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Being old in times of AIDS: aging, caring and relating in northwest Tanzania

Klerk, J. de

Citation

Klerk, J. de. (2011). *Being old in times of AIDS: aging, caring and relating in northwest Tanzania*. Leiden: African Studies Centre. Retrieved from <https://hdl.handle.net/1887/18610>

Version: Not Applicable (or Unknown)

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Being old in times of AIDS

African Studies Centre
African Studies Collection, vol. 37

Being old in times of AIDS

Aging, caring and relating in
northwest Tanzania

Josien de Klerk

Published by:
Africa Studies Centre
P.O.Box 9555
2300 RB Leiden
asc@ascleiden.nl
www.ascleiden.nl

Cover design: Heike Slingerland

Photos: Josien de Klerk
Cover photo: 'Older woman digging the land'

Printed by Ipskamp Drukkers, Enschede

ISSN: 1876-018X
ISBN: 978-90-5448-109-6

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To Gussy and Shani

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Acknowledgements

Several poignant memories surface when I think back to the fieldwork for this thesis which started almost eight years ago. One of the most salient ones takes me back to a hospital bed in 2003 in which my neighbour, 27 years old, was dying of AIDS. As we were discussing the merits of José Chameleon, a popular Ugandan singer, the young woman in the bed across from us suddenly uttered a sound and lay very still. While she was quickly wheeled into a side room, accompanied by her older mother, the women in the ward were quiet for what seemed a very long time. Then one woman clicked her tongue and another shook her head. They were discussing it quietly when the mother came back and started to collect her daughter's belongings and changed the sheets soiled with diarrhoea and there was silence once more. Some hours later I went back to the ward in the company of the AIDS counsellor who happened to be family of the woman who had just died in front of our eyes. We were met by the mother. When I offered my condolences she suddenly put her arms around me and started crying, me quietly holding her.

Moments like these were moments of connection and moments which made this fieldwork the emotional rollercoaster that I often felt it was. The long time between fieldwork and completion of this thesis has created some necessary detachment, in which I needed to think analytically about the stories older people told me. At the same time I have tried to not become too detached as I think it is the emotional engagement that made me reflect and question my methods, analysis and all the other aspects of doing ethnography, and shaped me as an anthropologist. It is impossible to thank those with whom I experienced these moments enough: The older men and women who shared personal and sometimes painful moments and stories with me, the chairman who was trusted and liked by older people and became invaluable in my access to households, the family who adopted me and my co-researcher Gussy, as a daughter and sister, the family who rented me a house and kept a quiet eye on my safety, the village guard who kept watch at night, and the villagers who sometimes amused, observed my walking around in their midst. I have, after long deliberation decided not to mention the village or people by name as the stories I tell in the thesis are very personal and detailed, and I want to protect people's privacy. I also owe thanks to COSTECH, the Tanzanian Commission for Science and Technology and the district officials for allowing me permission to conduct this study.

I owe a major ‘thank you’ to Augustina (Gussy) John, my wonderful companion during this research. Together we walked through the village, lived and cooked, did aerobics in the courtyard, and chatted about life. Without her this study would not have been possible. The same applies to Shanifa Mbaraka, ‘our’ foster daughter whose presence in my life, even from a distance, is enriching and wonderful.

There are many people who, over the eight years of this project have contributed to the eventual completion of this dissertation. NIZA, the Netherlands Institute for Southern Africa funded the pilot project for this study. The research for this PhD was made possible by the Amsterdam Institute for Social Science Research – both the possibility to pursue a PhD and in the final stages the grant that allowed me to spend three months finishing it. Thanks go to the secretariat of the AISSR, and to José Komen, Nicole Schulp and Hans Sonneveld for keeping track of students.

I am indebted to my supervisors Anita Hardon and Rijk van Dijk for dragging me on board again after a more than necessary break of three years. Without their encouragement, insights and quiet acceptance that I needed to do this project my way this thesis would not lie in front of you. I am also indebted to my previous supervisors: Corlien Varkevisser, Sjaak van der Geest en Els van Dongen. Corlien has been a presence and source of support in my anthropological life from the moment I started studying at the age of 19 and has remained there ever since. I highly value Sjaak van der Geest for our many stimulating discussions about older people, which have contributed substantially to my academic learning. Els van Dongen shaped me as an anthropologist, forcing me to embrace and work with chaos, and seeing the beauty and richness in that. Her untimely death has been a great loss for me personally and professionally. Thanks go to the other members of the cluster Health, Care and the Body, in particular Ria Reis for her support during the PhD trajectory. In the United States, I would like to thank Nancy Whichard for triggering my joy in writing.

Within the AISSR I would like to thank my roommates John Kinsman and Trudie Gerrits for our shared pleasures and pains in the writing process and for our current friendship. Though I am indebted to many colleagues at the AISSR who provided me with valuable critiques and insights, some have become really close friends: Marie Lindegaard, Eileen Moyer, Joost Beuving, Eelke Heemskerk, Nienke Muurling, Marleen de Witte, thanks for being there during the AISSR period, and beyond. Andrew Gebhardt provided valuable comments on the final draft of the manuscript.

My two nymphs, Marleen de Witte and Eileen Moyer, have been there throughout the entire process of writing, quitting and starting again, reading chapters and listening to ideas. Thanks for doing so. A special note to Eileen who

cornered me in a café one afternoon in late 2008 and in that way provided the trigger I needed to pick up the writing. I am also indebted to the Africa Studies Centre in Leiden for providing me with a workspace to write and to my colleagues at WorldGranny, in particular Caroline van Dullemen, for being so flexible as to allow me to disappear for weeks on end to write during this period.

In Tanzania I would like to thank Fia Rijneke and Erik de Vries, Medard Rubason, Dan Lee and Shelley Patterson, Sonya Krutikov, Joachim de Weerd, Stefan Hoffman and Kurt Madoerin for sharing ideas about this study and their friendship. A special word of thanks to Eefje Smet who shared the reality of fieldwork with me. Thanks also go to my friends: Karin Majoor, Mélanie van der Hoorn, Monique van Holland, Froukje Luske, Gijs Gerritsen, Bregje Esmeijer, Raf Dox and Robbert Maseland who provided a perfect counterweight to academia. Your friendship is invaluable.

Tanzanian older women told me that parents suffer for their children. My parents, all four of them, Angélique Hoenders, Gijs de Klerk, Ton van Egmond and José Wetsteijn definitely have, throughout the process of this thesis. It is their love and support that stand out during this process. Thanks also go to my siblings in my own extended kin-network: Gijs en Clasine de Klerk, Mariette de Klerk-Verbeek, Marie-Elaine and Paul van Egmond.

Harm, your calm pragmatism and continuous support (including the nutritional part) have placed writing where it belongs: In the arena of work, rather than life, as did our beautiful daughter Pien who was born shortly after the 'birth' of this thesis. Thanks for being there. A final word goes to my wonderful brother, Gijs, as I promised him a long time ago. A few years ago you wrote me a 'Sinterklaas Gedicht'. It ended with *Luctor et Emergo*. I have.

[illegible]

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PART 1

SITUATING OLD AGE

Introduction

It is the end of August and the summer heat has made the winding paths that criss-cross the village dusty. We are sitting in the brick house of Mae¹ Tibaigana, who adopted me into her family and her life. The sun shines through the barred window openings and from the open door we can see villagers passing; on foot carrying grass or baskets or the water boys on bicycles loaded with jerry cans, cycling down to the river at a dazzling speed. The leaves of the banana tree plantation surrounding the house rustle in the wind and tick against the corrugated iron roof. Once in a while a neighbour calls out a greeting '*Olailote, how have you slept!*' to which Mae Tibaigana replies from inside the house, often joking back and forth until the neighbour is out of sight. In the back of the house grandchildren go in and out doing their chores. In the midst of this activity we talk quietly. Mae Tibaigana tells me that the daughter of her deceased husband's brother² is seriously ill. She is only three years old and suffering from convulsions. Her parents live in Dar es Salaam, but her mother is visiting the village with the ill child. Two days later, when I come back from Rubya, the local hospital, she tells me that she just received the news that the child had died, and that the father is flying back from Dar es Salaam to attend the burial. The wake will be held the next day. Mae Tibaigana explains that she has not felt well for a day. 'I don't know, my body felt weak, I had no strength to get up in the morning, I don't know. And then I received this news. So maybe it was because of this child dying, after all it is the same blood running in the family'.

When I noted down this event, in the summer of 2002, when I was in Kagera Region in Tanzania, exploring the consequences of AIDS mortality for older people, I was struck by how kinship and care relations in the AIDS era are changing in both obvious and subtle ways, that these bonds are constantly forged and negotiated. Mae Tibaigana's story drew me to what would become a core

¹ In Kihaya, the local language, 'Mae' is a respectful way to address an older woman; 'Ta' is a respectful way to address an older man. In the thesis I use synonyms for older people's first names, with the adjective Mae or Ta.

² This was a classificatory brother; a father's brother's son. Four generations of this clan family live in this part of the sub-village and the family is divided into two branches of two brothers and their offspring who moved to the area in the late 1890s.

Photo 1.1 List of deceased people from Kashenye village, one of the most affected villages on the border with Uganda, recorded by village historian

[illegible]

focus in this dissertation, the disjunctures and continuities of practices around family care, and the evolving role of older people in modifying and running these institutions. I was intrigued by Mae Tibaigana's flexible way of practising kinship, how relations, property and power dynamics in Kagera Region are shaped by marriage, and shared history, to the extent that Mae Tibaigana related her own physical weakness to the death of a young child who was biologically not related to her. I had also noticed the physicality of her experiences before, when she discussed the death of her two daughters, who both died within three weeks of each other in October 2000. She always referred to bodily weakness, a head that was not working well, and a rising blood pressure. Her physical problems became acute when she was confronted with emotional events, such as burials - common public ceremonies in today's Kagera and an important part of social life. As a creative and resourceful woman, she found ways to adapt social obligations to fulfil social expectations.

These modes of speaking about experiences with grief and death are common practice amongst older men and women in this area of Tanzania. The first AIDS case in the region was officially diagnosed in 1983 and since then older men and

women have been confronted with the death of relatives. The challenges and contradictions older people face are intimately bound together with narratives of AIDS in Tanzania, and with the changes in the political landscape that have occurred in their lifetimes, from the colonial period to independence, from nationalism and socialism to neoliberalism. Their stories suggest that some important things have been left out of discussions about AIDS and kinship in East Africa: The challenges of care giving falling on older generations, and the shifting economic and social dynamics for, in particular, older women in this panorama. The embodiment of relations and distortions in those relations, the practices of relating, of creating 'kinship', (grand)parenthood, and friendship are what drew me to what would become the main question of this thesis: How do older men and women manage the new care realities that AIDS presents, in combination with out-migration and commoditisation of everyday life, while they are growing older themselves.

The central thread in this thesis is the tension between practices of care and processes of aging in new fields of care. Older people are being involved in more care tasks while at the same time, as a result of their physical aging, it is less easy for them to provide that care. The AIDS epidemic has an effect on the ability of older people to position themselves in intergenerational relations. There are new demands on old age which implies an alteration in older people's biographies. In this sense AIDS is disruptive; however, it is not the only factor disrupting older people's biographies; migration and monetisation of their livelihoods also play a role in the changing relations of care. The interaction between the disease and these wider socio-economic processes over time (cf Seeley 2010; Rugalema 2010), make for increasing complexities of these biographies that this thesis will address and explore.

Between the conception and completion of this study, the anthropological attention for older people as caregivers has grown. Older people are mainly studied in their role as caretakers for ill adults and orphans, but in recent years there has also been more attention paid to older people as subjects at risk from HIV/AIDS, mainly as a result of the realisation that patients using Anti-Retroviral Therapy (ART) drugs are aging. In this sense the body of literature on older people in relation to AIDS follows foci of attention in the broader field of AIDS, where the universal access campaigns from the late 1990s and early 2000s changed the face of AIDS forever.

The subsequent 'pharmaceuticalization of public health' (Biehl 2008: 12) implied a shift in anthropological attention to those who access medication and live with the drugs. AIDS medicines became available to villagers through Rubya district hospital in December 2004, six months after I left the village. In July

2005 villagers were hardly using the services, but in the second half of 2005 ART became a social reality in the village.

The rapid developments have also fundamentally altered the experience of care giving; whereas AIDS at the time of the study implied an almost certain death, in the years between the end of the fieldwork and the write up of this thesis, AIDS medicines slowly started to keep patients alive. This process is relevant for understanding the ways in which the demands of care giving as provided by older people changed once more. In this sense this study is part of a historical era. This change in the social realities of AIDS in Africa and the fact that this dissertation focuses on the pre-ART era is one of the reasons why the concept of 'time' emerged at the forefront of this dissertation leading to an examination of the value of my data. In this thesis I stress the analysis of the relationship between temporal moments of disruption (such as in this case caused by AIDS) and the sharp increase in demand for care placed on the shoulders of older people. I find value in the careful analysis of how relations of older men and women are shaped over time in response to extreme circumstances.

Old age, care and AIDS: Conceptual framework

This study aims at capturing older men and women's experiences with the AIDS epidemic, giving voice to overwhelming feelings of loss and breakage. It aims at deepening the knowledge on care relations in the context of AIDS, how these have altered over time and under the specific circumstances prevailing in north-west Tanzania. Specifically the thesis looks at how older men and women over 60 years of age shape and maintain their relations of mutual care in the era of AIDS in a rural village. Whereas early analyses of the consequences of AIDS for older people framed this in terms of fracturing family care systems (Ankrah 1993) and livelihood crises (Rugalema 1999; Williams 2003) others point to the continuing support of extended families, albeit under stress and with changes in family care systems (Foster 1995; Kaijage 1997; Nyambedha *et al.* 2003, Nyambedha 2004).

The conceptual framework of this thesis links to a revival of African kinship literature in the past decade, in which the focus came to be placed on the experience and continuous creation of kinship relations, thereby moving away from culturalist conceptions of kinship and concerns with social structure, biology and continuity (Alber *et al.* 2008: 3). Kinship and family care in this body of literature is seen as something that might be informed by ideologies but is practised and made in everyday life, hence allowing for a cultural creativity in the way relations can be shaped where they perhaps never existed before, under the influence of situational circumstances (Alber *et al.* 2008: 3; cf Hastrup 2005).

Particularly relevant are recent debates on relatedness defined as the experiences and practices of relations between generations. Relatedness opens the way to study experience of relations and practice of relations between generations (Carsten 2000), including the way kinship roles are adapting to new forms, and how practices around HIV/AIDS become part of kinship negotiations (Nyambedha & Aagaard-Hansen 2007: 518; Dilger 2008: 207-208). I use the term 'relating' instead of relatedness, to emphasise my experiential focus on the way caregivers are able to position themselves in the new realities of care. A relation of kin then becomes such a relation through practice; a grandparent becomes a grandparent when practising that role towards a grandchild.³

This new emphasis on the experiential dimensions of kinship is especially relevant to examine how AIDS distorts relations of care, as it draws attention to the many subtle ways in which older men and women attempt to manage the consequences of AIDS illness and death. These involve prolonged nursing of patients, bereavement, raising of orphaned grandchildren and a disintegration of their own old age security. A focus on AIDS also draws attention to the reverse process: How new relations of care are produced. It is therefore important to not look at AIDS in terms of crisis and disintegration but in terms of the creative ways in which older people re-institute their roles in relations of care. In this sense a focus on AIDS allows us to understand how social transformation takes place as well as how practices of 'making normalcy' become relevant. From this perspective we can see how older people have agency in recreating a new level of 'normality' of everyday life while living through a disruption that so deeply affects the fundamental relations of sociality.

Older men and women in the rural village in Kagera where this study took place, talk about the era of AIDS in terms of a break with the past. 'When the condition was still good', would be an opening when discussing AIDS. The long presence of AIDS in the village has changed narratives and understandings about the illness. When older people say: *Kifo ni kawaida*, death is normal, they refer to the banality of death, and the necessity to find a way to live with the constant threat of death. A longitudinal perspective in this sense is important as it allows for the balancing and evolution of different discourses around AIDS when people's experience with the epidemic increases.

What is special about the current group of older men and women in the village is that they are the last generation(s) who grew up in the pre-AIDS era. They were confronted with AIDS when they started to grow physically older, when

³ There are different schools of thought that are referred to in practice theory. I have mostly been inspired by Bourdieu's practice theory on looking at practices of making and engaging in relationships, in particular his work on the way people are influenced in their practice by unconscious frameworks of reference (Bourdieu 1977), but do not apply a Bourdieudian analysis. An alternative approach to practice theory is a focus on the senses, a phenomenological approach.

they were 60 and have provided care as they aged into their 70s and above. Younger relatives die at a time when these older people need them, and had counted on their support. The older men and women who are slightly younger and are still physically able to sustain themselves were in their middle ages when AIDS started and have seen different relatives die – siblings and spouses initially, those very people who were out trying to make a life through business and later on their adult children and sometimes grandchildren. Experiences of AIDS are therefore different in certain life phases, also calling for a longitudinal framework to explore these biographies of disruption. A focus on temporality makes it possible to frame experiences of long-term care in old age in broader kinship dynamics over time.

Aging in new fields of care

The increasing care tasks that older men and women in rural Tanzania are faced with coincide with their own process of growing older, physically and socially. In order to understand how older people's increasing care tasks in the era of AIDS feeds into their experiences of old age, and how these experiences differ amongst older men and women, it is necessary to explore the process of *aging* further.

There is a rich body of anthropological literature on aging in Africa which in recent years has increasingly concerned itself with the experience of older people, to provide an alternative to positivist modernisation theory. In particular this body of literature focuses on how older people experience old age within a particular socio-cultural context, and the various ways in which older people are able to create the conditions for their own existence, actively shaping this experience (Caplan 1995; Makoni & Stroeken 2002).⁴ Makoni & Stroeken identify a shift in thinking about intergenerational tensions and its consequences for old age identity. In early literature old age identity was linked to societal transformations where individual skills and achievement⁵ became more important than 'traditional' knowledge. In recent analyses a much more dynamic perspective of societies prevails, arguing that it is normal that the ascription of status in a society provokes conflict and contention (2002: 6). Important in this body of literature, they argue, are notions of old age identity as constructed intersubjectively in a social environment (McCall 1990 in Makoni & Stroeken 2002: 7), whereby older people's roles in continuously creating the social fabric (Devisch 1996 in Makoni & Stroeken 2002: 9) and the social techniques they use

⁴ In terms of theoretical work, there has been an emphasis on social structure and less on experience of old age until a narrative turn in anthropology emerged in the past decade (Makoni & Stroeken 2002: 4).

⁵ Here they refer to skills related to older people's functioning in emerging market economies and capitalism.

to avoid marginalisation (van der Geest 2002; van Dongen 2002)⁶ are important foci of attention.

The concept of *aging* is often used to denote the process of growing older, leading to the loss of bodily functions and increasing dependence (von Faber 2002: 36). Aging in this sense is referred to in terms of chronology, increasing biological age and has often been criticised for its negative associations with the stage of old age, where social categories such as widowhood are often more relevant social categories than chronological age (Makoni & Stroeken 2002: 6). Secondly old age is not necessarily a time of dependence (von Faber 2002: 36-37). On the contrary, old age, especially in the era of AIDS is a time of mutual, but shifting interdependencies. Though I concur with these critiques I find value in the concept of aging for its inherent notion of time. There are three relevant notions of time inherent 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.⁷

Whereas the interplay between aging and the physical body/illness constitutes an important subject in studies on aging in Africa, and especially its effect on the social status of older men and women (Makoni & Stroeken 2002: 6) the role of the body as a site for *experiences* of old age is relatively under-examined. Sagner (2002: 59) argues that in African self-identity the presence, continuity and connectedness of kin relations makes it possible to overcome the negative effects of bodily aging for self-identity in old age. This opens up an understanding of elderliness as constituted mainly by the aging body as a vehicle for constituting relations of care thereby avoiding marginalisation. The notion of physicality then centralises the concept of the *changing* body and the way older people live in and overcome the limits of their older body, in engaging in social action and remaking relations (Shilling 2008).

Old age is a time connected to past and present: Relations have been shaped over a life time and this has shaped the relative positions people have taken up towards one another over time and frames older people's perspectives of the present. Older men and women were born into a particular set of historical circumstances, a *historical time* that was partly shaped by the previous generations. In each generation social and cultural practices are reshaped. In this sense

⁶ Van der Geest argues that there is a disconnection between the younger generation and the older generation, whereby the younger generation merely conducts 'empty' performances of respect. Van Dongen in her treatise on South African society argues that in the post-apartheid era there is no social space anymore for the memories of older people. I take both these analyses as inspiration for the question how AIDS creates disconnectedness between generations as it is an illness attributed to younger people or on the other hand connectedness as older men and women play increasingly important roles in society (van der Geest 2004b; van Dongen 2003).

