its president, DMV community has about 5,000 members (Interview with the president of the DMV community, 12th April 2014).

[337] Usually, only men met at the community house. Many of the men I met at the house were either married to an American wife or lived on their own. Through my snowball sampling strategy and the equal number of women and men interviewed I cannot say much about the gendered dimension of Tanzanians migrating to the USA.

initiated and is managed from within the community house and seems to be one of the most frequented within the communities I visited on the East Coast of the USA. It discusses latest topics that concern the communities and presents or documents events that happen within the community.[338] Furthermore, the Tanzanian communities are connected through Facebook where they comment on posts of others. Sometimes these posts are private, sometimes political and sometimes also critical reflections about the Tanzanian society in Tanzania.[339] In July 2017, a member of the DMV community was apparently arrested with a high risk of being deported. The president of the DMV community started a "go fund me" call in order to pay for his lawyer.[340]

Engagements in Care

Many of the study participants with an insecure residence status in the USA did not send regular support to their parents. Due to their illegality, it was difficult to find work where they earned more than what they needed for their basic survival. Additionally, being new meant that they had to invest in building up an existence in the USA, and therefore not much money was left to send back to Tanzania. In our discussion, Yacinta explained that she could not send remittances in form of money on a monthly base but rather when money "was there," which was not easy to predict:

> Andrea: So, you said that at the moment they [your parents] are quite self-sufficient they do not need money from you, your sisters and your brother?
>
> Yacinta: From me for sure no and I haven't sent them money maybe for like four to five months but when I have [money] I send them and when I don't, I don't…
>
> (Yacinta 2014)

Many overstayers explained that they would only send money in case of health-related crises, for example, when a family member suddenly becomes ill and money is needed for treatment. In her article, Mazzucato therefore calls them "occasional helpers" who come in when a crisis arises and in case they have sufficient means to do so, while they are not involved in what Mazzucato calls a "planned or systematic way" of helping (Mazzucato 2008b, 101). Such health-related crises of family members can be burdensome for Tanzanian migrants who are yet undocumented and financially not very well off.[341]

---

[338] Since the owner of the blog found my research on older people important, I was able to initiate a discussion on old age care in Tanzania on his blog. For some of the active bloggers, the old age topic was useful to make a case about their claim for dual citizenship, since it would show again the importance of their support.

[339] In addition, there is a Tanzanian diaspora council (DICOTA 2017) based in the USA.

[340] The call started on 03.08.2017 on one of the leading American fundraising platforms called "go fund me" and by the 02.08.2017 already US$25'006 had been collected through 289 contributions of mostly other Tanzanians residing in the USA.

[341] Judith Schühle describes in her book the involvement of medical doctors who emigrated from Nigeria to the USA which is also much increased in health-related crises of relatives in their home country. In contrast to the doctors who have a documented migration status and earn an income as medical doctors in the USA, the Tanzanian migrants I met for this study have much less possibilities to react (c.f., Schühle 2020).

Prince experienced such a health-related crisis and sent all his money to his mother who was diagnosed with breast cancer in Tanzania. She went for chemotherapy to Kenya and each trip cost about US$4000. Since he was the only family member who could support her financially, he made debts to pay for the expensive therapy. The same happened to Abasi, who financially supported his stepfather's recovery after a stroke.

For overstayers it is not only difficult to earn enough money to be able to support older people in Tanzania, it also complicates the seemingly easier task of keeping contact and maintaining social relations. Their focus seemed to lay on their own establishment with the aim to support relatives in Tanzania once they succeeded in doing so. Maintaining social relations, some explained, was more difficult to manage without the possibility to travel back to Tanzania in case of important events.[342] Ali, for example, who has never gone back home coming to the USA ten years ago and who is now married to an American wife, talked about the difficulties he faced when his sister got married in Tanzania: "The bad thing [is], I missed her wedding—she married in 2007, actually I was not able to go there yah… so those are difficulties when you stay far from your family—sometimes you miss important things of your family such as wedding or funeral stuffs… you feel like you are not part of the family but you try to call to be close as much as you can" (Ali 2014).

At the same time, some study participants mentioned their concerns that it makes their parents sick if they do not see their children for such a long time. They feared that chronic conditions such as hypertension might derive from their parent's sorrows and longing to see their grandchildren they have never met. For this reason, Ali loaded phones with over 150 pictures of his American family to send them home to his parents and siblings in Tanzania so that they could "meet" his wife and daughter. Thanks to the phones he was then able to engage in virtual forms of care so as to compensate for not being there.

Linked to the fact that they want to have family members around and that another sibling could assist in providing (financial) care for parents back home, many study participants either joined another family member in the USA or were in the role of supporting another person to join them in the USA. Hence, as was already mentioned before, once they were settled, they often tried to bring other siblings over, so as to "join forces" to care for their parents or other relatives back in Tanzania.

However, the expectation that they should support not only their parents but many others of their kin network was also felt as a pressure. Rashid, for example, has more than ten siblings; although two of his sisters were also living in the USA and one brother in the UK, he always had to make sure that he

[342] If an undocumented migrant leaves the USA, he or she might face problems when re-entering the continent again after a visit in Tanzania.

distributes his support equally each month according to his means. Others also explained that they try to distribute their support and so, in one month, support goes to one particular person, and in the next to someone else. Interestingly, parents were usually not part of this distribution system, but received their support more regularly; thus, the support of other people seemed to add to what was already put aside for parents. This was different from what Mazzucato found in Ghana where quantitatively more remittances went to other family members than parents (Mazzucato 2008b, 95).

The transnational care that overstayers are able to provide for their parents and other older relatives can be described as less regular but more crisis-oriented, where big efforts are made in times of a health-related crisis of a family member that suddenly needs a substantial amount of money or medical remittances from abroad. Due to their undocumented status as well as the lack of financial means, visits to Tanzania are not possible. At the same time, no visitors can be invited to the USA to visit other Tanzanian migrants and their families. Care for aging parents in Tanzania is thus largely limited to virtual care through communication, with occasional monetary or material support.[343]

"Well-Established"

Being well-established comes along with a legalized status as a green card holder or US citizen. People whom I describe here as well-established either managed to turn their initially illegal status into a legal permission to stay or already traveled with such a permission to the USA.

Due to their immigration status, people like Maria manage to get involved differently in parental care.[344] They have more possibilities to engage in regular support of their relatives and either travel back to Tanzania or invite their parents for visits.

Maria, who was thirty-five years old when we met for the first time, came to the USA with a green card. She already applied for it when she went to college in Tanzania and left when she was twenty-four years old. She came to Ohio and finished her undergraduate studies in Social Work. She continued with her studies and got married to a Tanzanian with whom she has two boys. When she arrived in the USA for the first time, three of her brothers were already living in the same area, which made it easier for her to settle in, so she explained. However, from the beginning she made sure that she could travel back to Dar es Salaam once a year, because otherwise she would feel homesick.

[343] A tendency that was observed but would need further investigation is that some overstayers limit communication with home so as to escape the expectations of their relatives who might have supported their journey to the USA. Some overstayers furthermore, come from families that are not well off enough to support their children's emigration to the USA. This would be another explanation why these migrants feel less obliged to send support back home.

[344] Maria's story is also presented in the chapter on "Healthy Aging, Middle-Classness, and Transnational Care between Tanzania and the United States" (c.f., Kaiser-Grolimund 2018).

Maria worked night shifts in the nursing sector where she cared for disabled people. Her husband also worked night shifts as a social worker while he had another job during daytime and completed an MBA part time. Since both worked at night, they had a nanny from Tanzania who cared for their two little children when they were not around. The nanny, who was in her late fifties, was the mother of a friend of Maria. Soon after I spent a week with Maria's family, the nanny left for Tanzania after having cared for Maria's boys for two years. After that, Maria and her husband faced some challenges in finding another woman who was ready to come from Tanzania to the USA to work for them. It was important for Maria that her children learned both languages, Swahili and English, as a consequence she preferred a nanny from Tanzania. She tried to employ a Mexican woman with very little knowledge in English, however due to communication problems this did not work out.

Maria and her mother in Dar es Salaam communicated several times a week. After Maria's dad died in 2012, her mother had difficulties in coping with the situation. Maria's brother, Eric who lived in Ohio, too, remained in Tanzania after their father's funeral. Eric was in the process of extending his green card with a new employer, and when he left, this process was discontinued. Therefore, after he had left the USA he was no longer allowed to travel back. At the moment, Eric was thus taking care of his mother, by being there for her and staying with her in the family home in Dar es Salaam.

Although Eric was staying with their mother, Maria communicated more with her sister who was staying in Dar es Salaam, near the family house. Together the two sisters discussed their mother's needs and only thereafter, they informed their brothers, usually with the request for financial support. Although the siblings met at least weekly in Ohio, they did not routinely discuss the regular financial support that they were sending to their mother. Maria explained that she did not want her brothers to know how much "pocket money" she sent to her mother every month so that the brothers did not stop doing the same.

In 2014, Maria and her sister convinced their mother to travel to the USA to visit the family. The mother had already been in the USA in 2011 when Maria's second child had been born. Traveling on her own to the USA was a challenge for Bibi Veronica, as she did not know any English. Therefore, it took the two sisters some time to convince the mother to dare the journey. In the USA, the mother stayed with Maria who also took her to the doctor for checkups. Bibi Veronica got a new hypertension medication and her eyes were checked. After nearly three months, she went back to Tanzania. One year later, Bibi Veronica traveled again to the USA for checkups and to help Maria with the children during the summer break, since Maria and her husband had not found another nanny to care for the little ones until then.

As the story of Maria and her mother Bibi Veronica illustrates, Maria's immigration status in the USA shaped her possibilities of visiting her mother, or having her in the USA for visits. While some "well-

established" Tanzanians travel to the USA with a green card in their pocket, as was the case with Maria, others go through the process of being "overstayers" for some time before they can legalize their status and thus become more established in the USA.

Becoming Well-Established

While establishing oneself is a short process for some, it takes others many years. Some probably leave already before attaining the status I here call "well-established." After becoming established, only few of the Tanzanians I met decided to apply for the US citizenship. For green card holders, there is the possibility to become naturalized and to get the US citizenship. The process is bound to several requirements. One requirement is that you have to have lived in the USA for at least five years. In 2013, only 837 Tanzanians obtained "lawful permanent resident status" (green cards) by country of birth (Tanzania) in the USA.[345] A number of 647 Tanzanians got naturalized and thus became US citizens in 2013, this number has slightly increased in the last years.

While only few of the study participants aspired to become a US citizen in order to be able to apply for a green card for their parents, many would rather not swap their Tanzanian passport for an US passport, since their Tanzanian passport is closely linked to their future plans of going back to Tanzania. Some optimistic migrants also plan to go back home in old age while still a US citizen in order to live off the US social security in Tanzania (while hoping that until then the dual citizenship requirement will have passed). They make their own plans for their old age since they do not expect their (American) children to care for them in old age.[346] Abasi explains: "Yaah to save money to make sure that you have a pension to have whatever it takes for you to take care when you are older because I am responsible for my own life everybody is responsible for his own life that is the Western culture so to depend on someone is the risk… Yaah and that risk you know you can't take a risk to your life—that's what's going to happen" (Abasi 2014).

Migrants' Future as Older People

Although most of the participants of this study perceived it to be their responsibility to be involved in the care of their aging parents in Tanzania, on the basis of reciprocity and the moral duties as children, they did not expect the same from their own children in the future. Being the first-generation migrants,

---

[345] In 2012 and 2011 the number of Tanzanians who obtained green cards was almost double as high as in 2013 (1,516 and 1,427 respectively). According to the US yearbook of immigration, Tanzanians that obtained a lawful resident status in 2013 made less than 1 percent of Africans that obtained the legal status in 2013 (United States Department of Homeland Security 2017).

[346] As mentioned earlier, while focusing on adults whose parents are over sixty, I did not target much the adults' young children who grow up as American citizen. Long-term research to capture these children's plans (belonging to the second generation of migrants in the USA) to care for their parents would be interesting. When listening to the study participants, I had the impression that the change between these two generations would lead to a change in care, no longer provided by children, but by (American) institutions.

their double engagement in two different contexts, mentioned earlier, becomes evident here.[347] They rather envisioned their "good old age" linked to being able to provide for themselves—either through social security as for example when investing in houses or businesses in Tanzania or through the services of the American welfare system.

When asked about their own future, most of the study participants mentioned plans to go back to Tanzania later in life. Going back was for them very much linked to aging well (*kuzeeka vizuri*). By identifying with Tanzania and being Tanzanian, although some of them were naturalized Americans, many were hoping that the dual citizenship would soon be adopted so that they could live in either of the two countries.

Ali, for example, who was in his mid-thirties when we met, imagined moving back to Tanzania and living in his own house and that during holiday time all his children would come for visits. People would visit him in old age only if he was supportive of them earlier in their life. Ali considers being surrounded by his children and other relatives in old age as an important aspect of aging well. For Ali, thus, "successful" aging is linked to owning a house in Tanzania. Mazzucato described the process of building a house back home and having the parents to stay and oversee it as a way of combining "personal with social objectives," while the personal objectives target the wellbeing of the migrants' own (nuclear) family, and the social objectives point to the wellbeing of the extended family, including parents (Mazzucato 2008b, 97).[348] To build a house in a country like Tanzania while being far away requires trustworthy people who can supervise the construction. Many Tanzanians therefore assign their parents with the task of overseeing construction and sometimes they are involved in organizing the process, depending on their health condition.

Neema had her father supervising the construction process of her house in northern Tanzania. She explained that while she was very grateful to have someone trustworthy to administer the construction and document each step for her, she also realized that the "assignment" occupied her father, who had recently retired, in a good way:

> Yeah then they have something to do, you know how we build our houses—there it's not a project that can be finished in … it takes years—and there is always something to do and also to have *fundis* [craftsmen] you know working you need somebody trustworthy to make sure that cement is not you know—put only half full… you know… so it is something that is done early in the morning—somebody wakes up and they are excited because there is a project that comes to an end and it is good to see that

[347] I observed this mentioned change in expectations for care in the future not only among well-established Tanzanian migrants but also among others.

[348] Unlike in the description of Mazzucato (Mazzucato 2008b, 99), building a house and having one's own parents look after it was not very common in my research. Also, the fact that this service was linked to childcare of grandparents back home could be rarely observed. Only one family had two of their three children with their parents back in Dar es Salaam, while all other study participants stayed with their young children in the USA.

> actually that I contributed something for that house to be—yeah we did that… it kept them busy for a while and sometimes I sent my mom too… especially after my father [passed away]… The house is not done yet so my mom would go if something was done she would go and actually here are the pictures and she will send me the pictures—yeah, those kinds of things—I mean she does not go so regular… My father would, but once in a while when I know there is something that has been done maybe a fundi emailed me and said we have done this, then I say go and check and make sure for me that this is true and then they go and say yah or maybe not…haha!
>
> (Neema 2014)

Sadly, Neema's father passed away before the house was finished and after that Neema's mother sometimes went to the construction site to check. Parents, members of the extended family or friends that are involved in services for a migrant, such as looking after a house that is being constructed, engage in what Mazzucato calls "reverse remittances." Reverse remittances are "remittances that flow from home communities to migrants, drawing on cases of migration from the Global South to the Global North." (Mazzucato 2010, 454). These remittances are thus part of the care that circulates between the countries. Other examples are childcare, helping with investments in housing or business and services concerning the provision of identity papers (Mazzucato 2010, 454).[349]

Medical Checkups in the USA

Maria became US citizen so that she could apply for a green card for her mother. Her idea was that her mother could come and visit her without visa challenges and be treated medically in the USA. The visits for medical treatment were more common among the well-established Tanzanians, since financial means were required to be able to "fly in" the parents and having them treated without having a health insurance for them in the USA.

As mentioned earlier, bringing their parents to the USA can help foster relationships by creating closeness. Emigrated children are able to present grandchildren to them but also to assess their parent's wellbeing, which sometimes proves to be a challenge over a distance. By observing how they move or do activities, the children were able to get a better picture of their parents' health condition. Over a distance it was not easy for the Tanzanian study participants to get informed about a parents' health problem, as the statement by Uthman reveals whose father died after being taken to hospital in Dar es Salaam:

> …The health system is hard sometimes in Tanzania and also, they were hiding things they didn't want to tell me because they don't want to worry me but I wish if they did tell me probably I could have send some money you know I was then sending him a hundred and fifty dollars a month … After that happen I was really like waaaoh you know somebody can die just like that you know diabetic—here diabetic is not a death sentence, I would say here every disease is not… You know, as long as you direct [treat] it

[349] Saleh told me a nice story about his mother who purchased a plot for him in Tanzania with the money she saved from his remittances. Only when she bought the plot, she told Saleh about it. Saleh was very happy about his kind mother.

> early, you survive… And now from then I was like—I went home and spoke to my mom, I said you need to take care of yourself and we will take care of you to make sure that you know your health comes first, you know—and I remember, I came back here and then I got married yah… I brought my mom here for the first time—the first thing [I did when] she came here—I took her to the doctor. (Uthman 2014)

In the USA, they can take them to see a doctor and be involved in the process of medical treatment. Often study participants maintained that doctors in the USA could explain more about diseases and treatment options than this would be the case in Tanzania. Adult children used to the US health care system preferred the information provided at the hospitals in the USA when comparing it to what they were told about their parent's health in Tanzanian health care institutions. Furthermore, they perceived the quality of health care to be better in the USA.

Uthman quoted above, also shared with me his experience in terms of dental care. When his mother came to visit him, he took her to the dental hygiene service and described her delight when once again feeling air circulating through her teeth afterwards. When Uthman studied in Asia, he learned that this was an important health promoting treatment that he had not been aware of when growing up in Tanzania. Hence, Uthman concluded that the information on which health promoting treatment or checkup existed at a certain age was not sufficient in Tanzania—even for better-off people. Having access to information on health issues in the USA, that lays much more emphasis on health promotion, Uthman sees his duty in making sure that his mother gets her regular checkups in the USA in order to prevent illnesses.

Remittances

Sending regular support to ones' parents seemed more common among well-established Tanzanians residing in the USA. Regular support was mostly provided in form of money that was sent on a monthly, or at least regular, basis, making it thus a constant care practice. Goodfrey, who was in his late thirties when we met, had a rotation system with his siblings, in which each month one of them provided US$100 for their mother. Being able to travel back and forth between Tanzania and the USA furthermore enabled Tanzanian migrants not only to provide financial care for the parents but also to bring material support to Tanzania.

Some study participants highlighted the importance of sending financial support so that their parents could register a business that would keep them busy and provide them with a little income in Tanzania. One example is keeping poultry in the courtyard (cf. Part III). Keeping one's own parents busy was often mentioned when talking about how children care for their parents in Tanzania. Many children I met mentioned that especially still quite healthy older people needed exercise in order to remain physically healthy and mentally fit. The aspect of keeping busy, their engagement in their parents' health care, is reminiscent of the international discourse on "successful aging" or "active aging."

Other study participants were not much involved in sending their parents financial support, but for other reasons than the overstayers mentioned before. Especially when parents were slightly better off, they were usually still self-sufficient in caring for their own needs. The situation however changed when parents who were formally employed reached the age of retirement, and suddenly more support was needed because the pension was too small or non-existent. Due to a changing health condition, but also due to changes in the older person's career, transnational care provided by Tanzanian migrants in the USA changed over time. Very often it increased with the age of the older person.

While conducting research in the USA, the insurance called WESTADI led to discussions among Tanzanian communities, and community leaders were intent on informing the members about the possibility of insuring their relatives against health costs. The Welfare Scheme for Tanzanians in the Diaspora (WESTADI) is a service by the Tanzanian National Social Security Fund (NSSF) and targets "Tanzanians living abroad through special Diaspora coverage" (URT National Social Security Fund 2017b). According to one of my interview partners, it started in 2011. By paying US$300 per year, the migrant can determine four "dependents" in Tanzania who are then covered by the Social Health Insurance Benefits (SHIB); furthermore, the migrant him or herself is also insured when in Tanzania. In addition, repatriation is also covered by ensuring the transfer of the deceased body as well as a person accompanying it back to Tanzania or, instead, by ensuring burial costs in the country of migration (cf. URT National Social Security Fund 2017b).

While the existence of such a tool shows the awareness of the Tanzanian state about the presence of a migrant population, practically the insurance did not work well and those who were initially enthusiastic about the scheme, soon started to give up on it. At the time of this study, the insurance company failed to process identity cards for the dependents who then never received free medical care although migrants had paid for it. As the insurance holders are far away from Tanzania, it was difficult for them to make things work. In addition, the National Social Security Fund never replied to emails.

Although there are ways to insure older people in Tanzania, as the example of WESTADI shows, many adult children in the USA still seemed to prefer to bring their parents to the USA for checkups as the quality of care remained poor in Tanzania's hospitals.[350]

When medical treatment was needed outside Tanzania, children in the USA were also involved in organizing and providing the means for hospital visits elsewhere. For example, Maria's husband's

[350] According to Levitt and Glick Schiller, states adopt tasks in response to transnational migration; the fact that Tanzania passed a regulation as WESTADI shows their consideration of emigrated Tanzanians who contribute (mainly through remittances) to the country. These efforts might put Tanzania in the authors' category of a "Strategically Selective State" that encourages at least some forms of nationalism over distance (while their category of a "Disinterested and Denouncing State" would not do so (cf. earlier footnote on the topic) (cf. Levitt and Glick Schiller 2004, 1023-1024).

mother who went to India for health care every year because she there got a particular treatment that was not available in Tanzania. Or Maria's father, who went to India to treat his cancer but unfortunately died there. As mentioned in Part II, due to established contacts between hospitals in Dar es Salaam and hospitals in India, some patients whose treatment was not possible in Tanzania were transferred to the one of the Apollo hospitals in India.

Nursing Sector

Many of the study participants, overstayers as well as well-established, aspired towards employment in the nursing sector irrespective of what they had studied or learned. They did not work in the job they initially studied for. I can thus confirm Levitt and Glick Schiller's statement that "individuals occupy different gender, racial, and class positions within different states at the same time" when they accept low-status jobs and also tolerate employment discrimination (Levitt and Glick Schiller 2004, 1015). As mentioned earlier, statistically many Tanzanians residing in the USA are well educated, however, most of them are downscaled to work in the nursing sector. Since they reside in a foreign country where some of their certificates are not accepted, working in the nursing sector was welcome as it was not so difficult to find a job there due to an increased demand in the USA. Hence, men and women with different educational backgrounds "ended up" in the nursing sector. Saleh, who studied engineering in South Africa, even successfully opened his own company which was involved in the provision of home care.

Others, however, for example Susan repeated her medical degree in the USA in order to be able to practice as a medical doctor. During her studies in the USA, she was not able to support her parents sufficiently because of the high university costs. Susan explained that this was not a problem for her parents since her mother still worked as a physiotherapist at a hospital in Dar es Salaam and was therefore able to sustain the family with her salary. During her studies, Susan helped out in a kindergarten to earn at least some money. After some time, Susan was able to start working as a physician in a hospital and the family moved to another state for her new job. Her husband who had studied economics worked in the nursing sector (providing home care for those in need) and was involved in caring for their three children.

In the USA, responsibilities regarding childcare were sometimes rearranged according to pragmatic reasons about who finds a job and is able to provide financially for the family. This fact was also discussed in Levitt and Glick Schiller's text when they say: "Ironically, this heightened gender stratification often occurs in households where immigrant women have entered the workforce and men have begun to share the responsibility for childrearing and housekeeping, thereby redefining other aspects of gender dynamics in more egalitarian terms" (Levitt and Glick Schiller 2004, 1015). Hence, women like Susan can be described as being part of the so-called "sandwich generation," which describes "adult women pressed like sandwich meat between two generations, struggling arduously to

care simultaneously for both children and aging parents (though generally not by co-residing with the parents), while also pursuing careers" (Lamb 2009, 23).[351]

When it comes to professional success, some study participants emphasized that for their career it would be better to establish themselves in Tanzania at some point in time. In Tanzania they would profit from their education abroad and apply their skills at home. But if they wait for too long before going back, they cannot make use of their foreign education and climb up the career ladder quickly. In contrast, when remaining in the USA they would continue with a low paid job without perspectives and sometimes not even work in the field they had initially learned. Hence, when planning their successful future in Tanzania, this is an important aspect emigrated children seem to consider. Maria's brother Eric, who returned from the USA to care for his mother, opened his own construction company. Some returnees also found good positions in NGOs with direct links to the USA. Often, they face struggles they were not familiar with when residing in the USA, for example, slow administrative processes, or traffic jams.

Through their employment in the nursing sector, some Tanzanian migrants become part of the domestic labor market in the USA that is the main focus of the care chain literature discussed earlier. Maria and also Yacinta, cared for somebody else and thus received insight into how (institutional) care is provided in the USA. Those involved in eldercare agreed to care for somebody else's parents while their own parents were not with them: they engaged in what is called "care substitution" (cf. also the "third link" mentioned by van der Geest et al.; Scott 2012, 144).

