

# Transfigurations of aging

Everyday self-care in a civil servant milieu of Dar es Salaam,  
Tanzania

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## Abstract

To date, most social anthropological studies on aging in African contexts focus on care for poor older people provided by related others. The focus of this article is different as it focuses on older people with better financial means than the average: civil servants belonging to Dar es Salaam's middle class. Furthermore, this contribution shifts the focus from care provided through related others to practices of everyday self-care, the care that these older people provide for themselves with the help of relatives in Tanzania and the USA. In order to stay healthy and cope with diagnosed chronic conditions, older participants in this study engage in physical exercises, eat 'good food', and go for regular medical check-ups. This article argues that these health-promoting self-care practices of older urban dwellers reflect changing experiences of aging, health, and care, and point to transfigurations of the social imaginary of aging in Dar es Salaam's middle class.

## Keywords

aging, middle class, self-care, chronic illness, Tanzania

## Introduction

Most anthropological research on older people and care on the African continent focuses on the care that is provided for an older person by related others. Especially within the family, ideas about reciprocal duties of children play a major role when it comes to care for an older

person. On a normative level, the ‘intergenerational contract’ can be described 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 Van der Geest 2008, 7). At the same time, however, due to the fact that health in old age has its ups and downs, care has to be adapted on a daily basis and is thus provided ‘with considerable improvisation’ (Van der Geest 2002, 24).

In Tanzania, as elsewhere, being cared for as an older person is closely linked with the person’s health condition, as especially frail and ill older people need care provided by related others. In addition, especially during ill health, a family’s access to health infrastructure may be crucial. In Dar es Salaam, adult children as well as distant relatives engage in different forms of care, such as accompanying an older person to a health facility, washing an older person’s clothes, or helping the person take a daily bath. But what about those older people who are still capable of doing these activities on their own? In this contribution, I would like to shift the focus from relational care to what I call everyday self-care. Research in a former civil servant milieu<sup>1</sup> of Dar es Salaam showed that these comparatively wealthy older people engaged intensely in self-care practices. Mainly, but not exclusively, older study participants with a diagnosed chronic condition did physical exercises, ate ‘good food’, and went for regular medical check-ups in order to stay healthy or to cope with illness or frailty. Their self-care activities not only included practices directly targeted at physical health but also those that contribute to wellbeing in a broader sense.

I will argue that transfigurations of the social imaginary of aging become observable in some of the articulated self-care practices, thus reflecting a broad range of diverse experiences of aging, health, and care in Dar es Salaam’s heterogeneous aging population. Furthermore, these practices may also reveal changing social configurations, as new concepts of aging impact on shifting responsibilities within care arrangements. As I hope to show, these self-care practices aiming to promote health therefore suggest changing infrastructural and interactional framings on a macro-level that are closely linked to ongoing urbanization processes and demographic transitions in Tanzania which have led to a new generation of people staying in the city to age. At the same time, older people’s health-promoting activities are shaped not only by public health messages with regard to their chronic conditions, but also by a positive aging discourse that promotes a particular idea of ‘successful’ aging (e.g., Rowe and Kahn 1997).

1 I use a phenomenological approach to milieu which is inspired by Richard Grathoff (1989) and comes close to the approach of Sinus Sociovision (2017), which looks at the milieu members’ socioeconomic position but in addition emphasizes the ‘subjective’ sociocultural aspects of a milieu that is located within a particular socioeconomic position (see Kaiser-Grolimund 2017).

## Aging in Dar es Salaam's middle class

In Tanzania, the number of people above the age of sixty has increased in recent decades. Although the percentage of the Tanzanian population above the age of sixty remained at around 6 percent from 1988 to 2012 (URT 2013, 49), the actual number of older people increased rapidly due to massive population growth. Average life expectancy is also rising, having increased from forty-nine-and-a-half in 1997, to fifty-six in 2007, to sixty-four in 2017 (World Bank 2019). In response, Tanzania was the second country on the African continent to adopt an Aging Policy in 2003 in order to 'put ageing issues into the development agenda of the nation' (URT 2003, iii). This initiative shows that Tanzania has recognized the demographic transition the country is currently facing. Furthermore, attempts to meet the increasing burden of non-communicable diseases, estimated to cause nearly 60 percent of deaths among people over sixty in some districts of Tanzania (HelpAge International 2013), are slowly becoming visible in Tanzania's health system.