⁷ These notions of time parallel those recognised in the life course perspective, biological time, historical time and social time (Aldous 1990: 573).

the term ‘generation’ refers both to the generational roles that are shaped through everyday living together as well as the values that have been shaped in a specific time period (Alber *et al.* 2008: 5). This shapes notions of identity and feelings of belonging in old age (Sagner 2002; van Dongen 2003; van der Geest 2004a). Current practices of relating in old age are also linked to other events in the life-span of older people, such as widowhood and divorce. Both values and life-events over time influence how older people experience their current practices of relating and are able to engage in relations.

While the concept of aging in this sense connects the present era to the past, we also have to beware not to view historical events as determining social practice in the present. In living everyday life older men and women are mainly concerned with the present – the relations of today (Whyte & Whyte 2004). Haya experience time as a fluid and open process where the past and the future are continually amended by personal and communal narratives and only events in the present moment are fixed. Taking the meaning of social relations for experiences of old age as a central focus, Whyte & Whyte (2004) propose the concept of ‘inter-subjective time’; analysing shared time, and an imagined future embedded in certain kinship relations through living together. This notion of time allows for the understanding of how practices of relating are about situations and adapt as social realities change, but also to how within broader family relations the balance between care giving and receiving care shifts over time.

Aging as a concept linking past and present, natural aging processes and their interplay in everyday practices of relating, allows us to understand how inter-generational relations and roles of older people and family members change over time in response to new challenges, taking seriously the long presence of illness, death, mourning and loss.

Relational care

Care as it is comprised of in discussions on Home-Based Care (HBC) and Community-Based Care (CBC) contains both assistance and support through the extended family and informal social relations as well as care provided by (semi-) trained health professionals to the sick specifically.⁸ In this dissertation I focus on

⁸ These latter forms of care evolved in East-Africa in the late 1990s often under the influence of religious institutions and NGOs when health facilities could no longer handle the many dying patients (Iliffe 2006). The World Health Organization released the Community-Based Care in Resource-Limited Settings (CBCR) framework in 2002. CBCR was defined as any form of care given to the sick in their homes (2002: 95) The focus of CBCR is geared towards an approach to strengthen caregivers, in the beginning of the epidemic in their role as carers for ill people and their families, and as the epidemic progressed in the care for orphans (2002: 10-11). In this policy framework it is mentioned that caregivers suffer from burnout, fatigue and depression (2002: 42) and that their network should be strengthened by friends, neighbours, spiritual support (...) support in rotation, and recreational breaks. Care to caregivers is mainly provided through recreational breaks and through strength-

the former – care provided by the family, taking older men and women and their families as a starting point, rather than any formal or informal structures of home care. Care in this context is defined as broader than care for sick people and is defined as material, emotional and practical assistance (Kleinman & van der Geest 2009) to those who are unable to provide for their own needs. This inability may arise from physical incapacity as a result of aging, infancy or illness. Relational care then comprises the care in and for social relations.

Care in the family context is associated with *aid* by close relatives and friends, and often, but not solely includes nursing activities, but also emotional attention and affection. In this sense care is material, but is also about presence. Morgan (1996: 97-98 in Marianti 2002: 5) distinguishes caring ‘for’ and caring ‘about’. Care, outside the health care setting, therefore usually comprises a close relationship between the ‘carer’ and the ‘cared for’. A focus on care thus explicitly asks questions about close relations, the aid that flows between carers and the cared for and the biographies that emerge in and through the interaction that care represents.

Care giving is an interaction as well as a process which unfolds over the course of a relationship (Mol 2008). It also is an identity-production as it represents a shift in (social) positions. Relational care is not just about two interlocutors; it is also about those around them looking and commenting. In that sense care is the language of the relation rather than being a transaction. When I use the term relational care I refer to this, embedded, interaction. Practices of care are therefore practices in which relations are forged or strained. Relations are ‘made’ through everyday interaction – daily support, working on the land together, popping in to greet a parent in the morning, and gestures of intimacy, such as hanging on a grandmother’s lap, or being delegated to fetch water or milk (cf Whyte *et al.* 2004; Whyte & Whyte 2004; Geissler & Prince 2004). In situations of illness, especially AIDS, these practices of relating are magnified and thereby profoundly reshaped.

In the reflections of older people four elements are important in relations of care: Physicality, emotionality, morality and materiality. In terms of physicality, AIDS raises questions around the body and care in multiple ways. Acts of care giving are essentially about bodily contact, touch and intimacy. In this sense, the body as a relational vehicle is important in acts of care giving. Care is about spaces for touching, presence and closeness. Touch, argue Geissler & Prince (2010: 13), is a central practice of relatedness; touch makes relations by closing the physical separation between one and the other. At the same time older peo-

ening support systems of friends, spiritual leaders and neighbours (2002: 42). Older women are specifically mentioned as a group at risk of losing social security (Community-Based Care in Resource-Limited Settings, a framework for action. World Health Organization 2002: 27). In the village this form of care is virtually absent.

ple's bodies are socially and physically aging, constraining their ability to counter the new social realities of care that have emerged as a result of AIDS. Gender is important here – male bodies are able to move differently than female bodies – as social divisions are embodied in the gendered body (Shilling 1993: 14). The majority of caretakers are older women, though older men also play important roles. Here it is important to analyse the difference between female and male bodies and the acts of care giving.

AIDS illness evokes powerful emotions, especially when older caregivers are confronted with the disintegrating bodies of AIDS patients (Henderson 2004; Livingston 2008) and the imminent death of relatives. A focus on emotions draws attention to the concerns of older men and women with broader kinship relations and how emotional practices are responses to challenges of continuity and belonging in kinship relations (Dilger 2008: 211). A focus on emotional practice in relational care opens the door to the subjectivity of older caregivers and the way they experience their old age in the face of their growing responsibilities (Biehl *et al.* 2005: 5).

Care, as a result of its very close, interpersonal nature brings up questions of what good care entails and when practices can be seen as neglect (Mol 2008). In this sense gender and generation are part of the moral questions around appropriate care. Care giving takes place in a local moral world (Kleinman 2006). As a result of the new social realities of care that emerge as a result of AIDS, gender and generational roles in care practices have to be constantly defined as well. Older people expressed three core values or concepts which run through the ethnographic chapters of the thesis: *Kuvumilia*, 'putting up with' or enduring hardship, *huruma*, 'compassion' as a core quality of relations and *providing*, as a central element of today's relations of care.

Care giving also contains material aspects, both in terms of activities that come with care for patients and grandchildren as well as with the labour involved in earning money for care needs for the ill person. A focus on materiality draws attention to the ability of older persons to engage in or mobilise social relations through which they can live up to the material demands of care giving. It also illuminates the diversity in the economic and social capital of older people, and how this is reflected in the care demands that are made of them, as well as the way care practices deplete material assets and hence old-age security. These four elements of relational care are present in each of the new realities of care: Old-age care, bereavement, illness and raising grandchildren, and they intertwine with experiences of aging.

Growing old in the era of AIDS

To situate the analysis of changing care relations as a result of AIDS, as central to the experience of growing old in Kagera it is important to sketch the contemporary lives of older men and women in Kagera Region and Muleba District specifically. Experiences of old age are highly diverse and depend on gender, socio-economic status, personal history and physical capacity, but their common ground is that they lived through and embodied a period without AIDS for most of their lives. In this sense their experiences of contemporary care relations are coloured by this shared history.

The uncertainty of relations in Kagera

The research village is situated in the Nshamba ward of Muleba District, which roughly comprises the *Ihangiro* Chiefdom, 70 kilometres south of the regional capital Bukoba. The district is divided into five divisions; Kizigo, Muleba, Kamachumu, Nshamba and Kimwani, and has a total of 31 wards and 126 villages. Nshamba town is the main market town of the ward, situated in what is called the 'business triangle' between Kamachumu in the north, Muleba in the east, near the Lake Victoria and Nshamba town, 30 kilometres to the west. Nshamba town itself is small, but there are a number of NGOs and schools, including a vocational training centre based in the town. The weekly market in Nshamba town is held on Saturday and is one of the main places for shopping, socialising and trade. Nshamba town hosts a number of shops and repair shops most of which are owned by Muslims. The Muslim population in the district is quite large but dispersed patchily. To the east of the village is the district designated hospital in Rubya, and the Catholic Mission, with a weekly market on Sunday.

The village is built on a plateau, as are most of the older villages in Kagera region, above the rivers where the nights are cool with abundant rainfall. The village comprises six different sub-villages, with a total of 900 households and 3,460 inhabitants in 2001 and an average of 5.6 people per household. Each sub-village (*kitongoji*, *ks*) is divided into ten-cells, ten households headed by a ten-cell leader, who reports to the sub-village chairman.

In many ways the village is similar to other villages in Kagera Region: A centre on the roadside followed by vast banana plantations and coffee trees, which surround the homesteads. From a bird's eye view, villages are dark green patches situated on the plateau, surrounded by grassland running down to the river. From the main road, smaller paths move deep into the sub-village, branching off into a network of narrow footpaths winding through the *ebibanja(pl.)* – the family farms. Main crops include banana/plantain, primarily for home-use. Coffee is grown as a cash crop. Houses in the village are all built close together, sons build their houses close to their father's house and often a particular area in

a village will contain houses of one extended family. Most houses are made of mud but usually have corrugated iron roofs, and inside the floors are covered with grass.

Smith & Stevens relate the different economic situation of men and women in Kagera to their respective life courses. Men often had both large farms as well as salaried jobs in the village and could stay away for a long time because their wives were tending to the land. They could therefore build houses, hire labourers, buy more land and invest in cattle and transport. Men developed integrated businesses during their lifetimes, investing in the land the profit earned from tailoring, butchering and furniture making. Women were not supposed to engage in income generating activities such as selling produce or coffee (1988: 559). This social history is visible in the life courses of the current generation of older people. Older men had often engaged in business in addition to developing their farms. Older women had been mainly involved in working the land, though the majority was also involved in small-scale business such as mat making and beer brewing. Most of the older women in the village were living in single headed female households (20 widowed and ten divorced). Women often had smaller plots of land and insecure tenures (Smith & Stevens 1988: 553). Older men were almost always married to younger women. Women in their old age were therefore more dependent on members of the extended family.

The main economic activity of Muleba district is agriculture, especially for older men and women.⁹ Other economic activities include running shops selling electronic goods and household necessities as well as mobile phone shops and trading establishments in second-hand clothes, working for the plantain-traders, and transporting goods on bicycles. Other economic activities include fishing, often through seasonal migration to the islands off the coast from Muleba town. The islands were seen as dangerous places: Places where jealousy and hatred were rampant, and witchcraft was common. Despite these stories, quite a number of the village youths would go to the islands seasonally to work and earn money. These were the boys who had finished primary school and could not find a job or men who did not have enough land to support their families. Several older people had children living on the islands.

There are many factors that have been conducive to a greater uncertainty about social relations in the district in recent years. As a result of inheritance practices and population growth, the land has become smaller and it has become more and more difficult to survive off the land. Despite the AIDS epidemic the region experienced a rapid population growth: In 2004 the population living in rural areas measured almost 2 million, an average of 70 per km². Population density

⁹ District Development Plan 2001-2021, existing site report.

has increased threefold since 1967,¹⁰ despite the AIDS epidemic and out-migration. Twenty percent of these two million people lived in a peri-urban area.¹¹ The population of Muleba District was 386,328 in 2002.¹²

In the district itself there is hardly any formal employment outside the government sector (teaching, agricultural officers and health staff) and as a result many of the older people's children have moved to the major towns in Tanzania: Mwanza, Arusha, and Dar es Salaam. Between 1994 and 2004 the economy improved, mainly as a result of new orientations in business and trade and a stable political situation (Beegle *et al.* 2010), despite a decline in coffee prices. Monetisation of the economy following liberalisation has led to diversification of livelihoods (de Weerd 2010) but less so amongst older people. At the same time this economic development has increased disparities between families. Commodification and monetisation of the economy also find their way into care relations making it more difficult to provide care, especially for older people (cf van der Geest 1997).

Those older people with adult children who do well in town, receive remittances and luxury goods, such as mobile phones, televisions and video players, and visits once a year, or children invite their parents to the city. Those adult children who do not do well often disappear. Migration has changed care landscapes; older men and women value city life and education, but at the same time fear mobility, both within the region and the city. AIDS illness and death has, despite the decline of the epidemic, been an everyday reality for the past 25 years and the older people of today continue to lose relatives: Adult children and grandchildren, sometimes, the orphaned grandchildren they raised. This everyday uncertainty about social relations makes the experience of growing old one in which care relations have to be reframed and negotiated on a daily basis.

A heterogeneous epidemic

The AIDS epidemic in Kagera Region varies remarkably, both in terms of prevalence and incidence rates as well as in terms of historical background (Killewo *et al.* 1994). Historical sources show a history very much tied to the period of rapid political, social and economic change. Kagera Region, already isolated, squeezed between the Lake Victoria in the east and Uganda, Rwanda and Burundi in the north and west, became more isolated after the collapse of the East African Union in 1977. Tanzania's socialist politics, which included the closing of all

¹⁰ The United Republic of Tanzania: Kagera region: socio-economic profile. National Bureau of Statistics and Kagera regional commissioner's office (August 2003).

¹¹ Kagera rural CWIQ. Baseline survey on poverty, welfare and services in Kagera Rural Districts. April 2004, Economic Development Initiatives.

¹² The United Republic of Tanzania: Kagera region: socio-economic profile. National Bureau of Statistics and Kagera regional commissioner's office (August 2003: 26).

major stores, had led to a widespread scarcity of consumer goods and followed by a period of food insecurity after a plague destroyed banana plantations, the main staple crop in the region. Due to decentralisation politics the transport infrastructure declined resulting in a downfall in economic development and educational standard in one of the highest educated regions of Tanzania (Mutembei 2001). This was the period when many of the current generation of people in their late 50s and 60s were busy building their lives and raising families. Villagers developed new mechanisms to survive, which involved a risky illegal bidirectional trans-border trade with neighbouring Uganda. Done under the cover of night and taking days, this work attracted young men. Young women went into commercial sex work in the newly opening markets on the border and in town. Border posts became centres for trafficking, goods, alcohol and commercial sex (Kaijage 1992: 84). In 1978-9 the Uganda-Tanzania war which was fought in Kagera Region, caused social destruction and the soldiers who camped and fought in the region in combination with the already high mobility and commercial sex work¹³ created a favourable environment for the spread of HIV¹⁴ (Iliffe 2006; Mutembei 2001; Kwesigabo 2001; Rugalema 1999). The political change from socialism to a market economy increased mobility and business. This is visible in the life stories of older men in the village, many of whom were involved in business and were highly mobile, only settling in the village in retirement, some living in cities.

By the beginning of the 1980s many adults in Kagera started to become sick. The first people to die of AIDS were the most mobile people. These included young men who had been involved in the illegal cross-border trade, former soldiers of the TPDF,¹⁵ professional prostitutes, migrant labourers, commercial travellers, and town workers who came home to die (Kaijage 1992: 82). These people sometimes were siblings, spouses and friends of the current generation of older people, sometimes adult children.

The epidemic, in terms of prevalence and incidence¹⁶ had already reached a peak around 1987, similar to the patterns in neighbouring Uganda, and have since declined (Kwesigabo 2001; Lugalla 2004). The highest prevalence rates were measured in *Kiziba*, mainly in an area called Kanyigo, where the main cross-border trafficking took place and in Bukoba town, places with high mo-

¹³ The chairman of the village, when reading this chapter, criticised Hooper's association of commercial sex work and the camps of the soldiers. 'I was a soldier, Josien, and there was a war going on. When you are a prostitute and the scud rockets are flying around your ears, do you think that you would go to a soldier for 10,000 shillings? No! You run like hell. What happened is that many women were raped in that area.'

¹⁴ See also Chapter 2 in which I elaborate on the social history of the HIV epidemic in Kagera Region.

¹⁵ Tanzanian People's Defence Forces.

¹⁶ Prevalence: percentage of population found to be HIV positive at a certain moment in time. Incidence: percentage of population newly infected in a period of 12 months.

bility, wealth and high levels of education, where prevalence rates reached 24.2% in 1987.¹⁷ Within the region differences in AIDS prevalence and incidence also presented different dying patterns, indicating slight differences in history though there are hardly any sources about the historical background of the epidemiology of the AIDS epidemic in the southernmost districts of Muleba. The differences in dying patterns between the north and south are important to emphasise: both the scale of the epidemic and its social history have implications for family care patterns in the present. In Kanyigo some older men and women lost all of their children, sometimes up to 11, in a relatively small period of time. Since, orphans have grown up and have resettled the once empty houses of their parents or moved to other areas in Tanzania. Muleba district in the south was traditionally a trading area and with many fishing villages had prevalence rates of 10% in 1987, declining to 4.3% in 1999 (Kwesigabo 2001). Dying patterns here were much more spread over generations. Other districts, such as Karagwe, which are more isolated and Ngara and Birahamulo districts measured hardly any low rates of prevalence.

In popular narratives, northern Kagera is still seen as the most affected area. Data from voluntary blood donors¹⁸ show different results; according to national statistics Muleba district had the highest prevalence of HIV in blood donors (29.3% in 2003) in the region and nationwide (Kessy 2005: 14). The choice for this medium prevalence area, weaker in terms of education levels and wealth and with a more diverse population, from different clans and with histories of resettlement, raised the questions, how in areas where AIDS had not wiped out entire generations, but had affected more than one generation, were family care relations re-created and what role has the older generation been playing in that process? AIDS from this perspective is not framed as an illness or livelihood crisis but as an entry point to look at how relationships of care in old age are reframed and negotiated over time in this particular district.

Methodology

A conceptual framework, which focuses on individual social relationships and how these are formed, consolidated and lost, requires a methodology that allows for fluidity, attention to difference and openness. Doing research on AIDS and its consequences implies making explicit what is often hidden, private and painful:

¹⁷ Many lawyers, doctors and scientists in Tanzania are from the Kiziba area. This region is also less diverse in terms of clans and has since the start of the AIDS epidemic also been highly serviced by NGOs, in particular Partage, a French NGO taking over certain community structures.

¹⁸ These are relatives of patients admitted in the hospital. Prevalence rates amongst this group are often higher than in the general population. I do not have recent figures but personal communications with health staff of voluntary counselling and testing sites from 2003-5 suggest prevalence rates similar to what Kwesigabo (2001) found in 1999.

The tiring illness, the grief and anger over the death of loved ones, the fears that result from the implicit knowledge of the habits of one's adult child and anxieties over the future. These issues are often discussed in surreptitious ways, or not at all. For the researcher, this situation called for tact, sensitivity and self awareness, as well as a flexible methodology. My methodology has adapted to my growing understanding of the situation in which older people find themselves but remains based on two elements: A longitudinal perspective and a focus on storytelling around events, collecting in this way social biographies of older people and those they speak about, which fits the natural way in which older men and women discuss matters on an everyday basis. In this way I have pasted together the social construction of 'events' and analyse them in their broader context. Whilst doing the research I found myself mainly in the company of older women: They constitute the majority of older people over sixty years and provide most of the physical care tasks. Though this thesis focuses mainly on the experience of older women, I explicitly do not intend to engage in a women-centred approach as ignoring older men in care giving dynamics would misrepresent the broader dynamics of family care giving in a patrilineal society.

Data collection

Data collection started in the summer of 2002 when I spent four weeks in the village and interviewed ten older women and men. With the assistance of the village chairman I then selected three households of older women affected by AIDS. Mae Tibaigana, my 65-year-old key informant in the village and the chairman followed these households on a regular basis for eight months and made notes about everyday events. These households, all in the same sub-village, formed the start of the core group of older men and women who I followed, with varying degrees of intensity until the summer of 2005.

The importance of contextualising AIDS in the everyday lives of older people was the main reason for my initial decision to select one sub-village and visit each older person over 60 years, the retirement age in Tanzania.¹⁹ The sub-village comprised 105 households (in 2002), 51 older people, 19 men and 32 women. 13 of the 51 were above 80 years old. I visited these 51 older men and women and collected background information on their demography and death events in the family, and obtained a 'feel' for topics worthy of further study. These data provided me with background information on the daily lives of older men and women. From these 51 people four other families were selected to be

¹⁹ Age in Tanzania has more to do with ability than with age in years, and I did not stick closely to the 60-year cut-off line after the initial survey. I purposely chose to not use a cut-off line of 50 years old as is often done in demographic literature as many fifty year olds often are not yet confronted with the physical decline of their bodies.

followed more intensively. Another three families who did not live in the sub-village were added to the people to follow intensively; I was introduced to two families because of the intensity of their problems and the other family was my landlord and his wife and children. The core families differed on the role AIDS played in their lives, their status in the community, religious affiliation and the gender of the household head. Not all of these people were followed with the same intensity. Personal bonds and trust determined the frequency of our visits and often we visited a particular person at the timing of an important event in his or her life. Some of these older people started to take on an educator's role, alternating between being a subject of study and being a 'guide' to events in the village. In particular Mae Tibaigana and the chairman took on these roles, and I have highlighted where they were involved in the actual production of data.