The experiences and reflections on (residential) care for older people in the USA, as in the case of many Tanzanians who provided care to older American citizens residing in old age homes but also at home, may have shaped the children's care provision for their own aging parents in Tanzania. Debora also explained that because she worked in a nursing home, she was able to advise her father-in-law on how to support his recovery after a stroke.[352]

Mazzucato describes how migrants are confronted with different values concerning care in old age in the Global South and the Global North. While care in Ghana is a personal activity and "based on implicit norms of intergenerational reciprocity," in the Netherlands it is organized by the state and therefore impersonal (Mazzucato 2008b, 92). In the USA, too, while working in the nursing sector and

---

[351] The cited author especially emphasizes the changing responsibilities of women, although men experience similar transformations.

[352] Although her recommendations were not always accepted. In a follow-up study, it would be interesting to learn more about the ways in which advice from Tanzanian migrants is actually implemented in Tanzania.

observing how older people are institutionally cared for, many Tanzanian migrants praised the American system when the state takes over responsibility to care for its senior citizens.

Care Arrangements in the USA and in Tanzania

Ali observed that people in Tanzania at sixty-five would appear much older than people of the same age in the USA. He explained that people in Tanzania lose their energy at a certain age and are in need of care from their relatives. In the USA, at the same age they would still care for themselves (as promoted by the national discourse that target the empowered individual), or if they were not able to do so anymore, they would move to a governmental institution, leaving family members busy with their own lives. However, although admiring the American system, when I asked the study participants if they would hypothetically want their parents in such a home, most of the study participants said no.

Zuleikha, whom I met by chance, took her parents with her from Zanzibar and agreed to let her father stay in a nursing home. Her father was bound to a wheelchair and suffered from a form of dementia, therefore it was not possible for Zuleikha and her mother to live with him in their apartment on the second floor without elevator. When talking about their parents' frail future in advanced old age, some study participants living in the USA talked about the possibility of hiring somebody who did not belong to the family to take care of the elderly person in Tanzania. Considering this possibility might be influenced by their residence in the USA where they witness how Americans care for their older people.

As an exceptional case, Abasi and his wife hired a professional nurse to visit the wife's grandmother in Dar es Salaam on a regular basis, because of the particular (medical) care she needed. However, others again emphasized that there would always be a family member around who could take over the task of caring physically while they were still far away in the USA. Thus, Peter emphasized that in Tanzania he would need to organize someone from his family to care for his mother once she needed support. Peter explained, "You know … it's inevitable—so you need somebody to take care of the parents, since we have extended family members in Africa [it is] not going to be you [or] your sister who will be taking care of your mother—[but] somebody is always there to take care of that at very low cost compared to here" (Peter 2014).

Parents' Future

What seemed clear to most of the study participants is that they will be more involved in their parents' care once the parents become frailer and need physical support. During the time of research, most of the parents of the study participants were still in good health, without much need for physical care. Together with their siblings, Tanzanian migrants felt responsible for their parents' care and some even revealed that they were thinking of moving back to Tanzania once more practical elements of care were needed. As, for example, Maria who explained that she would not want someone else of the family taking over the intimate aspects of care but prefer to do it herself in order to fulfill her duty as a

daughter. For now, while far away, many study participants emphasized the importance of sending at least something to show their love: "So, if I have money, I will send them money but most of the time I have to send because am not there they need my love I need to show them love I need to love them I can't show them while am not [there] so at least I have to send money" (Angela 2014). The engagements in different forms of care over distance will be taken up again in the following chapter on care circulating within a transnational triangle of care.

In contrast to overstayers, who's struggles with their existence in the USA is mirrored in their restricted ability to care for their aging parents or relatives in Tanzania, well-established Tanzanian migrants seem to have more means to engage in transnational care for their elders back home. With their documented status and more stable jobs, their ability to send regular monetary support increased. Also because of their green cards or US citizenships they are able to travel back to Tanzania for visits or invite their parents or other relatives to the USA, amongst others, for medical reasons. Their possibility to react in times of crises was higher and they were usually able to adapt their care quickly to a new health condition with changing demands. Some well-established Tanzanians were also married to overstayers, they usually had more possibilities for care, however, only the person with the cleared status was able to travel back home in case of a health-related crisis.

As discussed above already, often well educated in Tanzania or somewhere else, some people experienced a downgrade when, for example, providing care for older American citizens. However, through their work, they were able to experience the "American way" of caring for older people and transferred some of their knowledge to the care of their own parents in Tanzania.

"TEMPORARILY EMPLOYED"

Although I came to meet the study participants residing in the USA on a temporary basis through the sample criteria of having a parent at the age of sixty and over in Tanzania, I found out that most of their involvement in transnational care was targeted towards their own children rather than their parents. Bibi Mercy, too, whose story will be presented below invests more in child care than in elder care.

Bibi Mercy's story furthermore shows how their idea of being in the USA for a limited amount of time impacted on being less integrated, when not speaking English well. While living in the USA without legal documents their access to health services is difficult. Also, the overstayers portrayed earlier had difficulties in accessing health care, but because nannies like Bibi Mercy were already themselves advanced in age, it was much of a concern for them. Not being able to access health care and regular checkups in the USA contributed to their wish to go back to Tanzania, as soon as possible.

Bibi Mercy was in her late fifties when we met. She was born in northern Tanzania as the third child of her parents. Her father did not like the idea that girls go to school, and Bibi Mercy much regretted that

she had to end schooling after standard seven (primary education). That is why she wanted to make sure that she provided enough education for her own children. Bibi Mercy had four children and was a widow. She was already a grandmother and one of her daughters created the link between her and Maria, her employer, who was portrayed above. Bibi Mercy came to the USA two years before we met to care for Maria's children.

Bibi Mercy lived in and worked for Maria's family and did not leave the house very often. Only every Sunday she joined the family to the Swahili church service, although only halfhearted because she was Roman Catholic while the church she frequented was a Protestant church. Since Bibi Mercy did not speak any English, she had problems moving around in the USA on her own. Luckily in one of the neighboring houses, Bibi Margaret lived with her daughter's family. Bibi Margaret cared for the children of her daughter and had frequent exchanges with Bibi Mercy.

Bibi Mercy did not have health insurance in the USA. She once had an eye problem and had to undergo a surgery, which was very costly. Luckily her employer (Maria) supported her in paying for the treatment. Her restricted access to health care, combined with her problems to understand American doctors contributed to her wish to go back to Tanzania soon. She told me that in Tanzania she would have gone for checkups, for example, for breast cancer which are free. In the USA, she was far away from health care and medical checkups. Not being able to check her health or access health care was a concern for Bibi Mercy, not least due to her advanced age. She nevertheless valued her loss of weight while residing in the USA. Bibi Mercy explained that through her stay in the USA she became much more conscious of what she eats, which was a good thing for her.

Bibi Mercy's mother was in her eighties and lived in a village in the northern part of Tanzania. Her mother did not suffer from any particular chronic condition—at least not a diagnosed one—but was slightly frail. Bibi Mercy's last-born brother and his family shared the house with their mother. Bibi Mercy's sister stayed next to the mother's house and Bibi Mercy usually communicated with her in order to arrange for their mother's care. She sent them money, but not on a monthly basis. She told me that if she sends them US$100 in one go, it remains virtually untouched because there are not too many expenses in the village. Already for some time Bibi Mercy had been planning to return to Tanzania. She asked her children to help her to find a new place to stay in Dar es Salaam. Since most of her children lived in the city she did not want to go back to the village, instead she preferred the neighborhood in the city where she had already lived before coming to the USA. She told me that she was very much looking forward to going back home because her stay in the USA had always been planned to be a temporary one and had lasted already too long.

While only four of the study participants were involved in caring for children in the USA on a temporary base, like Bibi Mercy, I am sure that there are many more nannies; however, I did not come across

them with my snowball sampling strategy, presumably because they tend to remain inside, in the private sphere, rather than joining public events. While Bibi Mercy was introduced to her employer through her own daughter, Bibi Zarota, who was in her mid-fifties when we met, came to the USA initially to take care of her niece's children. When the children were old enough, she moved to another family to take care of their children. Bibi Angel, who was in her mid-sixties when we met, came after being invited to the USA by a friend of hers and started taking care of the children of an African American family. Bibi Angel came with the intention of supporting her own children back home, since they were striving for higher education and she had problems providing the necessary means. Another elderly woman, the neighbor of Bibi Mercy, Bibi Margaret, came to the USA in order to care for her daughters' child. While doing so, she also cared for another child from a befriended Tanzanian family.

Intending to Stay for a Short Time

By traveling to the USA to engage in childcare, these slightly elderly nannies I met during my research perfectly match the situation in the care chain literature described above. They travel abroad and care for others in order to earn money to support their own family members in Tanzania. While not at home, others have to replace these women in performing care for their parents and their children. Like Bibi Zarota's husband who took care of her parents while she was away. He visited them regularly and organized food for them as well as for their cattle. The few nannies I met, however, only left Tanzania when their own children were already adolescents, and no longer needed (child)care. Furthermore, their stays were not organized by official labor offices but on a private basis, when other Tanzanian families whom they already knew employed them.

Those women employed for taking care of someone else's family all expressed their concern that they did not wish to remain in the USA for too long. They saw their task in earning enough money in order to support their beloved ones back home, and then leaving again to be with them. Since they considered their stay as temporary and were not well integrated in the USA, they did not learn English and thus did not feel comfortable in moving around in a foreign country. As in the case of Bibi Mercy mentioned earlier, owing to lacking financial means and English language skills, access to services as, for example, health care became difficult.

Everyday Self-Care in the USA

Similar to Bibi Mercy, many study participants belonging to the other groups described above adapt their health practices when staying in the USA. Bibi Mercy started to drink a glass of water in the afternoon and in the evening instead of eating a lot. She lost weight and felt more comfortable when climbing up stairs. Others observed some changes in their own health behavior when they began engaging in illness prevention of. Quite a few study participants tried to avoid the unhealthy American fast food and went to the gym to exercise. At this stage, they also often missed the perceived "healthier" food of Tanzania, with less chemicals such as flavor enhancers.

As mentioned earlier, many of the study participants frequented a restaurant that served Tanzanian and Kenyan food. Run by a Kenyan, and difficult to access by public transport, especially at weekends a lot of Tanzanian migrants frequented the place. The restaurant was rather expensive when compared to other middle-range restaurants in the USA. However, numerous Tanzanians seemed willing to invest a considerable amount of money in their home food.

When I got to know Bibi Zorota and Bibi Angel mentioned above, we were at the same health checkup organized by members of the DMV community. On a Saturday, they provided free checkups at a church with Swahili speaking doctors and nurses. The church was much frequented by Tanzanians because it offered Swahili church services by a Tanzanian pastor. In the church hall they set up a row of counters with information sheets on different diseases and health risks and also offered the opportunity to be checked by a medical doctor. Apparently, I was told, it was the first time such free health care for East Africans was offered, but the organization intended to conduct such events more regularly in future. They especially targeted people without official papers, since their access to health care in the USA was almost non-existent.

At the checkup, Bibi Zorota found out that she had a problem with her blood pressure and the doctor told her to come to the clinic on another day for more checks. After the diagnosis, Bibi Zorota was afraid that she might lose her job since there was not much job security when working as a nanny. In case she did not feel healthy enough, the employer might decide to take somebody else to care for the children. Apart from the pressure experienced in their jobs, being far away from home and leaving behind children, husbands, and parents was described as being very difficult. As Bibi Angel explained:

> Bibi Angel: When I came just as a visitor… my friend invited me, so when I got here she told me that you get something to do here and get money, so when I started working I say my goodness its better if I stay and help other people because, if I go back home maybe I couldn't take my son to college, maybe I couldn't take my grandson even to school and college so that's why I decided to stay but now my son has already finished his course and my grandson is about to finish then I think am getting myself prepared to go back…
>
> Andrea: That's nice… when you left how old were your children?
>
> Bibi Angel: Ooh my last my last born was born in 1988 and now she is 26 yah when I left there she was 19 and now she is 26 she has a child, a girl who is almost four years now and I haven't seen them…
>
> Andrea: Since you came in 2007 you never went back?
>
> Bibi Angel: I never went back…
>
> (Bibi Angel 2014)

Supporting Own Children

The study participants I describe here as temporarily employed were already at an advanced age themselves. I sampled them mainly because they had parents in Tanzania, but I realized that since they

had children of their own growing up in Tanzania, their support was more targeted towards their children. This may be due to the fact that their children were at an age where they needed financial support in order to pursue higher education. It was also much more their own children and their needs that made women work far away from home for a certain period of time. As, for example, Bibi Zorota who remained in the USA for some years to facilitate her son's studies in India. However, since the sample of the temporarily employed migrants is rather small further, investigations would be needed to draw representative conclusions.

The study participants idea of staying in the USA only for a short period of time much influenced their integration, for example in terms of language competence. Due to their temporary stay, they preferred to concentrate on earning money to take home rather than engaging in care across national borders. Being already advanced in age themselves, the group of the temporarily employed nannies can give us an idea how undocumented elderly migrants struggle when they need age-related health care. The topic of older migrants in the USA would open a completely new angle, therefore it is only treated as a minor aspect in this PhD thesis.

By artificially grouping the study participants into the three groups "overstayers," "well-established," and "temporarily employed," my aim is to emphasize their differing involvement in elder care over a distance. As I argued above, their involvement seems strongly influenced by their permission to legally stay in the USA as well as by intended duration of stay. Based on these distinctions, I will now focus on the circulation of care and people between Tanzania and the USA. Shaped by their legal permission to stay, there were various ways in which Tanzanian migrants interviewed in this study became involved in transnational care. The following chapter will no longer focus solely on Tanzanian migrants in the USA, but try to look at all actors involved in transnational care circulations.

TRIANGLES OF CARE

I open this chapter with an extract from an interview with Neema. Neema and her husband both teach at different universities in the USA. During the interview, we talked about the people who were around her mother in northern Tanzania, because she had told me that most of her siblings were based in the USA.

> Andrea: But is there still somebody [to care]?
>
> Neema: There is still one brother back home who doesn't want to move anywhere and we love him for that! Because then—he is the one who keeps the fort you know… he is there making sure that everything is going well and whenever we go home he is there to receive us and tell us—and taking care of our mom—taking care of our dad when he was really sick, the whole time he was there …

> Andrea: As we already discussed before, you feel like that to have a brother or sister back home helps to care for the parents?
>
> Neema: Oh yes!! I don't know how we could have done it because when our father was sick, we really wanted him to come here but I think he did not want to, he did not want to come here—So, having a brother there it was very helpful because he was the one taking him to the hospital, he was doing all this, my mother cannot drive and my father was very sick and he needed somebody to go and get medication and taking him to all his appointments, and things like that…
>
> And yes, our brother, you know he did a lot and without him I don't know what could have happened—it means that somebody of us would have had to go home and do what he was doing there… yeah which would have been much more difficult because all of us we have family…
>
> Andrea: Oh, that's great! And your brother who is in Tanzania and taking care of … is he also in [location]?
>
> Neema: Yeah, he lives also in [location], not very far from where my mom is.
>
> Andrea: Oh, that is helpful.
>
> Neema: Yeah. So, he passes by there maybe every other evening as he is going to his house, so maybe early in the morning as he is going to work, he will pass there, and he has ah… my mom does not have this app things called what is it on the phone?
>
> Andrea: WhatsApp?
>
> Neema: WhatsApp yeah—so I talk to him, you know, and tell [him] ask mom this and then… yeah and if I am in a hurry I don't have to call her all the time—then I am just using my brother with WhatsApp, for some reason my mother does not have it.
>
> …
>
> Neema: Yeah so it helps, you know, we stay in touch with a lot of people who can really check on mom and just making sure that she is fine.
>
> (Neema 2014)

When conducting research in the USA to find out more about care provided by Tanzanian migrants for their parents in Tanzania, I was intrigued by the essential involvement of caregivers in Tanzania when it comes to transnational care. Already after the first few weeks of research, it became evident that these caregivers in Tanzania, who communicate with the migrants in the USA and who organize the flow of remittances, are indispensable in transnational care. Yet neglected by literature on transnational care, these caregivers are greatly valued by Tanzanian migrants in the USA. Thomas, who lived with his parents in Ada Estate, Dar es Salaam, explained in an email conversation his function in the transnational care provided by his sister and his two brothers residing in the USA: "I am the eye of my brothers in America here in Tanzania, we often communicate through phone, WhatsApp and Facebook. They are highly involved in family issues" (Thomas 2013).

In the following text, inspired by Thomas' words, I will refer to these caregivers involved in transnational care as "observing eyes." The observing eyes in Tanzania were usually relatives of the

older person. Like Thomas, these caregivers were often siblings who remained with the parents in Tanzania. Due to their involvement in care provided by Tanzanian migrants in the USA to their parents at home, it became evident that transnational care circulates among several family members involved, as suggested by the authors Baldassar and Merla (2014a). As depicted above, the authors argue that transnational care cannot be seen as one-directional, traveling only from the migrants to the home country, instead it circulates among several family members in different locations. I will apply a more detailed specification of their concept of transnational care circulations by using the spatializing image of a triangle. I argue that transnational care circulates within a triangle of care, involving not only the older persons in Tanzania and Tanzanian migrants in the USA, but also an "observing eye" responsible for the organization of remittances and other forms of support coming from abroad. These observing eyes are "there" to provide more practical elements of care. They serve as nodes between the American and Tanzanian context. While transnational care travels from the USA to the older person in Tanzania, much information about the older person and his or her health condition flows from the observing eyes to the emigrated children in the USA.

In what follows, I will address the different actors involved in transnational care triangles and describe their practices of caregiving. Hereby my aim is to show in which ways these observing eyes play a major role. I start from the idea of a triangle to describe flows of people, goods and ideas circulating among several actors involved. In addition, I will explore relationships and motivations to engage within such triangles. Important is the fact that care provision within these triangles is dynamic and constantly adapted to changing circumstances in both countries, for example, with changing legal statuses and abilities to support, health problems of the older person or health-related crises in Tanzania.

Up to now, this part has underlined the changing involvement in elder care of Tanzanian migrants due to their legal permission to stay in the USA. I will now provide more details on the actual care giving practices. By describing these care practices within transnational triangles, it will become evident that most of the provision of care cannot be realized without the involvement of observing eyes. Not all forms of transnational care are observable. My descriptions are based mainly on articulations of the involved caregivers in the USA and also in Tanzania.[353]

In addition to the description of actors involved in the tri-directional care relations and their actual practices of caregiving, I highlight the ideas and ideologies that circulate within triangles of care.[354] The

---

[353] Findings that I analyzed for this part mainly consist of interview material and observations in the USA and Tanzania. Because people live in different places their relationships cannot be observed as would be the case when an adult child visits his/her mother or father in Tanzania and both engage in an interaction. Apart from witnessing phone calls I depended much on people's narratives about relationships and linked emotions, which is a possible shortcoming of this research project.

[354] My argumentation around the triangle of care were published in a book chapter of an edited volume with the title "Caring on the Move" (cf. Kaiser-Grolimund 2018) and in a co-authored publication entitled "Triangles of Care in

lives of older people are not only shaped by doctors who tell them what is good for their health in old age but also by their children residing abroad, since the children are again exposed to different (cultural, social, political, educational and financial) contexts by living, working and raising their own children in the USA.

The Tanzanian migrants I met in the USA were exposed to the American context of aging, for example, through employment in the nursing sector but also through personal experiences of their surroundings and the media that promotes living independently and alone or in an old age facility. In the current American context of aging, there are three different kinds of old age facilities, some government-funded, others private: a) "care facilities" with "assisted living" residences (with daily non-medical care) and "nursing homes" (twenty-four hours nursing care with medical supervision), b) "retirement housing" (planned senior communities, without medical or personal care but common social activities) and c) "continuing care retirement communities" (different options possible from independent living to assisted living to nursing care) (listing directly adopted from Lamb 2009, 84). In her book, Lamb emphasizes, however, that the majority of older people do not live in these residences and their aim is to be able to maintain independence in old age. Many Americans want to be close to their children, however, they do not want to depend on them or live with them (Lamb 2009, 135). Their ideal is thus a lifetime flow of resources from the parents to the child. Furthermore, apart from living independently, American seniors aim at sustaining an active life (permanent adulthood) and prolonging life through medicalization. I recall the earlier mentioned themes of the "successful aging" paradigm; individual agency and control, independence, productive activity and permanent personhood (cf. Lamb 2017b).

Tanzanian migrants residing in the USA are confronted with two differing ways of caring for older people. While the US system of welfare takes over much of the care for its "senior citizens," in Tanzania, the state's aging policy declares the family responsible for elderly care. Hence, in Tanzania, children or other family members are expected to care for their parents or older relatives on the bases of reciprocity: The parents raised their children and supported them to travel abroad for studies, but expect them to either come back or send back support from abroad, with definite preference for the first option.

The statement by Eric, who came back to Tanzania temporarily after his father had passed away and his mother needed support, reflects nicely the wish of older people to have their children around them: "So mom was happy for us to go but now she is not happy because we stayed there… that will happen to any mother because you have your parents, but you have to move out to find your own life and then

---

Transnational Spaces of Aging: Social Engagements between Urban Tanzania, Oman and the United States" (cf. Staudacher and Kaiser-Grolimund 2020). The image of a triangle is remindful of van Eeuwijk's "triangle of uncertainty" (Eeuwijk 2011, 96).

bring something home…" (Eric 2013). Hence, irrespective of staying in Tanzania or abroad, expectations based on reciprocity shape relational care giving between children and parents (cf. relational care in Part III).

Susan explained why she was expected to care for her parents in old age:

> Andrea: Do you think your parents; they have expectations towards you as their daughter? When it comes to care for them? Do you feel like you are meeting that responsibility?
>
> Susan: I think so. They may not say it directly but …and because my parents they are a little bit educated not as their parents so if they could prepare their future especially may be financially and they will do it am sure—because they always say that we don't want to bother you we just want you to live your life but at the end of the day I think they know that we will not abandon them like now they are taking care of their parents although not directly. Maybe they are sending money if they are sick—maybe grandfather will come to Dar es Salaam to be taken to the hospital—It's their responsibilities or if they have to go there and visit them, take care of this and that, so even for us that is like soon to be handed over to us—It will be our responsibility when they cannot do it themselves so we have to provide the care for them so they don't say it direct really but just like a natural decision: you will just go, they do it [and] when they cannot do it, you take over because they don't have pension they don't have any help from the government … or they may have a pension but it's not like sustainable.
>
> (Susan 2014)

This expectation was very much linked to reciprocate the care that the Tanzanian migrants in the USA received from their parents, especially when traveling abroad but also when still young. As Peter explained:

> Andrea: …and because you are her son you feel responsible for her?
>
> Prince: Yes, I do I would have said differently if she is just my mother [and] she never took care of me—as I have said, I had everything I wanted in my life because when I say something she will do, so yes, not [feelings of] guilt … but I am responsible because she took care of me—now I can take care of her.
>
> (Peter 2014)

Lamb describes similar ideas of older Indians whose children travel abroad to study. The parents want to invest in a good education abroad but they also want their children to be there in old age, because they would hope for more than just receiving money (Lamb 2009, 187). As already mentioned, during Tanzania's socialist regime, traveling abroad for further education was financially supported with scholarships, however, it was clearly declared that those who traveled abroad were supposed to bring back what they had learned outside their home country. I recall Mzee Ngowi's statement that all those who do not come back are "hooligans." Most of the older study participants of the former civil servants' milieu in Dar es Salaam invested much in their children's education in Tanzania and abroad. They considered this support as an important aspect of aging well when expecting to "earn from their investments" at a later stage.

For many of Tanzanian migrants in the USA it was clear that somebody in the family would take care of their parents, not necessarily a child but a relative. Many saw their role in offering financial support for the practical care provided by others on-site. However, other study participants also claimed that once their parents needed them, they would move back to Tanzania to care for them personally.

FROM TANZANIAN MIGRANTS TO OLDER PEOPLE IN TANZANIA

How do Tanzanian migrants in the USA actually engage in care for their parents back home? As mentioned above, their ability to engage in elder care over a distance very much depended on their immigration status. However, irrespective of their status, most Tanzanians remained emotionally attached to their parents, mainly through regular phone calls. Communication technologies played an important part, including access to them. Phone calls to parents can be described as virtual caregiving and allow for another form of "being together." Baldassar and Merla underline that normative understandings of migration have to be revisited since it is not always the distance and absence that impact negatively on being together (Baldassar and Merla 2014b, 40). Closeness may in some cases even increase over distance. These elements of emotional care (referring to what was called earlier "caring about") are important for cultivating and maintaining a good relationship with parents.

Apart from engaging in virtual care, migrants in the USA were involved in some practical support through the flows of remittances. Angela, for example, received text messages when her mother needed support. With a gentle smile on her face she explained: "I send [money] if it's needed [I do] not send every month, yah—when she [my mother] needs money she just texts me 'am broke' …hahaha! That's her text 'Angela I am broke' … hahaha" (Angela 2014). Flows of money increased during festive seasons such as Christmas or at the end of Ramadan but also when important events such as funerals and weddings or health related crises occurred. In addition, migrants sometimes contributed to school fees of extended family members. Apart from that, several Tanzanian migrants regularly transferred money to build houses for themselves or for their parents in Tanzania. Others invested in solar panels for electricity or in the installation of a water tap in their parents' house or the house of a relative. Some contributions also targeted the settlement of water or electricity bills.