The focus of this article is on urban older people living in Dar es Salaam, Tanzania's economic hub. The city is described as the ninth fastest growing city in the world, and is projected to become a megacity by 2030, reaching more than 10 million inhabitants (UN Department of Economic and Social Affairs 2016, 4). Dar es Salaam is home to more than 6 million people; that is, 10 percent of the total population of mainland Tanzania (World Population Review 2019). Based on the most recent census data, only 3.5 percent of the city's population is aged sixty years and above, but the number of older inhabitants is expected to rise dramatically over the coming years (URT 2013, 47). Whereas older people were asked to leave the city when no longer 'productive' during the country's socialist period, today many older people decide to remain in the urban space. Having mostly arrived in the city in the 1960s and 1970s when they were in their twenties or thirties, the participants of this study have already spent a considerable amount of their lives in Dar es Salaam, with many of them now owning houses in today's preferred localities. Although many older civil servants remained very mobile, regularly moving back and forth between their second home in the village and their city house, they nonetheless emphasized that the improved access to quality health care, and the availability of their own children or other close relatives living and working in the city, kept them in Dar es Salaam. However, many of them imagined they would be transferred back to their place of origin after death, just as the first president, Julius Nyerere, had been (Gerold 2013, 165).

This contribution mainly focuses on a privileged group of former civil servants in Dar es Salaam and their family members across Tanzania and abroad, who have at their disposal in the city a vast range of information and services. In socioeconomic terms, these retired members of different categories of civil service can be situated in Dar es Salaam's middle class. Although I am aware of the deficiencies of the term, I use 'middle class' here in the sense of the German *Mittelschicht*, to define the economic position within society without assuming a

socioculturally homogenous group (Stoll 2016, 195). Being part of the Tanzanian middle class, these former civil servants belong to a minority of older people who usually benefit from amenities such as pensions and health insurance.

## Methods

The study that informs this account draws on fifteen months of multi-sited ethnographic research conducted between 2012 and 2015. It explores how people aged sixty years and above experience aging and health, and how this is expressed, for instance, in living and care arrangements created in a changing urban setting in Tanzania and with transnational links to the USA. The author's PhD study was conducted as part of a comparative research project called 'Aging, Agency and Health in Urbanizing Tanzania' (<http://socialresilience.ch/old-age-agency/>), funded by the Swiss National Science Foundation (Nr. 140425 and Nr. 152694) and carried out in collaboration with the University of Dar es Salaam and the State University of Zanzibar in Tanzania.<sup>2</sup>

In Tanzania, I initially conducted fifty in-depth interviews with women and men aged sixty years and above who were randomly selected using transect walks in four different and heterogeneous *mitaa* (sub-wards) of the city of Dar es Salaam. In a second step, with the help of my research team,<sup>3</sup> I accompanied a group of eleven older people (five women and six men), together with their spouses and family members, in a former civil servants' area of Dar es Salaam over a period of almost four years. I applied a range of complementary methods such as observation, participation in daily activities, as well as informal conversations and life story interviews. I also shared the compound with an elderly couple throughout the data collection period. Almost all of the retired civil servants were not born in Dar es Salaam and most of them originated from upcountry. They were rather young (between sixty and seventy

- 2 The project is headed by Professor Dr. Brigit Obrist, and supervised by Prof. Dr. Brigit Obrist, PD Dr. Peter van Eeuwijk (University of Basel) and Dr. Joyce Nyoni (University of Dar es Salaam). Dr. Sandra Staudacher, my co-researcher, conducted a similar study in the city of Zanzibar with transnational care relations to Oman (Staudacher 2019). The National Institute for Medical Research (NIMR/HQ/R.8a/Vol.IX/1376 and NIMR/HQ/R.8a/Vol.II/266) in Tanzania and the Tanzania Commission for Science and Technology (COSTECH No. 2012-386-NA-2012-125 and No. 2013-305-NA-2013-81) supported the conduct of qualitative research in Tanzania, while Professor Sarah Lamb of Brandeis University supervised the research in the USA.
- 3 Elisha Mwamkinga Sibale served as expert, research assistant, translator, and organizer of this research project, while Monica Mandao and Frank Sanga supported me when visiting older people, and also spent time with them when I was not in Tanzania. Neema Duma, Emmanuel, Lucy Kira, Deogratias Rwechungura, Judith Valerian, and William supported this project at different stages.

years old) and in a relatively good health condition, although many of them either suffered from diabetes or hypertension or a combination of both. Many of the older study participants' children had studied abroad, although some of them had already returned to Tanzania before the time of this study.

In a third research phase, I followed children of older Tanzanian people to the USA in order to explore caregiving from a distance. Applying a snowball strategy, I conducted twenty-seven in-depth interviews with Tanzanians (twelve women and fifteen men), from twenty-five to sixty-five years of age, who had parents in the civil servant area, either in Dar es Salaam or in other parts of Tanzania. The research was conducted in four Tanzanian communities in US cities and suburbs in Massachusetts, New York, Maryland/D.C., and Ohio over a period of two months, and the interviews were complemented with informal conversations and participation in the daily lives of two host-families.

All participants consented, either in oral or written form, to participate in the research. The interviews were audio recorded and transcribed, and data were analyzed with the qualitative data analysis software MaxQDA. Data were coded and analyzed adapting Kathy Charmaz's (2006) constructivist grounded theory approach, whereby my analysis was grounded in the data.