In the first part of the study, which lasted seven months, the focus in the household interviews as well as the longitudinal following of the 12 older men and women, was on AIDS. I spoke at length about the sickness and death of children and siblings, how the same had changed the social position of the older person and observed how villagers spoke about AIDS. Besides this focus I collected informal conversations and observations about the daily lives of older men and women. I participated in village life through sitting at the roadside, visiting, being part of celebrations and attending some funerals. General discussions were recorded in the roadside kiosk where several men would meet in the evenings. Gradually the approach changed to simple note taking of the stories that they told during visits or when we or one of us met them at the roadside, on the land or in Church. We also collected stories that were told about our core families and made notes of major events that we observed happening in their lives.

In the second phase of the research lasting from November 2003 until April 2004, I kept track more systematically of everyday events. I collected some life histories of the people I followed longitudinally, sometimes through conversing, sometimes through walks through the village and sometimes through making kinship diagrams. The longer we stayed in the village, the more we became part of the network of these older people, helping out when they were in trouble and our involvement and how we were accepted and given 'roles' became an important learning instrument as well.

Because the village was situated in a 'medium' prevalence area I constructed a semi-structured interview guide based on the major themes emerging from the data. I conducted this questionnaire among five older people in the village and then went to the area in the north, Kanyigo Ward, *Kiziba*, which was historically seen as the most affected area in the region and selected 20 of the most severely affected families. In total I spent two weeks in Kanyigo in two villages, Kiga-

rama and Kashenye (the latter was situated on the infamous smuggling border), having spent a week discussing and travelling through the area first. An anthropology student from the University of Amsterdam who interviewed the children of the same families joined us in Kigarama. In Kashenye we spoke to older men and women who were extremely affected²⁰ by AIDS to see if some general ideas held ground. Differences between the two regions – Muleba/Inhangiro in the south and *Kiziba* region in the north – were confirmed during my stay in *Kiziba*. The comparison between the two places made me more aware of the particular context in the main research village in the south in terms of localised economy, education and migration patterns, and made me aware that family care relations in the southern village have to be situated in a different context than in the northern villages.²¹ Towards the end of the fieldwork I invited groups of older men and groups of older women to my house to discuss my preliminary findings. These discussions proved very fruitful and lasted between two and three hours each.

Cases and events

A central approach in the collection of data involved recording and assembling stories, where people recollected personal histories and recounted particular events. Events could include the neglect of an older woman, the impending death of a young man who had returned from the city, the HIV test of an older woman or the running away of a granddaughter. I recorded the discussions around these events from different perspectives and analysed the positions of older people in these events. The events unfolded mainly in the lives of the core group of older men and women whose everyday lives I followed over the period of time that I was living in the village. The living situation of the selected older men and women differed in terms of personal history and education, socio-economic means in old age, gender, physical strength as well as the way they had been affected by AIDS. There were also family connections between several of the older people in the core group.

There were several situations in which data collection in relation to events took place. I started my following of events through the analysis of the three diaries which Mae Tibaigana produced during the months of my absence. In these diaries everyday life was recorded, which I followed up through interviews and kept following. I also started with these notebooks on everyday life for the other households I was following. I collected data mainly in three different situ-

²⁰ Most of the older men and women I interviewed here had lost almost all of their children. One had lost her child, and raised her grandchild and lost her as well. I interviewed one person who had not lost all her children to provide a contrast.

²¹ In the dissertation whenever I use quotes from the northern villages I identify them as coming from the north. All other quotes are from the southern village, where the main research took place.

ations. One of the situations was spontaneous storytelling in a household, often during a visit, while chewing coffee beans and often initiated by the passing of a neighbour or a recent event, or a rumour that had spread through the village. Usually these stories were not taped, I often felt a tape recorder would disturb the spontaneity of a conversation. A second situation was in the form of a loosely structured interview during visits with the intention of collecting information on a certain subject. The conversation flowed naturally, but was initiated by me. All these interviews were taped and translated from *Kihaya* to English. A third situation comprised events such as a funeral or a wedding. In this way I was able to trace how narratives changed in relation to these events, what was expected from social relations and how they worked in relation to events. The combination of methods led to several rich cases, through the analysis of which I have constructed how older people form and consolidate the relationships that they are part of. Case studies are not an illustration of abstract patterns that an anthropologist discerns from the data but are the core of what analysis is about: They serve to illustrate the uncertainty and contradictions, the expectations, and practices that are the reality of everyday life as van Binsbergen argues.

‘Whatever happens concretely in a society – interactions, quarrels, reconciliation, collaboration, between very specific individual members, should not longer merely serve as apt illustrations, just to elucidate an ulterior abstract order of which these concrete cases are merely arbitrary examples. On the contrary, the social order is nothing but the ensemble of all such concrete interactions. It is in concrete cases that the fundamental contradictions and the in-built conflicts of the social texture come to the fore – the abstract structural principles only exist in and through the agency that is acted out in these concrete cases.’ (van Binsbergen 2006: 28)

Both gender and class were important themes that framed the case studies. Gender is central to the ability of women versus men to negotiate their relations of care, both in their access to resources and old age care as well as in nursing tasks and roles in raising grandchildren. In some cases such as in the chapter on emotional care, my informants were nearly all women. Though a gender analysis is not overtly present in each chapter, it does come back in every chapter. In terms of class, the group of older people is also diverse. Haya society is a hierarchical society where clan affiliation, material assets, and most importantly land and education determines the possibility for older people to negotiate certain relations of care. Since a traditional class analysis would be irrelevant to this context, I have conceptualised ‘class’ in terms of social positioning.

Storytelling and anecdotes

Storytelling offers one way to construct social biographies. Orally expressed, experience is conveyed through words, tone of voice, facial expressions and gestures, and often gives a compelling photo of what is at stake in a local world (Kleinman 1998). Through narratives, aspects of experience can be accessed, felt, analysed and assessed (Sagner 2002). The stories of my informants in Kagera typically reflected their position in the village, and offered a rich source of information and insight regarding historical changes, the evolution of the AIDS epidemic, and the adaptations over time of kinship bonds and the family, altering responsibilities, gender roles, and economic development. On a smaller, more personal scale, with storytelling, social relations between a self and others form, or between an individual and a collective, or tensions are created as to motives, accuracy or truth. For the listener and for the anthropologist, this may raise questions about subjectivity and authority, pointing out individual fallibility and the need to match personal narratives with those of other individuals, and with verifiable social documents. As Jackson argues:

‘If, however, (...) stories are neither the pure creations of autonomous individuals nor the unalloyed expressions of subjective views, but rather a result of ongoing dialogue and reaction within fields of intersubjectivity, then the very notions of selfhood and subjectivity that are brought into relief in the European tradition of story telling are themselves creations of a social relation between self and other, and do not exist outside or prior to the narrative process.’ (Feldman 1991: 13 quoted in Jackson 2002: 22)

What is also important is that a story will not stand on its own, but when written down, is recreated to fit a frame of meaning, and indeed reflects social values in various ways – those of both speakers and the writer may come through, for no text is value-neutral. But in the case of ethnography, committing oral knowledge to text, adds another layer of complexity. Though the speaker is important, often the stories reflect a collective nature: They emerge from and are situated in a particular locality like Kagera, and their narrative and emotional logic are embedded in local relationships. In a context far from Tanzanian villages, Hannah Arendt articulated this communal aspect of stories, reflecting on the importance of the web of human connections in which stories emerge and develop:

‘though every story discloses an agent who initiated and suffered the events recounted, this particular subject never remains the sole author of his or her own life story, for the story comes into being within an “already existing web of human relationships”.’ (Arendt 1958: 184, cited in Jackson 2002: 23)

Also, storytelling is something people do; it is active and performative (Fabian 1990). In my interviews and observations, I noticed how older people occupy different positions towards one other, and in each new situation might fall into another relationship, or assume another role. This did not lead me to question

their sincerity or authenticity, but as I came to know them as individuals, they taught me about local dynamics and convinced me of the value of their individual narratives in the life of this community struggling through disruption. Recording and analysing their stories now, in this format, seems like one way of catching and amplifying their voices from the whirlwind of cultural and historical changes that over the decades of their lives swept through their villages.

In listening to and recording stories, it's important to recall that people may create a sense of control that they lacked while living the experience. A narrator is also a protagonist, and may determine the stories' meaning and the roles of particular actors.

'Story telling reworks and remodels subject-object relations in ways that subtly alter the balance between actor and acted upon, thus allowing us to feel that we actively participate in a world that for a moment seemed to discount, demean and disempower us.' (Jackson 2002: 16)

Spaces for sharing stories and discussing events often occur in gender-exclusive environments. Many men meet in the evening at the end of a day's work, on the road or in bars to listen to news on the radio. During the day, many older men work on the land, go to the market or are otherwise busy arranging business or family affairs. At other times, men meet in a neighbour's home, particularly when beer has just been brewed. Or they meet after religious worship, on Fridays in the Mosque or on Sundays at Church. For older women, daily life tends to be tied to the family and hearth, where they work the land, cook, clean, and manage the household. Some older women may find community while they engage in beer brewing and mat weaving or through involvement in labour groups. Spaces for visiting include each other's houses between 5pm and 7pm and the roadside where some missing ingredients for dinner are bought. Meetings also occur on the narrow, winding paths through the banana groves and on Fridays and Sundays at church or the mosque. Older men and women alike often look back and reflect on the way their social relations are constituted and remark on how their physical strength is declining.

I collected stories together with Augustina (Gussy), a 33-year-old woman from the northern chiefdom of *Kiziba* who was invaluable to the research. She knew how to approach older people and put them at ease, and possessed an impressive ability to read through the lines of what was said and sort out what was done. She was an expert in collecting gossip and quickly understood what I was after. We soon developed a very close working relationship whereby I watched what people did and she sometimes translated the vernacular *Kihaya* in *Kiswahili*. In writing up discussions and events that were not taped, I would provide the structure of the conversation and that triggered her almost endless

memory for quoting verbatim statements. Other interviews, visits and observations were conducted by Gussy alone as in the following entry:

From Gussy's diary: It was the day I came back from Bukoba. I passed Mae Tibaigana to get the key and we greeted each other and she asked about Bukoba. I told her it was ok and there was rain now. A little bit later two women passed and I heard their voices greeting Mae Tibaigana. When I looked outside I saw Mae Tophista holding a stick, walking with another woman. I was confused because I did not expect this mama to be walking in the road on foot. I asked Mae Tibaigana: 'Is this Mae Tophista and she can walk?'

Mae Tibaigana: Yes, even the day before yesterday she was here and I gave her tea and coffee beans and she was telling me about her grandson who wants to chase her out of that house. That grandson says she has to go because nothing belongs to her there. She sold all her properties so she has to leave. (...)

Gussy: I feel very sorry for her (...).

The same issues we observed with older people telling stories about events that changed according to their interlocutor and according to their personal situation at that very moment were also valid for Gussy and I as interlocutors. Language was an important factor in this. I did not speak *Kihaya*, the vernacular, except for some phrases, which was the only language that older women without an education spoke. Gussy consequently often developed a closer connection with these particular women. I spoke reasonable *Kiswahili*, fluent enough to conduct interviews on my own and participate in discussions, but not fluent enough to follow the details and nuances of rapid discussions between groups of people in bars and gatherings, or to pick up on nuances in expressions and proverbs, though my language proficiency grew over the course of staying in the village. Moreover, for villagers *Kiswahili* was a second language and they would only speak it to me, not amongst themselves. Those older women who spoke *Kiswahili* were comfortable speaking *Kiswahili* with me, but afraid to make language mistakes with Gussy present. Language in this sense was also a way of subtle power plays; I remained in this sense 'the outsider' in many of the conversations that we conducted together. Being an outsider was not just negative however; those older people who had some knowledge of *Kiswahili*, consciously chose which stories they told Gussy and which stories they told me, as Gussy was sometimes too much of an insider. Working in this way with a translator, or as I would call it, co-researcher, might pose questions of representation and interpretation, and hence questions about anthropological knowledge production (Pool 2003). In my analysis I have as much as possible indicated the context in which stories were produced and who was involved in producing them. The quotes I use in the thesis are the literal quotes from the translated interviews and collected stories.

Overview of the dissertation

This dissertation is built around four core chapters (Chapters 3 to 6). In each of these chapters, I single out one new social reality: Care for older people in Chapter 3, bereavement around death in Chapter 4, care for terminal patients in Chapter 5 and care for grandchildren in Chapter 6. In this sense the chapters are organised to first highlight the present concerns of older people in terms of care and well-being as they gradually age and then focus on how in this context, they engage in two specific relations that are under pressure in new realities of care: The relation between older parents and dying children and the relation between grandparents and orphaned grandchildren. In each chapter I focus on how practices of relational care, its physicality, its emotional aspects, moral questions and material aspects intertwine with processes of aging, physically and socially. In doing so I examine how older people actively engage in shaping their old age. In Chapter 3, I argue that in the era of AIDS the social significance of the older body changed, to represent an indispensable capital for practices of relating and securing care and, and in that way a sense of belonging. In Chapter 4, I show how contemporary bereavement practices of older people provide the space for older people to engage in forging relations between kin and community members. In Chapter 5, I argue that a morality of inclusion has evolved around AIDS care, which has led to the smoothening of potential tenuous relations in long-term situations of care giving. In Chapter 6, I argue that while grandparenting over time creates new demands, grandparents in essence remain grandparents, leading to relationships that are marked by both closeness and conflict. The chapters follow Chapter 2 in which I examine how family care relations have transformed in relation to broader socio-political changes. Care practices reflect contentions in contemporary social relations, and, through reflections, a space to act. But care practices are also limited by the historical access of, in particular women, to land and property. The thesis concludes with a chapter in which I discuss how practices of care and processes of aging interplay in response to new challenges in the era of AIDS.

Photo 2.1 Graves of son, daughter-in-law and grandchild of Mae Elesta, in the banana plantation next to the house



Historical transformations: AIDS, land and family relations in Buhaya

Introduction

No-one became an old person without first having been young. But if we had not put in effort so that we could have a nice future life, then our old age would not exist. When we were born and our parents gave us part of the land as is the culture, we put in our effort and worked hard and in that way we obtained more land. And the one who did not do so is the one who you now see is suffering from lack of food (Ta Laurent, 78 years, southern area of *Ihangiro*).

In this statement, Ta Laurent connects generations to land. Land, according to older people is their pension; without land old age cannot be good. In Kagera Region or *Buhaya*¹ land represents more than the means to grow food or a place to live. The central argument that runs through this chapter is that experiences of old age in *Buhaya* are inextricably connected to broader processes of social transformation in the *ekibanja (kh)*² system – the system of landholding which till this day and especially for older people forms the core of existence and reference. In the present, processes of commoditisation, mobility and illness have influenced the possibility of the *ekibanja* to connect social relations, which is reflected in older people's concerns about care relations.

¹ The area known as *Buhaya*, the area of *Buhaya*, comprises three of Kagera's six districts: Bukoba Rural and Bukoba Urban and Muleba District, an area which covers several former chiefdoms. In the remainder of the thesis I use the term *Buhaya* as this term refers to social institutions specific to the Haya. I also refer to Ihangiro chiefdom rather than Muleba District when I discuss the area in which the main research village was situated

² I refer to *kh* when I use a *Kihaya* term and *ks* when I use a *Kiswahili* term.

The *ekibanja* system informs relations of care and connection between generations as well as gender relations. Haya society is in principle patri- and virilocal: Sons inherit land from their fathers and daughters move to their husband's family upon marriage (Manji 2000: 483-484).³ A major element of the *ekibanja* system is the endowment of land to sons, so that they are able to start families. When older people refer to land as wealth, they not only refer to its economic value. Wealth lies in the capacity of the *ekibanja* to 'endow' and 'provide'. Fathers can endow their sons with plots, husbands can provide for their wives and land connects the future, present and past of a clan. In short the 'wealth' that is embedded in the *ekibanja*, consolidates and generates social relations and is therefore solid and durable (Weiss 1996: 194). Moreover, the dead are buried in the *ekibanja* and in that way the land has a symbolic value in connecting generations through common ancestors buried on the land where other generations live (Weiss 1996: 194; Setel 1999: 30-34).

Mobility is an integral part of the *ekibanja system* as well; villages are built on plateaus and after several generations of inherited land, the plot sizes are not large enough to live off. The *ekibanja* as a focal place ensures the connection of those who migrate to cities from their homeland; many city dwellers own a piece of land in their natal homes. There is another side to mobility however; migration to cities has led to a type of wealth that differs from that associated with land wealth – money and consumer goods such as video sets, televisions and mobile phones. Whereas the wealth embedded in the *ekibanja* represents social stability, older people equate this type of wealth, wealth resulting from mobility, with danger and transformations in family care relations.

In this chapter I explore the broader societal transformations that inform current practices of care amongst the men and women who have aged in this historical period. I provide ample attention to gender, as the position of older men and women is vastly different. In the debate on gender, I do not treat the patriarchal system as a structural system determining the limits and possibilities of women and men, but as a dynamic one, informing underlying principles but with ample room for women and men to position themselves in creative ways in different situations. In particular, I pay attention to a central narrative about gender relations amongst older women: *Kuvumilia (ks)*, 'putting up with things', which represents their experience of gender relations over their lifetimes as well as their current experiences of generational authority or the lack thereof.

³ Manji (2000: 484-488) argues that a focus on jural matters – the structural ideology present in descent systems – obscures the matrifocality of Haya society and that Haya society contains elements of matrifocality in practices such as female-headed households, buying land and providing for one's family. An interactionist approach instead focuses on how women negotiate power and position within the ideology of the patrilineal descent system.

The historical transformation of family care took place over three political eras: 1) the colonial period starting around 1905 first under German and then under British rule, 2) the socialist period from independence in 1961 and 3) liberalism from 1985 onwards. In each of these periods there were certain historical transformations which influenced the experienced stability of the *ekibanja* system, according to older people. I employ these timeframes because they are the frames used by older people when they try to make sense of the messy chaotic present. I therefore intertwine the way they speak about these transformations with my analysis of how family care relations have transformed in these three time periods. Moreover, these periods of time roughly correspond to the life spans of the older men and women of today. As a historical generation, older people of today have certain values regarding social relations, and frame current events as well as the relations with their children, grandchildren and great-grandchildren in the light of the socio-political transformations which occurred during their lives. The older people whose stories feature in this chapter are both from the main research village in the southern chiefdom of *Ihangiro* and from the northernmost chiefdom of *Kiziba*. In representing their stories I take into account the different history and epidemiology of the two areas.

One of the aims of this chapter is to argue that AIDS should not be singled out as a cause which transformed family care relations, but to show how AIDS contributed to such transformations which have taken place in a wider socio-economic context. In addition I argue that because AIDS is experienced by those who live daily with its consequences, it is part of a particular history of a certain locality. In this sense, I follow the literature which argues against seeing AIDS as an emergency, and plea for historicising the epidemic and analysing how it feeds on continuities (Fee & Fox 1992: 2-3; Iliffe 2006; Becker & Geissler 2007: 17),⁴ in this case continuities that have characterised Haya family care relations during the lives of older men and women.

Family care in the colonial period

Commercialisation of the ekibanja

To understand the connections between money, mobility and the value of land, we have to go back to the beginning of the twentieth century and examine how

⁴ Fee & Fox (1992) write about the Western epidemic and initial responses in the first decade. Their argument is relevant to the first and second decade of the epidemic in Africa. AIDS has often been portrayed as a public health problem, an emergency and disaster. This lack of historicising has obstructed a solid understanding of the many ways in which AIDS feeds on continuities and reproduces continuities. Only since the introduction of Anti-Retroviral Therapy has a sense of AIDS as chronic disease emerged.

the joint influences of Christianity⁵ and colonisation changed the obligations that are attributed to the *ekibanja* system. Whereas the *ekibanja* system and in particular the prescriptions of rights and obligations through the patriliney are often portrayed as given, a historical analysis of the colonial period in *Buhaya* reveals the influence of colonial times on these rules. Before German settlers moved into *Buhaya* in 1890, Haya society had an elaborate system of clans (*oluganda, kh*) and lineage groups (*enda, kh*), some of which could trace their ancestry back to Uganda and Egypt (Stevens 1991: 16). Three types of clans were distinguished: The royal *Hinda* clan, the commoners with royal blood and commoners without royal blood. Haya society was hierarchical: Every clan had specific duties at the court, milkers, herdsmen, hide-makers, furniture makers, etc. (Cory & Hartnoll 1971(1945)). The *Hinda* had a monopoly over cattle, and formed the basis of the current *ekibanja* system; the cattle dung made fertilisation of the soil, required for long-term tending of banana gardens, possible. Clans were not so much political units or ritual entities but economic units with land tenure at their base (Stevens 1991: 16).