Financial support provided by Tanzanian children abroad not only flows directly to parents but circulates among different members of the extended family instead. As described by Baldassar and Merla, care circulations within transnational networks are informed by "generalized asymmetrical reciprocity" (Baldassar and Merla 2014a, 8-9). Hence, some study participants underlined that, with the help of observing eyes, the parents would distribute the money among other family members in need. Often, a niece or nephew living with the parents and supporting them in daily household tasks was sent to school with the help of this money. Some study participants not only supported their parents, but also their grandparents, who mostly resided in rural areas.

While remittances and thus financial elements of care were the most commonly described form of aid to parents and other relatives back home, Tanzanian migrants also emphasized the provision of material support. Study participants mentioned most often clothes and sometimes shoes which they sent to their relatives. Also very common was the transfer of technical devises such as laptops or mobile phones to Tanzania with the aim of facilitating communication but also in support of children at school. Yacinta, for example, mentioned the following items when asked about what she sent back home: "I sent them phones to use WhatsApp; a good phone, so that they can have WhatsApp. Also, I sent them laptops so that we can talk on the Skype, so sometimes we talk on the Skype" (Yacinta 2014).

Furthermore, perfumes, body lotion, artificial hair, chocolate, shoes, clothes, and wallets were mentioned as gifts that people sent to Tanzania. Usually, they gave the gifts on special occasions, such as Christmas or like festivities. While money could be sent to somebody's bank account or through Western Union, goods were usually given to someone traveling to Tanzania, since sending goods by post was not considered reliable.[355] To avoid high banking fees, money was preferably handed to traveling friends and family members. I also learned that sending goods through people was more frequent in the case of Tanzanians with parents or family members living in urban contexts, for example in Dar es Salaam. Apparently, it was much more difficult to guarantee the arrival of a parcel in a rural area. Obviously, sending money to rural areas was much more problematic and involved a higher input by relatives in Tanzania as they had to travel to a locality with a bank service.

Most fascinating for me were flows to Tanzania aimed at improving or maintaining the older parents' health. I described these flows earlier as medical remittances. Transnational care that targeted the improvement of older people's health involved considerable amounts of money for medical treatment (i.e., regular hospital visits, checkups or operations) in Tanzania and abroad. In addition, some study participants mentioned food supplements they sent to their parents or relatives. When talking to Emanuel, whose parents lived in Emanuel's house in Dar es Salaam and cared for his two schooling daughters, I asked which goods he and his wife Angela sent to their parents.[356] He replied by listing clothes and other items. When I probed for things concerning the health of his parents, he replied:

> Emanuel: Ooh there you go, there you go! Now you ask a good question … now I am in headache [since] I hooked up my mom with the vitamins… Hahaha! For I don't know four [or] five years—those women plus fifty.
>
> His wife Angela helps: Fifty plus!

[355] For instance, Ali who sent phones to his family in Tanzania, made the painful experience that the phones indeed arrived, however, without battery and charger.

[356] Only some weeks after our talk, Emanuel's father passed away and Emanuel traveled to Tanzania for the funeral.

> Emanuel: …Fifty plus! So I tested it: "Mom take this one!" She tried [and] since then I have to buy vitamins for mom all years…
>
> Andrea: So you advised her to take those [vitamins]?
>
> Emanuel: Yah I advised my mom to take it and I was testing… Oh my God she fell in love! So now [it] is my headache—I have to send [them] to her every year—she is feeling much better when she takes them—much stronger, she doesn't feel weak anymore… she continues taking them [and] she is fine.
>
> (Angela and Emanuel 2014)

Personally, I experienced a similar story when I learned that my landlords in Ada Estate used the same vitamin pills as my parents did, "Centrum Silver 50+" (in Switzerland "Centrum Generation 50+"), so I started bringing them along for the elderly couple every time I came to Tanzania for a stint of research. Mama Ngowi, my landlady, had almost blind trust in the pills and told me that she felt less tired after she had begun taking them.[357]

Apart from food supplements, other medications also traveled to Tanzania. Salma, who was in her mid-forties when we met and who herself is a medical doctor, provided her father with a constant supply of diabetes pills, while Monica sent her mother, who is also diabetic, insulin injections from the USA. Some study participants sent blood pressure monitors so that the older persons could better regulate their hypertensions without visiting a health facility, and paying each time for the check-up. In addition, Tanzanian migrants in the USA sent walkers and thermometers as well as diapers for incontinence. Furthermore, as mentioned earlier, some study participants had invested in a medical insurance for their parents or relative at home.

Another aspect aimed at improving the migrants' parents' health was giving advice on health-related topics. Some Tanzanian migrants regularly advised their parents in health-related crises, such as Angela who, based on her experience with older Americans in a nursing home, "googled" the health problems her mother was suffering from. Lately she had tried to find out why her mother occasionally felt dizzy. Others emphasized that their main part in caring for their parents' health was to pay for visits to see a medical doctor in Tanzania, since their parents would rather listen to a Tanzanian doctor than to their children abroad. Eric confirmed this observation, he explained that his busy mother would not listen to him when he told her to rest:

> In fact, people, here in Tanzania are difficult—older people will listen more to doctors than their own kids—If the doctor comes and says mama right now you need to rest towards the day she will do it, but if I tell her she is not going to do it.
>
> … Luckily my young brother is a doctor and you can read from my mother whatever he says she is listening, because he is a doctor—so unless I choose my boundaries very careful and leave some things

[357] Since the pills are less expensive in the USA than in Switzerland, I started to buy them during my field research in the USA and later traveled with them to Tanzania, thus experiencing the same flow of goods as many study participants.

> for my brother and my sister, because they are all women, I like her [my sister] to tell her things, and not me, so [I say:] "tell mama this!" … [and] that's it!
>
> (Eric 2013)

The quote by Eric also reveals gender aspects and related practices, when it comes to the question about who can advise whom. These strategic actions are connected to gendered practices of care touched upon in Part III. Like Eric, many of the migrants in the USA had their strategies to pass on health advice indirectly to their parents.

Recommendations and the aforementioned medical equipment were sent across national borders with a particular idea and ideology in mind (Yeates 2011, 1126). The same holds true for vitamin pills through which migrants impose a particular way of aging to an older person. The fact that healthy people take pills to remain healthy has a lot to do with the (American) culture of "successful aging."[358] It was therefore interesting to observe in Tanzania, that some older people did not take these pills on a regular basis, as prescribed by their children or the package insert, but swallowed them randomly, when they felt weak or dizzy. Pills became part of their everyday self-care (cf. Part III).

VISITS TO TANZANIA—VISITS TO THE USA

Transnational ties between older people in Tanzania and migrants in the USA can be enforced through visits. Hence, according to Baldassar and Wilding, who studied middle-class transnational caregiving among migrants in Australia with their parents in European or Asian countries, "ongoing synchronous and asynchronous communications and visits" can enforce the exchange of "generalized asymmetrical reciprocity" (Baldassar and Wilding 2014, 245). Care circulation varies over time and can be different during phases of routine and crisis. As observable in the case of Bibi Veronica, whose husband passed away, during a health-related crisis reorganizations of care arrangements are needed and sometimes they go hand in hand with prolonged visits. Hence, in health-related crises, "being there" physically can become important (Baldassar, Baldock, and Wilding 2007, 161; Baldassar et al. 2007 in Baldassar and Merla 2014b, 52/53). Visits are an occasion upon which physical care can be exchanged. However, in order to visit, time, money, and valid travel documents are needed (Baldassar and Merla 2014b, 49).

When looking at the group of the well-established migrants who are usually more likely to have time, money, and valid travel documents, the authors state that "the greater the intensity of transnational virtual communication, the greater the sense of obligation to visit, particularly in the case of the middle class who have access to the resources to fulfill these obligations …" (Baldassar and Wilding 2014,

[358] It would be an interesting to follow vitamin pills and "culturally unpack" them. Where do they travel to and what do people do with them? Since vitamin pills are one aspect of many treated in this PhD thesis, I cannot go into it more deeply.

248). With the flow of people moving in both directions, the social field is “active and activated” (Baldassar and Wilding 2014, 248). According to the authors, the capacity to be mobile enables these “middle class” transnational families to “be perceived by their members as both fairly commonplace, ordinary ways of practising familyhood, and as providing satisfactory and adequate flows of care and support that are associated with positive experiences of extended family relationships” (Baldassar and Wilding 2014, 249).

Visits can foster relationships between migrants and their parents in Tanzania. Either Tanzanians with legal immigration status travel back home to visit family and friends or parents are invited to travel to the USA. Only a few migrants undertook such visits on a regular base. An exception here was Neema, who took her children back home every year so that they did not only grow up as “Americans” but were also raised with Tanzanian “cultural” values. At the same time her mother visited the USA every second year. However, I did not meet many families like Neema’s family whose brothers and sisters, except for one, all lived in the USA and who had enough means to finance yearly trips to Tanzania and Kenya (to visit her husband’s family) and to invite family members from Tanzania to the USA. For other Tanzanian migrants, “flying in” their parents involved high expenses due to the medical costs they spent on their parents while they were in the USA. Migrants usually mentioned these high costs which consequently resulted in less frequent visits.

As mentioned above, visits of parents to the USA were often linked to medical treatment. These treatments were either organized for emergency situations or for regular checkups, whereas these regular checkups were sometimes enforced onto parents when they arrived in the USA for events such as weddings, childbirth, or graduations. In the case of Monica’s father in Dar es Salaam, the doctors discovered water on his lungs however, they sent him home without further treatment. Monica then made her father come to the USA. He almost died on the plane and was met by the ambulance at the airport. The American doctors found out that he had cancer that had already spread widely.[359]

Maria discussed with her sister in Dar es Salaam how she could best convince their mother to travel to the USA for a visit and a checkup. The mother arrived for a visit some years ago when Maria’s second son was born. Maria’s mother did not really like the USA. She felt lonely and dependent on her children, whereas in her house in Dar es Salaam she could move around, visit neighbors, and go to the local market for shopping. However, finally she agreed to a short visit in 2014. Maria who had learned from

[359] They found out that the lump he had in his throat eight years ago must have been the start. The doctors in Tanzania however just removed the tumor but did not further examine it. The American medical doctors then told Monica’s father that he has three to six months more to live which was a big shock for him, since doctors in Tanzania would never tell a patient directly how bad his or her health condition is (the aspect of not revealing much about the health condition of a patient was also partially confirmed by my colleague Andrea Buhl (cf. Buhl forthcoming) who conducted research in the cancer hospital in Dar es Salaam). Psychologically affected he refused chemotherapy and went back to Tanzania after two months. And another two months later he died in Dar es Salaam.

her sister that the mother had problems with her eyes made an appointment for an eye check-up soon after she had arrived. In Dar es Salaam they had diagnosed glaucoma, but in the USA they did not confirm this diagnosis and gave her spectacles to improve her vision.[360] Furthermore, since her mother suffered from hypertension, Maria arranged for a re-adjustment of her medication. The change in medication caused a health crisis and her mother was admitted to hospital in the USA for a few days. A year later, in 2015, the mother was again invited to the USA to stay with Maria and the family. While being able to check again on her health, the mother helped by taking care of Maria's children during the school summer break.

Bibi Mbujuni of the civil servants' milieu in Ada Estate also told me about her visits to the USA each time a grandchild was born. However, when only recently her twin grandchildren had been born, she was not able to travel. Not having to travel came as a relief to her since she described the trips as being exhausting and she did not like the American way of life.

> Bibi Mbujuni: Actually, they wanted me to go last year because one of [my] sons was expecting, his wife to deliver twins… then it was very difficult for me and after delivery this year they expected me to go—life in the USA is very lonely, I have been there trice, I was there in 2003 and 2006 and 2008 and I don't like that life! Hahaha, it is too lonely my dear! I remember in 2008, I was staying with one of my daughters she also delivered a baby and then I never knew their neighbors when we were in the hospital I came home to take some items to take to the hospital so I found that neighbor, that man now was helping to clean the compound—the compound of my daughter, she is married to a Tanzanian also, so that man was doing the gardening, the cutting of grass—because I did not know him I thought it was a city person doing that work—so, when my son-in-law came I told him you see somebody came and cut the grass and he said oh he is our neighbor! Can you imagine staying in one place for one month without knowing the neighbor! That is what is happening in USA I never knew those neighbors, but in Tanzania you open a gate and you say hi—*mambo*—*unaendeleaje*[361] —in the USA there is not that time to ask somebody unanedeleaje? Eeeeh! It is none of your business how I am doing! Hahaha! Yah so it is very lonely, you have to stay in the house and the children will go out to work and they will come in the evening and you stay on your own...
>
> Andrea: So you prefer to stay here?
>
> Bibi Mbujuni: If I go, I only visit for a very short time and then… I would not like to stay in America… Mmh it is not a life I would like to live anyway; I cannot live it—at this age in [the] USA, I cannot make it!
>
> (Bibi Mbujuni 2013)

---

[360] Maria thinks that in the private hospitals that her mother goes to in Tanzania, they make up health problems in order to sell their treatment.

[361] *Mambo* is used to greet and can be literally translated as "what are the news." *Unaendeleaje* can be translated as "how are you."

FROM TANZANIA TO TANZANIAN MIGRANTS IN THE USA

When parents visited, they usually arrived with "gifts" for their children. Gifts brought to the USA from Tanzania frequently mentioned included clothes, shoes (for example locally made sandals), necklaces, spices, *dagaa,*[362] cashews, *ubuyu*,[363] Africafe[364] and tea, local movies, cassava chips, *uji*[365] for children, medication (antibiotics[366]), and bibles. These goods were seen as gifts aimed at reciprocating some of the more regular support flowing in the other direction. Older people and family members in Tanzania thus engage in transnational relations through these reverse remittances (Mazzucato 2010, 454). Further, they help to maintain family bonds.

Older people in Tanzania were also able to advise their emigrated children in health or family issues—over a distance. During regular phone calls, which were usually initiated by the migrants in the USA, parents provided support by listening to their children's problems, and shared their expertise, for example, regarding topics around childcare. Some also suggested alternative solutions to health problems and sent herbs or "traditional" medicine to the USA.

While Tanzanian migrants in the USA felt responsible to reciprocate the care that they had received as children and therefore engaged heavily in old age care from a distance, parents, too, invested in these relationships by offering gifts and advises. What became evident when observing the flows in both directions was that help was needed to organize these flows of information, people, goods, and money. Here, the "observing eyes" played a crucial role.

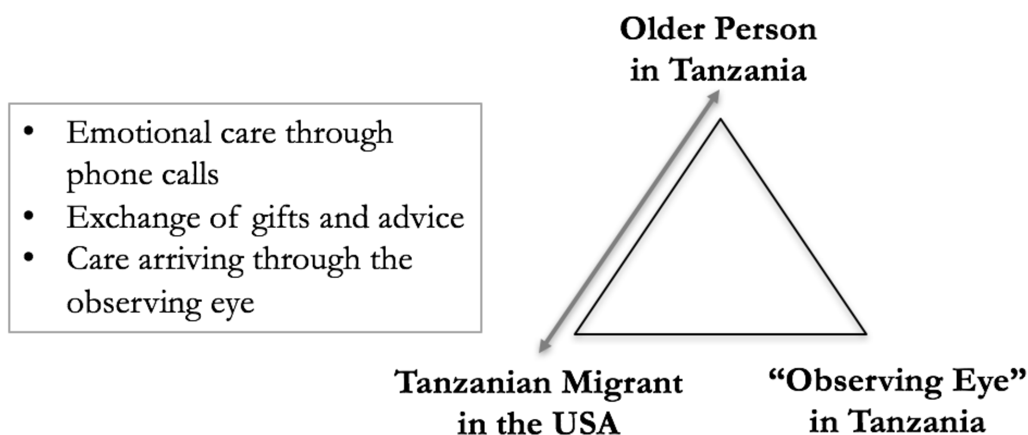

FIGURE 2 CARE BETWEEN OLDER PEOPLE AND TANZANIAN MIGRANTS

---

[362] *Dagaa* is also known as Lake Victoria sardine and eaten in a dried form.

[363] *Ubuyu* are sweets made from the baobab fruit.

[364] *Africafe* is a widely used instant coffee in Tanzania that can be mixed with hot water.

[365] As mentioned earlier *uji* is a homemade porridge.

[366] Especially for undocumented migrants whose access to health care in the USA is limited, antibiotics that need a prescription from an American medical doctor are difficult to get in the USA and therefore sent from Tanzania.

OBSERVING EYES IN TANZANIA

Tanzanian migrants in the USA involved in the above-described care practices over a distance pointed out that they largely missed out on providing practical elements such as intimate aspects of care which necessitates physical proximity. As emphasized earlier, when talking to study participants in the USA about their involvement in care, they considered their relatives back in Tanzania who were involved in these practical care practices much more important than their own contribution from a distance. When asked about their parents' three most important caregivers, they would usually not mention themselves first, but rather those people—sisters, brothers, nieces, nephews—who were on site.[367] Ali answered my question about the most important caregivers of his parents as follows: "I could say, because I am in America, I can send a lot of money there but I am not the most important [care giver] because others are there physically so probably they contribute more than I do but when they need a push, a financial push, then my money makes a difference. But in terms of personal attachment, more support I think [comes from] my sisters and my brothers they do a wonderful job so it's—it's not somebody doing the most but something we do it collectively together" (Ali 2014).

Like Ali, most of the Tanzanian migrants I met in the USA pointed to the importance of their siblings or members of the extended family that live with the older parents or at least reside closely. The hindered communication between parents and children over continents is one reason that made migrants value the role of the observing eyes back home. While for phone calls with parents, the time difference complicates smooth communication, chat exchange through instant messengers (for example WhatsApp) or Skype with other relatives helps to facilitate the provision of information at any time. Ali pointed out the difficulties caused by the time difference:

> Today I talked to my mom she says it has been two weeks since I call her—I said "Mom I was so busy! I think about you but most of time when I come back from my job is very late night over there" … I don't want to wake them up you know, they sleep, you don't want to call them at 4 [a.m.] in the morning or 5 in the morning, you know, so the difference of hours sometimes is very difficult when you get off, for myself when I get off from my job [at] 6 or 7 p.m. here, but over there is very night and I get up I leave my house at 6 in the morning that is the good time over there but here you need to go to work so that's a thing and I can't use my cell phone, so if I don't call them on Saturday and Sunday; if I forget then I have to wait [until] next week.
>
> (Ali 2014)

Ali uses US$2 phone cards to call his parents, they allow him to talk to his parents for twenty minutes. Although he usually spoke more than twenty minutes, technically, it is not possible to split the bought

[367] As mentioned earlier, the migrants' view on care was different from what their parents perceived: When asking about the most important care providers, most of my older study participants from the civil servants' milieu in Dar es Salaam would point to those who provided financial means from abroad or from within the country. However, I have to be careful here not to generalize too much since the answers of the older study participants in Dar es Salaam were greatly influenced by their understanding of my analytical concept of care.

minutes into two conversations if he buys US$5 cards. So it is better, he explained, to scratch another card in case, after twenty minutes, the conversation does not appear to be coming to an end. These difficulties were avoided when Tanzanian migrants communicated with "observing eyes" through social media. For instance, the use of WhatsApp is free and it allows you to write a message and receive an answer in no time. Only few parents of migrants in the USA used these new media tools at the time of the study. Most of them preferred "normal" phone calls. Some "observing eyes" also supported older people in using social media, like Ali' brother who occasionally facilitated a Skype conversation between Ali and his mother:

> Ah that is a very interesting thing: my brother he always goes there, he is not living with my mom but on weekends he takes his laptop [and] he goes there because my mom even the phone I sent, I downloaded all the apps; Skype Viber Tango… those apps like we can Skype but sometimes she finds [it] difficult to use those things—but if my brother goes home or if my mom goes to my brother then we can Skype… from my brother's house… she gets help from my brother—my brother is the one who is trying to take care of my mom because he is the older brother and am not trying to give him too much sometimes when I am in a good position, I try to help them as much as I can but my brother is the one because he is there close with them—so, he tries to go home as much as he can; once in a week or twice in a week, or if he is not going there—because my brother he travels a lot in Tanzania or in East African countries—so when he is not there my mom goes to my brother's family to see the kids… things like that. (Ali 2014)

Apart from these very practical aspects, communication with an "observing eye" allowed children residing in the USA to learn more about their parents' health condition. While parents would tell their children in the USA on the phone about recent events such as graduations, marriages or funerals, they did not talk in great detail about their own health condition. Many study participants in the USA perceived this circumstance of "not telling" to be problematic, as they wanted to be kept informed and, in addition, it hindered them in becoming involved and spending available resources on a particular treatment. Monica explained what she colloquially termed the "culture of not telling" as follows:

> So, I think we need to stop that culture of hiding stuff! Somebody might be sick in the family—they are hiding! Because, by the time my mom was telling us [that] my dad is sick, he had been … he had that problem for a while, they were just like… Nobody is saying anything, although calling you somebody is sick, it would be like, how big is the problem "oh no just a little bit!" Then two days [later] somebody [would ask] "What happened?"—"Oh yeah he has been struggling with this for years!"—"Why you did not tell us at least we could advise or tell not to do this!" Don't take these pills you know, you know, we have that culture… We are raised to not say anything about our family—don't say anything to anybody! (Monica 2014)

Monica told me another story of a friend of hers whose father came to the USA to visit the grandchildren. When she picked him up from the airport, she realized that he had massively lost weight and she took him straight to the hospital where they found out that he was diabetic and that the disease had already caused extensive damage to his body. He died before traveling back to Tanzania. The

discussion around not telling further shows how Tanzanians in the USA perceive the Tanzanian way of coping with disease in a different light while or due to staying abroad.[368]

"Not telling" also works the other way round: Saleh, who had a girlfriend and two children in South Africa but lived separated from his family, kept his mother under the illusion that his family was residing with him in the USA. Ali also explained, with a slight ironic tone in his voice: "The funny thing about my family is [that] they always update me on things but [on other] things they don't update me—they always tell me your sister has a baby they never tell me your sister is pregnant so am like ooh was she pregnant? I didn't know! …That is the funny thing like I don't know why they don't tell me when somebody is pregnant, they tell me somebody had a baby" (Ali 2014).

Especially when it comes to the often addressed aspect of not revealing everything, "observing eyes" are highly valued as nodes "through which information, resources and identities flow" (Levitt and Glick Schiller 2004: 1009). The nodes, or "observing eyes," were the ones who transmitted information between the two different contexts, the USA and Tanzania, over which the transnational field is spanned. Through conversations with "observing eyes," Tanzanian migrants receive straightforward information on their parent's health condition. Sometimes "observing eyes" also sent photos through their smart phones. In this sense, Tanzanian migrants depended on the information transmitted from the "observing eye" to the USA. Based on the "observing eye's" report, when, for example, it concerns the health condition of the older person, they can decide on their possible involvement from a distance. While the phone calls with parents are perceived as part of emotional care practices to foster the relationships between emigrated child and aging parent, communication with "observing eyes" was largely driven by receiving relevant and timely information.

"Observing eyes" were not only nodes to pass on information, they were also involved in organizing the flows of resources from the USA to Tanzania and back. The care practices mentioned above between Tanzanian migrants in the USA and their parents in Tanzania thus flew through the nodes to reach the older person. Maria communicated with her sister to organize the flow of goods to her mother: "Sometimes if she needs anything Lilian [the sister in Dar es Salaam] will call and say 'hey you need to get this for mom!' And because it is easier here and maybe good quality…" (Maria 2014). Also the visit of Maria's mother to the USA was organized by her sister Lilian in Dar es Salaam.[369] Somebody in Tanzania has to become involved when preparing travel documents and luggage for an older person.

---

[368] Both being concerned about the parent's health condition, hiding important information from siblings over distance seemed less of a problem.

[369] Sadly, Lilian died in 2017 in a car accident in Dar es Salaam, so the family's care giving had to be adapted following the loss of an important caregiver.