## Aging transfigurations in relational contexts

This article follows Nicholas Long and Henrietta Moore's (2012, 41) recently developed conceptualization of human sociality as a 'dynamic relational matrix within which human subjects are constantly interacting in ways that are co-productive, continually plastic and malleable, and through which they come to know the world they live in and find their purpose and meaning within it'. Their approach draws attention to the 'open-ended invocation of process' (Amit 2015, 3) and emphasizes the importance of the 'broader relational contexts within which people are embedded' (Long and Moore 2013, 7). Sociality can thus be described as a 'fundamental condition of human being' (Toren 2013, 48) that may be articulated in images of aging and linked (self-)care practices.

Furthermore, the contribution explores the concept of transfiguration within these relational contexts. The term 'transfiguration' has not yet been fully developed in the field of medical

anthropology (see Mattes, Hadolt, and Obrist, this issue). Sociologist Norbert Elias ([1976] 1993, lxvii; my translation) describes figuration as a ‘web of interdependent human beings’.<sup>4</sup>

Within a figuration, people are mutually oriented towards, and depend on, each other. A care arrangement for an older person can be understood as such a web of interdependent players; a web that is constantly changing as the involved people react to each other’s actions and changing (health) conditions. Such a web of actors may be situated within a dynamic interactional matrix, as defined above by Long and Moore. Changes in the social matrix – for example, new health care infrastructures (such as the Tanzania National NCD Response Programme) that widen the scope of possible treatment options for those older people who are able to access them – consequently impact on some of the figurations in which these older people find themselves. Looking at people’s aging experiences in different urban milieus at one point in time may reveal dynamics in their relational contexts that lead to processes of transfiguration, thus emphasizing processes of unexpected changes within such figurations (see also Schnepf 2017). This article focuses on relational care and self-care practices of former civil servants in Dar es Salaam in order to explore such transfigurations of aging. The concept of transfiguration can serve hereby as a useful lens to work out the ‘unusual’ or ‘unexpected’ aspects contained within figurations of aging and care – without losing sight of the broader picture (the social matrix) influencing these figurations.

## Changing urban landscapes and new options for care in old age

This section not only points to the infrastructural conditions that have changed in recent years, but also refers to the particularities of the services that have been put in place for the more privileged urban milieus of Dar es Salaam. These changes are closely connected with amendments to the legal framework as well as political developments in the country, while aging discourses from other parts of the world are introduced through transnational practices adopted by families and institutions.

In Dar es Salaam, a new group of older urban dwellers has emerged over recent years, due not least to increased life expectancy and the recent practice of remaining in the city past retirement. Under the politics of the first president of the United Republic of Tanzania (1964–1985), Julius Nyerere, people were supposed to leave when they stopped working. Only

4 ‘Das Geflecht der Angewiesenheiten von Menschen aufeinander, ihre Interdependenzen, sind das, was sie aneinander bindet. Sie sind das Kernstück dessen, was hier als Figuration bezeichnet wird, als Figuration aufeinander ausgerichteter, voneinander abhängiger Menschen’ (Elias [1976] 1993, lxvii).

‘productive’ citizens were allowed to live in the city.<sup>5</sup> Although this policy has changed, it remains fixed in many older citizens’ minds to this day. The generation of older people that forms the subject of this study can be described as the first generation of people who were born in the countryside but are aging in the city.<sup>6</sup> Many study participants perceived a difference between their own urban experiences of old age and their parents’ aging process, which they had witnessed in the village. They therefore often equated aging in former times (*zamani*) with the rural context, and aging today (*leo*) with the urban context. Furthermore, these ‘new old urbanites’ (see also Kaiser-Grolimund 2017) witnessed changes to the availability of services in the city after the country gained independence.

Since the 1960s, Tanzania has been described as a role model for providing equitable access to health services through free health care (Newell 1975). As the quote of Mzee Mohamad,<sup>7</sup> a former civil servant, reveals: ‘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’. The right to health care (see also Ellison 2014) that Mzee Mohamad is addressing in this quote gave way to user charges introduced in the early 1990s, when foreign aid was stopped and the government was under pressure to implement reforms (Obrist 2006, 87–88). These changing infrastructures form part of the dynamic matrix in which older people are embedded.

In this article, I focus mainly on those older people who tend to regard living in the metropolitan area of Dar es Salaam as an advantage, especially in view of the access to quality health care. Their compulsory retirement at the age of sixty made many of them experience ‘legal age’, with an artificially set benchmark defining when a person is ‘old’. For formally employed older people, turning sixty has meant the end of a particular stage in life and the start of a new phase as a retired older person. Thus, many state-employed older city dwellers were forced to prepare for retirement at some point in time, while others got around it by taking up some other form of income-earning activity after retirement. In contrast, older people who were not formally employed usually worked until their body became too weak to continue.