At the beginning of colonisation there were eight Haya kingdoms. *Buhaya* comprised roughly the current districts of Bukoba Rural, Bukoba Urban and *Ihangiro*. The southern-most chiefdom, where the village was situated was *Ihangiro*, ruled until 1936 by Chief Ruhinda, a member of a long dynasty of royals. He is still used as a reference point by older women:

I was growing breasts when Chief Ruhinda died, in the time that we were still growing chillies. (Mae Maria, aged ca. 80, southern area of *Ihangiro*)

Haya kings claimed property rights over a part of the land in their kingdom through a system of tribute and tenancy, the *nyarubanja* system (Hyden 1980: 82). Kings were also able to distribute land and several older men in their late 70s had parents who had migrated from the northern kingdoms and were granted land by Chief Ruhinda.

The colonial period, which started with the establishment of Bukoba Port, following the Anglo-German agreement in 1890 coincided with a gradual decrease in influence of the Haya kings. Rinderpest epidemics killed most of the cattle, weakening their power base and the German colonial administration fur-

⁵ In this chapter I mainly discuss Christianity when I refer to religion as Christianity plays a large role in the region's history. There is, historically, a minority of Muslims in the area and in many families there are both Muslim and Christian branches. Conversion is also common, often upon the marriage of a Christian woman to a Muslim man. This is generally seen in pragmatic terms. Though I did observe some level of religious tension, which is often voiced around national and global events (national election campaigns, the capture of Saddam Hussain, Al-Qaeda), and played out during important events, such as funerals, in general these tensions do not play a large role in everyday village life. In the thesis I have indicated, whenever I noticed these tensions or whenever people specifically mentioned their religion, whether the person in question was Muslim or Christian.

ther diminished their power by ruling through a system of favouritism (Hyden 1980; Larsson 1991: 19). The White Fathers, who resided in the region in 1892, brought Christianity and some argue that the Haya kings used religious conversion as a political strategy to reclaim power (Larsson 1991: 26). By 1914 most of the Haya kings had become Christians.

One of the most important influences of colonialism was its influence on the commercialisation of agriculture and in particular, coffee. Before the settlement of the White Fathers who introduced the Arabica variant of coffee in 1904 (Hyden 1980: 49; Weiss 1996: 17), Haya grew the indigenous *robusta* coffee which was used for trading and in its cooked form, *akamwani* (*kh*), for ritual purposes (Weiss 2003). Through the German stipulation of 1911, that coffee needed to be grown commercially, coffee changed from a symbolic to an economic substance. As a result of the 'hut tax', imposed in 1904, money had already increased in importance (Swantz 1985: 48). The new commercial coffee growth in combination with the need to fulfil tax duties changed the social relations in the villages. As elsewhere in East-Africa, labour migration, especially male labour migration developed as a result of colonial politics (White 1992: 29; Dilger 2002: 49-53; Spronk 2006: 42-43).

In *Buhaya* men moved away to Uganda to work on the railways or to Rwanda and Burundi to work on the cotton plantations. The position of women changed in this period as their situation had slightly improved under the influence of Christianity. Larsson (1991) argues that Christianity and conversion increased freedom (Ibid). But at the same time, the commercialisation and intensification of coffee growth deteriorated the situation of women as, in addition to their normal duties and strenuous physical work, they were forced to take over work from men who were looking for money or fulfilling duties at court. Women now had to divert time from growing food crops to growing cash crops (Larsson 1991: 92). The commercialisation of social life spurred a debate on morality amongst the White Fathers, who referred to the youth as immoral, lazy, smoking hash and drinking alcohol (Weiss 2003), indicating the felt changes in social relations that resulted from the availability of money.

In the 1920s, under British colonial rule, following the First World War, commercial coffee growth took off, again changing social relations in the village. Coffee was produced on family farms, intercropped with the perennial cultivation of plantains for consumption. The rapid growth of commercial coffee growth in the 1920s meant that by 1929 family households had become dependent on the revenue of the coffee harvest. Land on which coffee was grown, which was mainly in the hands of the ruling elite increased in value, deepening the inequality between different classes (Swantz 1985: 49). At the same time the pressure on women as a result of the growing workload increased, as men had to

increasingly find employment to meet the financial requirements of the hut tax system and, for the *nyarubanya* (*kh*) tenants, the additional tribute to the chiefs. While men received the income from the coffee harvest, women mainly did the work while continuing to grow food crops (Swantz 1985: 49).

According to Curtis (1992), unique to the history of coffee in *Buhaya* was the free market system, which functioned relatively independently of colonial state control. The basis of this system lay in the family farm production of coffee, which made it difficult for export traders, then mainly Asian merchants, to buy directly from producers. They cooperated with African traders, *wachunguzi*, mainly Muslims in an otherwise predominantly Christian area. Through these traders an intricate system of credit and loans with high interest rates evolved. A specific form of loans was the *obutura* (*kh*), which still exists today – a loan based on next season's harvests (Curtis 1992: 511).

Another subtle change was that as result of the availability of money, many farmers were now able to hire labour from impoverished areas around them as the story of an 80-year-old migrant from the border with Burundi shows:

- Ta Petro: I came from Ngara with my friend and my friend bought a *shamba* here. So I came here and I started to cultivate and eat and drink. I came for casual labour. I was working for that friend. And then the friend advised me to go and get my family and to stay here. He told me he would give me a *shamba* (land, *ks*) and a mattress. So I went to take my wife and children and came back.
- Josien: But why did you decide to do casual labour here? Was the condition bad in Ngara?
- Ta Petro: At that time there was no food, no bananas, so I left.
- Josien: Are there many people from Ngara here?
- Ta Petro: Yes, there are many here.

In the same period the world economic recession also hit *Buhaya*, where rapid upscaling of commercial coffee growth without proper attention to quality control had led to a low quality crop. When traders reclaimed their loans from village farmers as a result of the recession a deep societal crisis followed (Curtis 1992: 512). One of the responses to that collapse was to move around in search of new opportunities, which became an integral part of family care.

The moral economy of prostitution and family care

The particular history of coffee in *Buhaya* is essential in understanding how gender and generational relations relate to developments in the *ekibanja* system. In the 1920s and 1930s the new cash economy had increased bride wealth and consequently delayed marriages for young men, who needed to first establish a base for living. It also led to more marriages between young women and older men, and more polygamous marriages and consequently more divorces (Larsson

1991: 95). Others argue that the need for cash caused men to divorce in order to reclaim part of the bride wealth (Swantz 1985: 50-51). But this is only part of the story.

At the same time, labour migration⁶ and prostitution had also led to an epidemic of sexually transmitted diseases (STDs) in *Buhaya*, mainly gonorrhoea and syphilis, illnesses which can lead to infertility and infant mortality or still-birth respectively. Local and governmental concerns around this epidemic are intriguing because they foreshadow the concerns of the 1980s when the region was the first to report deaths on a large scale as a result of HIV. The epidemic of STDs spurred a series of studies between 1930 and 1960, trying to answer the question whether the Haya were a dying people. In 1928 the native authority sent a series of alarming reports to the colonial administration expressing the concern over declining birth rates, which led to several studies, one of which was conducted by a colonial epidemiologist, A.T. Culwick, in the 1930s. The results of this study were inconclusive. Though he confirmed a low birth rate of 19 per 1,000, and a serious epidemic of STDs (Larsson 1991: 101) it was not clear whether this birth rate would actually lead to a decline in the population.

The question about the Haya as a dying population remained urgent throughout the 1930s and 1940s. A second study by MacGregor from 1940-1941 showed that of 1,392 women, 26.3% tested positive for syphilis, often leading to stillbirth and infant mortality. Of 2,200 women 20% tested positive for gonorrhoea, which often leads to miscarriages and infertility (Larsson 1991: 102). A conclusive study in the 1950s as part of the East African Medical Survey showed that fertility rates were indeed low, equalling Western European countries, but this was mainly related to a combination of early cessation of child birth (before 30 years of age) and high infant mortality (Larsson 1991: 103). A comparison of the census of 1948 and 1957 shows an increase in population from 456,396 to 514,431 but this was mainly attributed to immigrants (Larsson 1991: 104).⁷

It is argued by some that the STD epidemic and consequent low birth rates led to higher divorce rates, as women who did not produce children were sent back to their natal homes. Larsson contends that the cause and effect occurred the other way around: Birth rates were low because divorce rates were so high as a consequence of the mistreatment within marriages. A study from the 1950s

⁶ The origins of the epidemic of sexually transmitted diseases were probably linked to labour migration. In the 1890s there was already mention of STDs at the court of the Baganda King in Uganda, allegedly traders from through Karagwe to the Zanzibari coast. Many Haya worked in the cotton fields and mining industry and on the railway from Kampala to Mombasa

⁷ Kagera Socio-Economic Profile 1998 A joint publication of the Planning Commission Dar es Salaam and the Regional Commissioner's Office, Kagera. Though the national population census quotes 456,395 people in 1948 other scientists quote different figures of 300,000 in 1948 and 370,000 in 1957 based on colonial records (Reining 1967: 81; Larsson 1991: 104).

among 2,355 women showed that only 50% of women from 20-29 and 40% of women from 30-39 were still married to their first husband (Larsson 1991: 104).

The combination of low birth rates, divorce and the economic crisis of the first part of the twentieth century led to a specific mobility from the 1920s onwards – the move of divorced women to the major developing East African towns of Kampala, Nairobi and Dar es Salaam to engage in a form of prostitution called *umalaya*.⁸ Specific to this type of prostitution was the connection with home. Women would move to the city and earn money for several years and then return and invest the money in land, a house and provisions for the family. Haya prostitution was highly organised; often family relations extended into the cities and women followed the footsteps of mother's sisters, sisters or village women.

The profits from Haya prostitution became integral to the maintenance and provision of family care. White (1992) describes prostitution as a form of domestic labour and emphasises the connection with the homeland that Haya prostitutes had. Yet other authors on the subject such as Swantz and Larsson argue that it is more than that; prostitution is a form of socio-economic exchange and is related to increasing numbers of immigrants in the region making women less needed (Larsson 1991: 91-94). Swantz shows how much the increase in female mobility concerned the native authority as well as the African Association, a political organisation, which pleaded with the council of chiefs for equal inheritance rights for women as a way of discouraging prostitution in 1933. They also suggested taxes on the income made from prostitution (1985: 52). These negative associations with prostitution were fed by the Churches. Prostitution during this period should be regarded with some nuance and ambivalence. Though prostitution increased the transmission of STDs, it also empowered women by earning them a relatively decent wage.

Money earned was usually invested in the family at the natal home. Many households depended on remittances sent by daughters or sisters who were working in Dar es Salaam, Nairobi, Kampala and other East African cities. This position, providing remittances, gave these women power in the family. Money was valued over the practical assistance of sons and money was therefore seen as a dangerous agent giving women power and thereby challenging gender norms and expectations of care between older parents and their children in Haya society.

⁸ At present, *umalaya* is used to refer to promiscuity, making the distinction between promiscuity and prostitution somewhat blurred. With regard to forms of Haya prostitution, White (1992) describes a specific form which was practised in colonial Nairobi, called *wazi wazi*, after the *waziba* from the Kiziba area in the north of *Buhaya*. This form of prostitution was different than that of *umalaya*, where a woman has one or more long-term lovers. *Wazi wazi* included casual connections and open practice; Haya women in Nairobi would sit out on the street and call out to potential customers. The term *wazi wazi* was not used however, by my informants.

The following comment from Ta Vedasto, 78, from the southern village in *Ihangiro*, points to these ambivalences:

They [parents] were counting on them [girls]. For example you are with two boys and the girl is going there [for prostitution]. The boys are staying at home, maybe helping the parents in this and this. But the daughter! When she is coming back wearing nice clothes, soap, bringing a little money. You will see that apart from the culture of inheritance, where giving land to boys is normal; the father will give the house and everything to the daughter. You will find that the daughter is *the* child, because of the money she came back with. These things with money (...) that is why you heard money, money from the beginning [of this conversation].

The former prostitutes I interviewed all built houses and bought land, but no one was exceptionally rich. Most of the personal stories relate to investments in family. Mae Nyakato, aged 59, also invested most of what she earned in the family at her natal home:

I reclaimed [*nilikombo*, *kh*] the land of my brother. I got that money from one of my husbands. That man loved me a lot.

In addition to these economic offerings, Mae Nyakato also cared intensively for her older father, making sure that there would be warm water for him to wash and inquiring after his health every moment of the day. As a result, she inherited her father's house and some land. This strained Mae Nyakato's relationships with her male siblings. The position of women in relation to land, financial independence and mobility changed social dynamics, and often spurred tensions in the household economy, and family care relations.

Whereas White (1992) links female mobility to the major East African cities to family care, older women themselves mainly associate it with a way out of a situation where women were increasingly involved in men's work and had to combine household duties as well as agricultural work to keep up with the demands of increased commercial coffee growth. Moreover women were discouraged from earning money or running a business. Stories about this particular aspect of history are made into stories of agency, both by the women who went, or who engaged in prostitution in the village, as well as by the majority of the women who decided not to engage in prostitution.

In the old days we women, we were suffering with our husbands, more than now. The only reason to stay with your husband is for the sake of your children as your children will suffer when you are not there. We women, we suffer for our children, especially in the old days when we could not have our own businesses or land or property. You would have two pairs of *kanga* (cloth, *ks*), one for everyday, and one dress and if you had a baby it would change colour on the back. So many women did not see the point in staying with their husbands. (Mae Elisa, 50 years)

Mae Elisa links care for children to the concept of 'suffering'. Often older women spoke about their lives and their relations with their husbands in terms of *kuvumilia*, endurance (*ks*), or 'putting up with it' or suffering for the sake of their

children. Some women even mentioned the verb *kutesa*, torture (*ks*), when they spoke about their maltreatment suffered at the hands of their husbands. Women who went away often remained away for several years and then came back and invested the money in land, as the narrative of Mae Lauriana, an 83-year-old woman from *Kiziba*, the northernmost chiefdom shows:

- Josien: Did you ever stay outside this region?
 Mae Lauriana: Yes I stayed in Dar and when I had children I came back. These children I did not get from a husband. I only got one from my husbands and it died and after my husband divorced me I went to Dar and there I had children and I came back.
 Gussy: You were staying there as a woman stayed there as they did usually when they went there?
 Mae Lauriana: Yes.
 Gussy: Prostitution?
 Mae Lauriana: Yes. I stayed for seven years.
 Josien: Can you tell us why you decided to go to Dar and how you lived there?
 Mae Lauriana: We went with other women enjoying, eating and drinking. I had children: Three and when they grew older I came back and bought a *shamba* [land, *ks*]. I decided there was no reason to stay there anymore.

The scale of the phenomenon was substantive if we look from a family level. One former *malaya* prostitute estimated that in one in ten families women were going. Half of the older women I interviewed had sisters, daughters, mothers who had been involved in prostitution at some point in their lives. Of the ten divorced older women in the survey, three had a history of prostitution. At the same time, the majority of women choose to remain with their husbands as Mae Sofia from the southern chiefdom argues:

Do you know why the women were going into prostitution a lot? It is because you find yourself being busy in the *ekibanja* with the husband and when he gets money from the *ekibanja* he just puts it in his pocket. (...) It happens you go to visit your home (parents) and you meet your sister or *mama mdogo* [mother's sister, *ks*] who is going into prostitution and is bringing many things and you tell her your problems, like: I have no body gel, I have no soap. (...) That is when the women start asking themselves. 'Shall I leave with my aunt or *mama mdogo*. Or shall I stay to care for my children?' And you find that you have no clothes for your children. So then you decide to tighten the money and to save it to buy clothes for the children and then big fights start in the family between the husband and the wife. So in general we were staying with our husbands to care for our children. We endured (*kuvumilia*, *ks*). But if we had not endured [*kuvumilia*] we would have gone [to Nairobi, Kampala or Dar]. (Mae Sofia, Ta Stephen's wife from the southern area of *Ihangiro*)

This statement reveals a lot about a moral economy of household finances and women's labour, and connects the value of *kuvumilia* to a love for children, which demanded personal sacrifice. These values resonate in current assessments of social relations.

Perhaps due to the ways prostitution empowered women in spite of the structural disadvantages they faced, explains why the institution was often viewed as such a threat. There were several reactions to it from within Haya society such as

a movement which did not allow women to board the steamer or buses to leave the area and discouragements to sell land to prostitutes (Swantz 1985: 77). This conflict in the way of looking at prostitution is still present in the narratives of older people. There is ambivalence in the way prostitution is spoken about; prostitution is rarely mentioned openly while at the same time stories of prostitution are stories of agency.

Vital in understanding the reasons why women had so little opportunities in *Buhaya* is the way in which the *ekibanja* system organises access to landholding and inheritance. Women, in the patriarchal and virilocal society had, until 1944, no formal right to inherit land from their husbands or fathers (Weiss 1996: 21). Power in the patriline is exercised along gender and generational lines (Kaijage 1997: 341-342): fathers exercise authority over their sons through endowing them with land, whereas the position of an older woman is more uncertain in her marital home, as she can exercise power mainly through her adult sons and daughter-in-law, but has no formal access to land. The clan will in many cases decide conflicts around inheritance, or support of widows,⁹ and orphans, who belong to the clan (Kaijage 1997). Only in 1946 did widows obtain the right to remarry. Before this time she could be inherited by her husband's brother (levirate) or move back to her natal home where she also often had a marginal position, except for when she brought in money (Swantz 1985: 68). For divorced women property was a way of gaining respect and a way for women to tie bonds with their male agnates, brothers and especially fathers in the natal home (Manji 2000: 490-491).

The rules and regulations pertaining to landholding and inheritance were written down by two colonial anthropologists, Cory & Hartnoll in 1945, following a series of consultations with Haya chiefs. The book 'Haya Customary Law' contains detailed descriptions about inheritance. Interestingly this book is currently the frame of reference in court cases around inheritance claims of orphans, as the true account of 'traditional law'.¹⁰ Their account reads that inheritance is arranged along the male line. There are three categories of heirs. The first one is the *Musika*, the primary heir (*kh*), the second one is the *Mainuku*, the secondary heir (*kh*), and the third is the *Kyagati*, the third heir (*kh*). The *Musika* is the eldest son who inherits three parts of the whole of the *shamba* and the house of the father. The *Mainuku* is the youngest son who receives two parts of the whole and

⁹ Women in Kagera often marry older men (sometimes the difference in marital age can be 20 years). This means that whereas most older men have a wife, most older women are widowed at a relatively young age.

¹⁰ I obtained a hardcopy of the book from the legal office of Wamata, the AIDS counselling organisation advising widows and orphans on inheritance issues, and assisting in the preparation of official court cases.

the *Kyagati* are the remaining sons who receive each one part of the whole, that is, if the father's land is big enough.

Land is only inherited upon the death of a father, but can be allocated to the sons before his death. When a son dies, however, before his father, the son cannot inherit and the father decides who will inherit the land, which may leave widows and children in a problematic position (Muchunguzi 2002). A widow would officially be allowed to live on the land for the rest of her life, but she was not allowed to pass it on to anyone but the sons of her husband. A divorced woman would move back to her father's home but was not allowed to pass the land to her children.¹¹ Weiss argues that there is in fact little evidence that clans were localised in certain places; claims to land are more political claims. Haya clanship is therefore diverse and fluid (1996: 20). In reality the rules and regulations were used in a much more flexible way and issues of favouritism often played a role. When there were no sons a father would divide the house amongst his daughters and when a daughter had provided substantial care for the household, she could also inherit. Moreover fathers assisted their daughters who had not had children as a result of the epidemic of STDs which was still rampant. This became possible when, in 1950, a colonial decree was passed allowing women to inherit. In order to keep land in the patriline, women could inherit but they could not give it to their children.¹² Women were also allowed to do casual labour and were allowed to take out loans, making them more independent in relation to their husbands as it allowed them access to land.¹³

In the personal histories of women older than 60 these changing regulations become visible. Table 2.1 shows first that there is a tendency for younger women to own land, which fits with the changing regulations in landholding. Whereas this fits the notion of inheritance the table also shows that of 31 women, 22 women owned land. The women who had the least access to land were widowed women.

¹¹ Though these inheritance 'rules' are generally recognised, Reining's (1967) account of the Haya towards the end of the 1950s states that land was not divided upon death, and remaining sons moved out of the village.

¹² Many women are not aware of the changes to the inheritance laws and some organisations give legal advice such as Wamata Rubya branch (and some other legal organisations).