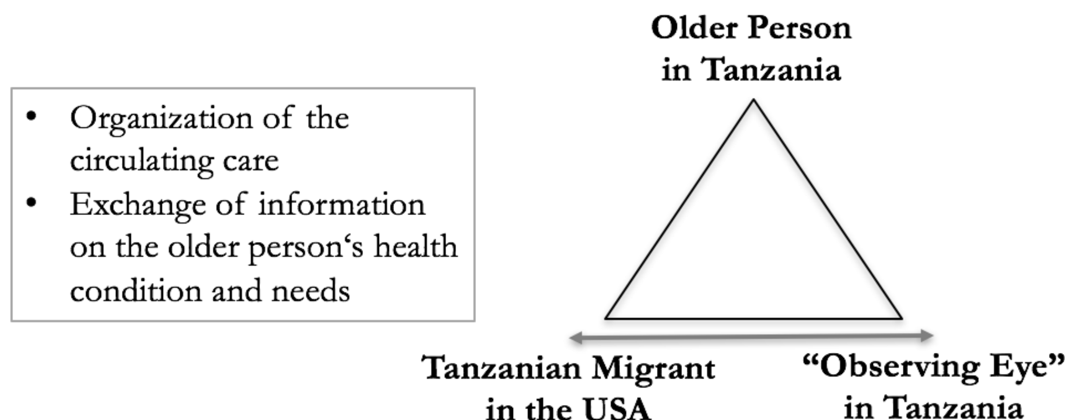

FIGURE 3 CARE BETWEEN TANZANIAN MIGRANTS AND OBSERVING EYES

Often, the "observing eye" and the financial supporter residing abroad discuss hospital visits. Thanks to the person of reference in Tanzania, the emigrated child abroad is able to engage in medical discussions around the older person's health condition. The Tanzania migrant can thereby offer new suggestions about how to proceed and which steps to take—influenced by what he or she has experienced in the USA context. While it is common for doctors in Tanzania not to disclose much about the actual health condition of a patient towards the patient and his or her relatives, children in the USA challenge doctors to share their knowledge about the case and bring in their suggestion on how to go about it.[370]

Among some non-poor families, siblings in Tanzania were involved equally in providing financial support to their parents. Maria is a case in point: Her sisters and brothers in the USA but also in Dar es Salaam negotiated the care of their mother and decided together on how to proceed when a (health) problem appeared. Eric, an "observing eye" living with his mother explained that all siblings were involved in their mother's (financial) care, while Lilian, his sister, and his younger brother in Dar es Salaam were mainly concerned with the practical support (for example, driving her to church, accompanying her to the hospital, checking on her hypertension). When talking with Eric about who contributes to the mother's upkeep, he answered as followed:

> Andrea: So you are like all contributing?
>
> Eric: Whatever she has and she is ok… whatever she wants anybody can [contribute]—there is no schedule "you do it" no we don't want to do that… *kwa mfano*,[371] it's like you and your husband if there

---

[370] Further research could focus on changing doctor-patient relationships by being embedded in transnational triangles of care. Schühle, who conducted her research with Nigerian medical doctors in the USA and their involvement in Nigeria, describes in her thesis the difficult role of emigrated medical doctors when communicating with local doctors in Nigeria who do not appreciate this involvement (personal communication with Judith Schühle, see also Schühle 2020)

[371] *Kwa mfano* means "for example."

> is something in the house, you don't say it's your turn now to buy… no—we all buy, whatever, you go—you shop for the house but other families they do that—they really fight, they say it's your turn and your turn, but there is no turn—you try to minimize the turns, but there is no turn—once you have turns, you will fight, because suppose one of them cannot do it then you do fight… but if there is no turn there is no fight, because you find if it [the money] is not here you put it there and if it's here you can add… from my view I think it's simple like that.
>
> (Eric 2013)

Only in very rare cases did all siblings reside abroad, leaving no one around to engage in practical care practices in Tanzania. In contrast, in Lamb's research with Indians residing alone in Kolkata, only very few older people had a child living in the same city, but in a different household. The others had all their children either abroad or in other Indian cities (Lamb 2009, 178-179).[372] I did not experience the loneliness that came from living alone, as described by Lamb, so much when talking to older people in Tanzania and their children in the USA.

Similarly, van der Geest et al. in their article talk about the possibility that, due to out-migration of young people, parents are left behind without children who can engage in caring for them (Geest, Mul, and Vermeulen 2004). As described in Part II of this PhD thesis, in Tanzania, the risk of being left alone without any children around seemed much higher in rural areas that do not provide job opportunities for them unlike in Dar es Salaam where very few of the older study participants with children abroad were left behind without any children. And if it happened that no child was living in the same household, children organized someone else to take over the task of being there on a daily basis. Van der Geest et al. explain for Kwahu-Tafo in Ghana that usually several people are involved in caring for an older person (Geest, Mul, and Vermeulen 2004, 441).[373] Hence in the Ghanaian case, too, siblings living abroad or elsewhere "are expected to contribute to the care of frail or vulnerable old parents by sending money to the one who actually does the caring" (Geest, Mul, and Vermeulen 2004, 442). In this sense, money pulls children away but also allows them to provide for a replacement (Geest, Mul, and Vermeulen 2004, 444).

It was common, especially among those whose parents resided outside of Dar es Salaam, that grandchildren, nieces or nephews stayed with an elderly parent. Thus, not only children can serve as "observing eyes" but also other members of the extended kin network who are around to provide

---

[372] In India apparently, those parents with all their children abroad are called "NRI (Non-Resident Indian) parents" (Lamb 2009, 178-179).

[373] Moreover, the authors found that if there was no child around, almost any other relative could take over the task: "The decisive factor is not the exact relationship but who is staying in the house" (Geest, Mul, and Vermeulen 2004, 442). The decision about who is entitled to stay in the house is often made by the older person himself/herself (as owner of the house) and/or by a child. Van der Geest et al. emphasize that "the resulting arrangement of care-giving may look haphazard or capricious, but the underlying *principle of reciprocity* is clear" (emphasis in original, Geest, Mul, and Vermeulen 2004, 442). In this connection, also leaving behind parents to study or work in the city or abroad does not break with principles of reciprocity, since benefits are expected later (Geest, Mul, and Vermeulen 2004, 442).

practical elements of care and communicate with those abroad. In this connection, Uthman, who was in his mid-forties when we met, talked about a "win-win situation" because he had nephews or nieces staying with his mother in the rural area. In the village, it was not common to have household helpers, so these children supported his mother in daily household activities while, at the same time, the mother provided them with a good learning environment and the money she received from her son abroad. While his mother's house had electricity, many in the village did not. Children were able to conduct their homework in the evening and school fees were paid for them. This very much confirms what Baldassar and Wilding say of care as an asymmetrical reciprocal exchange that is "not measured and exchanged in a two-way equivalent swap but shared between members of the family, given as and when needed by who is best able to provide at that particular time" (Baldassar and Wilding 2014, 248).

Mazzucato emphasizes in her article that those at home care out of reciprocal expectations while they hope that at one point they will gain something from caring for an older person. Of course, the organization of care does not always happen in a smooth way and there are always siblings or other relatives who refuse to care.[374] For example, Saleh's brother in Tanzania did not visit their mother at all even though the mother even supported him with Saleh's money.[375] However, Saleh would prefer somebody of the extended family to watch over his mother rather than employ someone from outside the family. Bibi Mbujuni, who had three children in the USA and who is part of the civil servants' milieu in Ada Estate, made bad experiences with hiring someone to care for her late mother: "So, hiring a person… you should have somebody who is related to see [supervise] the care [that] the old person is getting—otherwise they just handle him or her anyhow—so, there must be somebody to manage them to give instructions—to check if the old person is getting sufficient care, eats on time, [gets] medical attention, for example" (Bibi Mbujuni 2013). The person who manages and supervises the hired staff that takes over practical care responsibilities such as household tasks, is an "observing eye."

While transnational care practices between emigrated children in the USA and parents in Tanzania can be described as inter-generational exchanges, the circulation of care and especially the communication about it and the organization of it happened mainly between siblings, cousins, or other relatives from the same generation, thus, intra-generational. What became evident in the above-described circulations is that it needs both to provide transnational old age care.

---

[374] Long-term field research in the USA might have revealed more conflicts that developed over a certain period of time.

[375] Saleh sent the money directly to his mother and not to the brother, because his brother was according to Saleh a drug addicted and not capable to provide for himself and for others, according to Saleh.

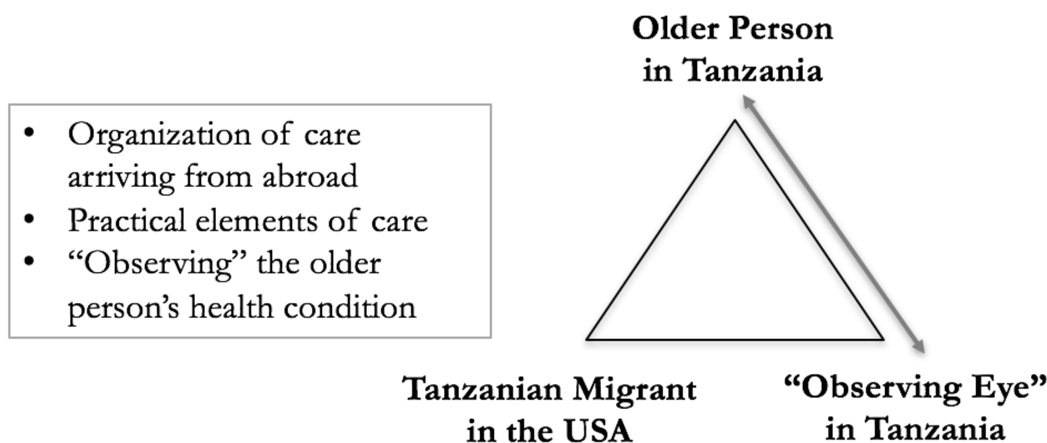

FIGURE 4 CARE BETWEEN OBSERVING EYES AND OLDER PEOPLE IN TANZANIA

The care practices between the "observing eyes" and the older person in Tanzania very much reflects what I described in Part III under relational care. The "observing eyes" provided practical elements of care for their parents. While they were responsible for intimate care, other practical elements concerning the household could be out-sourced to household helpers, however they needed to be supervised. As expressed by the denomer "observing eyes," the additional task when caring for parents lies in the communication with abroad.

Conclusion: Transnational Triangles in Care

At the outset of this part on transnational triangles of care, I cited Appadurai who talks about "new global realities" at stake in our interconnected world. Looking at aging, health, and care in Tanzania, and in a Tanzanian former civil servants' milieu in particular, these global connections constituted an essential part of this PhD thesis. People, goods, and ideas flow within so-called transnational social fields encompassing those who travel but also those who remain where they are. In the literature, care has been amply described within these new global realities, however, with a main focus on childcare and traveling mothers. This study shifted the focus to care for older people provided over a distance by especially focusing on emigrated Tanzanians, women and men, in the USA. Their double engagement by simultaneously raising their children in an American context while providing care for their parents in Tanzania, shaped the care, which was consequently described as transnational care.

Based on Baldassar and Merla, I used the concept of "care circulations" to describe people, goods, and ideas that flow in both directions; from the USA to Tanzania, but also from Tanzania to the USA. It became evident that these exchanges do not only encompass two people (for example, the older person in Tanzania and the Tanzanian migrant in the USA), but circulate between several and shifting members

of a kin network based in different localities. Grounded in the findings of this study, I proposed the spatializing image of a triangle of care to describe the tri-directional flows of transnational old age care between Tanzania and the USA.

The triangle involves apart from emigrated Tanzanians in the USA and their parents in Tanzania a third person, namely the "observing eye" in Tanzania. These "observing eyes" are the ones who engage in the practical and technical elements of care. By "being there" they can provide practical forms of care and closely observe the health condition of an aging parent. The "observing eye's" engagement comes close to what is described by the Swahili notion of *kuangalia*; to watch over an older person. In most of cases, one person was the responsible "observing eye," however, the task could also be shared among more than one sibling or relative. They provide information for those far away which is crucial as often not all aspects are exchanged over the phone when the older person is "not telling" the migrant child details about, for example, a health condition. "Observing eyes" become crucial when flows of goods and money arrive in Tanzania, since the transfer of financial support but also gifts or medical equipment has to be organized by someone on site. Furthermore, they support the communication between the older person and the migrant through their knowledge of new communication technologies such as WhatsApp or Skype. When talking to Tanzanian migrants in the USA it became evident, that "observing eyes" were important for all migrant groups.

In the USA, this study distinguished three different groups of emigrated Tanzanians in order to underline the importance of a legal permission to stay in the country in connection with transnational care. While well-established Tanzanians seemed to engage a lot in transnational care by regularly sending money but also by reinforcing relationships over a distance through regular visits, the group of the overstayers had more difficulties in doing so and thus needed other ways to maintain their cross-border relationships. Having newly arrived in the USA and/or not (yet) able to work to make a living, their financial support was more irregular and tended to be concentrated on emergency situations. The third group of the temporarily employed constituted a rather special case, because the study data on these nannies remained very limited. Furthermore, they seemed to target their own schooling children in Tanzania with their support, rather than their aging parents. Their focus on their children when it comes to care across national borders leaves open the question about who takes care of their parents; here further research would be needed.

The three groups have to be perceived as analytical categories and belonging to one or the other group can change over time. Consequently, the involvement in care over distance has also to be understood as being dynamically adapted to changing local circumstances in both Tanzania and the USA. When looking at these three groups and their care practices over a distance, it became evident that they do not only send remittances, which would rather correspond to the Swahili notion of *kusaidia*, they also engage considerably in emotional elements of care. Mainly through phone calls they try to create

closeness with their parents over a distance, compensating for not being around. I therefore proposed a rethink of relational care that implies physical closeness. Changing care practices over distance are also mirrored in the gendered aspects of care. While for "observing eyes" it is important to respect gendered norms about who is able to engage in (intimate) care for whom, for Tanzanian migrants in the USA these norms were less strict when it comes to the provision of transnational care.

Finally, the older people themselves play a crucial part in the care triangles. By using the concept of circulations, this study sought to show that the older people involved in these triangles are by no means passive receivers of care but also actively engage in these relations, for example, by sending gifts to their children or advising them. Especially counseling around child raising issues were highly welcomed. While in Tanzania children are usually raised by several family members, in the USA it remained the responsibility of the parents in most families. Through the older people's engagement in transnational care, they were also exposed to new ideas on how to age well. These concepts travel with care across national borders. This study was therefore interested in medical remittances that were sent from one country to the other. International discourse around "successful aging" shaped care practices and were then mirrored in the older people's everyday self-care when, for example, taking vitamin pills. While the triangles of care could also be observed within Tanzania, when children and parents do not reside in same locality, through the flows of ideas and ideologies they differ when spanning across national borders.

When older people traveled to the USA for medical checkups and visits, they were confronted with other practices of doctors who did not withhold information. Often institutional elder care in the USA was perceived with great ambivalence, by the older people as well as the Tanzanian migrants.

In this part, I rather narrowly focused on parent-children relationships when it comes to transnational care. Of course, also other actors can be involved, including non-kin. In the long term, it would be interesting to study the involvement in transnational care of the children of Tanzanian migrants in the USA. As mentioned at the start of this part, these children belonging to a second generation of Tanzanian migrants grow up in an American context and might have other ideas on how care of their parents should be organized in future.

PART V CONCLUSION

This PhD thesis contributes to a better understanding of older people's everyday lives in the rapidly changing urban context of Dar es Salaam. It is about their imaginations of how to age well. Because more and more people are currently growing old in Tanzania's biggest city, there is a rising need to know more about older urban dweller's everyday lives and the existing and needed future care arrangements. Similar processes of population aging and urbanization may also be witnessed in other growing cities on the African continent. In addition, the recent growth of an "urban middle class" in several African cities also calls for more insight into urban lives with slightly more financial means than the average elderly resident. Especially in the Tanzanian setting with its socialist past, it is important to look at those older people who decide to remain in the city, as they face new conditions in terms of social relations, income or available infrastructure.

In this conclusion, I provide a summary of the main findings of this PhD thesis, while taking up the leading questions that I presented at the outset. Furthermore, I will relate my observations and the subsequent analysis to the academic field of anthropology of aging by providing possible answers to how older people live their everyday lives in changing urban milieus. In a subsequent chapter, I would like to take up some of the tensions and struggles mentioned by older urbanites when reflecting about the contribution of this PhD thesis to urban anthropology more generally, before I end with possible questions for further research.

CONCLUDING SUMMARY

This PhD thesis contains three thematic and interlinked sections (Part II—IV) that contribute to a better understanding of how older people live their everyday lives in changing urban milieus of Dar es Salaam and how they imagine possible future trajectories of aging well.

I explored older people's everyday lives in Dar es Salaam by introducing the urban context of Dar es Salaam. I presented the relatively recent processes of population aging and urbanization as it shapes older people's everyday lives in the city. I argued that the older participants of this study are among the first generation of older people in Dar es Salaam who decided to stay in the city although, by remaining, they break with the country's former *Ujamaa* philosophy. Most of these older people were able to buy plots and build houses upon their arrival in the city. These houses are important assets in advanced age.

I emphasized two different frames of references that older people draw on when it comes to their own perception of aging and being old. Firstly, older people draw on their legal age that is informed by Dar

es Salaam's institutional landscapes that offer legal definitions of old age. These landscapes are usually connected to entitlements (for example, free health care or pension) or duties (for example, compulsory retirement) of older people and usually include a threshold of sixty years.

At the same time, it is crucial to contrast this legal definition with the social definition of old age which comes closer to what anthropological and gerontological studies describe when they point to an aging process that is socially constructed and fluid (Makoni 2008, 203). In this connection I analyzed the language used to demonstrate deference to older people when greeting them in a respectful way by saying *Shikamoo*. Older people in Dar es Salaam described their own old age in physical terms by pointing to their strength and their ability to walk upright, and their old-looking face or their old voice. When discussing these different repertoires of old age in the city, one needs to keep in mind that these frames of references are situational because they can be played out in different situations by older people, for instance, when bargaining for care at health facilities and at home.

I presented my approach to the city with a focus on social differentiation. I find the concept of social milieu (Grathoff 1989; Hradil 2001) useful for studying aging in the four different neighborhoods I had chosen for the field research in Dar es Salaam. I criticize the shortcomings of a focus on "class" or "ethnic" differences within the city because they both only consider one out of many important dimensions; instead, I opted for a social milieu approach that reconsiders not only socio-economic positions but also socio-cultural dimensions of a particular group. Especially for the focus on aging and health, a purely socio-economic differentiation would not have been sufficient to cater to the particularities of the aging former civil servants with the subjective aspects (i.e. values and lifestyles) inherent to the milieu.

The milieu approach makes us aware that aging in the city varies greatly across different urban settings. The story of Bibi Ruth reveals a narrative of struggle in a "guilty city" that she makes responsible for the harm and misery she faces in aging, without much support from relatives or neighbors. While Mzee Dunford's case points to the city's ambivalence that he experiences through accessible, good quality health care, on the one hand (the "healthy" city), and contaminated food and an "unhealthy lifestyle," on the other (the "unhealthy" city). Bibi Veronica and her story show more an "enabling city" which she prefers over the prospect of going back to her village in the north, precisely because of the quality health care as well as the proximity of her children and relatives in the city. The ethnographic insights furthermore revealed different support networks, from being restricted to one sub-ward of the city (Bibi Ruth), to extending to other places within Tanzania (Mzee Dunford), to the USA (Bibi Veronica), which impacted on the received quality and quantity of care.

I discussed the perceived tensions between the village and the city and took up the older people's narratives about "traditional" village life versus "modern" city life. These contrasts are important as

they reveal much about the older people's everyday lives and the perceived difference between aging in the city and in the countryside. Furthermore, I critically reflect on the complaint discourse and point out that they not only mirror perceived differences between urban and rural aging, but also reveal claims towards others for more care.

In the second part of the first section, I focused mainly on the former civil servants' milieu and presented an introduction of the sub-ward Ada Estate and, in a next step, discussed some socio-economic as well as socio-cultural dimensions of the milieu. I showed how this middle-income milieu is very particular in the sense that it consists of former civil servants who were entitled to buy houses and apartments in the area. Their everyday lives are strongly shaped by socio-cultural aspects such as a conscious, healthy way of living. Although my ethnographic focus was on one particular milieu, I considered it important to sketch out earlier the tendencies for other milieus, too, such as the "older urban poor" or the "older wakubwa" in order to have a better basis for comparison.

I presented my understanding of old age care based on my empirical findings as well as on the existing body of literature on care (Kleinman and Geest 2009; Klerk 2011; Tronto 1993; Schnabl 2005; Mol, Moser, and Pols 2010; Geest 2010; Eeuwijk 2014; Reynolds Whyte, Alber, and Geest 2008; Roth 2008). In order to adequately understand care dynamics in contemporary Dar es Salaam, I developed an inclusive definition of care that not only encompasses activities directly targeting older people's health, but also other small tasks that contribute to an older person's well-being in a broad sense, such as household activities or emotional support. The rather broad definition of care in this PhD thesis may however give the impression that all the older people we met during this study received care. It was therefore important to ask what "good" care means for the older people themselves in order to age well.

I have argued for a differentiation between care provided by related others and care that is provided for oneself. I hereby addressed a research gap in the anthropological literature on care, in so far as self-care practices in old age are concerned. As with relational care, self-care practices may also have various shades, allowing us to distinguish future-oriented health promoting activities from self-care that becomes necessary because no one else is around to take over. Approaching the local meanings of "care," I analyzed the Swahili semantics and pointed to the various shades of care, in which some Swahili verbs for care implicated financial support rather than physical care.

I focused on articulated expectations of older people in terms of their care arrangement but I also found it important to mirror their perceptions with the statements of their (younger) caregivers about their engagement in care. Both, caregivers and care receivers, emphasized the significance of reciprocal norms they are expected to fulfil. Through my inclusive definition of old age care that also contains

activities performed by household helpers, I touched upon care activities that are accepted from people outside the family.

One major finding of this part is that the health condition of an older person, often described with reference to *nguvu*, plays a major role in care giving and receiving. Therefore, I discussed different health conditions and related care practices. Mzee Juma's case reflects on an older person who had lost his strength due to his advanced age as well as an untreated prostate problem. Mzee Juma's condition necessitated much support from others, meaning his existing care arrangement was no longer able to provide the needed care. As a consequence, Mzee Juma's already married daughter moved back in with her parents to support them, while his son was absent which may also hint to aspects of missing care. Mzee Bariki's care holds ups and downs that are inherent to chronic conditions that older people and their families have to cope with. His case points to the dynamics over time, insofar as on one day he was able to perform garden work, while on others he needed someone to assist him with bathing. Bibi Veroncia's case that was taken up again reveals that the loss of her husband led to changing care needs within her family. I used her case to show that such health-related crises usually necessitate new care arrangements. In Bibi Veronica's case, her son, who was living in the USA, came back to support her.

Drawing on these ethnographic insights, the empirical material further allows us to analyze the agency of older people (Emirbayer and Mische 1998). I emphasized that the older participants of this study often base their habitual actions on reciprocal norms in order to bargain for care. However, especially in health-related crises, they may be asked to critically evaluate a situation anew in search of the best solution. Moreover, by calling it "relational" care I point to the social relations that are formed or reinforced through care but sometimes also break up due to missing care. The empirical data has shown that when it comes to relational care, especially adult children became important care providers or care organizers.

While embodied experiences and habitual practices shape older people's agency, especially when it comes to relational care, I also addressed their imaginations about aging well, particularly when analyzing their self-care practices. I presented older people's engagements in what they called *kujitunza* in order to point to their agentic future orientation. I focused mainly on older people from the former civil servants' milieu, since empirical data revealed that the older civil servants engaged more in these future oriented, health promoting practices than older people from other research areas in this study. In the subject-specific literature, these kind of self-care practices have so far tended to be attributed to an "American way" of aging. I consequently compare locally relevant self-care practices to and against the currently prominent "successful aging" paradigms (Rowe and Kahn 1997) that put forward individual agency and control, independence, productive activity, and permanent personhood (Lamb, Robbins-Ruszkowski, and Corwin 2017, 7) in order to highlight similarities and differences of these different ways of aging well. Important hereby seems to me the empirically grounded insights that

explored these notions of "good" aging or "good" care from the perspective of older people—belonging to different urban milieus and engaging in different contexts of action.

I argued that the city provides a conducive environment for everyday self-care as it offers increased access to information on health promotion and disease prevention in old age. In addition, relatives in the city provided financial means, knowledge, and practical support for self-care practices when living close-by. Bibi Helen's case describes her engagements in spiritual care as an active member of a Pentecostal church. Her example shows that investments in "good" food constituted an important aspect of caring for oneself. I discuss Mzee Dunford's case to point out practices of an older person with a chronic illness, where the aim was not so much to remain healthy, but instead to cope successfully with an already existing illness. Bibi Annette's example in turn raises another aspect of self-care, namely when caring for others in advanced age. Caring for grandchildren, for example, kept older people active and contributed to their mental well-being. I concluded for Part III that an older person's health condition becomes crucial for the reception of relational care as well as for the provision of everyday self-care, because all aspects of care are subject to an underlying dynamic process, particularly in respect to fluctuating health conditions.

I discussed care in transnational triangles and pointed to the fact that there is yet not very much subject-specific literature available that focuses on care across national borders for older people. I therefore drew parallels to child care (Hochschild 2000; Ehrenreich and Hochschild 2002) and emphasized the importance not only to look at financial remittances but also emotional forms of (virtual) care used to create closeness and cultivate social relations over a distance. I opted for a transnational social fields approach (Levitt and Glick Schiller 2004) because it also encompasses older people living in Tanzania, while I argue that care circulated among several family members within these fields (Baldassar and Merla 2014a). By calling it transnational care, I highlighted the fact that Tanzanian migrants in the USA as well as their older relatives in Tanzania become doubly engaged in more than one context.

With a focus on caregivers in the USA, I opt for a closer look at migrants' legal status because it can become a precondition for their provision of care across national borders. Based on empirical evidence, I developed three analytical groups of Tanzanian migrants in the USA, (1) the "overstayers," (2) the "well-established" and (3) the "temporarily employed" that helped me to analyze different engagements in transnational care—based on their legal residence status in the USA. Yacinta, who had overstayed her visa, faced difficulties in sending remittances to her parents in Tanzania since she was concerned with making ends meet in the USA. Furthermore, missing papers prevented her from traveling home to Tanzania for important events which would have helped to cultivate relationships within the family, and therefore her emotional care was more or less limited to communication through social media. Maria, on the other hand, I described as a well-established migrant who had even become an US citizen. Her financial means as well as her legal status allowed her to engage far more in her mother's care; she

even organized trips for her mother to the USA in order to take her to see American doctors for checkup. The story of Mercy, a temporarily employed nanny, showed yet another way of transnational engagement in that she directed her earned money more towards her children than her parents.