5 Nyerere’s new society was founded on the basis of Ujamaa, an African version of socialism, which stipulated basic social rights 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).

6 I use ‘generation’ here as a descriptive concept rather than as an analytical tool.

7 The Swahili word ‘*mzee*’ is the term for a respected elderly man.

Some civil servants retired early because the state-owned companies they worked for were restructured in the context of the civil service reforms in the 1980s and especially in the 1990s. At that time, Tanzania's civil service was known to be overstaffed and underpaid (Temu and Due 2000, 703–704). Others quit their jobs because of ill health or family issues, while some of them were not entitled to a monthly pension after retirement for various reasons. Although the monthly payment is not enough to sustain their habitual living standard, it is a welcome supplement to other, often meagre sources of income (e.g., small earnings from economic activities, rental incomes, support money from children). During their formal employment as civil servants, the retirees were entitled to health insurance which covered their expenses at public hospitals. Paradoxically, however, once retired, they were no longer covered by the National Health Insurance Fund.<sup>8</sup> According to some of the older study participants, this changed in 2009. From that year on, coverage continued also after retirement. Consequently, people who retired after 2009 are now covered by health insurance, while those who retired before are not. After retirement, people were only covered by the insurance fund if they had a child or some other family member working as a public servant who was able to include them on their own insurance card as long as they were state-employed. Among many older people considered in this study, this was common practice.

Although people over sixty have been entitled to free treatment in Tanzania's health facilities since 1999 (Mubyazi 2004, 2), having valid health insurance is a real asset, especially for older people with chronic conditions. It covers the costs of medication and may thus contribute to the regular intake of drugs, as the cost of medication has proved to be a major barrier in this regard (for diabetes in Southeastern Tanzania, see Metta et al. 2015, 7). For instance, as a diabetes and hypertension patient and insurance card holder, Bibi Hilda<sup>9</sup> can go to a particular pharmacy next to the district hospital and get her medication for free (that is, if they run out of the drugs at the hospital, which is frequently the case). In addition, she does not have to pay for the clinical assessment (weight, blood pressure, and blood glucose level) which is already heavily subsidized and, without health insurance, would cost TZS 1,000 (approximately US \$0.50) a month (see also Kolling, Winkley, and von Deden 2010).

8 The National Health Insurance Fund typically covers public servants and their dependents. It is a compulsory health insurance scheme that was established by the Act of Parliament No.8 of 1999. It is the largest social health insurance scheme in Tanzania (URT 2004) and covers more services than the Community Health Fund aimed at the rural population (Ellison 2014, 170). According to information on the website of the National Health Insurance Fund, coverage continues after retirement, but only after a certain amount of contribution years.

9 The Swahili word '*bibi*' is a term for grandmother.



For older people with chronic illnesses, like Bibi Hilda, new services have emerged in recent years. The Tanzania National NCD Response Programme, for example, has improved access to treatment for many diabetes patients within the country. Although the Tanzanian Diabetes Association (TDA) was established in 1985, it took some time to raise awareness and consequently integrate the new program within the existing services at health facilities. The Tanzania National NCD Response Programme was implemented by the TDA and is funded by the World Diabetes Foundation (World Diabetes Foundation 2017). According to a Diabetes Foundation report, Tanzania has established forty-four clinics to consult patients with diabetes and hypertension in district, regional, and referral hospitals (Beran 2007, 33). Thanks to the program, three diabetes clinics were also established in Dar es Salaam's three district hospitals in 2003 (WHO 2006). Through the establishments of the diabetes clinics, access to diabetes treatments and services has improved, although it is important to note that these services are mainly available in urban areas (Metta et al. 2015, 2).

As Susan Reynolds Whyte (2012, 68) puts it, the social existence of chronic illnesses such as diabetes is closely connected with the ability to control them. Especially among older people with chronic illnesses, frequent visits to hospitals to monitor their condition are common. During these visits, patients do not only receive their dose of drugs for the coming weeks, but frequently also attend information sessions concerning their condition. The diabetes units at the district hospitals in Dar es Salaam offer weekly information sessions to diabetic patients, where a trained nurse informs them about healthy eating, medication intake, and the importance of physical exercise. Thus, older people registered at the diabetes clinic are asked to comply with a regular schedule of monitoring their disease at the clinic, as well as to follow certain aspects of self-monitoring for the rest of their lives (for Cameroon, see Awah and Phillimore 2008, 482).

Apart from the government hospitals that accept health insurance, the city of Dar es Salaam offers a wide range of information on health promotion and disease prevention along with various treatment options, depending on available means. Privately owned clinics that offer traditional Chinese or Korean medicine have been set up in the city, adding to an already wide array of therapeutic choices. Newspapers promote special diets in their health sections, TV channels stream aerobic exercises, and NGOs advertise screenings and treatments for particular diseases (for HIV/AIDS, see e.g., Hardon and Dilger 2011). Furthermore, when Tanzanian hospitals are not sufficiently equipped to treat a particular health problem, people who can afford it are transferred to India for specialized treatment. Long established as well as more recent flows of medicine, knowledge, and people are thus important globalizing forces that can be observed between Tanzania and other countries – not only Asian countries but also the USA, when children of older people travel abroad.