¹³ All old men in the sub-village, but two, had land. One of these men was from an impoverished area on the border with Burundi and had come to the village to find casual labour; the other man had been accused of witchcraft in his home village and his possessions had been burned to the ground and he had fled. These two men were not among the most respected in the village. Among the women there were clear differences. One woman I followed intensively had cared for her father and was given the house as a gesture of appreciation upon his death, other women had become prostitutes after divorce and had built their houses themselves, other women had borrowed money from relatives and another woman built her house from pension money. Most of the divorced women owned land, but only 2/3 of the widowed women

Table 2.1 Female ownership of land by marital status and age (n=31)

Marital status	> 60	> 70	>80	Unknown age	Total
Married (n=1)	-	1 of 1	-	-	1 of 1
Divorced (n=10)	3 of 3	1 of 1	1 of 2	2 of 4*	7 of 10
Widowed (n=20)	6 of 7	3 of 3	4 of 8	1 of 2	14 of 20

* One of these women sold her land.

Several older women, mainly those who had been widowed, had inherited land from their husband or father; a minority of the divorced women had inherited (Table 2.2). Four of the ten divorced women had bought land, two through money earned from businesses such as brewing local beer and bought land and built a house with the assistance of male family members from their natal home. And indeed two out of the ten had invested the money made from prostitution in land.

Table 2.2 Source of land for women

Source of land*	Married (1)	Widowed (20)	Divorced (10)*
Inheritance of husband	-	9	-
Inheritance of father	-	5	2 of 10
Bought	1 (brewing gin)	2 (1 through small business)	4 of 10 (two through prostitution)

* Most women had obtained land through a combination of the above.

After the 1950s the issue of clan land, which often contained the graves of deceased family members of the patriline, and married women entered the discussion. Weiss argues that 'clan' land is a political construct which only emerged in the 1950s and did not exist before. In the account of Reining from 1967 on the Haya agricultural system the term 'clan land' does not feature (Reining 1967; Weiss 1996).

When the colonial period drew to a close, the social basis of family care as informed by the *ekibanja* system had drastically changed. The increasing importance of money, labour migration, and the political economy of prostitution influenced gender relations and changed access to land.

Family care in the socialist period

Population growth and the availability of land

The last years of colonialism and the first years of Tanzania as an independent nation were defining years for the current generation of older people – years in which they built their lives. Julius Nyerere shepherded the nation from independence in 1961 through a period of socialism and into the liberal period of the 1980s. Older people recall with nostalgia the hope and pride of this early era, and register disappointment and pessimism as time wore on. It is therefore important to understand how the political and social developments which evolved from the early 1960s onwards influenced the *ekibanja* system. One of the issues in this period was an increase in population growth. As giving birth in the area had been so difficult for a long time, children were highly valued and, when in the 1950s medicines for STDs became available, birth rates increased rapidly. In the census of 1967, five years after independence, the population measured 658,712. The genocide of the 1960s in Burundi led to refugees contributing to the population growth in the census of 1978.¹⁴

With the high infant mortality rates of the earlier part of the century, in order to ensure survival, women had many children. But when medicine improved the infant mortality rate, the pregnancy rate did not drop. As a result, the population continued to grow rapidly. Due to this, in combination with inheritance laws, plot sizes gradually decreased. This was also related to the specific nature of Haya villages, being built on plateaus with farms taking years to turn into a functioning plantation. Therefore people tended to stay in a fertile place and to not move to other lands until plots became too small as Mae Tibaigana relates.

In the time of my father we had many diseases, so women did not have many children. If you had two or three children they would think you were a witch [for having many children]. So due to this, people valued children very much. And when the diseases were treated, people gave birth [around the end of the 1950s/60s]. So from then there were many children. And now these children have grown up and have children and the land has become small and not enough to provide families with food.

Parents struggled to school their kids, as education was made difficult by the large number of children in combination with the dominance of a cash economy and a weak national infrastructure (in spite of attempts to modernise). Education had, under the influence of the mission, become very important, and Kagera Region was known for its highly educated people. This had already had its effects on family care relations as children who used to be herders were now in

¹⁴ The Haya population increased to 1,009,379 in 1978 and 1,313,643 in 1988.

school. Education was considered very important, especially in the northern areas of Kagera, the area which also delivered the first African Bishop.¹⁵

Education was also highly valued in response to declining land plots. Many farmers realised that the shortage of land would not enable them to sustain their children and they consequently needed to find a different way of earning a living (Hyden 1980: 91). Yet education also increased the commercialisation of farming, as children contributed financially to the family and in this way facilitated cash crop production and the acceleration of trade (Swantz 1985: 67). Education also changed the basis of clan authority. While the hierarchical social system remained intact, and class remained important, it was no longer necessarily clan affiliation which defined class and social position. It was a combination of wealth, education and clan affiliation. A class of small socially conservative entrepreneurs had developed which were often put forward as village representatives by peasants as they were considered to be able to best manage government development plans to the benefit of the small farmers (Hyden 1980).

The many young people who were not educated and remained in the village, engaged in business at a time when the plantations were affected by a series of pests, leading to decreasing yields, causing food shortages and increasing the necessity for money to buy food (Kaijage 1992: 82). Ironically, under socialism the economy became even more monetised, cash dependant and integrated in the global system. A series of government policies that increased scarcity only accelerated these processes.

State interventions and the stability of 'clan' land

President Nyerere's Arusha Declaration of 1967 called for a transformation of Tanzania's economic system, to create a form of African socialism which emphasised self-reliance and the importance of local village economies. He called this project '*Ujamaa*' (ks), a term that implies the kinship bonds and loyalties of an extended family, but here applied to the entire country, suggesting the nation be re-imagined as a form of family. The programme of *Ujamaa* was also based on principles that were part of African village life, principles such as reciprocity, respect and communality. Hyden argues that these principles were part of family life, not of communities in a wider sense and the application of these principles to everyone in a community did not work (Hyden 1980). Especially in *Buhaya*, where land symbolised the continuity of generations (Weiss 1996), people did not comply easily with new regulations such as communal land, as was part of the ideology of the *Ujamaa* village, based on a collective self-sufficient model

¹⁵ Some have argued that Kagera Region, which was, as a result of early missionisation, education and the economic power of coffee, already a wealthy area was purposely neglected during *Ujamaa* as Nyerere focused on other more impoverished areas (Moyer, personal communication).

including communal stores, collective agriculture, and amenities such as water taps and health centres.¹⁶ Moreover, *Ujamaa* went against the principles of an economy of affection based on patron and client relations, based on land and kinships (Hyden 1980; Stevens 1991), which was very much part of the hierarchical Haya society. Haya generally were critical of *Ujamaa*, as the following statements from the southern area of *Ihangiro* attest to.

- Ta Stephen: *Ujamaa* was not bad, but it did not work because people do not like to do things equally.
- Ta Cypilianus: On my side, under the first president life [Julius Nyerere, nicknamed ‘the teacher’] was difficult. We started and it was difficult. That was the month of *mwaliimu* [the teacher, *ks*]. Under the second president [Ali Hassan Mwinyi, nicknamed Mr Permission] people were crazy. We got everything. Everything was available. Soap. In the 1980s [during *Ujamaa*] you went to get sugar and you could only get half a kilo. You waited in the shops. And you would buy *everything* you could get that was *obligatory*: Batteries, everything. When you could you would get it! Under *Ruksa* (Mr Permission), people could get everything. *Uchumi wa nchi nzuri wananchi* [For the people in the country the economy was great, *ks*]. Mkapa, they were pissed off at him [The third president, Benjamin Mkapa introduced the politics of *kubana*: ‘to tighten the belt’, in an attempt to straighten out the economic crisis in which Tanzania found itself (cf Moyer 2003)].
- Ta Laurens: The big change that happened and changed our development, which caused a downfall in development was the changes to the Society [Kagera Coffee Union] since 1950. So the changes [that occurred] in the [Coffee] corporation. We were selling our crops and received money and some time after selling the coffee, they gave you a supplement. But when the government interfered everything was spoiled.

In spite of the programme’s ambitions, *Ujamaa* is mainly remembered as a period of increased state control and scarcity. For farmers who had by then become dependent on coffee as their major cash crop, the way coffee was sold, through the Kagera Coffee Union, *the Society*, as Ta Laurens calls it, changed. Under *Ujamaa* the colonial way of managing coffee through a trading house with small merchants, was abolished, impoverishing the smaller farmers (Curtis 1992). Still, Stevens (1991: 16) argues that no economic change has altered the mode of production in villages substantially – the lineage system as the basis of family care still prevails.

However, *Ujamaa* also led to the development of new social institutions, which have today become important in the way family care works. These social institutions have also strengthened the position of women. These included the development of Women’s Unions, the *Umoja wa Wanawake (ks)*, Unity of Women. These groups provided an addition to clan-based and religious groups, and

¹⁶ A central part of the *Ujamaa* ideology was the restructuring of rural areas with the intention of moving the Tanzanian population into planned villages, with communal cultivation and cooperative activities. In Kagera region few villages reached the full *Ujamaa* stage (Swantz 1985: 62-63).

were an important influence in relation to the development of security mechanisms in sub-villages (de Weerd 2001). Under *Ujamaa* the possibilities for women to earn an income became larger when women received more chances to obtain an education. Some older women had leadership roles in their lives,¹⁷ as the story of Florida shows.

Mae Florida's husband died in 1960 when she was 33; they had been married for 12 years. To avoid being inherited by her husband's brother, Mae Florida moved to her natal home. 'So before independence I was already back home'. In her natal village Mae Florida joined three self-support groups, and became a leader of a group of older people who were advising on how to settle quarrels, 'but the group was broken because the young ones took over leadership and said old people could not guide them'. Through that group she became a ten-cell leader, leader of ten households under the old *Ujamaa*/socialist system and engaged in small businesses like selling fish, buying and selling beans, and *akamwani* (cooked coffee, *kh*), and growing and selling groundnuts.

In the *Ujamaa* villages women had access to land as land was communal thereby improving their position slightly (Swantz 1985). At the same time in traditional villages, which dominated in number, women remained in a subordinate position in families, being still dependent on their own income to secure access to land. Within *Ujamaa* villages collective work mainly placed an extra demand on the strength of women as it did not replace traditional farming (Swantz 1985: 64). Women in the *Ujamaa* ideology were viewed as mothers and nation builders, through the focus on the bounded social unit of the individual household, a vision that largely ignored the often unstable marriage arrangements, high mobility of women and the moving within larger kinship networks (Lal 2010).¹⁸

Survival became more difficult after the socialist government enforced politics of decentralisation from 1967 onwards, resulting in a decline of the transport infrastructure. These measures resulted in a downfall in economic development and the educational standard in one of the highest educated regions of Tanzania (Mutembei 2001). The enforcement of *Ujamaa* ideology included the forced formation of communal villages in 1972. Yet this politics cut across local boundaries, particularly land, and though there are remnants of *Ujamaa* in Kagera such as former *Ujamaa* villages, Union buildings and Union stores, the enforced villagisation never took off. Many villages remained traditional villages; newly established villages were mainly occupied by the landless and those without

¹⁷ As ten-cell leaders: the representatives of ten households in the village. Communal agriculture was to operate through the division of villages into ten-cell units, each composed of ten *Kaya*, whose representatives were to labour alongside one another on the village's communal farm (Lal 2010: 3).

¹⁸ Lal (2010: 19) argues that both men and women during *Ujamaa* used flexibility and diversification as ways to increase personal security.

work in the traditional villages as a way to enhance their own development (Hyden 1980; Swantz 1985: 62).

When the *Ujamaa* ideology in Kagera region was enforced, it had dramatic consequences. Part of the strategy was the opening of communal stores. In an attempt to get rid of the petty bourgeois – the Indian and Arab traders who controlled business in Kagera since the colonialist period – shops were closed overnight¹⁹ before collective stores were opened. In the context of the declining yields that the *ekibanja* produced, this led to another societal crisis. Mobility was once more a strategy to respond to the difficulties involved in making a life for oneself, thereby repeating the same pattern of male and female mobility as a central part of family care.

Money and the 'value' of land

In the early 1970s a series of political changes led to the isolation of Kagera Region. One of the major changes was the abolition of the East African Union in 1971 following the coup of Idi Amin in Uganda. Suddenly it was more difficult for traders in Kagera to connect to trading partners in Kenya and Uganda. Moreover Kagera was now spatially isolated in Tanzania, 48 hours from the commercial capital Dar es Salaam. Border posts became centres of trafficking in goods, alcohol and commercial sex (Kaijage 1992: 84). Empty shops, isolation and the need for money again led to labour migration. Both women and men went into business. Divorce rates were 10% in 1967 and 8% in 1978. Reasons cited for divorce were often lack of support from the husband, cruelty and better opportunities in town (Swantz 1985: 72).

In the middle of this economic crisis and a quickly developing business mentality, Idi Amin invaded Tanzania in 1978 to reclaim the *Missenyi* area north of the Kagera River, an area which was given to Tanzania in the Anglo-German agreement of 1890. Nyerere's response was harsh and immediate: The Tanzanian army invaded Uganda from Kagera and the year of war that was partly fought in Kagera region wreaked havoc, particularly in the northern part of Kagera Region. Many of the current older men joined the army and the villagers in the north were suddenly involved in war. Mae Tibaigana, living in Kanyigo, part of *Kiziba* remembers stories of soldiers raping women:

During the war of Amin, wasn't it true that the soldiers were spreading everywhere? When they saw a woman going to fetch grass, they would follow her. (...) I will never forget Kashenye²⁰ (...) here was one woman and they followed her home and she ran away but they saw the house she entered and entered as well and when her husband asked what the problem was they tied him up. One man had a gun and told the husband: 'you look to be jealous, wait

¹⁹ Business went underground (Mutembei 2001).

²⁰ The northernmost village of Tanzania, where AIDS allegedly spread into the country but which was at that time called Little Europe due to the enormous wealth from contraband trade.

and look at the work we are doing' and they grabbed her and one went with her and then the other and then the other. Around here another bad thing happened and they forbade the soldiers to walk in the village. At that time they were staying in nice houses; they would rent them. Now they stay in camps.

In his popular account of AIDS, *The River, a journey to the source of HIV and AIDS*, Edward Hooper suggests that the highest HIV prevalence rates can be mapped around the so-called smuggling zone, the *kikomela* border and around the route of the 207th brigade of the Tanzanian People's Defence Force (TPDF), the Tanzanian army. This regiment consisted mainly of volunteers from the people's militia²¹ who required extra training before marching into Uganda and stayed in one area, bordering the free trade zone in Kagera, for a three-month period. The highest prevalence rates in the region were later measured along the route that the brigade followed into Uganda. The chairman of Kashenye on the *kikomela* border described the beginning of AIDS²² as follows:

I have to start with the story of Idi Amin. Do not write yet, because I want to explain so that you understand. In 1979 Idi Amin entered the country. The Ugandans lacked support, they lacked things and they came to Tanzania to buy things. In 1980 they needed many things because of that war; they needed coffee and sugar and things like that. So they brought business. Many Ugandans came because Idi Amin had ruined all the factories, so they had nothing. So people would buy *Jembe* [hoes, ks], they would buy many other things, and go to Uganda to sell these things and to do business. They would go on Wednesday and come back on Sunday and Monday and on Tuesday they rested. The business was big: *Pombe* [beer, ks], everything. And *Bahati mzuri, mbaya* [good or bad luck, ks], I do not know; both women and men went into business. Many women left their husbands and went into business. Even from Mwanza (...) the women came for the business of *Umalaya* [prostitution, ks] because there was such a big market here [right on the border].

So this disease came and people saw other people having diarrhea, vomiting, and drying up like bones. (...) The sickness came from Zaïre. Ugandans went there to do business. And in the beginning of the 1980s, between 1980 and 1985 every young person [here], like this one (points to our guide who is about 20) owned a motorcycle. They had so much money. And the business went like this: There would be a man who would give me 1,000,000 shillings²³ to go to Arusha and buy tyres. And because I knew Kiswahili he would ask me to go. You would go with your brother to Arusha and live there. (...) And then you were in Arusha and would buy beers and get a lover. Or you would go on a boat to Kenya, because you were someone who was not scared to travel across water and there were no barriers then and the life was very good with a very high standard of living. That is history now! But you would have a person like this one [points to a 30-year-old man]. In the 1980s he would have 1,000,000 or he would have 500,000 or 700,000. Ah!! In the beginning we were afraid to carry that amount in our pockets! But we got used to it. And the sickness came in big time [*uliingia sana, ks*] and a person started to vomit and have diarrhea and houses were closed.

²¹ A semi-trained fighting force that provided security at village level in Tanzania (Hooper 1999: 767).

²² The highest prevalence rates were measured in the smuggling zone and in Bukoba town. Ihangiro district, traditionally a business area and an area with many fishing villages was not as highly affected as the smuggling zone but was second after the highly affected areas (Kwesigabo 2001).

²³ At the time of the study this amounted to 1,000 USD, a substantial amount of money. I assume here the chairman used current amounts to discuss the wealth of those days.

The era of AIDS, from the 1980s onwards is characterised in popular narratives by the emergence of these new markets. Older people described this period as one in which the desire of wealth overtook (*tamaa ya mali, ks*) (cf Moyer 2003; Setel 1999). *Tamaa*, desire, was an equivalent for everything that was dangerous, yet desirable in society. Whereas labour migration in the colonial period had increased gender inequality and patriarchal authority and *Ujamaa* had led to more possibilities for women, labour migration as a result of scarcity and war led to serious ruptures in family relations.

Family care in the period of neo-liberalism

Gender, AIDS and generational authority

The need to find a life (*kutafuta maisha, ks*) through business, prostitution or other means took flight when in 1985 Ali Hassan Mwinyi was elected president. Weiss (1996) describes this time as the time of commoditisation. Everything was suddenly available. Businessmen travelling to Dubai imported hoes and *panga* (cutting knives, *ks*) as well as kerosene lamps, stereos and TVs from Taiwan and China. There were second-hand clothes and shoes from Europe. During this time, however, many people started to die – the businessmen and women who had gone into prostitution. 1985 was a turning point when the particular Haya form of prostitution to cities decreased in importance, as a conversation between women from the southern area of *Ihangiro* shows:

- Josien: How many years is it since they stopped this [prostitution]?
- Monica: Like in 1985, when *Ukimwi* [AIDS, *ks*] became hot. And in 1987 many stopped.
- Fatuma: Yah, yah, even the children of my sibling from Bilabu all died at that time. And in Dar es Salaam they have one place in Manzese, there is a place called Ithongo. It is a house from one son from here and all prostitutes from *Ihangiro* were there. So that son has died and all the women have died already.
- Monica: In 1983, when the disease started, I remember the first woman dying from Dar es Salaam. She died in Bukoba and at that time they called it Juliana²⁴ and the people did not yet know that it was this disease. So in 1985 and 1986 they knew it was *Ukimwi* and in 1987 many women stopped.

Women, though laws had increased their chances to obtain money, had also experienced the death of many of their sisters and friends. Despite business and education opportunities that resulted from the socialist period, the position of women in their marriages and husband's family was still subordinate; many women reported abuse and being controlled. Business, in the era of AIDS, was the only way to gain some power in the marriage.

Josien, even our parents cannot tell you that you have to change. Even our mothers had these problems with their husbands; this thing is inherited from generation to generation. If the woman says she is tired of these problems, she can decide to go back home (to the parent's

²⁴ After a popular cloth that was a primary trade commodity between Kagera and Uganda at the time.

place) but there she has no *shamba*, she did not inherit, and because of her husband she does not have sufficient money. If she could have an income she could build her own house and live well. Husbands like their wives to stay in poverty. You tell him there are loans for women, but they do not like that; they think that you are going to do business and show off. If women have no income, no *shamba*, where will they go? That is why you see them staying with their husband and this disease (AIDS) is hindering them from divorcing. (Lydia, mid-30s, southern area of *Ihangiro*)

A new phrase developed: ‘when the conditions were still good’, referring to the time before ‘that disease entered’ (*ugonjwa huu iliingia, ks*), a phrase which was contrary to the *kutafuta maisha*, ‘finding a life’ which had been the rationale for mobility for so long. When old women speak of the possibilities of having a life they refer to the changed position of women as a result of AIDS. All the older women I spoke with who had been engaged in prostitution referred to the AIDS epidemic as the time when this particular form of prostitution stopped and when the opportunities of women to have a life disappeared. In the narratives of the older women whom I interviewed about prostitution a distinction was always made between ‘when the conditions were still good’, referring to the time before AIDS and nowadays, references within which a certain nostalgia was present.