Based on the ethnographic insights, I was able to show that the provision of care over distance in some cases led to a reconfiguration of responsibilities, because gendered aspects of care played a lesser role across national borders since financial support can be provided by both, daughters and sons, while gendered physical care is not possible over a distance. Likewise, the stories disclosed dynamic adaptations of care arrangements over time. Based on my empirical material I developed the spatializing image of a triangle of transnational care through which care circulates in several directions. My intension with the triangle of care was to emphasize the importance of an "observing eye" in Tanzania who is involved in the care that circulates between Tanzania and the USA. "Observing eyes" are physically and geographically close to an older person, and inform Tanzanian migrants about the older person's health condition and needs.

Moreover, I emphasized that through these transnational triangles not only money is transferred to the older person but also, especially with the circulation of medical remittances (Zanini et al. 2013), ideas on health and care travel from one context to the other and are thus likely to shape older people's imaginations about aging well. Finally, I argued that literature on transnational care has so far neglected the crucial position of the "observing eyes" within transnational care triangles; there is thus a need for further research to learn more about these crucial caregivers.

Putting Self-Care on the Spot

In the course of the study it became evident that aging well is about notions of the "right" care, provided by others but also by the older people themselves. An anthropology of aging therefore has to take care into account. Furthermore, aging and care are closely linked to health. The stories of the older people and their caregivers in this PhD thesis have shown that the reception of care usually had a positive effect on the older persons' health. Furthermore, the care that an older person received very much depended on the perception of his or her condition as either old or ill. I recall the story of Bibi Selma who received particular treatment for her illness (pneumonia), but not for her paralyzed legs which were explained as a result of her advanced age. At the same time, however, based on reciprocal duties between parents and children, someone who is old has an increased likelihood of receiving care. Ideally, based on the idea of reciprocity, older people raise their children in order to be able to "harvest" the investments in old age. Again, when looking at everyday self-care, these (health promoting) practices are reserved for those older people who are healthy enough to engage in such practices, for example,

when conducting walking exercises or Yoga. While the focus here was less on self-care practices older people who have to care for themselves because there is no one else to do it.

Throughout this PhD thesis, I opted for an inclusive definition of aging, health, and care because it encompasses many aspects of older people's everyday lives. My analytical concept of care was therefore usually much broader than the older people's own understandings of it. While older people often highlighted financial aspects of support (mainly triggered by using the Swahili word *kusaidia*), I looked at all activities that contributed to an older person's well-being. Hence, I perceived household activities that someone else does for an older person as part of this person's care arrangement. In the former civil servants' milieu these activities were often conducted by an employed household helper. Depending on the perspective on care, these activities could thus be described as care provided through non-kin. Although in many instances older people and their caregivers emphasized that care through non-kin is not acceptable in Tanzania, these grounds became slippery in cases when no relatives were around to take over particular care activities. Neighbors (I recall Bibi Elizabeth's case whose only son settled for financial care while the elderly woman was immobile and in need of help) and household helpers (I recall Mzee Dunford's case who remained in his apartment with a household helper after his children had moved out and his wife passed away) may therefore take over many responsibilities for older people, although in none of these cases they were involved in physical forms of care, for example, bathing an older person.

When expanding the scope to encompass transnational care within a care arrangement, not many changes within the locally existing care setting become visible. Going from the concept of a transnational care triangle, many aspects of care for an older person are still provided by the same relatives who are around (the "observing eyes") as well as, in some cases, household helpers employed for the practical household tasks. The number of older participants we met during this study in Dar es Salaam with transnational links was rather limited. Hence, whether Tanzania represents a special case here, with usually not more than one child migrating so that often other adult children are still around, would have to be ascertained by further research on the topic.

Although financial contributions from abroad as well as emotional care through money and communication should not be neglected, I wish to emphasize one important additional aspect of transnational care; this concerns the medical remittances and information on aging, health, and care. Vitamin pills, for example, are sent to Tanzania by migrants in the USA together with ideas about health prevention; however, this knowledge is occasionally thwarted, for example, when older people swallow them only when feeling weak and not on a regular basis (I recall Bibi Ngowi's case who swallowed them when feeling tired). These transnational links as well as the urban context of Dar es Salaam with its differing repertoires of aging, provide additional orientations for older people's actions with regard to aging, health, and care and may thus shape older people's imaginations about aging well.

This PhD thesis contributes to the ongoing social-anthropological debate on aging, health, and care in Africa through its focus on "middle class" older people. It adds a yet missing perspective with its ethnographic accounts of older people who have slightly more means available than the average older people. Although focusing on the non-poor may appear incompatible with a development agenda that is inherent to some of the research on older people, the focus on families with access to not only financial means but also to information and international discourses prompts innovative new ways for Tanzanian older people in the future. In this PhD thesis, I highlighted the fact that the older people from the former civil servants' milieu orient themselves towards legal age definitions and face a life as an "older person" after retirement that they are asked to organize. As a consequence, many of them actively shaped their own old age and invested in self-care practices in the hope of aging well. With the sample of this ethnographic study being rather small, further research would be needed to explore similarities and differences.

By opting for an all-embracing definition of care, I would like to draw particular attention to these everyday self-care practices that became important in this study, predominantly in the former civil servants' milieu. I focused mainly on self-care practices of older study participants from the middle-income milieu who had the time, financial means, and access to information about how to best promote health or at least cope with existing chronic illnesses. Although, of course, there are other circumstances that necessitate self-care, for example when older people are on their own. I encourage social anthropologists working on aging to be open to everyday self-care in different milieus and to look at self-care as a part of care along with the entanglements between the two. It may also be important to emphasize that self-care is not something only practiced by better-off older people. In the diverse urban milieus, older people perceived fetching water as a good exercise for their health, while they were concerned about their food which sometimes did not seem beneficial for their illnesses—thus pointing to the diverse shades of self-care. With a focus on self-care practices, the perspective on older people may shift as they are no longer seen as passive care receivers but as older people who actively engage in care practices they conduct for themselves—with the help of others.

Urban Aging: African Cities' Future

At the beginning of the PhD project, I had the idea that in this study the urban mainly served as a context in which people grew old while facing rapid changes due to population aging and urbanization processes. Over time, I became more and more fascinated by the ways the "power of the urban" shaped older people's everyday practices and how, in turn, older people's everyday practices shaped the urban context.

When I began my field research in Dar es Salaam, my guiding research questions led me to look at everyday lives and care practices of older people in different milieus. While I was mainly focused on observing care practices and listening to older people telling me about their (lacking) care, the older people often emphasized the particularities of the fact that they were "in the city" (in Swahili *mjini*). Their continuous emphasis made me look closer at this urban aspect. In Part II of this PhD thesis, I therefore pointed to diverse articulated aging experiences in different social milieus of the city. I got to know differing images of the city, when older people, for example, referred to the city as an un-healthy city, with contaminated food and hindered access to biomedical health care. At the same time, other older urban residents spoke of a healthy city that improved their access to timely high quality health care. For others again, the city was an enabling city, with close-by relatives who contributed to an older person's care arrangements. Yet, for still another group, the city was a guilty city, while shifting responsibility for their suffering and loneliness to "Bongoland." In brief, contradicting images constitute the city's imagery.

Because people over the age of sixty came to Dar es Salaam when still young, consequentially these study's participants witnessed much of the urban development with the improvements of living standards and health care services in the 1960s and the decline that followed in the early 1980s. They were part of the new urban population after independence that was based on the *Ujamaa* politics of the country's first president, but nevertheless opted to become old in the city, even though the policy demanded that they leave after no longer being productive. Listening to older people's life stories revealed a great deal of the city's transformations as well as the older people's lives in their "home" villages and in the city. The empirical data showed that older people often pointed to the perceived differences between the "traditional" village life (*zamani*) and the "modern" city life (*ya kisasa*). Their complaint discourse reflected modernization theories that point to the neglect of older people through outmigration or disinterest on the part of the younger generations.

While older people are thus often associated with the "village," "history," "tradition," "family" or maybe out-of-date world views, looking at "the urban" through the eyes of elderly people provides a surprising, unusual perspective on what is commonly associated with a city—namely creativity, change, dynamics, young people or global flows. How can then "the old" and the city go together? In this PhD thesis, older people serve as a lens for viewing the city.

Especially when looking at older people's care arrangement, these tensions between the urban and the old become revealed. When age advances, older people's needs for care grow, and children and relatives become crucial for the provision of care. These aspects of familial support are especially relevant in a country like Tanzania where there are not many institutional solutions for old age care available. I recall Simone who writes that in cities of the Global South extended family ties become strained and that therefore falling back on extended family networks equals falling into harm (Simone 2004, 11). Yet my

research has shown that particularly in the city, aging urban dwellers can rely much more on their children and relatives than if they were to move back to the countryside. The older study participants' children, who were often born in Dar es Salaam, usually worked in the city, and thus moving back to the village would mean that an older person moves away from his or her potential caregivers. In the light of the above mentioned Ujamaa idea that stuck in people's minds, older people have to weigh up the existing social network in the city as well as the accessible quality health care with the nostalgic image of the village where life is envisaged as healthier due to "good" food and constant exercise due to *shamba* work.

Relatives become crucial for older people as age advances and with increased frailty the ability to move around the city decreases. As Obrist writes, place starts to matter when the movements of older people become restricted (Obrist 2016, 95). Older people who have to stop their work, have less opportunities to mingle with others, while some do not easily trust neighbours. These older people build their islands of peace within a particular sub-ward of the city and thus have limited encounters with other urbanites. Their everyday lives could therefore in some sense be reconnected to rural life as this was seen by those urban scholars who studied urban neighbourhoods as villages (for a critical voice, cf. Förster 2014, 34). This shows how strongly space and difference are intertwined. For younger people, a particular neighbourhood might be one spot in a broad network of physically and virtually connected urban places, while for certain older people, a sub-ward of the city may become their "urban village," the centre of their life, which they hardly ever leave.

In this PhD thesis, a special focus lies on older people that belong to a Tanzanian "urban middle class." In Part II, I argued that by particularly looking at better-off people one may learn more about current trends of urban aging. Through their financial means, but also through their access to a transnational network and information on health care, these older people may imagine alternative trajectories of aging in the city. With a focus on a specific former civil servants' milieu, I pointed to the importance of their preparations for a future old age when facing compulsory retirement at the age of sixty years—while being aware that former civil servants provide a special example of state loyal people that profited more than others during their employment.

I emphasized that the older study participants I encountered in the city during research belonged to a first generation of older people that has grown old in the city. I supported my argument with a historical overview on the socialist philosophy of Ujamaa that encouraged people to only remain in the city when productively contributing to its development. The older urbanites are currently witnessing processes of urbanization and population aging that are also at stake in many other African countries, although for now the proportion of older people in cities is still small, and thus one may assume that older people do not have much of a future to be concerned about because Africa is generally thought of as a "continent of the young."

An analysis of older people's agentic orientations revealed that, in the urban context, they disassociated themselves from certain habits, thus imagining new possible future trajectories of aging in the city, for example, by conducting Yoga in order to cope with diabetes. Although a one-sided understanding of agency in urban theory solely based on imagination and creativity may be criticized (for a critical voice, cf. Förster 2014, 32), in this PhD thesis I showed that older people based their actions on various, local and global frames of reference (or contexts of action) at once while their agency was not only directed to the past, as could be expected of older people who are often described as the "stronghold of tradition," but also to the future. I recall Mzee Dunford who explained at the very beginning of this PhD thesis, "a good way of getting old is when you are able to control your body like when you are doing physical exercise [like] that you are getting old in the best way, because instead of dying today you will die tomorrow instead of dying this week you will die next week …[376]" (Mzee Dunford 2013). Especially for the former civil servants who are confronted with the organization of their lives after retirement, but also for many other older city dwellers, new social spaces may open up while others might close and thus imagination of future alternatives is needed in order to age well. Studying aging and old age in the city therefore offers a new perspective on the city—through the eyes of "the old," so to speak.

Questions For Further Research

I close with some questions that had to be left open for future research.

In this study, I focused on a particular milieu of former civil servants in one sub-ward of the city. The dimensions of the milieu therefore are based on a small sample of older civil servants I accompanied for several years, offering in depth insights into the lives of a small number of older people. As mentioned earlier, my grounded approach mainly explored older civil servants' perspectives on what they perceived as a good old age in the city, while it was again up to me as a researcher to situate their experiences in the broader context. Extending the focus to other groups would therefore be a necessary next step to more thoroughly explore some of the nuances of their privileged position as former public servants who worked for the state during the "golden age" of public service. In order to learn more about particularities of either "civil servant" aging or "middle class" aging, it would be interesting not only to explore other civil servants' areas of Dar es Salaam, but also of other African cities along with other older people who had been formally employed and thus confronted with "legal age" but not as state employees. Further research on "middle class aging" in general would contribute to a deeper

[376] Mzee Dunford: "Kuzeeka vizuri ni kule ambako unajicontrol mwili wako kama kufanya mazoezi ndiko kuzeeka vizuri, kwa sababu badala ya kufa leo unakufa kesho, badala ya kufa wiki hii unakufa wiki ijayo …"

understanding of articulated aging experiences of former civil servants because being able to compare them with other middle-income milieus would bring forward other lifestyles or aims for their old age.

In this study, I focused on urban elders who decided to remain in the city in old age. At the same time, there are several other urban dwellers who leave the city in order to return to the countryside for their old age. Capturing their lived experiences would add much to the various images about the city and the countryside and about aspects around health and care in old age that could be then compared to those older people who remained in the city.

Due to the multi-sited design of this study, I spent a great deal of time in Dar es Salaam but only few months in the USA in order to learn more about the Tanzanian migrants' involvements in transnational care. Further long-term research could explore how care circulations over distance assume different shapes as they adapt to the dynamics of old age and migration. It would be interesting to find out how the encountered first generation migrants in the USA configure their old age, either in the USA or in Tanzania. In addition, their long-term engagements in initiatives to improve their parents and other older people's livelihoods may give shape to future developments of institutional landscapes for older people that are currently being discussed in the context of rapid population aging, so that the city may become an enabling place for more of its aging inhabitants in the future.

REFERENCES

Aboderin, Isabella. 2004. "Modernisation and Ageing Theory Revisited: Current Explanations of Recent Developing World and Historical Western Shifts in Material Family Support for Older People." *Ageing and Society* 24:29-50. doi: https://doi.org/10.1017/S0144686X03001521.

Aboderin, Isabella, and John R. Beard. 2015. "Older People's Health in Sub-Saharan Africa." *The Lancet* 385 (9968):e9-e11. doi: https://doi.org/10.1016/S0140-6736(14)61602-0.

Aceska, Ana, Barbara Heer, and Andrea Kaiser-Grolimund. 2019. "Doing the City from the Margins: Critical Perspectives on Urban Marginality." *Anthropological Forum* 29 (1):1-11. doi: https://doi.org/10.1080/00664677.2019.1588100.

Alber, Erdmute, and Tabea Häberlein. 2010. "Ethnologische Genereationenforschung in Afrika." In *Verwandtschaft heute. Positionen, Ergebnisse und Perspektiven*, edited by Erdmute Alber, Bettina Beer, Julia Pauli and Michael Schnegg, 281-304. Berlin: Reimer.

Alber, Erdmute, Tabea Häberlein, and Jeannett Martin. 2010. "Changing Webs of Kinship: Spotlights on West Africa." *Africa Spectrum* 45 (3):43-67. doi: http://www.jstor.org/stable/41336265.

Alli, Farzana, and Pranitha Maharaj. 2013. "The Health Situation of Older People in Africa." In *Aging and Health in Africa*, edited by Pranitha Maharaj, 53-89. New York: Springer.

Appadurai, Arjun. 1996. *Modernity at Large. Cultural Dimensions of Globalization*. Minneapolis: University of Minnesota Press.

Aulino, Felicity. 2017. "Narrating the Future: Population Aging and the Demographic Imaginary in Thailand." *Medical Anthropology* 36 (4):319-331. doi: https://doi.org/10.1080/01459740.2017.1287181.

Bailey, P.J.M. 1968. "The Changing Economy of the Chagga Cultivators of Marangu, Kilimanjaro." *Geography* 53 (2):163-169.

Baldassar, Loretta, Cora Vellekoop Baldock, and Raelene Wilding. 2007. *Families Caring Across Borders: Migration, Ageing and Transnational Caregiving*. New York: Palgrave.

Baldassar, Loretta, and Laura Merla. 2014a. "Introduction: Transnational Family Caregiving Through the Lens of Circulation." In *Transnational Families, Migration and the Circulation of Care. Understanding Mobility and Absence of Family Life*, edited by Loretta Baldassar and Laura Merla, 3-24. New York/London: Routledge.

Baldassar, Loretta, and Laura Merla. 2014b. "Locating Transnational Care Circulation in Migration and Family Studies." In *Transnational Families, Migration and the Circulation of Care. Understanding Mobility and Absence of Family Life*, edited by Loretta Baldassar and Laura Merla, 25-58. New York/London: Routledge.

Baldassar, Loretta, and Raelene Wilding. 2014. "Middle-Class Transnational Caregiving. The Circulation of Care Between Family and Extended Kin Networks in the Global North." In *Transnational Families, Migration and the Circulation of Care. Understanding Mobility and Absence of Family Life*, edited by Loretta Baldassar and Laura Merla, 235-251. New York/London: Routledge.

Banerjee, Abhijit V., and Esther Duflo. 2008. "What is Middle Class About the Middle Classes around the World?" *Journal of Economic Perspectives* 22 (2):3-28. doi: 10.1257/jep.22.2.3.

Basch, Linda, Nina Glick Schiller, and Christina Szanton Blanc. 1994. *Nations Unbound: Transnational Projects, Postcolonial Predicaments, and Deterritorialized Nation-States*. Langhorne, PA: Gordon and Breach.

Bauer, Kerstin. 2007. *Kleidung und Kleidungspraktiken im Norden der Cote d'Ivoire. Geschichte und Dynamiken des Wandels vom Ende des 19. Jahrhunderts bis zur Gegenwart*. Münster: LIT.

Blommaert, Jan. 2014. *State Ideology and Language in Tanzania: Second and Revised Edition*. Edinburgh: University Press.

Blumer, Herbert. 1954. "What is Wrong with Social Theory?" *American Sociological Review* 19 (1):3–10. doi: https://doi.org/10.2307/2088165.

Bowen, Glenn A. 2006. "Grounded Theory and Sensitizing Concepts." *International Journal of Qualitative Methods* 5 (3):12-23. doi: https://doi.org/10.1177/160940690600500304.

Brennan, James R., and Andrew Burton. 2007. "The Emerging Metropolis: A History of Dar es Salaam, circa 1862-2000." In *Dar es Salaam: Histories from an Emerging African Metropolis*, edited by James R. Brennan, Andrew Burton and Yusuf Lawi, 13-75. Dar es Salaam: Mkuki na Nyota Publishers.

Brennan, James R., Andrew Burton, and Yusuf Lawi, eds. 2007. *Dar es Salaam: Histories from an Emerging African Metropolis*. Dar es Salaam: Mkuki na Nyota Publishers.

Bryceson, Deborah Fahy 2010. "Dar es Salaam as a 'Harbour of Peace' in East Africa. Tracing the Role of Creolized Urban Ethnicity in Nation-State Formation." *WIDER Working Paper 2010/019*:219-234.

Buhl, Andrea. forthcoming. *Palliative Care in Tanzania for Cancer Patients: A Hospital Ethnography*: Doctoral Thesis, University of Basel, Faculty of Humanities and Social Sciences.

Bülow, Morton Hillgaard, and Thomas Söderqvist. 2014. "Successful Ageing: A Historical Overview and Critical Analysis of a Successful Concept." *Journal of Aging Studies* 31:139-149. doi: https://doi.org/10.1016/j.jaging.2014.08.009.

Burton, Andrew. 2005. *African Underclass. Urbanisation, Crime and Colonial Order in Dar es Salaam.* Oxford: James Currey.

Burzan, Nicole. 2011. *Soziale Ungleichheit. Eine Einführung in die zentralen Theorien*. 4 ed. Wiesbaden: VS Verlag.

Büsch, Fortunat. 2014. "Giving the Elderly People a Voice. Care Arrangments for and by Frail Elderly People in Rural and Remote Communities in Tanzania." tropEd Masters Programme in International Health, Swiss Tropical and Public Health Institute, University of Basel, Master thesis.

Calas, Bernard. 2010. "Form as a Pretext from Investigating Urban Mutations." In *From Dar es Salaam to Bongoland. Urban Mutations in Tanzania*, edited by Bernard Calas, 3-22. Dar es Salaam: Mkuki na Nyota Publishers.

Campbell, Elizabeth, and Luke Eric Lassiter. 2015. *Doing Ethnography Today: Theories, Methods, Exercises.* Chichester West Sussex: Wiley-Blackwell.

Carsten, Janet. 2000. "Introduction: Cultures of Relatedness." In *Cultures of Relatedness. New Approaches to the Study of Kinship*, edited by Janet Carsten, 1-36. Cambridge: Cambridge University Press.

Carsten, Janet. 2004. *After Kinship*. Cambridge: Cambridge University Press.

Carter, Stacy M., and Miles Little. 2007. "Justifying Knowledge, Justifying Method, Taking Action: Epistemologies, Methodologies, and Methods in Qualitative Research." *Qualitative Health Research* 17 (10):1316-1328. doi: https://doi.org/10.1177/1049732307306927.

Cattell, Maria G. 1997. "The Discourse of Neglect: Family Support for the Elderly in Samia." In *African Families and the Crisis of Social Change*, edited by Thomas S. Weisner, Candice Bradley and Philip Leroy Kilbride, 157–183. Westport, CT: Bergin & Garvey.

Charmaz, Kathy. 2006. *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London: SAGE.

Clurman, Ann, and J. Walker Smith. 2007. *Generation Ageless. How baby boomers are changing the way we live today… And they're just getting started.* New York: Harper-Collins.

Cohen, Lawrence. 1994. "Old Age: Cultural and Critical Perspectives." *Annual Review of Anthropology* 23:137-158. doi: https://doi.org/10.1146/annurev.an.23.100194.001033.

Comaroff, Jean, and John L. Comaroff. 2004. "Notes on Afromodernity and the Neo World Order: An Afterword." In *Producing African Futures. Ritual and Reproduction in a Neoliberal Age*, edited by Brad Weiss, 329–348. Leiden/Boston: Brill.

Corwin, Anna I. 2017. "Growing Old With God. An Alternative Vision of Successful Aging Among Cathollic Nuns." In *Successful Aging as a Contemporary Obsession. Global Perspectives*, edited by Sarah Lamb, 98-111. New Brunswick: Rutgers University Press.

Csordas, Thomas J. 1990. "Embodiment as a Paradigm for Anthropology." *Ethos* 18 (1):5-47.

Daar, Abdallah S., Peter A. Singer, Deepa Leah Persad, Stig K. Pramming, David R. Matthews, Robert Beaglehole, Alan Bernstein, Leszek K. Borysiewicz, Stephen Colagiuri, Nirmal Ganguly, Roger I. Glass, Diane T. Finegood, Jeffrey Koplan, Elizabeth G. Nabel, George Sarna, Nizal Sarrafzadegan, Richard Smith, Derek Yach, and John Bell. 2007. "Grand Challenges in Chronic Non-Communicable Diseases: The Top 20 Policy and Research

Priorities for Conditions such as Diabetes, Stroke and Heart Disease." *Nature* 450:494-496. doi: https://doi.org/10.1038/450494a.

Desjarlais, Robert, and C. Jason Throop. 2011. "Phenomenological Approaches in Anthropology." *Annual Review of Anthropology* 40:87-102. doi: https://doi.org/10.1146/annurev-anthro-092010-153345.

Dilger, Hansjörg. 2009. "The Power of AIDS: Kinship, Mobility and the Valuing of Social and Ritual elationships in Tanzania." *African Journal of AIDS Research* 5 (2):109-121. doi: https://doi.org/10.2989/16085900609490371

Dilger, Hansjörg. 2010. "My Relatives Are Running Away From Me! Kinship and Care in the Wake of Structural Adjustment, Privatization and HIV/AIDS in Tanzania." In *Morality, Hope and Grief: Anthropologies of Aids in Africa*, edited by Hansjörg Dilger and Ute Luig, 102-124. New York/ Oxford: Berghahn.

Dilger, Hansjörg. 2012. "Targeting the Empowered Individual: Transnational Policy Making, the Global Economy of Aid, and the Limitations of Biopower in Tanzania." In *Medicine, Mobility and Power in Global Africa*, edited by Hansjörg Dilger, Abdoulaye Kane and Stacey A. Langwick, 60-91. Bloomington/Indianapolis: Indiana University Press.

Dilger, Hansjörg. 2014. "Claiming Territory: Medical Mission, Interreligious Revivalism, and the Spatialization of Health Intervention in Urban Tanzania." *Medical Anthropology* 33 (1):52-67. doi: https://doi.org/10.1080/01459740.2013.821987.