## Transnational circulation of ideas and (self-)care

Older urbanites with children abroad often engage in transnational care circulations (Baldassar and Merla 2014) which sometimes span continents. Relatives of study participants in the USA send medical remittances to their older family members in Tanzania (for example, in the form of food supplements, ambulatory blood pressure units, or insulin injections).<sup>10</sup> Together with these remittances, advice about how to remain healthy in old age is imparted. Furthermore, visits by older people to the USA or some other country are usually connected with a visit to a health facility for a check-up to discover possible future chronic conditions at an early stage.

Visits to the American health care system, and the advice deriving therefrom, are shaped by ongoing American discourses on ‘successful aging’ as an individual project (Rowe and Kahn 1997). Within the paradigms of ‘successful aging’ (ibid.) and other positive aging discourses (see Rudman 2015), four common themes are promoted across both the scientific and popular literature: individual agency and control, independence, productive activity, and permanent personhood (Lamb, Robbins-Ruszkowski, and Corwin 2017, 7). Sarah Lamb and her colleagues call for a critical reflection on the pressure such discourses exert on older people while they are, at the same time, ‘tied to dominant US cultural ideals about how people should be’ (ibid., 16). Neoliberal ideals of personal responsibility create the image of older people who do not want to become a burden by being dependent on others, but continue to contribute to society, while ‘[o]lder adults who do not engage in these pursuits [ideals of health and life] are assumed to be burdensome’ (ibid., 7) for their families or the state. Positive aging discourses thus reflect a particular neoliberal ideology when it comes to how people should grow old, while shifting responsibility to individuals and ‘promoting engagements in various techniques of the self’ (Rudman 2015, 19).

This health promotion aspect also features prominently in the World Health Organization (WHO) definitions of self-care. Self-care is often used synonymously for self-medication and equated with self-reliance, as put forward in the WHO policy on Primary Health Care (Van der Geest 1987, 294). In the WHO definitions of self-care, the concept has an educational and empowering component (WHO 2009, 2) and primarily targets healthy people (Webber, Guo, and Mann 2013, 103). In their revised definition of self-care, WHO writes, ‘[s]elf-care is the ability of individuals, families and communities to promote health, prevent disease, and

10 With the concept of medical remittances, Guilia Zanini et al. (2013, 15) ‘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 et al. base their concept on Abdoulaye Kane (2012), who talks about remittances of medicine, and Jason Pribilsky (2008), who uses the concept mainly as a descriptive tool without detailed definition.

maintain health and to cope with illness and disability with or without the support of a health-care provider' (WHO 2009, 18).

The aging discourses, as well as other globally advertised ideals on health promotion, starkly contrast with the values advanced by the Tanzanian state and the country's Aging Policy, which holds the family and especially adult children responsible for the care of older people. The National Aging Policy of Tanzania states that '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 2003, 10). Sinfree Makoni (2008, 200) therefore puts forward a critical reflection on aging discourses, as in some African contexts 'successful aging' can be connected to being dependent. What Hansjörg Dilger (2012) describes for the context of HIV/AIDS also holds true for other international discourses which bring forward empowerment approaches. Dilger (2012, 82) rightly points out that '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'.

These international ideas advocate individual self-care on the part of an empowered older person whose aim in old age is to remain independent from others and healthy. Older people are asked to adopt techniques of the self (Foucault 1988) to remain productive and not become dependent on others' care (Buch 2015, 282). However, engagement in self-care practices does not necessarily have to do with neoliberal rationality; Tom Hickey, Kathryn Dean, and Bjorn Holstein (1986, 1368) emphasize that 'self-care represents a "two-edged sword" for the elderly. For many – especially the younger, healthier, and generally better-off elderly group – enhancing self-care will be a tool of prevention, health maintenance and consumer protection. For many others among the chronically-impaired and the very old, self-treatment may be their only, and often inadequate recourse'. Thus, health promotion is described as only one context of self-care (Kickbush 1989).

The changing urban landscape described above shapes the dynamic relational context in which some older urban dwellers find themselves and consequently impacts how older people in different social milieus of Dar es Salaam experience and imagine aging, health, and care. In the next section, I present the case of Mzee Dunford. As a diabetic patient, Mzee Dunford is very concerned about his physical health and regularly visits the diabetes clinic at the district hospital. Through his health insurance, the older man accesses a wide range of treatment options, which have in turn impacted the web of care givers surrounding him. As a rather exceptional case, his example allows us to take a closer look at possible transfigurations of aging.