At least in the past women got *nafuu* (space, relief, *ks*). In the past women divorced as well, but before this illness came (*ugonjwa huu uliingia*) a woman had freedom. She went to Dar or to Kenya. The conditions were good – better than the conditions now, after we got that disease and the condition of going there became difficult. It is tightening here. If it is bad at home, where can you go? A woman used to be big inside the house, she used to be big. (married woman, end-forties, southern area of *Ihangiro*)

AIDS not only changed the opportunity for women to escape their marriages, it also changed the opportunity for their parents, who had often benefited from the money made through prostitution. Women in this period increasingly became dependent on small businesses, which made them more independent *within* their marriages and marital families. This subtle change had also an effect on generational authority, in particular the power which older women exercised over their daughters-in-law through their sons. This power was essential for older women because daughters-in-law assisted them in their households in old age. The increasing independence of women was what old women saw as both a negative and a positive development. It was positive in the sense that old women realised that women had access to an income, yet older women were also frightened of the increasing freedom of young women who were their daughters-in-law and were the ones they counted on for care in old age. When older women talk about issues like suffering and endurance, *kuvumilia*, they also refer to the increasing independence of younger women today making it less necessary to endure in the way they did over their lifetimes. And whereas these older women had themselves tried to find a way out of their own situation, they now, for their own

security, needed to perpetuate the same patterns that they had been caught in themselves.

Conflicts in family care

In the late 1980s and the early 1990s family care patterns that were implicit in the *ekibanja* system became visible as a result of AIDS, especially the rules and obligations pertaining to the situation of widows and orphans but also divorced women, as they generally had sought a life in town and returned to their parents place when they fell ill. In the northernmost villages, in Kanyigo, on the border with Uganda AIDS caused disaster in a short period of time, as the following story of an older woman from the northernmost village in *Kiziba* shows:

My first son died 12 years ago (1992) at 32 years old; all his children died as well as his wife. He stayed in Dar²⁵ and came home sick. I cared for him here for six months. He was a businessman. He died first. I do not know where he got the disease, but he was already sick when he arrived from Dar.

My second son died only a few months after my son. He left five children and the wife died first.

He died when he was 38 years old. He stayed in Dar for business and was already sick when he came. I cared for him for 8 months.

My third son died one year later (1993). He was around 40 years old. He left six children. His wife died in November last year. The children are in my hands.

My fourth son died three years later and his wife drowned when the MV Victoria sank, together with their baby. He was 28 years old. They used to live in Dar.

My fifth son died at 22 years of age. He was not yet married. We were staying here together and were doing *shamba* work.

My daughter was not yet married and was 17 years old. We stayed together.

All my children died of this disease, even my daughters-in-law and everyone. AHHHHH (shouts). I am here, here, just here; the problems are finishing me! Even all my siblings have died – I do not even have one!! And one of my siblings used to be a doctor in Muhumbili University; he became sick and then he died. I do not know if it was this disease. This I do not know.

In this area, new patterns of family care emerged. The people in this area, who had become very wealthy in the business frenzy in the mid-80s and who had been highly educated happened to belong to one clan, the *Waziba*. The many orphans were taken in by relatives in the city, mainly in Dar es Salaam, where educated relatives had found employment, but also by non-relatives belonging to the same clan, strengthening rural-urban connections even further. Dispersal of kinship ties therefore does not necessarily lead to less family care. In the village, an NGO, Partage, stepped into the broken social institutions and built houses for orphans, as well as schools.

In *Inhangiro* the area of the research village, there were many clans. Moreover the area had always focused on business, more than on education, thriving in the

²⁵ In the villages in the north people were highly educated and many occupied important positions in Dar es Salaam. In the stories about death Dar es Salaam therefore features often.

business triangle that comprised the major market towns of Kamachumu, Nshamba and *Ihangiro*. Moreover, AIDS prevalence was not as high as on the border where those who died were those engaged in cross-border trade with Uganda. In the village AIDS was much patchier: Mobile businessmen and women involved in prostitution started to die first and slowly also village people became ill and started to die. In the death histories I recorded that many of the deaths took place around the end of the 1990s, a timeframe that fits the business frenzy that emerged under the rule of the second president from 1985 to 1995. What is interesting is that older people in the village lost not only children but also other relatives as Table 2.3 shows.

Table 2.3 Number of older people who lost the following relatives per relative (n=50)

Lost whom?	Older men	Older women	Total
Spouse	- (1 ex)	3	3
Siblings	6	6	12
Children	10	15	25
Grandchildren	3	3	6

Moreover extreme changes in family care were not that visible in the village because prevalence was lower. Table 2.4 shows the number of deaths of children per women and men.

Table 2.4 Summary of child mortality amongst older men and women aged 58-86 (n=49)

	Total no. of children	Total no. of children still alive	Total no. dead as infant	Total no. as dead adult	Total deaths attributed to AIDS
Women (33)	184 (5.6 births per woman) ^a	119	29	36	31
Average age: Unknown ^b		117	21	21	13
Men(16)	159 children				
Average age: 70.3	(9.9 children per man) ^c				

Notes:

- a) Of the 34 women four were infertile and four only had one child.
- b) The majority of women in the sample did not know their exact age. Only the younger people (above 60) knew the year that they had been born.
- c) The higher average number of children per man is due to polygamy: eight of the 17 men had more than one wife.

What AIDS did evoke was a new discussion of certain family care regulations, such as how care for orphans and widows should be organised. Land, already scarce as a result of population growth received a new meaning: It served as an asset to pay for the cost of looking after ill children. The *obutura, kh*, the system of borrowing against future harvests, also became a resource for obtaining needed cash. But land, in particular the notion of ‘home’, in the sense of the natal home, also served to reconnect generations; through burial on the clan land, parents are connected to orphans, and deceased adults remain near their older parents. Politics of belonging are sometimes played out when confronted with the death of those who have given birth without being officially married, when ‘home’ is not established, sometimes leading to conflicts over where deceased bodies belong (Whyte 2005). But belonging is also reproduced through a new focus on clan land and in particular inheritance of orphaned children.²⁶ Whereas ‘home’ in *Buhaya* has always been a focal place, and a core feature of rural-urban connections, the importance of home claims has increased manifold in recent years. For male orphans staying on the father’s land, being fostered with the father’s children to have access to land is especially important for male children, who are then faced with obligations towards their sisters. But questions of inheritance also abound around those who are fostered by maternal relatives and later need to reclaim their access to land. Land grabbing by distant relatives abounds as do court cases against those who unrightfully claimed or disposed of land. More than ever the *ekibanja* became a focal place for connection and power struggles in the family, and more than ever the wealth of land and the volatility of money became an issue of debate.

New connections to the land

The political changes in the 1990s when Benjamin Mkapa took office made it increasingly difficult for younger people to make ends meet. ‘Capability’ and more to the point, the lack of it, became the key-word in the stories of both young and old people. Markets for agricultural input and output were gradually liberalised under the influence of Tanzania’s structural adjustment programme²⁷

²⁶ I observed that there are also conflicts in the village office or even in court. Muchunguzi states that there are many women, more than men who have conflicts, though the data he presents does not show this clearly. Most complaints were related to confiscation of farms (37.5%) and sale of land by relatives (32.5%). In total he counted 37 cases in 2000 and 40 in 2002 in *Wamata* covering 5,000 households. Problems with land included lack of a will and the hiding of a will – traditions as described above. Some of the problems for which advice is asked include selling land to cover costs or drinking alcohol. Conflicts are also related to the value of land in contemporary *Buhaya*. This is related to population growth without moving to other areas and the cutting up of land. A producing *shamba* can amount to US\$ 1,000-2,000 per acre, which is a lot of money in a poor economy (2002).

²⁷ Tanzania’s first structural adjustment programme was launched in 1986 with the support of the IMF and World Bank and was mainly geared towards import liberalisation, adaptations in monetary policy and an active exchange policy (Ferreira 1996: 7).

in the late 1980s (de Weerd 2010). In the last decade the village was able to profit from major markets which became more and more important in the absence of other employment opportunities and fluctuating world markets.

For those who remained in the village, sometimes working as a seasonal migrant on the fishing islands off the coast of *Ihangiro*, life in the 1990s was difficult. Means of income were subsistence farming and additional business: Selling surplus, keeping cows, trading of clothes, making beer, running small grocery shops or being a handyman (electricity, carpeting and bicycles). The district has major fishing islands where many young people from the villages go to engage in seasonal labour, selling to the large fish factory in Kemondo Bay and to the markets, or are involved in public transport.

The new tarmac road which has been built between *Ihangiro* and Bukoba town, has given trade a boost because the travel time has been reduced considerably. Different from the areas to the north, business links in *Ihangiro* district focus more on trans-regional connections with Mwanza, one of the largest transit ports in Tanzania. As a 25-year-old man explains:

You have two types of young people: The ones without schooling who go into business. Maybe they work for the ones who are bringing the bananas to Mwanza. They cut them and then bring them to the road where you see them lying around. [If they go outside the village] (...) many go to Buganguzi or Kamachumu, on business, or to the island to fish. There are no industries. But a large percent does not work. Have you reached the road around 10am? They are there. Then there are the ones with school [who have had education]. Many will try to get a job here, for example with World Vision or an organisation like that because they do not ask for many more qualifications than secondary school.

This generation of young people is more educated than the current generation of older men and women, despite the long history of education in the region. Education in previous times focused on the northernmost districts.²⁸ Education influenced the possibilities for care in old age. Older people of today realise that education is a must if children are to care for you. There are however, two sides to education. An educated child can take care of you in terms of money, but many have left the village and migrated out of the region. Where older men and women summarise their current concerns with the state of social relations in *Buhaya* as being caused by the *desire* of the younger generation, both young people relate problems to their lack of capability and the lack of possibilities for youths. The growing focus on money has, according to older people shifted generational power, so the roles of older people are changing and the presence of people to deliver care is not certain. This is reflected in narratives over the loss of

²⁸ Of the 31 older women above 65 I interviewed, 28 had had no formal education. One of the three remaining women had married into the village but had been born in the northern districts and had worked there with her husband for a large part of her adult life.

control over children and grandchildren. Weiss (1996: 179) argues that money is blamed for the loss of values of the Haya world.

The past three decades has seen the possibility of the *ekibanja* system to regulate family care change due to the commoditisation of social life, intensification of migration in response to population pressure, fragmented land, increasing need for money and the lack of employment opportunities (Weiss 1996). In *Ihangiro*, the majority of older people and their families live off the sale of coffee and bananas and small-scale business. Yet the scarcity of land and the increasing need for money in combination with adult death has made land a valuable commodity and hence inheritance conflicts are prominent in families often to the detriment of older widows and orphans (Kaijage 1997: 341-342), as also the many cases in the legal offices testify to.

Economic figures in the village, however, showed fluctuating growth over the mid-90s and early years of the 21st century. Between 1994 and 1997 coffee prices rose and many villagers, especially young adults, but also businessmen from Dar es Salaam invested their money in building houses and setting up small businesses (Kessy 2005). Around 2000 the coffee price started to drop dramatically again until it reached a low point of no more than 40 shillings per kilo in 2002.²⁹ A sack of 80 kilos of coffee thus amounted to no more than 24,000 shillings, not enough to pay for all the investment: Pruning, harvesting and drying the coffee in the middle of the rainy season.

Though the village in *Ihangiro* generally profited economically in the period between 1990 and 2004 from the markets³⁰ in *Ihangiro* and Kamachumu, the increasing availability of money also created more societal differences. The overall economic growth in the last decade has contributed little to poverty reduction (de Weerd 2010). In the hierarchical Haya society differences are growing, also amongst the older men and women. De Weerd distinguishes three types of farmers: The poor who mainly work as subsistence labourers and perform casual labour, the traders and small businessmen/women and the wealthy and educated class of people, with differing capacities to counter problems (*Ibid.*). In recent years in the village older men and women have noticed that the land is too small and does not produce enough food anymore. Processes of migration have started:

²⁹ This amounted to US\$ 0.045 in 2002.

³⁰ The opportunities for economic growth within Kagera Region differ according to the area. In some areas like *Ihangiro* district the major opportunity is market development and trade. In villages along the lakeside, fishing activities are major off-farming ways of generating income, though these activities have been affected by the opening of the fish factories in Mwanza and by government restrictions on certain types of fishing nets. Some fishermen have therefore seen their investments go down the drain; others have been able to step into the new opportunities. The villages around the Ugandan border profit from cross-border trade, especially of coffee as the prices in Uganda are much better than those of the Kagera Coffee Union. Villages along the main tarred roads profit from the decreased travel time (Kessy 2005; de Weerd, personal communication).

Now to the less fertile and isolated villages in valleys, to the fishing islands in Lake Victoria for seasonal work or to the large East-African cities.

The limited availability of land, the experiences of the possibilities of business under president Ali Hassan Mwinyi and the difficulties under the structural adjustments that followed have contributed to the appeal of the major cities, with the difference that many people, the children of the current generation of older people who migrated to the cities in the 1980s and 1990s, settled there and had children. Some of these grandchildren do not speak the local Haya language anymore and will never return. Other adults may build a house in the village for their old age as a connection to the land of their parents, even though they may never return to actually live there.

Whereas the *ekibanja* is still able to connect generations, family care has become dispersed and more translocal. The new technologies that have reached the village play a role in creating new forms of connection, however. The most important technology is the introduction of the mobile phone to the village in 2002. In 2008 wealthier older people who had children in Dar es Salaam had mobile phones and regularly communicated with their children. Moreover, recent years have shown a growth of regional airlines, improved roads and an increase in the mass media such as radio, television, and the internet. Whereas older men and women complain about such commodities they also embrace them. Other forms of more distant 'care' have emerged in this way. The era of AIDS has strengthened or even created a new morality of family connections, by foregrounding issues of control over reproduction, mobility and land in accounts of older people, in response to the spatial dispersal of kinship relations. Older men and women of today use the above history as a reference to understand the AIDS epidemic. Their concerns with care are about the present but in their explanations they refer to the history that they have lived.

Conclusion

When older people talk about their concerns about care, they are talking about a present which is marked by commoditisation, mobility and illness. Land, the *ekibanja*, and the stability it represents, is a core orientation in the way older people experience the present era of AIDS. The *ekibanja* informs gender relations as well as the way different generations can connect to each other in the current era of AIDS. In this respect the concept of historical generation, originally from Mannheim (1952(1927) quoted in Prince 2008: 138), but revived by several authors in contemporary kinship debates (Prince 2008; Alber *et al.* 2008) is useful because it illuminates how the values of different generations, the habitus of certain age-cohorts, was shaped by the particular social transforma-

tions that took place over their lifetimes, and hence their frames of reference in experiencing the current era of AIDS.

The older people who form the core of this study are the generations who grew up without AIDS as part of their everyday life. They therefore perceive a sharp demarcation between the pre-AIDS era and the current era. AIDS is perceived in terms of the demise of social relations and values for which mainly the increasing importance of money is to blame. Yet if anything, the history of *Buhaya* shows that this macro social narrative of money is not something that belongs to the present era only. The inherent tension between mobility and locality in family care relations that is embedded in the land system has transformed relations since colonialism. Though older men and women firmly live in the present, they refer to historical periods which were also marked by rapid social transformations. A reference to the dangers of money is a reflection of concerns in the 1930s and 1940s. It is therefore important, in discussions on morality and the change of social institutions such as family care, to understand how AIDS feeds on such continuities (Fee & Fox 1992).

The institution of family care in *Buhaya* has changed over the past 100 years, under the influence of major political-economic processes. The increasing centrality of money to care relations (cf van der Geest 1997) and mobility over the past century has become a fundamental aspect of family care. This includes mobility in terms of the semi-permanent migration to cities, which led to new forms of care: Closeness in absence through new technologies such as mobile phones but also to distance as caregivers for older people are no longer present on the land. Mobility also refers to the mobility of women, who have gained more access to employment and to land outside the patriarchal and virilocal system of land inheritance. This changed the position of women and generational authority in the family care system. What is important for the current generation of especially older women is how they, over the course of their lives, are able to secure access to land or not. Social status has increasingly become connected to economic wealth and clan-based affiliation has decreased in importance, and access to land represents possibilities for older women to negotiate relations of care. Though older women blame their lack of opportunities in life on a lack of social and spatial mobility, the same mobility now compromises the care provided by a daughter-in-law.

The link between mobility and the notion of home has also been a constant over time. The natal home is where divorced women return and the natal home is an essential part of the rural-urban connection; rural-urban migration in *Buhaya* has a tendency to be organised around family lines. Home in recent years has taken on a more symbolic function; it is where patients return to be cared for; it is also the place where bodies are buried. At the same time home, and the land that

represents home, is a source of intense and increasing tension in families as inheritance disputes over orphans' ownership of their father's land are rife. This becomes more complicated as orphans are fostered by maternal relatives or by relatives in the city, or are sent from the city to grandparents in the village.

Illness and the moral questions which have framed illnesses have been part of the life experiences of older people over time. The current AIDS epidemic and loss of children ties into these concerns for care. The aforementioned influences of money on the *ekibanja* system were the realities that shaped the particular historical values of this generation. In discussing contemporary relations of care, older men and women refer to a morality of care with values such as compassion (*huruma*), endurance/suffering (*kuvumilia*), and providing which is based on their assessments of changing family relations over their lifetimes, in particular in terms of gender and generational authority. Older men and women perceive the disruptions in the possibility of the *ekibanja* to connect generations as deeply disturbing which is reflected in the way they practise care and manage contested values.

PART 2

DOING OLD AGE

Caring and belonging: The necessity of physical strength for practices of relating

Introduction

When you are old
And your back is bent
And you have no child
To whom will you belong?¹

Saida Karoli, popular Haya singer

The worst thing about growing old is losing your strength. You say I look youthful but I am not. Look at that man tending my garden [coffee plantation]. My son had to hire him to do the work. If he had not been able to pay for the man, who would have cut my banana trees? And do you remember that old neighbour? She said if she would lose her strength, she would just sit there and die (...). It is bad.

This fragment is from a conversation with a 65-year-old woman who lost her husband and her daughter to AIDS, and about the blessings and drawbacks of growing old in northwest Tanzania. A recurrent theme in the conversations with older men and women was the issue of strength and health. Growing old comes with a natural decline of strength. Bodies age and tire easily, backs start to hurt, limbs become stiffer, eyes and ears deteriorate and some older people experience chronic diseases. As older men and women are confronted with long-term care for patients dying from AIDS and with the responsibility of raising grandchildren, strength and physical capacity become a focus of concern.

¹ These lines from a Haya song were quoted by an 86-year-old, childless woman. She used it to discuss the respect and future care for women without children. In her situation she was dependent on her younger brother. After he died in 2005, she died only a few months later.

Photo 3.1 Mae Elesta engaged in labour on the land



In this chapter I examine the role of the aging body in managing the demands that derive from a changed landscape of care in Kagera. The aging body needs to remain strong in the face of demands made on it for everyday living, in particular the material and physical demands that are essential elements in relations of care. The physical body is declining as a result of aging. This makes it harder for older people to live up to these demands, making them increasingly dependent on their remaining relatives for care. The central argument of this chapter is that the older body has become an indispensable capital for engaging in social practices and relationships. This chapter explores how older people employ this capital under insecure, evolving circumstances and a changing moral economy, resulting from HIV and out-migration. As older people face advanced old age, a big anxiety is where and to whom they will belong in their last years, especially if they have no children (or they have died) and no one to care for them as they grow weaker and less capable. Whereas this is a normal aspect of old age, these anxieties are exacerbated in the context of AIDS, as there is more caring to be done by older people, and there are fewer people to take care of them. But older people are not helpless: They may own land and assets and their past achievements might elevate their status. If they're women, as two-thirds of the women over 60 years of age were, they may be responsible for grand- or great grandchildren. It is in this changed landscape of care that caregivers' concerns for strength must be understood. As physically challenging and emotionally draining as care giving is for these older people, it also provides a new way for them to belong as they are forced to reconfigure relationships of care in response to disruptions in relations.

Only recently did attention in relation to this essential experience of aging, the physical body, rise in discussions on the impact of AIDS on older people (Seeley *et al.* 2008; Ssengonzi 2007). At the time of fieldwork the physical consequences of added care demands for older people were unexplored. In this sense this study taps into a body of literature that emerged after data collection. Important contributions of recent debates recognise the challenges of the increased care giving role for older people, (Knodel & Saengtienchai 2005; Knodel *et al.* 2006; Bohman *et al.* 2007). Care giving for dying patients and grandchildren, for example, has adverse effects on the health of older people (Dayton & Ainsworth 2002), and creates anxiety for future health and well-being as a major concern of older people (Ssengonzi 2007). AIDS also has an effect beyond the immediate care giving tasks: Stress and material consequences of care giving are mentioned as causes for the disruptions in broader family care giving arrangements (Ankrah 1993). But the body of literature also points to less researched domains: How family care arrangements are affected in the longer term, when older people's physical strength declines (Ssengonzi 2007: 341; Seeley *et al.* 2008: 4).

Older people care about their strength, and at the same time are caring to get strength socially. How does the inevitable loss of physical strength as a result of aging influence the ability of older people to maintain or regain their position in a context where relations of care are often disrupted? In my discussion I add to the emerging literature by exploring the older body as an essential form of capital in relations of care. I understand physical capital as the ability of the older body to engage in work, and in activities that will generate income, but also to participate in events that will create relations, that are important for a sense of belonging.