Dossa, Parin, and Cati Coe, eds. 2017. *Transnational Aging and Reconfigurations of Kin Work*. New Brunswick/Camden/Newark/New Jersey/London: Rutgers University Press.

Dunleavy, Patrick. 1980. *Urban Political Analysis: The Politics of Collective Consumption*. London: Palgrave Macmillan UK.

Eckert, Andreas. 2014. "“We must run while others walk”: African Civil Servants, State Ideologies and Bureaucratic Practices in Tanzania, from the 1950s to the 1970s." In *States at Work. Dynamics of African Bureaucracies*, edited by Thomas Bierschenk and Jean-Pierre Olivier de Sardan, 205-219. Leiden/Boston: Brill.

Eeuwijk, Peter van. 2007. "The Power of Food: Mediating Social Relationships in the Care of Chronically Ill Elderly People in Urban Indonesia." *Anthropology of Food* S3:1-23. doi: https://doi.org/10.4000/aof.2052.

Eeuwijk, Peter van. 2011. "Altern in Unsicherheit. Gesundheit und Pflege von alten Menschen in Indonesien und Tansania." In *Alter: unbekannt. Über die Vielfalt des Älterwerdens. Internationale Perspektiven*, edited by Carolin Kollewe and Elmar Schenkel, 83-111. Bielefeld: Transcript-Verlag.

Eeuwijk, Peter van. 2014. "The Elderly Providing Care for the Elderly in Tanzania and Indonesia: Making ‚Elder to Elder' Care Visible." *Sociologus* 64 (1):29-52.

Eeuwijk, Peter van. 2017. "When Religion Matters – Aging, Health and Care in Indonesia and Tanzania." In *Aging and Religion – Interdisciplinary and Intercultural Explorations*, edited by Andrea Bieler, Matthias Stracke and Angelika Veddeler, 71-98. Leipzig: Evangelische Verlagsanstalt/EVA.

Eeuwijk, Peter van, and Brigit Obrist. 2016. "Becoming Old and Frail in Coastal Tanzania." In *The Routledge Handbook of Medical Anthropology*, edited by Leonore Manderson, Elizabeth Cartwright and Anita Hardon, 189-192. New York/Oxford: Routledge.

Ehrenreich, Barbara, and Arlie Hochschild. 2002. "Introduction." In *Global Woman: Nannies, Maids, and Sex Workers in the New Economy*, edited by Barbara Ehrenreich and Arlie Hochschild, 1-13. New York: Owl Books.

Emerson, Robert M., Rachel I. Fretz, and Linda L. Shaw. 1995. *Writing Ethnographic Fieldnotes*. Chicago/London: The University of Chicago Press.

Emirbayer, Mustafa, and Jeff Goodwin. 1996. "Symbols, Positions, Objects: Toward a New Theory of Revolutions and Collective Action." *History and Theory* 35 (3):358-374. doi: https://doi.org/10.2307/2505454.

Emirbayer, Mustafa, and Ann Mische. 1998. "What is Agency?" *American Journal of Sociology* 103 (4):962-1023. doi: https://doi.org/10.1086/231294.

Featherstone, Mike, and Mike Hepworth. 2009. "Images of Aging: Cultural Representations of Later Life." In *The Cultural Context of Aging: Worldwide Perspectives*, edited by Jay Sokolovsky, 134-144. Westport: Praeger.
Fischer, Hans. 1998. "Feldforschung." In *Ethnologie. Einführung und Überblick*, edited by Hans Fischer, 73-92. Berlin, Hamburg: Reimer.
Fluehr-Lobban, Carolyn. 2008. "Collaborative Anthropology as Twenty-first-Century Ethical Anthropology." *Collaborative Anthropologies* 1:175-182. doi: 10.1353/cla.0.0000.
Fluehr-Lobban, Carolyn. 2013. *Ethics and Anthropology: Ideas and Practice*. Lanham, MD: AltaMira Press.
Förster, Till. 1997. *Zerrissene Entfaltung. Alltag, Ritual und künstlerische Ausdrucksformen im Norden der Côte d'Ivoire*. Köln: Rüdiger Köppe Verlag.
Förster, Till. 2001. "Sehen und Beobachten: Ethnographie nach der Postmoderne." *Sozialer Sinn* 3 (1):459–484. doi: https://doi.org/10.1515/sosi-2001-0304.
Förster, Till. 2010. "'Greener Pastures': Afrikanische Europabilder vom besseren Leben." In *Europa und Afrika. Betrachtungen zu einem komplexen Verhältnis*, edited by Georg Kreis, 59-78. Basel: Schwabe.
Förster, Till. 2011a. "Coda - Participation and Experience as Ethnographic Practice." *Basel Papers on Political Transformations* 3:39-43.
Förster, Till. 2011b. "Emic Evaluation Approach - Some Remarks on its Epistemological Background." *Basel Papers on Political Transformations* 3:3-12.
Förster, Till. 2013. "On Urbanity: Creativity and Emancipation in African Urban Life." In *Living the City in Africa. Processes of Invention and Intervention*, edited by Brigit Obrist, Veit Arlt and ElÍsio Macamo, 235-251. Berlin/Münster/Wien/Zürich/London: LIT.
Förster, Till. 2014. "On Creativity in African Urban Life: African Cities as Sites of Creativity and Emancipation." In *Popular Culture in Africa. The Episteme of the Everyday*, edited by Stephanie Newel and Onookome Okome, 27-46. New York/London: Routledge.
Förster, Till. 2018. "The Unbearable Lightness of African Cities." *Social Dynamics* 44 (3):405-424. doi: 10.1080/02533952.2018.1501546.
Förster, Till. 2023. "Imagining Together: The Social Dimension of Imagination." In *In Tandem – Pathways Towards a Post-Colonial Anthropology*, edited by Mirjam Lücking, Andrea Meiser and Ingo Rohrer. Wiesbaden: Springer VS.
Förster, Till. forthcoming. "Handlungsfähigkeit, Artikulation, Diskurs. Was leistet die politische Anthropologie?" In *Anthropologie der Praxis*, edited by Felix Girke, Christian Meyer, Anna Lisa Ramella and Martin Zillinger, 1-20 (forthcoming). Stuttgart: J.B. Metzler.
Förster, Till, and Carole Ammann. 2018. "Chapter 1 African Cities and the Development Conundrum: Actors and Agency in the Urban Grey Zone." In *African Cities and the Development Conundrum*, edited by Till Förster and Carole Ammann, 3-25. Leiden: Brill.
Förster, Till, Barbara Heer, Michelle Engeler, Andrea A. Kaufmann, Kerstin Bauer, and Kathrin Heitz. 2011. "The Emic Evaluation Approach: Epistemologies, Experience, and Ethnographic Practice." *Basel Papers on Political Transformations* 3.
Fortes, Meyer. 1969. *Kinship and the Social Order. The Legacy of Lewis Henri Morgan*. Chicago, IL: Aldine Publishing Company.
Foucault, Michel. 1988. "Technologies of the Self." In *Technologies of the Self: A Seminar with Michel Foucault*, edited by Luther H. Martin, Huck Gutman and Patrick H. Hutton, 16-49. Amherst: University of Massachusets Press.
Freeman, Emily. 2016. "Care and Identity in Rural Malawi." In *Ageing in Sub-Saharan Africa. Spaces and Practices of Care*, edited by Jaco Hoffman and Katrien Pype, 115-136. Bristol: Policy Press.
Frey, Oliver. 2012. "Städtische Milieus." In *Handbuch Stadtsoziologie*, edited by Frank Eckardt, 503-525. Wiesbaden: VS Verlag für Sozialwissenschaften.
Gambino, Christine P., Edward N. Trevelyan, and John Thomas Fitzwater. 2014. The Foreign-Born Population from Africa: 2008-2012. In *American Community Survey Briefs*. Washington DC: US Census Bureau.
Geertz, Clifford. 1973. *The Interpretation of Cultures: Selected Essays*. New York: Basic Books.
Geest, Sjaak van der. 1987. "Self-Care and the Informal Sale of Drugs in South Cameroon." *Social Science & Medicine* 25 (3):293-305. doi: https://doi.org/10.1016/0277-9536(87)90232-2.

Geest, Sjaak van der. 1998. "Yebisa Wo Fie: Growing Old and Building a House in the Akan Culture of Ghana." *Journal of Cross-Cultural Gerontology* 13:333-359. doi: https://doi.org/10.1023/A:1006563032706.

Geest, Sjaak van der. 2002. "Respect and Reciprocity – Care of Elderly People in Rural Ghana." *Journal of Cross-Cultural Gerontology* 17:3-31. doi: https://doi.org/10.1023/A:1014843004627.

Geest, Sjaak van der. 2004. "Grandparents and Grandchildren in Kwahu, Ghana: The Performance of Respect." *Africa* 74 (1):47-61. doi: 10.3366/afr.2004.74.1.47.

Geest, Sjaak van der. 2007. "Complaining and not Complaining: Social Strategies of Older People in Kwahu, Ghana." *Global Aging: Issues and Action* 4 (3):55-65.

Geest, Sjaak van der. 2010. "Introducing 'Care and Health Care'." *Medische Anthropologie* 22 (1):5-11.

Geest, Sjaak van der. 2016. "Will Families in Ghana Continue to Care for Older People? Logic and Contradiction in Policy." In *Ageing in Sub-Saharan Africa. Spaces and Practices of Care*, edited by Jaco Hoffman and Katrien Pype, 21-41. Bristol: Policy Press.

Geest, Sjaak van der, Anke Mul, and Hans Vermeulen. 2004. "Linkages Between Migration and the Care of Frail Older People: Observations from Greece, Ghana and The Netherlands." *Ageing and Society* 24:431-450. doi: 10.1017/S0144686X04002302.

Geissler, P. Wenzel, and Ruth J. Prince. 2004. "Shared lives: Exploring Practices of Amity Between Grandmothers and Grandchildren in Western Kenya." *Africa* 74 (1):95-120. doi: 10.3366/afr.2004.74.1.95.

Gerold, Jana. 2013. "On The Move: Elderly People Living the City of Dar es Salaam, Tanzania." In *Living the City in Africa. Processes of Invention and Intervention*, edited by Brigit Obrist, Veit Arlt and ElÍsio Macamo, 153-170. Berlin/Münster/Wien/Zürich/London: LIT.

Gerold, Jana. 2017. *Full of Life. Old Age and Care in Urban Dar es Salaam, Tanzania.* Zürich: LIT.

Glaser, Barney G., and Anselm L. Strauss. 1967. *The Discovery of Grounded Theory. Strategies for Qualitative Research.* New Brunswick/London: AldineTansaction.

Glick Schiller, Nina, Linda Basch, and Cristina Szanton Blanc. 1995. "From Immigrant to Transmigrant: Theorizing Transnational Migration." *Anthropological Quarterly* 68 (1):48-63. doi: https://doi.org/10.2307/3317464.

Goankar, Dilip Parameshwar. 2001. "On Alternative Modernities." In *Alternative Modernities*, edited by Dilip Parameshwar Goankar, 1-23. Durham: Duke University Press.

Grathoff, Richard. 1989. *Milieu und Lebenswelt. Einführung in die phänomenologische Soziologie und die sozialphänomenologische Forschung.* Frankfurt am Main: Suhrkamp.

Grove, Alison. 1993. "Water Use by the Chagga on Kilimanjaro." *African Affairs* 92 (368):431-448. doi: https://doi.org/10.1093/oxfordjournals.afraf.a098644.

Gupta, Akhil. 2014. "Authorship, Research Assistants and the Ethnographic Field." *Ethnography* 15 (3):394-400.

Gupta, Akhil, and James Ferguson. 1997. "Culture, Power, Place: Ethnography at the End of an Era." In *Culture, Power, Place: Explorations in Critical Anthropology*, edited by Akhil Gupta and James Ferguson, 1-30. Durham/London: Duke University Press.

Häberlein, Tabea. 2014. "Teilnehmende Beobachtung als dichte Teilhabe - Ein Plädoyer zur ethnologischen Forschung über soziale Nahbeziehungen." *Sociologus* 64 (2):127-154.

Hannerz, Ulf. 1976. "Methods in an African Urban Study." *Journal of Anthropology* 41 (1-4):68-98. doi: https://doi.org/10.1080/00141844.1976.9981119.

Hannerz, Ulf. 2006. "Studying Down, Up, Sideways, Through, Backwards, Forwards, Away and at Home: Reflections on the Field Worries of an Expansive Discipline." In *Locating the Field: Space, Place and Context in Anthropology*, edited by Simon Coleman and Peter Collins, 23-41. Oxford/New York: Berg.

Hannerz, Ulf. 2010. "The Management of Danger." *Ethnos* 46 (1-2):19-46. doi: https://doi.org/10.1080/00141844.1981.9981208

Hannerz, Ulf. 2012 [2003]. "Being there … and there … and there! Reflections on Multi-Site Ethnography." In *Ethnographic Fieldwork. An Anthropological Reader*, edited by Antonius C. G. M. Robben and Jeffrey A. Sluka, 399-408. Malden, MA: Wiley-Blackwell.

Harpham, Trudy. 2009. "Urban Health in Developing Countries: What Do We Know and Where Do We Go?" *Health & Place* 15:107-116. doi: https://doi.org/10.1016/j.healthplace.2008.03.004.

Hashim, Ismail. 1999. "Nyerere: A Tribute to a Statesman." *Review of African Political Economy* 26 (82):516-518. doi: https://doi.org/10.1080/03056249908704420.
Heer, Barbara. 2019. *Cities of Entanglements. Social Life in Johannesburg and Maputo Through Ethnographic Comparison*. Bielefeld: Transcript-Verlag.
HelpAge International. 2013. Tanzania Brochure: The State of Older People in Tanzania. Dar es Salaam: HelpAge International Tanzania.
Hickey, Tom, Kathryn Dean, and Bjorn E. Holstein. 1986. "Emerging Trends in Gerontology and Geriatrics: Implications for the Self-Care of the Elderly." *Social Science & Medicine* 23 (12):1363-1396. doi: https://doi.org/10.1016/0277-9536(86)90299-6.
Hochschild, Arlie. 2000. "The Nanny Chain." *Cover article in The American Prospect* 11 (4):32-36.
Hoffman, Jaco. 2016. "Negotiating Care for Older People in South Africa: Between the Ideal and the Pragmatics." In *Ageing in Sub-Saharan Africa. Spaces and Practices of Care*, edited by Jaco Hoffman and Katrien Pype, 159-181. Bristol: Policy Press.
Howard, Mary. 1994. "Socio-Economic Causes and Cultural Explanations of Childhood Malnutrition Among the Chagga of Tanzania." *Social Science & Medicine* 38 (2):239-251. doi: https://doi.org/10.1016/0277-9536(94)90394-8.
Howell, Signe. 2006. *The Kinning of Foreigners. Transnational Adoption in Global Perspective*. New York, Oxford: Berghahn Books.
Hradil, Stefan. 2001. *Soziale Ungleichheit in Deutschland*. 8 ed. Wiesbaden: VS Verlag für Sozialwissenschaften.
Hromadžić, Azra, and Monika Palmberger. 2018. *Care Across Distance. Ethnographic Explorations of Aging and Migration*, edited by Azra Hromadžić and Monika Palmberger. 1 ed. Vol. 4. Brooklyn NY: Berghahn Books.
Huang, Shirlena, Leng Leng Thang, and Mika Toyota. 2012. "Transnational Mobilities for Care: Rethinking the Dynamics of Care in Asia." *Global Networks* 12 (2):129-134. doi: https://doi.org/10.1111/j.1471-0374.2012.00343.x.
Ingstad, Benedicte. 2004. "The Value of Grandchildren: Changing Relations Between Generations in Botswana." *Africa* 74 (1):62-75. doi: 10.3366/afr.2004.74.1.62.
International Diabetes Federation. 2014. Global Diabetes Scorecard. Tracking Progress for Action. Brussels: International Diabetes Federation.
Isenböck, Peter, Linda Nell, and Joachim Renn, eds. 2014. *Die Form des Milieus. Zum Verhältnis von gesellschaftlicher Differenzierung und Formen der Vergemeinschaftung*. Vol. 1, *Zeitschrift für Theoretische Soziologie*. Weinheim: Beltz Juventa.
Israel, Mark, and Iain Hay. 2006. *Research Ethics for Social Scientists*. London: SAGE.
Janes, Craig R., and Kitty K. Corbett. 2009. "Anthropology and Global Health." *Annual Review of Anthropology* 38 (1):167-183. doi: https://doi.org/10.1146/annurev-anthro-091908-164314.
Jensen, Ines. 1998. "Ja, ja, bald muss ein Rentner einem anderen helfen." In *Alt und zahm? Alter und Älterwerden in unterschiedlichen Kulturen*, edited by Dorle Dracklé, 185-199. Berlin/Hamburg: Reimer.
Kaiser-Grolimund, Andrea. 2018. "Healthy Aging, Middle-Classness, and Transnational Care between Tanzania and the United States." In *Care Across Distance. Ethnographic Explorations of Aging and Migration*, edited by Azra Hromadžić and Monica Palmberger, 32-54. New York: Berghahn Books.
Kaiser-Grolimund, Andrea. 2020. "Transfigurations of Aging." *Medicine Anthropology Theory* 7 (1). doi: https://doi.org/10.17157/mat.7.1.649.
Kaiser-Grolimund, Andrea, Carole Ammann, and Sandra Staudacher. 2016. "Research Assistants: Invisible but Indispensable in Ethnographic Research." *TSANTSA* 21:132-136.
Kane, Abdoulaye. 2012. "Flows of Medicine, Healers, Health Professionals, and Patients between Home and Host Countries." In *Medicine, Mobility, and Power in Global Africa. Transnational Health and Healing*, edited by Hansjörg Dilger, Abdoulaye Kane and Stacy A. Langwick, 190-212. Bloomington: Indiana University Press.
Kaufmann, Andrea. 2011. "The EEA in an Urban, Post-Conflict Setting." *Basel Papers on Political Transformations* 3:25-29.

Kesselring, Rita. 2015. "Moments of Dislocation: Why the Body Matters in Ethnographic Research." *Basel Papers on Political Transformations* 8:3-24.

Kironde, J.M. Lusugga. 2007. "Race, Class and Housing in Dar es Salaam: The Colonial Impact on Land Use Structure, 1891-1961." In *Dar es Salaam: Histories From an Emerging African Metropolis*, edited by James R. Brennan, Andrew Burton and Yusuf Lawi, 97-117. Dar es Salaam: Mkuki na Nyota Publishers.

Kleinman, Arthur. 1980. *Patients and Healers in the Context of Culture. An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry*. Berkeley/Los Angeles/London: University of California Press.

Kleinman, Arthur, and Sjaak van der Geest. 2009. "'Care' in Health Care. Remaking the Moral World of Medicine." *Medische Anthropologie* 21 (1):159-168.

Klerk, Josien de. 2011. *Being Old in Times of AIDS. Aging, Caring and Relating in Northwest Tanzania*. Vol. 37. Leiden: African Studies Centre, African Studies Collection.

Klerk, Josien de. 2016. "Making Sense of Neglect in Northwest Tanzania." In *Ageing in Sub-Saharan Africa. Spaces and Practices of Care*, edited by Jaco Hoffman and Katrien Pype, 137-157. Bristol: Policy Press.

Kokot, Waltraud 2007. "Culture and Space - Anthropological Approaches." *Ethnoscripts* 9 (1):10-23.

Krause, Kristine. 2008. "Transnational Therapy Networks among Ghanaians in London." *Journal of Ethnic and Migration Studies* 34 (2):235-251. doi: https://doi.org/10.1080/13691830701823863.

Lamb, Sarah. 2009. *Aging and the Indian Diaspora. Cosmopolitan Families in India and Abroad.* Bloomington: Indiana University Press.

Lamb, Sarah. 2013. "In/dependence, Intergenerational Uncertainty, and the Ambivalent State: Perceptions of Old Age Security in India, South Asia." *Journal of South Asian Studies* 36 (1):65-78. doi: https://doi.org/10.1080/00856401.2012.732552.

Lamb, Sarah. 2014. "Permanent Personhood or Meaningful Decline? Toward a Critical Anthropology of Successful Aging." *Journal of Aging Studies* 29:41-52. doi: https://doi.org/10.1016/j.jaging.2013.12.006.

Lamb, Sarah. 2017a. "Ageless Aging or Meaningful Decline? Aspirations of Aging and Dying in the United States." In *Successful Aging as a Contemporary Obsession. Global Perspectives*, edited by Sarah Lamb, 230-242. New Brunswick: Rutgers University Press.

Lamb, Sarah, ed. 2017b. *Successful Aging as a Contemporary Obsession. Global Perspectives*. New Brunswick: Rutgers University Press.

Lamb, Sarah, Jessica Robbins-Ruszkowski, and Anna I. Corwin. 2017. "Introduction: Successful Aging as a Twenty-First-Century Obsession." In *Successful Aging as a Contemporary Obsession. Global Perspectives*, edited by Sarah Lamb, 1-23. New Brunswick: Rutgers University Press.

Lefebvre, Henri, and Christine Levich. 1987. "The Everyday and Everydayness." *Yale French Studies* 73:7-11. doi: https://doi.org/10.2307/2930193.

Lentz, Carola. 2016. "African Middle Classes: Lessons from Transnational Studies and a Research Agenda." In *The Rise of Africa's Middle Class: Myths, Realities and Critical Engagements*, edited by Henning Melber, 17-53. London: Zed Books.

Leslie, John Arthur Kingsley. 1963. *A Survey of Dar es Salaam*. London: Oxford University Press.

Levin, Lowell S. 1977. "Forces and Issues in the Revival of Interests in Self-Care." *Health Education & Behavior* 5 (2):115-120. doi: https://doi.org/10.1177/109019817700500202.

Levitt, Peggy, and Nina Glick Schiller. 2004. "Conceptualizing Simultaneity: A Transnational Social Field Perspective on Society." *International Migration Review* 38 (3):1002-1039.

Lugalla, Joe. 1995. *Crisis, Urbanization, and Urban Poverty in Tanzania. A Study of Urban Poverty and Survival Politics*. Lanham/New York/London: University Press of America.

Luttrell, Wendy. 2005. "'Good Enough' Methods for Life-Story Analysis." In *Finding Culture in Talk: A Collection of Methods*, edited by Naomi Quinn, 243–268. New York: Palgrave Macmillan.

Makoni, Sinfree. 2008. "Ageing in Africa: A Critical Review." *Cross Cultural Gerontology* 23:199-209. doi: https://doi.org/10.1007/s10823-008-9068-4.

Makoni, Sinfree, and Koen Stroeken. 2002. "Introduction: Towards Transdisciplinary Studies on Aging in Africa." In *Ageing in Afrika. Sociolinguistic and Anthropological Approaches.*, edited by Sinfree Makoni and Koen Stroeken, 1-18. Aldershot: Ashgate Publishing Limited.

Manderson, Leonore. 2008. "Anthropological Perspective on the Health Transition." In *International Encyclopedia of Public Health*, edited by Kris Heggenhougen and Stella Quah, 193-200. San Diego: Academic Press.

Marcus, George E. . 1995. "Ethnography in/of the World System: The Emergence of Multi-Sited Ethnography." *Annual Review of Anthropology* 24:95-117.

Marzi, Hiltrud. 1998. "Ethnologische Altersforschung im Wandel." In *Alt und zahm? Alter und Älterwerden in unterschiedlichen Kulturen*, edited by Dorle Dracklé, 13-31. Berlin: Dietrich Reimer Verlag.

Mazzucato, Valentina. 2008a. "The Double Engagement: Transnationalism and Integration - Ghanaian migrants' Lives Between Ghana and the Netherlands." *Journal of Ethnic and Migration Studies* 34 (2):199-216. doi: https://doi.org/10.1080/13691830701823871.

Mazzucato, Valentina. 2008b. "Transnational Reciprocity: Ghanaian Migrants and the Care of their Parents Back Home." In *Generations in Africa*, edited by Erdmute Alber, Sjaak van der Geest and Susan Reynolds Whyte, 91-112. Berlin: LIT.

Mazzucato, Valentina. 2009. "Bridging Boundaries with a Transnational Research Approach: A Simultaneous Matched Sample Methodology." In *Multi-Sited Ethnography. Theory, Praxis and Locality in Contemporary Research*, edited by Mark-Anthony Falzon, 215-232. Farnham: Ashgate.

Mazzucato, Valentina. 2010. "Reverse Remittances in the Migration-Development Nexus: Two-Way Flows Between Ghana and the Netherlands." *Population, Space and Place* 17:454-468. doi: https://doi.org/10.1002/psp.646.

Mboghoina, Thadeus, and Lars Olsberg. 2010. Social Protection of the Elderly in Tanzania: Current Status and Future Possibilities. In *Special Paper 10/5*. Dar es Salaam: Repoa.

McIntosh, Janet. 2017. "Depreciating Age, Disintegrating Ties. On Being Old in a Century of Declining Elderhood in Kenya." In *Successful Aging as a Contemporary Obsession. Global Perspectives*, edited by Sarah Lamb, 185-199. New Brunswick: Rutgers University Press.