## The case of Mzee Dunford

Mzee Dunford was seventy years old when we first met in 2012. He had a special living arrangement, residing alone with his female household helper in his apartment in one of Dar es Salaam's civil servant areas. A district of government employees during colonial times (Brennan and Burton 2007, 33), the area later transformed into a civil servants' area, where the government provided housing to government employees after independence. Today, many of the government buildings are still inhabited by state-employed people, former civil servants, or family members of civil servants who were able to buy the houses cheaply between 1995 and 2005.

During our talks, Mzee Dunford was usually calm and did not talk much on his own initiative. I was therefore rather surprised to learn that he was a Jehovah's Witness who spent a couple of hours every week going from door to door, encouraging others to join his faith. He usually met with other Jehovah's Witnesses to do these rounds together. Mzee Dunford had come to the city in the 1970s. He grew up in a village in the southwestern part of Tanzania. He studied economics at the University of Dar es Salaam and worked for a state-owned company in the tourism sector until the company was dissolved in the early 1990s when the Tanzanian government changed its policy regarding tourism. After his forced retirement, Mzee Dunford worked in his garden and around the house and kept poultry until his health prevented him from pursuing these activities. Since his retirement, he has benefited from a small monthly pension of TZS 50,000 (about US \$25), as well as his late wife's pension. Because one of his three children works for the government, he is covered by this daughter's health insurance.

Mzee Dunford described himself as having little strength (*nguvu*) due to his diabetes, although he was still able to carry out minor tasks such as doing the laundry or watering the plants in his garden. He struggled considerably with his diet and tried different foods in the hope of feeling better. His two sisters regularly sent him a juice made from particular plants from his home village to complement his diet. His blood sugar level rose and fell, which made him feel either better or worse, day to day. On good days, Mzee Dunford conducted walking exercises around the neighborhood ward for almost two hours. Usually he did this early in the morning at around 6 am, in view of the better traffic and climate conditions at that hour of the day.

Mzee Dunford was enrolled in a diabetic program at one of the city's district hospitals where he attended monthly appointments with a diabetologist. During the monthly controls of his blood sugar level, he also received his medication for the following month. Usually he walked to the clinic for the purpose of physical exercise. While many other diabetic patients arrived at the clinic in the company of a younger relative, Mzee Dunford usually went there on his own. His children, who all live in Dar es Salaam, bought food for him on a monthly basis and

helped him to meet his financial obligations. As far as his disease was concerned, he had an overview over the schedule of his visits to the clinic, although one of his daughters, who worked as a nurse at the city's cancer hospital, used to pass by from time to time to check on his blood sugar level. Still, it is worth noting that once, after his medication had been changed to insulin injections and he had suffered a crisis after injecting far too much insulin, he did not call any of his children but went to the health facility on his own so as not to burden or worry them.

After having tried different diets and forms of exercise, Mzee Dunford's health seemed to have improved significantly when I met him again at the end of 2013. He told me that he had discovered a healthy diet that helped to stabilize his blood sugar level. Furthermore, he had started doing yoga exercises, which also brought improvement. After getting to know about yoga in the early 1990s whilst traveling for his job in northern Tanzania, in 2013 he discovered, an American yoga book from the 1970s in an Indian secondhand bookstore close to his house in Dar es Salaam.

Through his investments in self-care, Mzee Dunford succeeded in stabilizing his diabetes for a short time. In 2015, he experienced a minor stroke and his son, who lived close by, visited him on a daily basis to provide the necessary physical care until he recovered. Mzee Dunford was even able to resume some of his self-care practices. However, in the summer of 2017, after suffering a severe malaria infection, he unfortunately received a treatment that was contraindicated for diabetes patients. His daughter, the trained nurse, arrived too late and Mzee Dunford passed away, having received the wrong type of treatment at a health facility which probably did not have his patient file, but must have been geographically close to his home.<sup>11</sup>

## Everyday self-care and shifting interdependencies

Mzee Dunford's case is only one example of diverse engagements in self-care practices. The understanding of what people do for themselves in old age is expressed by the Swahili word *kujitunza*. The verb *kutunza* can be translated as 'to care', 'to provide for', 'to protect', and 'to maintain', while the reflexive *-ji-* prefix adds the dimension of self. *Kujitunza* (or 'everyday self-care') refers not only to activities that target a direct improvement of physical health, but also includes other practices that contribute to the wellbeing of the older person in a more general

11 Since Mzee Dunford was our main contact in his family, it was difficult to learn more about the sad incident that led to his death.

sense (e.g., looking after grandchildren or praying) and thus to a way of aging well (Swahili tr. *kuzeeka vizuri*).

Older people, especially those with a diagnosed chronic disease such as hypertension or diabetes, were frequently exposed to messages with regard to lifestyle changes. In order to cope well with their chronic conditions, they were expected to make regular visits to health facilities to receive medication. In Mzee Dunford's view, however, the advice he received was not enough, and he actively searched for information about other forms of self-care (e.g., yoga or walking exercises) by watching the television, listening to the radio, and looking for books or brochures with information about his illness.