The core of this chapter consists of two parts, each built around an extensive case study. The first part discusses why future loss of strength is a concern in forging new relations of care after AIDS death.² The second part highlights how older people who have lost strength engage in forging new relations after AIDS death and explores the question of who will do in terms of providing care in the context of disrupted relationships. The combined sections in this way provide a gradual perspective of changing bodies over time and its effects on relations of care.

Aging, the body and belonging

Aging in Kagera is often experienced in physical terms: Older people describe their difficulty to walk long distances, ailments such as back pain, loss of hearing, decreased eyesight and general body fatigue. Older people are also more susceptible to pneumonia and malaria, especially during the cold nights which accompany the rainy seasons. Health problems are usually solved using local herbs and some over the counter medicines that are available at the many kiosks. Other older people also reported that they were suffering from chronic illness such as high blood pressure, diabetes and heart problems. These general ailments make everyday chores more difficult. Digging on the land does not go as smoothly as before, walking the paths along the hill to the market or the Church takes time and washing clothes, peeling bananas or pruning coffee trees are physically demanding tasks.

The *ability* of the aging body is a central part of well-being; older people attempt to stay active for as long as possible (Bohman *et al.* 2007; Sagner 2002). Biophysical changes that come with aging then often have significant social consequences for daily living, social relations and personal identity (Nettleton & Watson 1998: 5). The explicit physical experience of aging and its link to the state of relations of care is reflected in the metaphors which older people use to speak about the time of old age, linking belonging and well-being to the presence

² This chapter does not focus explicitly on the physical demands of nursing patients as this is discussed in Chapter 5.

of children and being ‘stuffed’ with food, and linking a bad old age with metaphors of physical violence. Take the example of the following conversation between two women, aged 58 and 65 about the lack of care of children nowadays:

Mae Nyakato: You know in the whole of my life I have been really relying on my offspring. My children are here, what problems will I have? This one can bring water and this one can bring this, as I have so many children.

Mae Tibaigana laughs: You give birth to animals beating you!

Mae Nyakato laughs and agrees: I tell you the truth Mae Tibaigana, I was a rich person. If I had known I would not have taken my money from the bank to give to my children, I would have left it there. I could have been going [to the bank], taking some and spending it for my needs. But I just gave it to my children. And the problem is because of education. If I could have been educated I would not have done so. I gave one 50,000 Shilling and the other one 200,000 Shilling.³ I they were going to do business, and when they bring in money I would be stuffing myself [*mbutabute, kh*].

Mae Nyakato speaks of a good old age as a period in which she should be ‘stuffing’ herself. And Mae Tibaigana voices her experiences with children as physical beating. These complaints are ways to frame a moral notion of old age care. Sagner reads complaints such as these as ways for older people to reproduce themselves as active members of society (2002: 56). When older people spoke about a good old age, they used metaphors that were physical and had direct connotations with food and eating enough, something that is central to the lives of older people. Weiss describes how food and being full is equated to well-being (Weiss 1996). Food satisfies a body, making it full. Strength, or more importantly the lack of it (*sina nguvu, ks*) was therefore both an explicit physical state as well as a metaphor through which older women and some older men, could discuss worries that kept them awake at night: How to work the land with an aching back, how to cook breakfast for the grandchildren when waking up with a weak body.

The relation between a strong body and the ability to participate in relationships is also visible in the terminology that is used to denote older people in the village. The words for an older person who is independent and able-bodied are *Mkaile* (old woman, *kh*) and *Mzee* (old man, *kh*), which are used to refer to someone who is able-bodied and independent. The other two words, *Mkaikulu* and *Mgurusi*, Haya words for older women and men respectively, are usually used to refer to someone who is very old and dependent on others for care and support. The core of well-being then seems to be the possibility to maintain, build and invest in social relations, to remain in what Sagner calls a relational matrix (2002: 59). Growing physical dependence then immediately lays bare the state of social relationships on which an old person depends.

³ 200,000 Tanzanian Shilling in 2003 was equivalent to 200 US\$.

In the following sections, I use two cases to explore the changing role of the aging body in a morality of care. Through snippets of diary entries over the course of six months, which make up the first case study, I explore how an older woman, who has strength, uses this strength in everyday living. The personal narrative adds local colour and offers a more immediate lived sense of the landscape of care, but also reflects and takes the reader to the contradictions and contestations that are part of the everyday reality that older people have to navigate.

The second case involves a woman without strength who uses her assets to compensate for the lack of physical strength. As the care landscape changes, new constellations of giving and receiving care are forged and dissolved. These relations are influenced by norms which derive from the *ekibanja* system: Gender roles which structure hidden expectations in the relation between older women and their daughters and daughters-in-law as well as roles of older fathers, brothers and sons. The actual practice of care in everyday life is where relations are forged, where conflict and closeness shape the outcome of care.

The role of the physical body in shaping relational care

In this section I discuss how in contemporary Kagera, the physical strength of older people plays more than ever a key role in daily life. Relational care is built up over years by securing ties between generations over a long period of time. In the current era, this is increasingly difficult as events such as AIDS-related death might rapidly change the constellations of care. Strength is then a central asset and essential in the continuous forging of care relations. The case of Mae Mectrida, an able-bodied widow, which forms the first part of this section, shows how important strength is in the daily shaping of social relations. The diary of Mae Mectrida followed on a period of six months of intensive care for three terminal patients and shows how she is building up her life in a drastically altered situation. The information was collected by Mae Tibaigana (65 in 2002) while visiting Mae Mectrida (66 in 2002). The story of Mae Mectrida represents the situation of many older widows after being confronted with the demanding tasks of nursing patients – the way strength is used to fit in with and participate in a social matrix after relations of care have been ruptured.

Shaping relations of care after AIDS death: The case of Mae Mectrida

It is September 2002 and the bean-planting season is about to begin. In Mae Mectrida's house nobody is home. She is out, doing casual labour with the Union of the Sub-Village group, the main labour group for women in the sub-village. Mae Mectrida, a mother of 12, lives in the western part of the sub-village where the paths start sloping down from the high, cool plateau towards the river in the valley. Her house is a standard modern Haya house, built of mud and sticks with

a corrugated iron roof and an outside kitchen. The house does not belong to Mae Mectrida; she moved in with her two youngest children, a daughter of 13 and a son of 15, and four grandchildren only six months earlier when her husband died of AIDS at the age of 66. Our first encounters with Mae Mectrida, through the diary, show two overarching problems: The housing situation and the gradual loss of strength, issues which increase her anxiety and add pressure to her multiple responsibilities.

13 September 2002

The 13-year-old daughter of Mae Mectrida has fetched water and cleaned the house. She did not wash the clothes because there was no soap. The other children remained at home alone until Mae Mectrida's daughter came back from fetching water. Mae Mectrida's married daughter came for a visit. She told Mae Mectrida to go and visit neighbours because that would decrease her worries. Mae Mectrida explained to us that her main problems were that she had no *shamba* and no house. 'Then there are expenses like medical care for the children and me and school expenses. The children usually go to school till 2pm without eating anything'. Mae Mectrida explained that her other problem was that she was growing old.

My grandchildren are going to leave me and who will care for me? This problem cannot be solved; I only pray to God. When the problems become too much I ask my son to assist me but he can only help a little bit because he is not capable. When the problems become difficult sometimes I leave them as they are, for example when we get ill, we will just be cured without medicine'.

The turning point in the life of Mae Mectrida is the loss of her husband and with him, the loss of what gave her security, her house. Mae Mectrida's co-wife inherited the marital home and the land, and Mae Mectrida, his first wife, was evicted. Going home to her natal land and her siblings was not an option so Mae Mectrida moved to the house belonging to the widow of her deceased son, who died eight years earlier of AIDS. The widow left two of her children with Mae Mectrida and moved out of the village. Work in this newly formed household is divided amongst the children and Mae Mectrida. As the grandchildren are still young, they mostly play and go to school in the daytime. Most household chores such as fetching water and firewood are done by 13-year-old Asimwe, who does not go to school. Asimwe also washes clothes if soap is available. Deogratius, aged 18, dropped out of school when his father became ill. To obtain cash income he sews clothes with a sewing machine that his brother gave him, which he sells in the market. Mae Mectrida earns money by doing casual labour on other people's land. If something goes wrong – the failing of the harvest or illness of household members – there is a direct impact on the household's finances. Mae Mectrida's support system comprises a mixture of family members: Her married sons who live nearby and daughters who come to visit. She has good relations with neighbouring women, whom she goes to visit and who can advise what to do in case of illness. Yet, financial assistance is limited; her children are not 'capable' (financially well-off), and the rainy season brings bouts of illness:

Pneumonia, malaria and hence the need for money. The following entries in the diary over the month of October 2002 also show the problem of income and its relation to strength.

13 October 2002

When we arrive Mae Mectrida is cooking. Nobody has washed clothes as there is no soap. This week Mae Mectrida and her daughter will start planting beans. Two grandchildren from Mae Mectrida's daughter who is married in a neighbouring village came to visit her. This week there is no money for soap and salt because she suffers from pains in her lower back. The Union group chased her out because she had no strength. Neighbours also refused to give her labour because of her lack of strength. Mae Mectrida commented that youth was good because you have the strength to work yourself. 'You cannot prevent old age coming but it is a problem, especially for a person who is not capable' (has no wealth). As far as vegetables are concerned, this week she did not even get beans.

Older women depend more than men on remittances and assistance of children to solve daily events needs such as household expenditure and tablets to cure illness. However, older women cannot 'over ask' their children. Mae Mectrida only asks her son for assistance when there are 'really big problems'. Illness of a household member is especially problematic in certain seasons. The agricultural cycle structures the daily lives of older men and women in the village. The two rainy seasons, from mid-February until the end of June and from mid-September until December are the times to cultivate food for consumption such as beans, which supplement the staple crop bananas that grow throughout the year. The crops generate food and cash income in the harvest season, which means that there is money flowing into the household. In other seasons such as the dry season, money can only flow into the household through casual labour activities for others and through the assistance of others, such as gifts by children.

The case of Mae Mectrida's attempts to use her body to manoeuvre through everyday life, highlights four interrelated areas in which physical strength is transformed into a capital which older people can use to build relations to be in allegiance with and form an essential part of a community, to be a requisite part of the moral- and actual-economy. Firstly older people need their bodies to care and nurse as a result of AIDS. Secondly older people need their bodies to work, to earn money and cultivate food. Thirdly older people need their bodies to look well, a central asset to maintain their position in relation to others, through appearance. And finally older people need their bodies to be able to socialise, build friendships and in that way maintain their position.

Strength to care for others

As Mae Mectrida's case showed, episodes of giving and receiving care within families often occur at the same time, especially in the era of AIDS. A patient may become ill and get better and work the land for a little while or engage in

small-scale business, before becoming ill again, and an orphaned grandchild is fostered by a grandparent but will also assist the grandparent in daily chores. A son might bring kerosene to a mother who is caring for his brother, and a daughter may come to stay for some days to wash, clean and assist on the land. As the care landscape changes constantly, new constellations of giving and receiving care are forged and dissolved. These relations are influenced by norms which derive from the *ekibanja* system, gender roles which structure hidden expectations in the relation between older women and their daughters and daughters-in-law as well as roles of older fathers, brothers and sons. The actual practice of care in everyday life is where relations are forged, and where conflict and closeness shape the outcome of care.

Physical care for and by older people mainly takes place in the domestic unit (cf Cliggett 2002). Here gender is important; it is a woman's role to cook, to clean, to dig the land and to provide physical care to patients or to grandchildren. Older men need their physical strength to work but perform fewer household duties. In the era of AIDS there are more responsibilities that demand something from the aging body – both in the area of direct care as well as in the tasks that older men and women need to do in households. Often shifts in family care arrangements result in conflicts because those who remain become overburdened. The danger of losing strength lies in the inability of the older body to participate easily in daily life, at a time when to remain strong and healthy is a necessity in order not to have to demand too much of children who are dealing with more than they bargained for. Older men and women are then using their body to maintain as much as possible a status quo within shifted family care relations. The physical body is employed here to engage in relations with those who need care.

Strength to earn an income

Everyday living in an area in which there is structural poverty and an increasing use of commodities, requires a daily struggle to earn enough income. Money has, increasingly, become more important in the lives of older men and women; it is needed to buy household necessities such as cooking oil, salt, soap and kerosene. But also medical expenses, school and clothes require access to money. Earning income for a household is, as Mae Mectrida's case shows, often a family affair. Her eldest son is contributing as is she through doing casual labour. Other older people engage in small businesses of repairing bicycles, welding kerosene lamps and weaving mats or beer brewing. But the majority of older people earn money through selling the coffee harvest or surplus from the land. Another, often small, source of income is through support provided by children. Depending on their own economic situation they support their parents in buying everyday necessi-

ties, kerosene, cooking oil, salt and soap or provide cash and luxury items: Televisions, mobile phones and video players.

Two issues are important in relation to the extent to which physical strength is needed to live up to these demands: Gender and assets. The importance of having land is central to the ability to secure everyday living and this means that those who do have land are often in a much less vulnerable position. Both women and men who are landowners can eat from their land and use the surplus food or coffee as a cash crop to generate a regular income. Those older men and women with money or with children who have money can also hire casual labourers to spare their own bodies from having to do the heavy work of maintaining the land, harvesting coffee or bananas (which can weigh up to 70 kg) and dig the land.

Older women in similar situations to Mae Mectrida, who have lost their land, depend mainly on casual labour to earn money. A major problem for older women is the way the '*kibarua system*' (day labour, *ks*), is organised. A condition for working in labour groups is physical strength and that is something many older people lack. The loss of strength and illnesses have consequences – sometimes very direct – as was the case when Mae Mectrida was expelled from the women's group. As an older woman she is not regarded as a valuable asset in the labour groups as the group earns as a joint force. Some older women, especially widows from less wealthy families use their strength to do casual labour, sometimes in groups, though seven of the 14 women I interviewed about being a group member had to leave the group because their strength had gone. A decrease of strength meant an immediate change in household income.

There are differences between the ways men and women need physical strength to ensure their position in everyday practices of relating. Men usually have land and can rely on their able-bodied wives, who are often younger. Having a strong body helps Mae Mectrida to overcome the structural disadvantages that are part of everyday life, especially the disadvantages created by the vulnerable position of widows.

In the current era widows argue that the care of the clan has been limited. Mae Tibaigana, who was 50 when her husband died of AIDS, is still a bit bitter:

When my husband died I was left alone. My father-in-law took in two of my children, but the rest of the family did nothing. Only my brother-in-law gave me these windows (she points at the windows in her brick house). But I had to suffer in order to send the children to school. While they [my in-laws] were wealthy [but did not assist].

The position of an older woman is strongly related to that of her husband, and her sons. In this sense the extended family in contemporary *Buhaya*, consisting of the brothers of the husband and the broader clan are less involved in providing care to widows than before (Kaijage 1997). When women become widows they either remain on the land of their sons in their marital homes or they return to

their natal home. Financial assistance of members of the extended family then became more important. Materially, Mae Mectrida as a widow does not have access to her own land, neither in her marital home, as her husband preferred the second wife, nor in her natal home where her brothers inherited the land. She is dependent on her adult sons, who live nearby as well as her son who lives in the household. Widows need their physical strength to not to become too dependent on their remaining children for as long as possible. The independent body in this context is an important capital to stabilise and maintain relations with children and others, and represents another kind of ‘currency’ that is equally essential to the contemporary economy.

Strength to keep up one’s appearance

So far I have discussed the two tangible fields in which the body is employed: Care and work. A third field in which older people need their physical body as a form of capital is less tangible and includes what the body represents about social position. An indication of a respected social position is looking clean and washed. The following was said by Mae Mectrida about a neighbouring woman:

I look at Mae Elesta with fear [respect] because she is older than me. But I also look at how she is dressed and how she behaves nicely.

This shows the importance of Mae Mectrida’s continuous statements about soap. Without soap she cannot wash herself and will smell, without soap she cannot wash her clothes and will look dirty. The actual physical body is key in bringing dignity. In a survey about the impact of monthly income amongst 600 older people in Muleba district, the theme of soap was so prominent that it became part of the report’s title. The ability to wash with soap and to wash clothes radically influences an older person’s position and makes older women confident to go out and socialise (Hoffman *et al.* 2008).

The ability of the body is related to keeping up a social standing. By being able to socialise, through physical representation the older person is able to show that she is loved by those who care for her, which also reflects positively on her caregivers. In advanced old age the physical body, appearance, is a marker for the state of family relations. A well nurtured and clean body is indicative of one’s health and well-being (see also Weiss 1997a: 343) and hence an older person’s ability to negotiate relations of care. In this sense the temporal aspect of relational care is important; as older people grow older and more dependent, they need to draw more on care relations to ensure dignity. Strength in this context refers to the way that an older person can move in the world. One is judged on one’s appearance, one is judged on the ability to visit and interact socially and one is judged on the ability to invest in others. Dignity is an expression of good relations, a nicely dressed body, with shining skin, being well fed and surrounded

by grandchildren touching. The physical body in that sense represents a capital to maintain one's position in social relations.

Strength to relate to others

Sociality is achieved through investments over time, through the daily interaction of working together, living together, attending religious services and shared personal histories. Socially, being able to earn money allows Mae Mectrida to buy certain foods which she can offer visitors and it allows her to buy soap to wash her clothes. Most older men still work the land on a regular basis and provided for their families and often also for clan relatives. They generate income through the sale of crops like trees, coffee and bananas plus other activities such as repairing bicycles, making lamps and selling them at the large markets which are held almost daily in the surrounding roadside towns. The most important assets for both men and women are land, livestock, and a house. Some men and women brew beer, an occasion to assemble in a house to drink and socialise. Sunday is a day of rest, frequenting the church, and visiting friends and neighbours. Through their bodies older men and women therefore ensure income and maintain relations. The loss of her material possessions has changed Mae Mectrida's social position.

The people who I thought were my friends are now the friends of my co-wife. They go to visit her, not me. From this I know that no-one loves you if you have nothing.

Through the loss of her land and her house Mae Mectrida had lost several possibilities to maintain her social position. The concept of love in *Buhaya* is attached to assisting each other and giving each other. The reciprocal aspect of relations of care is not particular to *Buhaya* – van der Geest shows for Ghana that whereas the basis of care for older people is said to be respect, this respect is often performative; it serves to maintain relationships of the household to the outer world and that the basis of care lies in the relationships that have been built up from before (van der Geest 2002). Yet not all relations from before are equal. While Mae Mectrida's relations with her children remained the same, without land Mae Mectrida for example could not give as much, and relations like neighbours abandoned her. She bitterly remarked that people whom she saw as friends now went to be friends with her co-wife. It is the older person's body that can be employed here to regain some position. Through the possibility of her body to earn income Mae Mectrida was able to provide something for those who came to visit, in that way reclaiming her position.

The fact that Mae Mectrida was able to engage in social interaction: Go to the neighbours to chat and socialize, and momentarily decrease her worries about lack of food, insecure housing and her grief as well as being seen in Church, is how she employed her body to continuously strengthen those relations that she

could rely on. In times of need, when her children were ill she could then use these relations to ask for assistance. A functioning body in other words, allows people to relate with others and in that way continuously define their position (cf Caplan 1995).

Ensuring relational care without strength

As older people increasingly need physical care, and sometimes become confused as a result of loss of facultative capacity, loss of strength shows cracks in family care relations which are often already under strain as a result of limited financial capacity and adult death. How do older people deal with the fact that they do not have a body to rely on in an era in which care is increasingly insecure? The way older people manage their aging bodies in social action shows how older people's bodies are never fixed forms (Taylor 2005: 747), bodies naturally age, thereby shifting relations of care, but also become sick, are weak and regain strength on a continuous basis, constantly affecting the way older people can forge relations of care (cf Hastrup 2005). Despite this volatility it is important not to see older people as defined by the limits and possibilities of their bodies in the everyday social practices that consolidate or break relations of care (Mol 2008: 45). As the physical strength as a form of capital declines, new practices are developed to build relations.

The case of Mae Tophista's eventual death, which forms the first two parts of the section, highlights the importance of land as an asset in relational care when physical strength is gone. Land helps to manage care demands on the aged body, it ties families together and it presents an asset to forge new relations of care. Care giving thus provides new ways for people to belong to each other, and for families and clans to relate to the land.

The loss of care in advanced old age: The case of Mae Tophista

'Wait', said the village chairman. 'I just want to go and check on a woman there. *Analala kitandani*' [lit: She is sleeping on the bed, meaning she is ill, ks]. We walk around the house and enter into a side room. The room is dark and almost completely filled by a bed. On the bed is an old, fragile woman who lifts herself with difficulty when we enter. We sit and talk with her for a while and when we leave she says, 'I am not sure whether you will see me alive next time'. It would become her normal greeting in the months we followed her life until her death.