McLean, Stuart. 2007. "Introduction: Why Imagination." *Irish Journal of Anthropology* 10 (2):5-9.

Mercer, Claire. 2014. "Middle Class Construction: Domestic Architecture, Aesthetics and Anxieties in Tanzania." *The Journal of Modern African Studies* 52 (02):227-250. doi: 10.1017/s0022278x14000068.

Middleton, John. 1992. *The World of the Swahili. An African Mercantile Civilization*. New Haven: Yale University Press.

Middleton, Townsend, and Jason Cons. 2014. "Coming to Terms: Reinserting Research Assistants into Ethnography's Past and Present." *Ethnography* 15 (3):279-290. doi: https://doi.org/10.1177/1466138114533466.

Middleton, Townsend, and Eklavya Pradhan. 2014. "Dynamic Duos: On Partnership and the Possibilities of Postcolonial Ethnography." *Ethnography* 15 (3):355-374. doi: https://doi.org/10.1177/1466138114533451.

Miller, Daniel. 2007. "What is a Relationship? Is Kinship Negotiated Experience?" *Ethnos: Journal of Anthropology* 72 (4):535-554. doi: https://doi.org/10.1080/00141840701768334.

Mills, Albert, Gabrielle Durepos, and Elden Wiebe. 2010. *Encyclopedia of Case Study Research*. Thousand Oaks/California: SAGE.

Mol, Annemarie. 2008. *The Logic of Care. Health and the Problem of Patient Choice*. London/New York: Routledge.

Mol, Annemarie, Ingunn Moser, and Jeannette Pols. 2010. "Care: Putting Practice into Theory." In *Care in Practice. On Tinkering in Clinics, Homes and Farms*, edited by Annemarie Mol, Ingunn Moser and Jeannette Pols, 7-25. Bielefeld: Transcript-Verlag.

Moody, Harry. 2009. "From Successful Aging to Conscious Aging." In *The Cultural Context of Aging: Worldwide Perspectives*, edited by Jay Sokolovsky, 67-76. Westport: Praeger.

Moyer, Eileen. 2003. *In the Shadow of the Sheraton: Imagining Localities in Global Spaces in Dar es Salaam, Tanzania*: Doctoral Thesis, University of Amsterdam, Faculty of Social and Behavioural Sciences.

Mubyazi, Godfrey, Julius Massaga, Mathias Kamugisha, J-Nyangoma Mbuyazi, Grace C Magogo, K-Yahya Mdira, Samuel Gesase, and Tom Sukwa. 2005. "User Charges in Public Health Facilities in Tanzania: Effect on Revenues, Quality of Services and People's Health-Seeking

Behaviour for Malaria Illnesses in Korogwe District." *Health Services Management Research* 19 (1):23-35. doi: https://doi.org/10.1258/095148406775322061.
Ncube, Mthuli. 2015. "Introduction." In *The Emerging Middle Class in Africa*, edited by Mthuli Ncube and Charles Leyeka Lufumpa, 1-8. Abingdon, New York: Routledge.
Ncube, Mthuli, Charles Leyeka Lufumpa, and Steve Kayizzi-Mugerwa. 2011. The Middle of the Pyramid: Dynamics of the Middle Class in Africa. Tunis: African Development Bank.
Needham, Rodney. 1971. "Remarks on the Analysis of Kinship and Marriage." In *Rethinking Kinship and Marriage*, edited by Rodney Needham, 96-101. London: Travistock Publications.
Neubert, Dieter. 2005. "Kulturelle Differenz und soziale Strukturierung in Afrika." In *Gesellschafttheorie und Provokationen der Moderne. Gerhard Hauck zum 65. Geburtstag*, edited by Reinhart Kössler and Gerhard Hauck, 178-192. Münster: Westfälisches Dampfboot.
Neubert, Dieter. 2014. "What is "Middle Class?": In Search of an Appropriate Concept." *Middle East: Topics & Arguments* 2:23-35. doi: https://doi.org/10.17192/meta.2014.2.1330.
Neubert, Dieter, and Florian Stoll. 2015. Socio-Cultural Diversity of the African Middle Class. The Case of Urban Kenya. In *Academy reflexts no. 1, IAS Working Paper Series no. 14*. Bayreuth: Institute of Africa Studies/University of Bayreuth.
Newell, Kenneth W. 1975. Health by the People. Geneva: WHO.
Obrist, Brigit. 2003. "Urban Health in Daily Practice: Livelihood, Vulnerability and Resilience in Dar es Salaam, Tanzania." *Anthropology & Medicine* 10 (3):275-290. doi: https://doi.org/10.1080/1364847032000145930.
Obrist, Brigit. 2006. *Struggling for health in the city. An anthropological inquiry of health, vulnerability and resilience in Dar es Salaam, Tanzania*. Bern: Peter Lang.
Obrist, Brigit. 2010a. "Soziale Vulnerabilität im städtischen Kontext: Eine medizinethnologische Perspektive." In *Medizin im Kontext*, edited by Hansjorg Dilger and Bernhard Hadolt, 411-428. Frankfurt a.M.: Lang.
Obrist, Brigit. 2010b. "Urbanisierung - Eine Gefahr für die Gesundheit? Einleitung." In *Medizin im Kontext*, edited by Hansjorg Dilger and Bernhard Hadolt, 349-350. Frankfurt a.M.: Lang.
Obrist, Brigit. 2013. "Introduction to Living the City in Africa." In *Living the City in Africa. Processes of Invention and Intervention*, edited by Brigit Obrist, Veit Arlt and ElIsio Macamo, 9-22. Berlin/Münster/Wien/Zürich/London: LIT.
Obrist, Brigit. 2016. "Place Matters: The Home as a Key Site of Old-Age-Care in Coastal Tanzania." In *Ageing in Sub-Saharan Africa. Spaces and Practices of care*, edited by Jaco Hoffman and Katrien Pype, 95-114. Bristol: Policy Press.
Obrist, Brigit, Veit Arlt, and Elisio Macamo. 2013. *Living the City in Africa. Processes of Invention and Intervention*. Berlin/Münster/Wien/Zürich/London: LIT.
Obrist, Brigit, Marcel Tanner, and Trudy Harpham. 2003. "Engaging Anthropology in Urban Health Research: Issues and Prospects." *Anthropol Med* 10 (3):361-71. doi: 10.1080/1364847032000133861.
Obrist, Brigit, and Peter van Eeuwijk. 2020. "Medical Anthropology in, of, for and with Africa: Three Hotspots." *Medical Anthropology* 39 (8):782-793. doi: https://doi.org/10.1080/01459740.2020.1734929.
Obrist, Brigit, Peter van Eeuwijk, and Mitchell G. Weiss. 2003. "Health Anthropology and Urban Health Research." *Anthropology & Medicine* 10 (3):267-274. doi: https://doi.org/10.1080/1364847032000133816.
Okely, Judith. 1994. "Vicarious and Sensory Knowledge of Chronology and Change: Ageing in Rural France." In *Social Experience and Anthropological Knowledge*, edited by Kirsten Hastrup and Peter Hervik, 34-48. London: Routledge.
Ortner, Sherry B. 2005. "Subjectivity and Cultural Critique." *Anthropological Theory* 5 (1):31-52. doi: https://doi.org/10.1177/1463499605050867.
Parreñas, Rhacel Salazar. 2012. "The Reproductive Labour of Migrant Workers." *Global Networks* 12 (2):269-275. doi: https://doi.org/10.1111/j.1471-0374.2012.00351.x.
Phillips, Judith, Kristine Ajrouch, and Sarah Hillcoat-Nallétamby. 2010. *Key Concepts in Social Gerontology*. London: SAGE.

Pribilsky, Jason. 2008. "Sending Energías from the Andes: the Social Efficacy of Travelling Medicines." *Anthropology News* 49 (5):13-14.
Quénot-Suarez, Hélène. 2012. Consumption in a Uncertain Environment. The Paradox of the African Middle Classes. In *Note de l'ifri*. Paris/Brussels: Ifri Sub-Saharan Africa Program.
Reynolds Whyte, Susan. 2012. "Chronicity and Control: Framing 'Noncommunicable Diseases' in Africa." *Anthropology & Medicine* 19 (1):63–74. doi: https://doi.org/10.1080/13648470.2012.660465.
Reynolds Whyte, Susan. 2017. "Epilogue: Successful Aging and Desired Interdependence." In *Successful Aging as a Contemporary Obsession. Global Perspectives*, edited by Sarah Lamb, 243-247. New Brunswick: Rutgers University Press.
Reynolds Whyte, Susan, Erdmute Alber, and Sjaak van der Geest. 2008. "Generational Connections and Conflicts in Africa: An Introduction." In *Generations in Africa. Connections and Conflicts*, edited by Erdmute Alber, Sjaak van der Geest and Susan Reynolds Whyte, 1-23. Berlin: LIT.
Robben, Antonius C. G. M. 2007. "Reflexive Ethnography." In *Ethnographic Fieldwork: An Anthropological Reader*, edited by Antonius C. G. M. Robben and Jeffrey A. Sluka, 443-446. Malden: Blackwell Publishing.
Robbins, Joel. 2013a. "Beyond the Suffering Subject: Toward an Anthropology of the Good." *Journal of the Royal Anthropological Institute* 19 (3):447-462. doi: https://doi.org/10.1111/1467-9655.12044.
Robbins, Joel. 2013b. "On Kinship and Comparsion, Intersubjectivity and Mutuality of Being." *HAU: Journal of Ethnographic Theory* 3 (2):309-316.
Robinson, Jennifer. 2006. *Ordinary Cities. Between Modernity and Development*. London/New York: Routledge.
Rosenberg, Harriet G. 2009. "Complaint Discourse, Aging and Caregiving among the Ju/'hoansi of Botswana." In *The Cultural Context of Aging: Worldwide Perspectives*, edited by Jay Sokolovsky, 30-52. Westport: Praeger.
Roth, Claudia. 2008. "'Shameful!' The Inverted Intergenerational Contract in Bobo-Dioulasso, Burkina Faso." In *Generations in Africa*, edited by Erdmute Alber, Sjaak van der Geest and Susan Reynolds Whyte, 47 – 71. Berlin: LIT.
Rouse, Roger. 1995. "Questions of Identity: Personhood and Collectivity in Transnational Migration to the United States." *Critique of Anthropology* 15 (4):351-380. doi: https://doi.org/10.1177/0308275X9501500406.
Rowe, John, and Robert Kahn. 1997. "Successful Ageing." *The Gerontologist* 37 (4):433-440 doi: https://doi.org/10.1093/geront/37.4.433.
Rudman, Debbie Laliberte. 2015. "Embodying Positive Aging and Neoliberal Rationality: Talking About the Aging Body Within Narratives of Retirement." *Journal of Aging Studies* 34:10-20. doi: https://doi.org/10.1016/j.jaging.2015.03.005.
Schnabl, Christa. 2005. *Gerecht sorgen. Grundlagen einer sozialethischen Theorie der Fürsorge*, *Studien zur theologischen Ethik*. Fribourg: Academic Press.
Schnegg, Michael, Julia Pauli, Bettina Beer, and Erdmute Alber. 2010. "Verwandtschaft heute: Positionen, Ergebnisse und Forschungsperspektiven." In *Verwandtschaft heute. Positionen, Ergebnisse und Perspektiven*, edited by Erdmute Alber, Bettina Beer, Julia Pauli and Michael Schnegg, 7-44. Berlin: Reimer.
Schnur, Olaf. 2012. "Nachbarschaft und Quartier." In *Handbuch Stadtsoziologie*, edited by Frank Eckardt, 449-474. Wiesbaden: Springer.
Schühle, Judith. 2020. *Traversing Transnational Biomedical Landscapes*. Bielefeld: Transcript-Verlag.
Scott, Mary Alice. 2012. "Paying Down the Care Deficit." *Anthropology & Aging Quarterly* 33 (4):142-151. doi: https://doi.org/10.5195/aa.2012.31.
Shannon, Jennifer. 2007. "Informed Consent: Documenting the Intersection of Bureaucratic Regulation and Ethnographic Practice." *PoLAR: Political and Legal Anthropology Review* 30 (2):229-248. doi: https://doi.org/10.1525/pol.2007.30.2.229.
Simon, Vendelin T. 2015. *Ageing, Health and Care in Rural Tanzania*: Doctoral Thesis, University of Basel, Faculty of Humanities and Social Sciences.

Simone, AbdouMaliq. 2004. *For the City Yet to Come: Changing African Life in Four Cities.* Durham/London: Duke University Press.

Sinus Sociovision. 2017. Informationen zu den Sinus-Milieus 2017. Heidelberg/Berlin: Sinus Sociovision GmbH.

Skornia, Anna Katharina. 2015. *Entangled Inequalities in Transnational Care Chains. Practices Across the Borders of Peru and Italy*. Bielefeld: Transcript-Verlag.

Sluka, Jeffrey A., and Antonius C. G. M. Robben. 2007. "Fieldwork in Cultural Anthropology: An Introduction." In *Ethnographic Fieldwork: An Anthropological Reader*, edited by Antonius C. G. M. Robben and Jeffrey A. Sluka, 1-28. Malden: Blackwell Publishing.

Sokolovsky, Jay. 2009. "Introduction: Human Maturity and Global Aging in Cultural Context." In *The Cultural Context of Aging: Worldwide Perspectives*, edited by Jay Sokolovsky, 3rd edition, xv-xxxv. Westport: Praeger.

Sousa, Paulo. 2003. "The Fall of Kinship: Towards an Epidemiological Explanation." *Journal of Cognition and Culture* 3 (4):265-303. doi: https://doi.org/10.1163/156853703771818019.

Spittler, Gerd. 2001. "Teilnehmende Beobachtung als Dichte Teilnahme." *Zeitschrift für Ethnologie* 126 (1):1-25. doi: https://www.jstor.org/stable/25842798.

Spittler, Gerd. 2014. "Dichte Teilnahme und darüber hinaus." *Sociologus* 64 (2):207-230. doi: https://doi.org/10.3790/soc.64.2.207.

Spitzer, Helmut, Hossea Rwegoshora, and Zena Mnasi Mabeyo. 2009. The (Missing) Social Protection of Older People in Tanzania. A Comparative Study in Rural and Urban Areas. Feldkirchen/Dar es Salaam: Carinthia University of Applied Sciences, Austria and Institute of Social Work, Tanzania.

Staudacher, Sandra. 2019a. *Cosmopolitan Aging in Zanzibar: Elderhood, Health and Transnational Care from Oman*: Doctoral Thesis, University of Basel, Faculty of Humanities and Social Sciences.

Staudacher, Sandra. 2019b. "Shifting Urban Margins: Accessing Unequal Spaces of Ageing and Care in Zanzibar and Muscat." *Anthropological Forum* 29 (1):77-94. doi: https://doi.org/10.1080/00664677.2019.1586644.

Staudacher, Sandra, and Andrea Kaiser-Grolimund. 2016. "WhatsApp in Ethnographic Research: Methodological Reflections on New Edges of the Field." *Basel Papers on Political Transformations* 10:24-40.

Staudacher, Sandra, and Andrea Kaiser-Grolimund. 2020. "Triangles of Care in Transnational Spaces of Aging: Social Engagements between Urban Tanzania, Oman and the United States." In *The Cultural Context of Aging: Worldwide Perspectives*, edited by Jay Sokolovsky, 4th edition, 633-656. Santa Barbara, California: Praeger.

Stoll, Florian. 2016. "Lebensweisen von Mittelschicht-Milieus in Nairobi: Eine Analyse mit Randall Collins' Interaction Ritual Chains." In *Mittelklassen, Mittelschichten oder Milieus in Afrika?*, edited by Antje Daniel, Sebastian Müller, Florian Stoll and Rainer Öhlschläger, 195-216. Baden-Baden: Nomos.

Stoll, Florian. 2018. "The City and Its Ways of Life: Local Influences on Middle-Income Milieus in Nairobi." *International Development Policy | Revue internationale de politique de développement* 10:275-301. doi: https://doi.org/10.4000/poldev.2759.

Strahl, Hilde. 2003. "Cultural Interpretations of an Emerging Health Problem: Blood Pressure in Dar es Salaam, Tanzania." *Anthropology & Medicine* 10 (3):309-324. doi: https://doi.org/10.1080/1364847032000133834

Strahl, Hilde. 2006. *Pressure of Life – Pressure of Blood. Local Illness Experiences Related to Hypertension in a Lower Middle Class Society of Dar es Salaam, Tanzania*. Herbolzheim: Centaurus Verlag.

Teke, John, and Waleed Navarro. 2016. Nonimmigrant Admissions to the United States: 2015. In *Annual Flow Report*. Washington D.C.: DHS Office of Immigration Statistics.

Tiehme, Frank. 2008. *Alter(n) in der alternden Gesellschaft. Eine soziologische Einführung in die Wissenschaft vom Alter(n)*. Wiesbaden: Verlag für Sozialwissenschaften.

Torres, Sandra, and Ute Karl. 2016. "A Migration Lens on Inquiries Into Ageing, Old Age and Elderly Care: Carving a Space While Assessing the State of Affairs." In *Ageing in Contexts of Migration*, edited by Ute Karl and Sandra Torres, 1-12. London/New York: Routledge.

Tronto, Joan C. 1993. *Moral Boundaries. A Political Argument for an Ethic of Care*. London: Routledge.

TzPPA. 2002/2003. Vulnerability and Resilience to Poverty in Tanzania. Causes, Consequences and Policy Implications. Main Report of Tanzania Participatory Poverty Assessment. Dar es Salaam: The Economic and Social Research Foundation.

UN-HABITAT. 2009. Tanzania: Dar es Salaam City Profile. Nairobi: United Nations Human Settlement Programme.

URT. 1999. Public Service Retirement Benefits Act. Dar es Salaam, Tanzania: The United Republic of Tanzania.

URT. 2001. The Community Health Fund Act, 2001. Dar es Salaam, Tanzania: The United Republic of Tanzania.

URT Dar es Salaam City Council. 2004. Dar es Salaam City Profile. Dar es Salaam, Tanzania: Dar es Salaam City Council.

URT Ministry of Finance and Economic Affairs. 2010. National Strategy for Growth and Reduction of Poverty II. Dar es Salaam, Tanzania: Ministry of Finance and Economic Affairs.

URT Ministry of Health. 2003. National Health Policy. Dar es Salaam, Tanzania: Ministry of Health.

URT Ministry of Health and Social Welfare. 2008. Health Sector Strategic Plan III July 2009 - June 2015. Partnership for Delivering the MDGs. Dar es Salaam, Tanzania: Ministry of Health and Social Welfare.

URT Ministry of Labour, Youth Development and Sports. 2003. National Ageing Policy. Dar es Salaam, Tanzania: Ministry of Labour, Youth Development and Sports.

URT National Bureau of Statistics. 2013. 2012 Population and Housing Census. Population Distribution by Age and Sex. Dar es Salaam, Tanzania: National Bureau of Statistics.

URT National Bureau of Statistics. 2016. Basic Demographic and Socio-Economic Profile Dar es Salaam Region. Dar es Salaam: National Bureau of Statistics.

URT Wizara ya Afya na Ustawi wa Jamii. 2007. Sera ya Afya. Dar es Salaam: Ministry of Health and Social Welfare.

Velkoff, Victoria A. , and Paul R. Kowal. 2006. "Aging in Sub-Saharan Africa: The Changing Demography of the Region." In *Aging in Sub-Saharan Africa: Recommendation for Furthering Research*, edited by Barney Cohen and Jane Menken, 53-91. Washington (DC): National Academies Press (US).

Vertovec, Steven. 2007. "Super-Diversity and its Implications." *Ethnic and Racial Studies* 30 (6):1024-1054. doi: https://doi.org/10.1080/01419870701599465.

Vester, Michael, Heiko Geiling, Thomas Hermann, Dagmar Müller, and Peter von Oertzen. 2001. *Soziale Milieus im gesellschaftlichen Strukturwandel. Zwischen Integration und Ausgrenzung*. Frankfurt am Main: Suhrkamp.

Webber, David, Zhenyu Guo, and Stephan Mann. 2013. "Self-Care in Health: We Can Define It, But Should We Also Measure It?" *SelfCare* 4 (5):101-106.

WHO. 1967. *Constitution of the WHO*. Geneva: World Health Organization.

WHO. 1983. Health Education in Self-Sare: Possibilities and Limitations. Report of a Scientific Consultation. Geneva: World Health Organization.

WHO. 1998. The Role of the Pharmacists in Self-Care and Self Medication: Report of the 4th WHO Consultative Group on the Role of the Pharmacist. Geneva: World Health Organization.

WHO. 2002. Active Ageing: A Policy Framework. Geneva: World Health Organization.

WHO. 2004. Health Systems Profile. United Republic of Tanzania. Brazzaville: World Health Organization. Country Office for Africa.

WHO. 2005. Healthy Ageing. Practical Pointers on Keeping Well. Geneva: Word Health Institution.

WHO. 2007. Global Age-Friendly Cities: A Guide. Geneva: World Health Organization.

WHO. 2009. Self-Care in the Context of Primary Health Care. Report of the Regional Consultation Bangkok, Thailand. Geneva: World Health Organization.

Whyte, Susan Reynolds, Erdmute Alber, and P. Wenzel Geissler. 2004. "Lifetimes Intertwined: African Grandparents and Grandchildren." *Africa* 74 (1):1-5. doi: https://doi.org/10.3366/afr.2004.74.1.1.

Yeates, Nicola. 2011. "Going Global: The Transnationalization of Care." *Development and Change* 42 (4):1109-1130. doi: https://doi.org/10.1111/j.1467-7660.2011.01718.x.

Yhdego, Micheal. 1991. "Urban Environmental Degradation in Tanzania." *Environment and Urbanization* 3 (1):147-152. doi: https://doi.org/10.1177/095624789100300114.

Zanini, Giulia, Roberta Raffaetà, Kristine Krause, and Gabriele Alex. 2013. "Transnational Medical Spaces: Opportunities and Restrictions." *MMG Working Paper* 13-16.

WEBSITES

African Languages. 2017. "Online Swahili - English Dictionary." http://africanlanguages.com/swahili/.

Apollo Hospitals Group. 2017. "International Patient Care. Apollo Hospital Group." accessed 13.10.2017. https://www.apollohospitals.com/international-patient-services/.

DICOTA. 2017. "Home. Diaspora Council of Tanzanians in America." accessed 03.11.2017. http://dicotaus.org/.

Facebook Group TCCA. 2017. "Tanzanian Columbus Community Association - TCCA." Facebook.com, accessed 08.10.2017. https://www.facebook.com/tanzaniancolumbuscommunityassociation/.

Gillam, Sarah. 2016. "Zanzibar's New Universal Pension the First of its Kind in East Africa. HelpAge International." accessed 09.03.2017. http://www.helpage.org/newsroom/latest-news/zanzibars-new-universal-pension-the-first-of-its-kind-in-east-africa/

HelpAge International. 2015. "91st United Republic of Tanzania. AgeWatch report card." accessed 04.10.2017. http://www.helpage.org/global-agewatch/population-ageing-data/country-ageing-data/?country=United+Republic+of+Tanzania.

HelpAge International. 2017. "Tanzania. HelpAge International.", accessed 09.03.2017. http://www.helpage.org/where-we-work/africa/tanzania/.

Höpflinger, Francois. 2014. "Langlebigkeit und Hochaltrigkeit. Gesellschaftliche und individuelle Dimensionen." accessed 12.10.2017. http://www.hoepflinger.com/fhtop/ViertesLebensalter.pdf.

International Organization for Migration. 2014. "IOM Participantes in Tanzania's First Ever Diaspora Conference." accessed 03.11.2017. https://tanzania.iom.int/press-releases/iom-participates-tanzanias-first-ever-diaspora-conference.

Masare, Alawi. 2013. "Revealed: Dar's New Emerging 'Gold Mine'." *The Citizen*, 7th November 2013. http://www.thecitizen.co.tz/News/national/Revealed--Dar-s-new-emerging--gold-mine-/-/1840392/2063202/-/12ki4nxz/-/index.html.

New York Tanzanian Community. 2017. "Photo Gallery. New York Tanzanian Community." accessed 08.10.2017. http://www.nytanzaniancommunity.org/home.html.

OANDA. 2017. "Currency Converter." accessed 12.10.2017. https://www.oanda.com/lang/de/currency/converter/.

TAZARA Tanzania-Zambia Railway Authority. 2016. "Our History. Tanzania-Zambia Railway Authority." accessed 15.05.2017. http://tazarasite.com/?page_id=131.

U.S. Department of State. 2017. "U.S. Visas. U.S. Department of State. Bureau of Consular Affairs." accessed 21.08.2017. https://travel.state.gov/content/visas/en.html.

United States Census Bureau. 2017a. "Foreign Born. Population. United States Census Bureau." accessed 03.11.2017. https://www.census.gov/topics/population/foreign-born.html.

United States Census Bureau. 2017b. "Quick Facts. Census 2010. Selected: New York city, New York; Columbus city, Ohio; Washington city, District of Columbia; Boston city, Massachusetts." accessed 08.10.2017. https://www.census.gov/quickfacts/fact/table/newyorkcitynewyork,columbuscityohio,washingtoncitydistrictofcolumbia,bostoncitymassachusetts/POP010210.