When talking to Mzee Dunford and other older study participants, the term *mazoezi* (exercises) featured prominently. When asked what they thought was good for their health in old age, physical exercises and eating well topped the list. On the whole, this reflects the health advice that older people usually receive from their doctors. However, as far as some older study participants were concerned, there was a gap between talking about *mazoezi* and conducting *mazoezi*; that is, they supported the idea of *mazoezi* as a means to a healthy life in old age, but they did not practice it. Being a frequent attendant of the information sessions at the hospital, Mzee Dunford described his idea about the good (or successful) way of aging as follows: 'A good way of getting old is when you are able to control your body like when you are doing physical exercises... because instead of dying today you will die tomorrow, instead of dying this week you will die next week'.<sup>12</sup>

While some elderly men purposefully left the house to exercise, as Mzee Dunford did, none of the elderly women mentioned doing this. They, too, pointed to the importance of conducting *mazoezi*, but most of the elderly women simply incorporated physical exercise into their daily activities. In other words, they did not conduct exercises for the sake of exercise, but instead usually identified the activity they were pursuing regularly anyhow as their own form of *mazoezi*. For instance, for one elderly lady, engaging in physical exercise meant walking fast when going somewhere – in her own words, 'pretending to catch a plane'. In addition, *mazoezi* not only had a gendered aspect but was also considered differently in the countryside, where working on a *shamba* (farm) was considered a form of daily exercise that cannot always be easily replaced in the urban area.

Aside from physical exercise, the topic of healthy food was often discussed among the middle-class older study participants who had the means to choose from different groceries; this was

12 'Kuzeeka vizuri ni kule ambako unajitunza mwili wako kama kufanya mazoezi ni kuzeeka vizuri kwa sababu badala ya kufa leo unakufa kesho badala ya kufa wiki hii unakufa wiki ijayo'.

not the case for less privileged older city dwellers. In the financially poorer areas, people, especially those with chronic conditions, struggled to find food that was good for their health. Doctors advised them, for example, to buy whole wheat toast bread instead of white bread, but this is more expensive and only available in the big supermarkets on the city outskirts. While older study participants with diagnosed hypertension usually said they made sure that their food did not contain much salt, diabetic patients discussed the amount of sugar in their tea or in soft drinks. Advertisements in the health section of the local newspaper, which most former civil servants read daily, also provided information on how to eat healthily.

Older people tried to make sense of the information they received from diverse sources (including medical doctors, media, social and church environments in Tanzania, and children abroad) and integrate particular aspects into their care arrangements. Much of the responsibility was thereby assumed by the older person himself/herself. Most of the older study participants emphasized that they were often better informed than their adult children who were involved in their care. Although care was normally provided within a figuration – a web of interdependent actors – many older people became experts on their own health condition and in consequence did not trust others to judge, for example, how much salt their food should contain.

The older people's engagement in health-promoting aspects of everyday self-care described above usually did not only start in old age; some of the study participants underlined that they had already been engaging in physical exercise when they were younger. Others mentioned travels to foreign countries which inspired them to engage in health-promoting activities. Still others started to change their health behavior after the appearance of an illness and the linked enrolment in a health program. Older people of different urban milieus have different reasons to engage in self-care, while members of the middle class usually have more opportunities and means (not least financial) to make use of certain forms of aging in the city (such as, for example, exercising at expensive gyms). Because of this connection, the retired civil servants praised the city for its opportunities, while older people from other milieus met in this study pointed out the hardships that living in the city engenders.

While care for older people in Tanzania is usually provided by related others, investing in self-care may bring about shifting interdependencies when older people assume some of the care work themselves. This can occur out of pure necessity because no other options are available, but also for health-promoting reasons. As described in self-help books around successful aging, old age becomes an individual project for some older people.

Older study participants' narratives revealed that they engaged in health-promoting activities with the aim of retaining a certain degree of independence (*uhuru*) in old age. An important aspect in regard to older people's healthy diet concerns their wish to be able to choose for

themselves what they eat. Many associated their status as homeowners who share their house with adult children with the choice of food. As homeowners, they participated in decision-making around food, which was then often prepared by a household helper or family member. According to Peter van Eeuwijk (2007), food reveals power relations. In his field site, Indonesia, a caregiver-care receiver relationship 'is largely defined by the giving and receiving of food and nutrition which generates very powerful interpersonal relationships' (ibid., 3). Especially in the case of more deprived households, the author describes older people as 'net consumers' who are considered rather 'weak, passive household members' (ibid., 4). In contrast, in Dar es Salaam, many older study participants who were homeowners underlined the importance of being able to choose the kind of food they prepared or had prepared for them. The influence of adult children or other caregivers on an older person's diet tended to be rather marginal, as study participants from different urban milieus claimed that they knew better which food was best for them.