United States Department of Homeland Security. 2017. "Yearbook of Immigration Statistics 2013." accessed 03.11.2017. https://www.dhs.gov/immigration-statistics/yearbook/2013.

URT Ministry of Health, Community Development, Gender, Elderly and Children. 2017. "Facilities List. Health Facility Registry (HFR)." accessed 09.03.2017. http://hfrportal.ehealth.go.tz/index.php?r=facilities/facilitiesList.
URT National Health Insurance Fund. 2017. "Health Insurance for Retirees. URT National Health Insurance Fund." accessed 09.03.2017. http://www.nhif.or.tz/index.php/membership/retirees.
URT National Social Security Fund. 2017a. "Old Age Pension. URT National Social Security Fund." accessed 09.03.2017. https://www.nssf.or.tz/benefits/old-age-pension.
URT National Social Security Fund. 2017b. "WESTADI. URT National Social Security Fund." accessed 22.08.2017. https://www.nssf.or.tz/index.php/schemes/westadi.
Watanzania DMV. 2017. "ATC Metro. Washington DC Maryland Virgina." accessed 08.10.2017. http://www.watanzaniadmv.org.
WHO. 2017. "Research Policy. Developing Proposals That Meet ERC Requirements." accessed 23.10.2007. http://www.who.int/rpc/research_ethics/guidelines/en/.
World Bank. 2014. “Tanzania: Economic Overview.” accessed 12 June 2014. http://www.worldbank.org/en/country/tanzania/overview
World Bank. 2022a. "Life Expectancy at Birth, Total (Years) - Sub-Saharan Africa." accessed 24 July 2022. https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=ZG.
World Bank. 2022b. "Life Expectancy at Birth, Total (Years) - Tanzania." accessed 24 July 2022. https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=TZ.

Appendix

Study Participants' Information

Pseudonym	Location	Dates of Interviews (I) and visits (V) with informal conversations, observations, participation in daily activities	Relevant background information
Mzee Bariki	ADE, Dar es Salaam	I: 28.09.2012, 14.03.2013, 04.11.2013 V: 18.03.2013, 21.04.2013, 03.05.2013, 19.05.2013, 27.05.2013, 25.06.2013, 27.07.2013, 28.08.2013, 17.10.2013, 10.11.2013, 23.01.2015, 14.02.2015	born 1928
Children Mzee Bariki	ADE, Dar es Salaam	I: 11.05.2013	
Bibi Helen	ADE, Dar es Salaam	I: 08.10.2012, 19.03.2013, 28.05.2013, 07.11.2013 V: 19.03.2013, 12.05.2013, 11.04.2013, 26.04.2013, 02.09.2013, 21.10.2013, 24.11.2013, 17.01.2015	born 1945
Mzee Baden, Bibi Honorata	ADE, Dar es Salaam	I: 09.05.2013 V: 07.11.2013	Brother and sister of Bibi Helen
Bibi Annette	ADE, Dar es Salaam, northern Tanzania	I: 01.10.2012, 15.03.2013, 11.11.2013 V: 16.-17.4.2013, 14.05.2013, 18.10.2013, 13.02.2015	born 1942

Debora	ADE, Dar es Salaam, NYC, USA	I: 28.04.14 (NYC) V: 16.02.2015 (ADE)	Daughter of Bibi Annette
Mzee Mohamad	ADE, Dar es Salaam	I: 03.10.2012, 16.03.2013, 23.05.2013, 06.11.2013 V: 24.04.2013, 27.07.2013, 31.08.2013, 23.10.2013, 19.11.2013, 23.01.2015, 29.01.2015, 14.02.2015	born 1948
Asya	ADE, Dar es Salaam	I: 07.05.2013	Daughter of Mzee Mohamad
Mzee Mbujuni	ADE, Dar es Salaam	I: 03.10.2012, 25.03.2013, 23.04.2013, 25.10.2013 V: 28.04.2013, 19.05.2013, 30.06.2013, 28.07.2013, 25.08.2013, 20.10.2013, 16.02.2015	born 1949
Thomas	ADE, Dar es Salaam	I: 25.11.2013 (Mail)	Son of Mzee Mbujuni
Bibi Mbunjuni	ADE	I: 11.05.2013 V: 29.01.2015	
Mzee Dunford	ADE, Dar es Salaam	I: 03.10.2012, 13.03.2013, 27.05.2013, 04.11.2013 V: 13.03.2013, 22.03.2013, 18.04.2013, 03.05.2013, 03.06.2013, 25.06.2013, 27.07.2013, 27.08.2013, 27.09.2013, 17.10.2013, 11.11.2013, 23.01.2015, 15.02.2015	born 1942
Christian	ADE, Dar es Salaam	I: 10.11.2013	Son of Mzee Dunford
Dada Martha	ADE, Dar es Salaam	I: 03.05.2013	Household helper of Mzee Dunford

Mzee Buni	ADE, Dar es Salaam	I: 04.10.2012, 15.03.2013, 21.05.2013, 22.11.2013 V: 23.03.2013, 10.04.2013, 26.06.2013, 28.07.2013, 02.09.2013, 26.09.2013, 21.10.2013, 07.11.2013, 24.01.2015, 15.02.2015	born 1950
Bibi Buni	ADE, Dar es Salaam	I: 12.05.2013	
Bibi Veronica	ADE, Dar es Salaam	I: 08.10.2012, 15.03.2013, 20.05.2013, 27.11.2103 V: 21.03.2013, 19.04.2013, 20.05.2013, 22.06.2013, 02.09.2013, 18.10.2013, 12.11.2013, 17.01.2015, 15.02.2015	born 1949
Eric and Robert	ADE, Dar es Salaam	I: 30.04.2013 V: 22.03.2013, 03.11.2013, 09.11.2013, 23.11.2013, 24.11.2013	Sons of Bibi Veronica
Mzee Tenga	ADE, Dar es Salaam	I: 12.10.2012, 15.03.2013, 22.04.2013, 04.11.2013 V: 22.03.2013, 22.04.2013, 21.05.2013, 25.06.2013, 27.07.2013, 27.08.2013, 27.09.2013, 17.10.2013, 23.01.2015, 15.02.2015	born 1951
Mzee Duni	Mlimani, Dar es Salaam	I: 08.05.2013	Friend of Mzee Tenga
Bibi Lucy	ADE, Dar es Salaam	I: 23.11.2013	Sister of Mzee Tenga

Bibi Rose	ADE, Dar es Salaam	I: 15.10.2012, 10.04.2013, 23.05.2013, 06.11.2013 V: 01.05.2013, 06.09.2013, 18.10.2013, 06.11.2013, 10.11.2013, 26.01.2015	born 1950
Charles	ADE, Dar es Salaam	V: 06.11.2013, 22.11.2013, 30.01.2015	Son of Bibi Rose
Bibi Hilda	ADE, Dar es Salaam	I: 16.10.2012, 15.03.2013, 28.05.2013, 00.11.2013 V: 20.03.2013, 19.04.2013, 10.05.2013, 02.09.2013, 05.11.2013, 19.11.2013, 16.01.2015, 24.01.2015, 16.02.2015	born 1947
Mary	ADE, Dar es Salaam	I: 11.05.2013	Daughter of Bibi Hilda
Bibi Cyntia	ADE, Dar es Salaam	I: 17.10.2012	born 1950
Mzee Mtoro	ADE, Dar es Salaam	I: 28.09.2012	born 1945
Mzee Daudi	ILM, Dar es Salaam	I: 20.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1952
Mzee Hussein	ILM, Dar es Salaam	I: 20.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1928

Mzee Doto	ILM, Dar es Salaam	I: 20.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1947
Bibi Elizabeth	ILM, Dar es Salaam	I: 25.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1930
Bibi Furaha	ILM, Dar es Salaam	I: 25.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1944
Bibi Zaina	ILM, Dar es Salaam	I: 25.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1939
Mzee Juma, daughter Mariamu	ILM, Dar es Salaam	I: 26.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1924 (Mzee)
Bibi Mariam	ILM, Dar es Salaam	I: 27.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1932 (approx.)
Bibi Nuru	ILM, Dar es Salaam	I: 27.09.2012 V: March, May and Nov. 2013	born 1947
Mzee Rajani	ILM, Dar es Salaam	I: 05.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1937
Bibi Lea	ILM, Dar es Salaam	I: 08.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1949

Mzee Hafith	ILM, Dar es Salaam	I: 07.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1936
Bibi Bahati	KICH, Dar es Salaam	I: 09.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1947
Bibi Khadija	KICH, Dar es Salaam	I: 09.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1950
Bibi Yasmin	KICH, Dar es Salaam	I: 09.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1927
Bibi Sharifa	KICH, Dar es Salaam	I: 09.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1942 (approx.)
Mzee Simon	KICH, Dar es Salaam	I: 10.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1951
Mzee Omari	KICH, Dar es Salaam	I: 10.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1922
Mzee Nassor	KICH, Dar es Salaam	I: 10.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1935

Bibi Zulfa	KICH, Dar es Salaam	I: 11.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1945
Bibi Saba	KICH, Dar es Salaam	I: 11.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1917
Bibi Salum	KICH, Dar es Salaam	I: 11.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1912
Mzee Mahir	KICH, Dar es Salaam	I: 12.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1947
Mzee Hassan	KICH, Dar es Salaam	I: 17.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1947
Mzee Rasul	KICH, Dar es Salaam	I: 17.10.2012 V: March, May and Nov. 2013, Jan. 2015	born 1952 (approx.)
Mzee Khalid	MNM, Dar es Salaam	I: 07.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1922
Mzee Abdhalla	MNM, Dar es Salaam	I: 07.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1939
Bibi Ruth	MNM, Dar es Salaam	I: 07.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1936 (approx.)

Bibi Selma	MNM, Dar es Salaam	I: 07.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1932
Mzee Baraka	MNM, Dar es Salaam	I: 13.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1938
Mzee Nelson	MNM, Dar es Salaam	I: 13.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1940
Mzee Chumbuni	MNM, Dar es Salaam	I: 13.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1945
Bibi Asha	MNM, Dar es Salaam	I: 18.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1935
Bibi Amina	MNM, Dar es Salaam	I: 18.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1945
Bibi Maimuna	MNM, Dar es Salaam	I: 18.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1948
Mzee Alpha	MNM, Dar es Salaam	I: 19.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1948

Mzee Amani	MNM, Dar es Salaam	I: 19.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1947
Bibi Shani	MNM, Dar es Salaam	I: 24.09.2012 V: March, May and Nov. 2013, Jan. 2015	born 1952
Mzee and Bibi Ngowi	ADE, Dar es Salaam	I: 03.10.2012 V: Daily visits and talks between June-Okt. 2012, Feb.-May, Okt.-Dez. 2013, Jan.-Feb. 2015	My hosts in Dar es Salaam, born 1936 (mzee)
Mtaa leader Ada Estate	ADE, Dar es Salaam	V: 26.11.2013	
Mtaa leader Mafuriko	ILM, Dar es Salaam	V: 12.03.2013	
Mtaa leader Mnazi Mmoja	MNM, Dar es Salaam	V: 26.03.2013	
Mama Zamira	MNM, Dar es Salaam	V: Several conversations in 2012, 2013 and 2015	At that time TCU Leader
Acting assistant commissioner for Social Welfare in the Ministry of Health and Social Welfare	Dar es Salaam	V: 13.02.2015	Telephone conversation
Angela and Emanuel	USA	I:02.04.0214	
Saleh	USA	I: 06.04.2014 V: several visits and conversation from April-May 2014, Dec. 2014	Facilitated contacts to other Tanzanians in the USA

Rashid	USA	I: 06.04.2014	
Godfrey	USA	I: 06.04.2014	
Saad	USA	I: 07.04.2014	
Khamis	USA	I: 09.04.2014	
Bibi Angel	USA	I: 12.04.0215	
Bibi Zarota	USA	I: 12.04.2015	
Uthman	USA	I: 12.04.2015	
Faisal	USA	I: 13.04.2015	
Ali	USA	I: 13.04.2015	
Zachary	USA	I: 14.04.2015	
Yacinta	USA	I: 14.04.2015 V: several conversations between April-May 2014, Dec. 2014	My host, together with Joy
Joy	USA	V: several conversations between April-May 2014, Dec. 2014	My host, together with Yacinta
Salma	USA	I: 15.04.2015 V: several conversations between April-May 2014	Leader of a women's group

Anna	USA	V: several conversations between April-May 2014	My host, wife of Eric, who is the son of Bibi Veronica
Mzee Mwinkwera	USA	I: 20.04.0214	Father of my host Anna
Bibi Margaret	USA	I: 21.04.2014	
Samuel	USA	I: 21.04.2014	Husband of Maria
Bibi Mercy	USA	I: 20.04.2014	Nanny of Maria and Samuel's children
Maria	USA	I: 21.04.2014 V: several conversations between April-May 2014, Dec. 2014	Wife of Samuel, daughter of Bibi Veronica
Monica	USA	I: 21.04.2014 V: several conversations between April-May 2014	Wife of Maria's brother
Susan	USA	I: 21.04.2014 V: several conversations between April-May 2014	Friend of Maria
Bibi Miriam	Dar es Salaam	V: 28.01.2015	Mother of Susan
Abasi	USA	I: 24.04.2014	Friend of Saleh
Peter	USA	I: 24.04.2014	Friend of Abasi
Zuleikha	USA	I: 24.04.2014	Friend of Abasi
Said	USA	V: several conversations between April-May 2014	

John	USA	I: 08.05.2014	
Neema	USA	I: 24.05.2014	

LIST OF SWAHILI WORDS

Ada Estate	sub-ward of Dar es Salaam. Ada Estate is an administrative residential *mtaa* in the district of Kinondoni, situated in the northern part of the city of Dar es Salaam.
Africafe	is a widely used instant coffee in Tanzania that can be mixed with hot water
Azimio Kichangani	sub-ward of Dar es Salaam
baadhi ya wakati	(having strength) sometimes—or wakati mwingine sina
babu	grandfather
bajaj	a mototaxi with three wheels used to transport passengers. The name seems to derive from the Indian company that produces such trycicles.
balozi	a Swahili word for ambassador, it can also be a name for a person
banda	describes a shed or hut where people usually sell food on the street, it can also be used to describe a construction used for living
baraza	describes a patio or veranda in front of a house where people sit and talk to neighbors
bibi	grandmother
bima	can be translated as insurance
BP	The abbreviation *BP* was used when talking in Swahili as well as in English and derives from the English expression "blood pressure." It does not specify if high or low blood pressure is meant, however in most cases it was used to circumscribe a chronic condition of hypertension.
bodaboda	is a colloquial word for motorbike taxi, reflecting its speed in crossing roads and in traffic. The word is derived from the English word border.
Bongoland	*Ubongo* in Swahili means brain; you need to have brains to survive in Bongoland
Butiame	village of origin of the first president of Tanzania, Julius Nyerere
Chagga	The Chagga ethnic group only began to develop a common identity during the colonial times, before it was a rather loose grouping of people to the south and southeast of Kilimanjaro in Northern Tanzania.
chai	The Swahili word chai means tea in English. The tea is usually black tea produced in western Tanzania. Many people take it with a lot of sugar, those with more financial means afford milk powder.
Chakula ni Uhai	Food is Life
chapati	are locally made flatbreads eaten for breakfast but also with other dishes
dada	Directly translated; the Swahili word *dada* means "sister" in English. In my research context, the word is used for a female household helper who usually lives with a family and performs different activities around the house.
dagaa	is also known as Lake Victoria sardine and eaten in dried form

dalili za mtu kuwa mzee	signs of old age, literally translated as signs of a person who has grown old
daladala	daladala buses were legalized in 1983. The name daladala derives from the bus fare which amounted, in the 1980s, to five Tanzanian shillings and the five-shilling coin resembles the American dollar.
Dar es Salaam	was founded by Sultan Majid in the 1860s; the name derives from Arabic *Bandar as-salâm* (harbor of peace) and served as a place of refuge for the Sultan of Zanzibar
familia	family
fundi	craftsmen
genge	a food stall or shop where apart from food, and mainly vegetables, also detergent or soap is sold
hali	can be translated as (health) condition. It is used in colloquial speech to ask somebody how he or she is (for example*, vipi hali?*).
Ilala Mafuriko	sub-ward of Dar es Salaam, rebuilt by the National Housing Corporation
jamaa	relatives
jamani	interjection that can be translated as hi there but is also used to express astonishment
kata	can be translated as ward
Kariakoo	market area in the city center
Kawe	ward in the Kinondoni district of Dar es Salaam
khanga	is a traditional cloth that women wear as skirts, headscarves or use to carry children. Khangas are usually colorful and contain a saying in Swahili. They can be used to transfer messages; for example, when attending a funeral particular funeral khangas are worn.
Kichangani	sub-ward of Dar es Salaam
Kinondoni Makaburini	well-known graveyard, official boundary of the neighborhood Ada Estate
Kinondoni Shamba	in the vernacular, it is an informal settlement adjoining the Ada Estate (the administrative name of the settlement is Hanna Nassif)
kipindi cha fimbo	time of the stick, by which Nyerere's presidency is known; meaning a strong state
kitungu saumu	garlic
kuangalia	literally means to watch, check, look, and observe. The term kuangalia is often used to circumscribe the task of looking after children.
kuangalia watoto	looking after children
kuangalia wajukuu	looking after grandchildren
kuhudumia	means to assist, help, serve, and, rather pointedly, to care in the form of services provided in a hospital context or with regard to care activities of a (hired) household helper

kujali	verb pointing to the quality of care that people receive; kujali was not much used in my research context
kujitunza	reflexive form of *kutunza* to describe what somebody does for his or her own health
kuku	means chicken in English; it refers to both the animal and its cooked form
kula kizuri / vizuri	to eat well
kusaidia	is one of the broadest terms describing care, used not only for relatives but also for neighbors or household helpers who help the older person with something. It is literally translated with to help, assist, protect, and support, sometimes, rather pointedly, to the economic aspects of care.
kusindikiza	can be translated as to accompany someone
kutunza	means to care for, to provide for, to protect, to maintain. In this research project, kutunza was more used when generally speaking about who should care for older people in Tanzania, including the state. The term is also used in policy documents, such as the aging policy of Tanzania.
kuzeeka vizuri	The expression *kuzeeka vizuri* is a main focus of this PhD thesis, as it describes a good way of growing old. It can be directly translated as aging well.
kwa mfano	means for example
Leaders club	former government officers club in Ada Estate
leo	or *ya kisasa* points to something that is current, from today, the present time (leo) or new, modern, up-to-date (ya kisasa).
leo sina nguvu	being without strength today, when referring to those older people who try to ease their frailty and expect to improve their health
mababu	grandfathers (see also *babu)*
mabanda	In singular, *banda* can be translated as a shed or barn where people sell food.
mabibi	grandmothers (see also *bibi*)
mafuriko	in Swahili means flood, especially during the long rainy season from March to May and the short rainy season from November to December
makaburi	Swahili word *makaburi* means graveyard in English
mambo	is used to greet and can be literally translated as "what are the news"
mandazi	can be described as small fried bread rolls that are usually eaten for breakfast together with black tea
Manzese	ward of Kinondoni district in Dar es Salaam
Masaki	sub-ward area in the north of Dar es Salaam where mostly high government officers and NGO employees reside
mawinyi	also mamwinyi, traditional landowners
mazoezi	can be translated as physical exercise but also as customs or habits. In this PhD thesis, the word is mainly used in the sense of exercise.
Mbagala	sub-ward of Temeke district in Dar es Salaam

mboga za majani	The side dish can be translated as leafy vegetables.
Mchagga	somebody who belongs to the group of the *Wachagga* is called *Mchagga*
mgambo	can be translated as public proclamation and is also used to refer to a civilian militia involved in community policing
mgeni	guest
mitaa	sub-wards
mjini	which is composed of two elements; *mji* for city and *-ni* for place (suffix *–ni* is used to turn a noun into an adverb)
Mji Mzima	which means "complete town", or "whole town"
mlinzi	is a watchman
Mnazi Mmoja	sub-ward of Manzese in the Kinondoni district of Dar es Salaam
Moshi	village in Northern Tanzania
m-pesa	The *m* stands for mobile, *pesa* is the Swahili word for money. M-pesa is a money transfer system based on mobile phones; it also provides financing and microfinancing services. M-pesa was launched by Vodafone in 2007 for Vodacom and Safaricom, which are the largest mobile phone network providers and operators in Tanzania and Kenya.
mtaa	can be translated as quarter or neighborhood. It depicts an official level of division. A ward is divided into several *mitaa* (plural of mtaa), in this PhD thesis I therefore translate mtaa as sub-ward.
mtu	person
Mtu ni Afya	Man is Health
mtu mzima	old person (see also *mzee*), can also be an adult or grown-up, mature person
Muhimbili	the National Referral Hospital
Mwananyamala Hospital	the district hospital in Kinondoni
mzee	term for a respected elderly man, and depending on the context, it can also be used to refer to an older woman
mzima	refers to being adult but also being complete, whole or healthy
Namanga Hospital	private hospital
Ndengereko	ethnic group
Ngoma	can be translated as dance but also drum
nguvu	can be translated as strength, power, and also energy
Nguvu Kazi	can be translated as hard work, productive force
nina nguvu	older people who refer to themselves as having strength
nipo tu	meaning that "I am just here" and thus, God decides what he does with me

pilau	cooked rice dish with meat and spices of Indian origin
roho mbaya	in English a bad heart or soul. In the research context, older people would call a caregiver who does not provide the expected care as somebody with a bad heart or soul.
Rufiji	district in Pwani Region of Tanzania, town with the same name, *warufiji* as the ethnic group
sina nguvu	refers to no longer having sufficient strength to cope with daily activities
sio pesa tu	it is not only about financial support
shamba	field or farm. The older study participants referred to shamba, when they talked about a field or garden where they cultivated food crops.
shikamoo	the address of welcome when greeting an older person. The respectful greeting is a particular greeting to somebody who is older (or of higher rank) than the person who offers the address.
Shomvi	described in the literature as Swahili or "Shirazi" people, originating from the coastal town of Barawa in today's Somalia
shughuli	can be translated as activity or business
Temeke	the district of Temeke in the south of Dar es Salaam was considered to be an African residential settlement
ubaguzi wa umri	discrimination of the aged
ubongo	brain
ubuyu	are sweets made from the baobab fruit
ugali	is Tanzania's main dish. The mash is usually made of corn flour, depending on the quality of flour, the prize can vary. The preparation of ugali is tiring as it takes some time to stir the gooey mash for it to reach the right consistency.
Uhindini	place of Indians
uhuru	can be translated as freedom but also as independence. The word is used in several instances in connection with Tanzania's independence from colonial rule. Independence Day is locally called "uhuru day" and the "uhuru torch" is one of the national symbols of Tanzania.
uhuru newspaper	the newspaper of the ruling party
Uhuru ni Kazi	Freedom is Work
Ujamaa	African version of socialism; *Ujamaa na Kujitegemea* can be described as a particular form of socialism in Tanzania, the Swahili word Ujamaa can be translated as "familyhood"
uji	can be translated as porridge
ukapa	presidency of Mkapa is known as ukapa, pointing to the "belt-tightening" rhetoric
unaendeleaje	can be translated as "how are you"

Upanga	ward in Ilala district, contains another former civil servants' area
Uswahilini	place of Swahili people historically used term for the zone of the city inhabited by local "Swahili" people; today it serves as a marker for deprived areas
Uwanja wa Fisi	In English, *uwanja wa fisi* can be described as "field of hyenas."
uzee	means old age
uzima	refers to being well or healthy
Uzunguni	place of Europeans
Wachagga	ethnic group of the Chagga, from the Northern Kilimanjaro region (see Chagga)
wakati mwingine sina (nguvu)	having (strength) sometimes—or baadhi ya wakati sina
wakubwa	the big ones, those with financial means and power, but also those who belong to the new middle class
watoto wa siku hizi	youth or children of today
watu wa bara	people from the mainland
watu wa pwani	people of the coast
Wazaramo	ethnic group, coastal people but not considered Swahili people despite being closely related in terms of language
wazee	plural for older people, deriving from the word *uzee,* which means old age
wazee ambao wanajiweza	is an expression applied meaning "older people who are themselves able, well off." In Swahili the reflexive "*-ji-*" can be added to a verb, as is the case with *wanajiweza*. Wanaweza means "they are able to" and with the reflexive prefix a direct translation leads to "they are themselves able to." Colloquially, the verb form is used to describe people who are well off financially. In the case of the members of the former civil servants' milieu in Ada Estate, both, the direct translation and the colloquial meaning apply.
wazee abao wasiojiweza	an expression applied meaning "older people who are themselves not able, less well off"
wote wazima	daily welcome addresses, the question is also used to ask if everyone in the family is well
ya kisasa	or *leo* points to something that is current, from today, the present time (leo) or new, modern, up-to-date (ya kisasa)
zamani	means in the past, earlier. Older participants of this study normally used the word to describe something that happened a long time ago (i.e. when they were young).
Zaramo	ethnic group, coastal people but not considered Swahili people despite being closely related in terms of language (see *Wazaramo*)
zawadi	a small present or gift, it is also a common name in Tanzania