In most cases, the older people in the study group did not have sufficient financial means of their own to sustain themselves in old age, but through their small pensions they were at least able to partially cover the costs of living. Others were able to rent out rooms in their house, food stalls in front of the house, or whole apartments. When it comes to investing in health care, adult children become crucial. In this respect, the older people often mentioned the importance of their children's education, which gave them well-paid jobs and thus the ability to (financially) care for their parents when needed. One older study participant belonging to the former civil servants' milieu claimed: 'If you are blessed with children and they are educated and they are working, then you have at least some security'.

None of the older study participants I met engaged exclusively in either relational care or self-care, as these practices often go hand in hand. Mzee Dunford was an exception in the sense that he shared his home with no one but a household helper while much of his medical care was provided through the diabetes unit. Most of the older people resided with adult children and other relatives, and were thus also engaged in giving care (e.g., looking after grandchildren) and in receiving care from family members (e.g., when adult children assisted them in doing the washing or bathed them when sick or frail). Activities such as looking after grandchildren seem to especially contribute to an older person's mental and physical wellbeing, as long as grandchildren were not fully dependent on and thus more of a (financial) burden to their grandparents.

None of the middle-class study participants believed that *kuzeeka vizuri* (aging well) meant living independently but alone forever. To them, investing in practices of self-responsibility to improve their (chronic) condition – for example, through physical exercises such as yoga but also through working in their small gardens around the house – seemed to be a way of avoiding



becoming a burden to their adult children. However, once they did become dependent as ‘Mandela-like’ very old people (an expression an older study participant used to refer to frail, really old people), they envision that their children were prepared to take over, which would then again lead to shifts in their figurations.

## Conclusion: Transfigured imaginaries of aging

Changing ideologies about aging successfully, shaped by international discourses on aging as well as altering health care settings in Tanzania, have an impact on lived relations between different (family) members involved in a figuration, or care arrangement. In Mzee Dunford’s case, his ideas about aging well differed from those of other older people I met in Dar es Salaam, who depended increasingly on their children, invested less in health promotion, and relied solely on relational care instead. Mzee Dunford’s engagement in self-care practices shaped his social relations as well as his care arrangement: his children reduced their care to emotional inputs through visits as well as financial support through providing food and paying for the household helper. These shifts in care were not only observable in Mzee Dunford’s case. Hence, the (health-promoting) everyday self-care practices depicted in this contribution are connected to shifting the responsibilities of care between family members and the older person himself/herself (that is, once the older person is no longer capable of engaging in self-care, care by others has to increase, if possible). These practices can thus be considered as belonging to an emerging biomedical citizenship in Tanzania, such as that described by James Ellison (2014, 163). At the same time, they are an expression of changing experiences of aging, health, and care.

New configurations in health and medicine – such as, for example, the mentioned aging discourses that propagate an empowered individual whose main aim in life is to remain healthy and independent, as well as global health funding with preferences for particular health problems – can impact older city dweller’s imaginations of how to age well. At the same time, local initiatives promote relational care through adult children in terms of the ‘intergenerational contract’ mentioned in the introduction; although again, some of these children may reside abroad and have their own conceptions about how their parents should grow old. Relatives in the countryside may also offer advice and send – as in Mzee Dunford’s case – herbal treatments to their urban family members.

Following the approach to sociality described by Long and Moore (2012), the above described urban landscape shapes the dynamic relational matrix in which the older city dwellers are embedded. Not only for me as a researcher, but also for the older people themselves, the health sector remains rather non-transparent, and information (for example, about particular exemption policies) is usually random and only applicable situationally. Although enrolled in

a particular disease program, access to quality primary health care can still become a sudden challenge, as the avoidable death of Mzee Dunford shows. Belonging to a new generation of older urbanites, older people try to make sense of such manifold and differing sources of information, and describe their old age as being different from that of their parents back home in the village.

Although older people seem to appreciate and seek a certain degree of freedom of decision, they still imagine living with their own children in the city and enjoying their (financial) support in old age. Through the older civil servants' engagements in their own health promotion and care, we observe shifting interdependencies among family members; for instance, when children living in Tanzania and abroad remain financial supporters but retire from other forms of physical or emotional care because the older person assumes responsibility for these aspects herself/himself (with the help of his or her health insurance). With a focus on health-promoting self-care practices, the aim of this article was to show how macro-level changes may impact some older people's figurations but not others', depending on their engagement in the changing urban landscape and ability to make use of it.

The concept of transfiguration may help to disclose ongoing processes of change that are currently at stake in dynamic figurations of older people and their caregivers in Dar es Salaam. In particular, by looking at a slightly better-off urban milieu, we can learn much about current trends in urban aging in Tanzania and new social spaces that open up for older urban residents: with the help of financial means and access to information, these middle-class elderly urban dwellers follow creative ways of becoming old in the city of Dar es Salaam.

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