The woman on the bed was 86-year-old Mae Tophista. When we met her for the first time she was ill and lived with a trusted grandson. The young wife of her grandson cared for her, but was struggling to make ends meet. Soon after we first met Mae Tophista she therefore moved to another home in the village, which belonged to Laurent, her youngest grandson. Here she stayed until her death in May 2004.

The living situation of Mae Tophista, staying with adult grandchildren was not how she originally envisioned her old age. She used to live with her only son in her former marital home. In 2000, however, tragedy struck, when her son died from AIDS. At that time Mae Tophista was already elderly, and unexpectedly childless. Her care now depended on her grandchildren, in particular Laurent, who had inherited his father's house with the agreement that he should take care of his grandmother until her death.

After some time a fight ensued between Laurent and Mae Tophista and she decided to leave her marital home and move back to her siblings in her natal home, 30 kilometres from the village. The decision backfired: Mae Tophista was beaten and abused because her family wanted a share of her wealth. One of her grandsons took pity on her and brought her back to the village where she eventually moved back to the home of Laurent, but the conflict between the two was never resolved. As Laurent summarised it:

This is because of my good heart; any other person would not have done so as she did not love me and never gave me anything. But because my father told me to do so I brought her back. I could also not bring her before as I was staying alone. I was waiting until I got married and that is why I brought her now.

Laurent points to the physicality and intimacy of old age care: This entails washing an older person's body, but also applying body gel and removing *jiggers*, sand fleas which lay eggs under the toenails. This is a woman's job: Usually performed by a daughter-in-law or a wife. Over the months we visited Mae Tophista in the home of Laurent we saw her deteriorate rapidly. She was confused and tried to kill herself, and then ran away to the house of a friend. The feeling she was uncared for resonated in her explanation of why she was running away:

I went outside to look for someone to take the jiggers out of my feet for me and without knowing I reached Mulela, entering into a house I know and suddenly I fell down. It was the house of Evodi. There is something that makes me run away. It makes me want to run away but the people here say I do it purposely.

In the quote her mental confusion also features. Whereas we had been able to talk normally with Mae Tophista for the first few times, she now changed her behaviour every time she saw us. She started to scratch herself, moan and shiver, and often almost dropped to the floor. She also started to wolf down food and tea, her body smelled of urine, her feet were infested with jiggers and her skin was dry. In conversations she accused her caregivers and immediately took it back:

Mae Tophista to wife of Laurent, in a soft voice: But are you going to take out these jiggers? Is your husband not going to kill you?

Gussy to wife of Laurent: Does Laurent not like you to take out the jiggers?

Mae Tophista: Ah! What am I saying now, what am I telling them, being somehow confused. I want to go and sleep'.

Towards the end of her life we heard stories of her going through the village naked and Laurent locked her in a room when he and his wife were working on the land. Here she died a few months later. The above events triggered discussions on how older people should build relations of care and why this failed in Mae Tophista's case. In the remainder of the case description I present the rationale of three different people: Mae Tophista, her older brother-in-law and a neighbour.

'Preparing for old age': Perceptions of Mae Tophista's loss of old age care

The first perspective comes from Mae Tophista. She related her lack of care to the consequences of the death of her only son from AIDS and the failure of her subsequent investments in her grandchildren. Being old and widowed with no other children, Mae Tophista needed money to care for her son. Her only access to money was her land. Mae Tophista had inherited land from her grandfather, her father and her husband. She decided to sell a piece of her land and a piece of land from her son so she could buy medicines, food and other expenses for her son.

He died from this bad thing that came to us. You know some people think of something, which is not true, have beliefs about bewitching, while the problem is seen. His wife started to die and I cared a lot for my son when he was sick. I even sold my land to care for him; I have land in R. (an area north of the sub-village), which I sold to buy needs. You know when my son saw the first wife die from this disease, he told me: 'even I am going to die'. So he asked me, 'As I have a *shamba* (land, ks), sell the *shamba* to help me in caring by buying some needs'.

Land is often sold by older women to be able to meet the many expenses that come with the illness and funeral of an adult child. And as Mae Tophista still had both land in her marital home and her natal home she did not lose all her assets as is often the case with widows who own less land, so she did not compromise her old age security. Secondly Mae Tophista strengthened those relations she trusted most: Jovari and Teddy and 'endowed' them, which is also a common way to bind relations:

I sold a *shamba* to pay the bride price of my grandson Jovari, the one who came with me from Kamachumu. That *shamba* was inherited from my grandparents. I sold three parts of a *shamba* to care for myself as I am sick and have no strength. I had a bicycle; I bought it when I sold three parts of my *shamba* but I gave it to my grandson who I stay with. Some (of my grandchildren) love me but some not because of my *shamba* and my house. Only two grandchildren support me and their wives as well. Those are the one I stay with [Teddy] and the one who stays near Mae Tibaigana [Jovari].

Thirdly, she decided to sell all her land in the village after the argument with Laurent as she did not think that she would return to the village again and need her land, especially since she had land left in her natal home. When we went to

visit her after her return from her natal home she was standing in her former *shamba* and looked around saying:

This is the *shamba* which was mine and which I sold. Now nobody cares for me. All are blaming me; that is why I sold my *shamba*. But I sold it when I was going to my home [natal home], thinking I would stay there. But now nobody is caring for me, not even giving me a single cent of money. While before I was rich, giving things to people. *Ninshaba owonaimile nimanya akebwa* [Haya proverb: Now I am asking something of the one I once refused, hoping he has forgotten that I once refused].

Mae Tophista had tried to use her land to strengthen the relationships with her grandchildren whom she trusted but circumstances made her dependent on the one grandson who she was in conflict with.

According to the extended family of Mae Tophista, however, her situation was her own fault because she had created discord in the extended family by openly favouring certain grandsons over others. Especially Ta Vedasto (78), the family patriarch condemned this decision:

You know, that son of Mae Tophista, before he died he asked his mother to stay with Laurent to care for him and him to care for her because Laurent was very young. So at the time of selling the *shamba*, she did not involve Laurent and he did not know anything. The one who knew everything and who was helping to sell and put signatures was her grandson Jovari. From there it is that Laurent is asking her where she has left her wealth and from there he tells her to go to the ones she shared her wealth with before.

A second reason why Ta Vedasto blamed Mae Tophista was that when she sold all her remaining land in the village, she had made the decision to sell what was considered clan-land to outsiders. Ta Vedasto had intervened; his son had eventually bought the piece of land which contained graves. In Haya society selling land which contains graves makes it impossible for generations to connect. This sequence of events had created discord (*fitina, ks*), in the extended family. Vedasto understood why Laurent was angry:

Some bring problems themselves. Like Mae Tophista, she sold all her wealth in disorder creating discord. Then she went to Kamachumu where she took the money and it was eaten by termites. When the money was gone the termites started to eat her. She has two big *shamba* and another *shamba* near their house which was bought by my son. I forgive the grandchildren. She is causing disease to herself!

When Jovari took pity on his grandmother and went to fetch her from her natal home, Ta Vedasto envisioned an escalation of the conflict because none of the grandchildren were financially or practically able to provide the intensive care that Mae Tophista needed and advised against it, but his advice was ignored. Mae Tophista ended up in Laurent's home because her trusted grandsons had spent her money and had left the village, but in Ta Vedasto's opinion she had not handled her family relations in a proper way and created the situation herself. She was de facto expelled from the family.

Also Mae Tibaigana, a neighbour and family friend interpreted Mae Tophista's situation as her own fault. The fact that Mae Tophista demanded care without having anything to give to those who had to give her care had been bad judgment.

You know that if you are not going to keep any property for yourself in later life, you know that when you are old you are going to suffer. If she could have kept a *shamba* or a house or other things, she could be cared for, because even those who would care for her then could get food from the *shamba*. But no-one is going to care for you when they have to do casual labour for food and money for expenditure. It is not easy to get help.

Moreover, Mae Tophista had been wealthy, she was known in the village as a person who could afford beer and cook town food such as *chapati* (pancakes, *ks*) and *sambusa* (fried dough with meat, *ks*) and own land. This history was remembered and her fall from wealth was considered shameful. The shame over this loss is what had made Mae Tophista confused. Mae Tibaigana interpreted Mae Tophista's confusion, her shivering and the way she constantly showed her hunger as conscious practice. According to Mae Tibaigana Mae Tophista pretended to be ill to trigger pity in people around her and make them forget that she was once wealthy and has now lost everything. This argument portrayed Mae Tophista's behaviour as her pretending to be a victim of her own actions to consolidate care. In the following three sections I present the different ways older people like Mae Tophista in the era of AIDS employ creative ways to compensate for their loss of strength in old age.

Linking bodies: Building closeness over time

Ensuring good care in old age is dependent on social relations that have been built during a lifetime. There is a strong narrative in the village that one has to 'prepare for old age' by having a house and land and by investing in relationships/children for the stage of life without strength. As Whyte & Whyte (2004: 85) point out, relatedness between parents and children is about relations of property; fathers endow their sons with land, to provide the necessities for them to establish a life (Weiss 1996). Mothers in *Buhaya* struggle and 'suffer' for their children; giving birth first of all and then staying in often volatile marriages in order to not let children suffer under a stepmother and working hard to provide a child with opportunities.

The history that is embedded in the relations between older people and their relatives creates conflict or closeness when older people start aging and become dependent on others for everyday needs as the analysis of a 65-year-old-mother about her 85-year-old mother-in-law shows:

My mother-in-law was making *konyagi* [locally brewed gin, *ks*] to earn money to send these children to school. So she suffered a lot in making *konyagi*. She was going in the village collecting beer bananas, brewing bananas and collecting the money from coffee sales, but

sometimes the money was not enough. But she reached the time to die in good condition. The children, you saw at the closing of the funeral [22nd July] that they respected her, even during the day of burial and in her life: Mama did not lack *mboga* [a side dish, *ks*], mama did not lack *pombe* [beer, *ks*], even clothes [she did not lack].

Care for older people is intimate and requires effort. In advanced old age older people are not physically able to wash themselves and are sometimes incontinent. Older people often do have enough strength to wash clothes and often not enough money to buy body-lotion to prevent the skin from becoming grey and dirty. In providing care, not every person will be considered an appropriate caregiver (cf Shaibu & Wallhagen 2002). Care for older people in times of illness is performed by specific close persons: Often a daughter or a sister for older women, and a wife or a son for older men. Intimate 'loving' care, when someone is ill, weak or very old, is an indication of a good relationship that has been built up over a lifetime. Building closeness over time is an important way for older women in particular to counter the failing of their own strength; it allows them to *lean on* another person's strong body. The physicality of these connections is present in the terms that we often use to discuss close relations: 'leaning on' and 'carrying on the back'.

The closeness in kinship ties is related to shared lives (Whyte & Whyte 2004) in which a 'sense of place' is central. For older women the natal home is important, especially the bond with sisters even though they often marry outside the natal home. Also the relationship with daughters who have married into their husband's home is important. But daily support comes from those who live in proximity: Sons and daughters-in-law, but also sisters-in-law and husband's siblings and often good friends, sometimes friends made through church or mosque or in the women's groups. Older men often are close to brothers and clan-related family situated in one place. Especially in proximate family relationships conflicts, often about the allocation of resources, goes hand in hand with closeness.

The way kinship relations shape movement and place is also present in the living situation of older women in advanced old age. Amongst the 51 older men and women I interviewed in the sub-village, there were five households where older siblings lived together; in the majority of cases an older woman, either childless or divorced had moved back to their natal home. Most older people had one intimate person on whom they were dependent and who would organise care for them. This could be an older brother making sure that his wife would care for his sister, or a son, making sure that his wife would care for his mother-in-law. But in other cases it would be a female relative with whom an older person was close. Old age care in many ways is also a reflection of the continuity of the family and kinship relations, whereby continuity in kinship relations weakens the negative effects of bodily decline for the identity of older people (Sagner 2002: 59).

When that closeness is not present as was visible in the relationship between Mae Tophista and Laurent, old age care becomes insecure: Mae Tophista requests care from someone with whom no closeness has been built over time. Both are confronted with a situation that arose after the death of Mae Tophista's son. Mae Tophista's selling of assets is what could have improved the relationship: Laurent might have wanted to take care of Mae Tophista if he had felt that his grandmother wanted to invest in him as well financially, but her choice to favour Teddy and Jovari, her two other grandsons had a serious impact that she had not anticipated. Mae Tophista's case was extreme in the sense that it shows how she tries to invest in those relations she trusts, after she has lost her physical strength already, yet her actions to create alternative forms of closeness back-fired. The case triggered discussion because it emphasises for other older people that practices of relating might not always work in the era of AIDS.

The narrative on managing old age care when strength has been lost reflects a notion of self-responsibility of older people as well as the importance of land and endowing as central tools in managing to receive care. Land presents security and physically shapes the presence of those relatives of whom daily care is requested: A son and a daughter-in-law for an elderly mother, a brother and his wife for a childless divorced sister, a sister for a sister or a grandchild as the above case presents. In case of illness a daughter may travel from her marital home to stay with her elderly mother. Often, the strength of elderly caregivers becomes an important currency in holding together community and tying the family to the land. Yet owning land, as Mae Tophista did, does not present the security that older people evoke in their narrative. This is the subject of the next section.

Using possessions to bind relations

A third way older people overcome the limits of their physical body is through using property. A core aspect of the 'preparing for old age' narrative is having the material assets to 'bind' relations through endowing. This is a central Haya practice in which older men exercise authority over their sons, through endowing them with land and a house, and remain with land which will be inherited after their death but which is always sufficient to provide food (although they say it is not enough as a result of land inheritance). In current social practice most of the women had also inherited land. Widowed women who grew older were officially dependent on their husband's family and sons. In contemporary *Buhaya* these women are now treated as single men: They are expected to build their relations well, to invest in children, to have assets and land, but have limited possibilities. Some older widows were AIDS widows who had single handedly raised children.

When strength is failing as was the case with around eight older women and two older men I was following, it became clear whether the ‘preparations for old age’, had been sufficient. As these older women grew older, care became more and more uncertain as children moved out of the village to get married or ‘find a life’ in town. Assets gave a person the capital to engage in relationships, as the following statement from Ta Athumani from one of the Northern villages shows:

Josien: We have seen in Nshamba that older people say that you have to prepare for your old age by having *mali* [wealth, *ks*] and a house and a *shamba* in order to get care.

Ta Athumani: This is true. If a man grows there, if you have everything you are not running everywhere for everything, you will see everyone coming because they know everything is there. The food is there, the money to buy [things]. Even in religion it is written that you have to prepare yourself before you go to build a future life.

Those older people who had lost all their children and who were faced with declining strength had to resort to the rebuilding of relations. Subtle practices to ensure care include binding relations by investing in them. An older person can borrow land in exchange for care or promising inheritance in exchange for care. Another practice includes the building of relations with others such as neighbours and friends. A 66-year old woman from the northern district of Kagera⁴ who lost six children and lived with her grandchildren said:

When I am sick I sell two bunches of bananas and I go to hospital. In case of care, I cannot miss someone. I can ask anyone to help, children of my neighbours are there, and we are on good terms. They give children who can care. [She has been building relations with neighbours over time; good relations are essential in receiving care].

Mae Tophista overcame the limits of her physical body through endowing her grandsons, and using the money of her land sales for daily expenditure. She, however, sold all her land, making it not interesting for caregivers with whom she had no close connection to care for her. In the current social situation in which relational care is continuously forged, land is in short supply and can be used as a way to bind potential caregivers. At the same time there is quite some aggression against older men and women, stories of blind men who are cheated to sign over land by their sons, and resulting court cases, making this practice also a liability. Whereas the *ekibanja* is still a source of wealth it can, for that very reason, also become a source of violence against older people because it is scarce and claims to clan land are rife as a result of untimely death.

⁴ According to the older people in the main research village, care for older people in the northern district is much better organised even though AIDS had ravaged villages, because people possess compassion due to education. The economy of these villages seemed much more tied to educated migrants living in Dar es Salaam, who have more economic capacity, but the scale of the AIDS epidemic in the northern villages also seems to have forced new forms of solidarity. This impression is however based on a two-week stay and requires more in-depth investigation.

Complaining

A third practice which older women use within their families is complaining. 'Complaints', which I write between brackets because I do not attach a negative meaning to it, can take various forms: Talking about weaknesses and pains, lying down, pitying themselves or accusations, or subtly reminding caregivers of the presence. In Mae Tophista's case we saw her drawing attention to her weakening body, closing each conversation with the sentence that she was not sure we would see her again, but she also displayed weakness by shivering. Other older women stay in bed when they feel weak, also after emotional situations, and refer to themselves as being ill. Mae Tophista also showed her body to us to accuse her caregivers. Though older people in advanced old age are unable to use strength they use the fact that they have a weak body to accumulate capital in that way attempting to forge relations in the context of insecure family arrangements through explicit bodily displays.

Older people are, according to those taking care of them, not always easy to satisfy. They are ascribed agency and they manipulate the relations to those who care for them in subtle ways out of *tamaa*, desire (*ks*). This practice however often evokes irritation and produces the opposite effect:

They are just complaining. The problem is if someone is old, even the mind decreases. Maybe what he is expecting is the child to do for him is not what the child is doing. So the older person complains even though he is being cared for. But he is not satisfied. It is not according to his expectation, which is more than the *uwezo* [means, wealth, *ks*] of the child. Take the government for example: We cannot be satisfied that the government has cared for us, so we say it is not enough all the time'

Those older people who are respected are those who do not complain and who do not enforce care through shaming relatives. Complaint discourse, according to Sagner is a form of identity management; it affirms a moral conception of society and positions older people towards other generations (2002: 56). But Sagner also sees complaints as identity management in the sense that they are subtle reminders of kinship obligations and in that sense social action (Sagner 2002: 58-61). In this sense complaints confirm existing but strained relations of care.

There are limits to the way older people can overcome the limits of the physical body in the continuous shaping of relations of care. Older people frame old age care in terms of their accumulated experiences and emphasise the building of relations, the importance of land and a house as well as dignified behaviour as core assets.

Conclusion: The dangers of losing strength

In the continuous shaping of relations of care, there are limits to the way that older people can overcome the bodily restrictions of aging. Older people frame

old age care in terms of their accumulated experiences and emphasise the building of relations, the importance of land and a house as well as dignified behaviour as core assets. In the era of AIDS older bodies are explicitly burdened as a result of extra care tasks, emotional exhaustion and the challenges of living daily life in changed constellations of family care. AIDS has a further effect than the increased care giving role which older women have to fulfill with their aging bodies; it also shifts those relations of which older women but also men are a part. Yet while care giving is physically taxing and emotionally challenging, it does allow a new way for older people to pursue these ends – to forge ways of belonging. Older women experience the insecurities embedded in the social relations in contemporary *Buhaya* in both physical and emotional terms, emphasising the necessity to remain strong and the value of self-reliance in creating new forms of affiliation, responsibility, and dependence. Ultimately, this configuration also influences gender dynamics and authority in the family as well as the community.

Both cases explored in this chapter show how much older people and those around them construct their old age as a period of time for which they are responsible themselves, through the establishment or deepening of relations requiring strength, and through building relations of care. Old age as a life stage almost unconsciously leads to a different praxis: As bodies age and change older people's activities change as well. Relational care in advanced old age is about closeness and physical touch. This has the implication that not all caregivers will do and that not all care is sufficient. These established links of intimacy that are an integral part of care giving have become a central part of the morality of care. At the same time relations that have been built up over time through shared living can be suddenly broken. Loss of strength makes it difficult to navigate new relations when care constellations shift. Possessing land and a house provides stability, and the possibility to 'buy' care, by promising inheritance, or endowing, which both reclaims authority and re-insinuates older people in the family and the community, making them feel needed and integrated, their role essential to daily life and to the future.

Caring through forgetting: Emotion, remembrance and bereavement

Introduction

When I pass the house of Mae Adventina, I hear crying. The crying comes from inside the house. (...) Mae Adventina, (ca 75) is sitting against the bed inside the house.

Gussy: Mama why are you crying?

Mae Adventina: I cry because of all the problems, what do you think?!

Gussy: *Pole sana* [I am very sorry, ks] mama. But do not cry. Crying makes problems like yours increase even more. Your blood pressure increases and that is what causes the problems you have. Try to tolerate it. Do not cry. (Excerpt from the notes of Gussy)

Mae Adventina had lost several children to AIDS over the past years. Another child was ill and died just before Gussy and I left the village in the spring of 2004. Mae Adventina had had a stroke and was partly paralysed. Gussy first met her at a funeral in the sub-village where we were conducting our research, visiting all the people above 60 of that particular sub-village. She asked us when we could come to visit her, referring to the funeral and the pain of losing children. When we went to her home, a few days later, she surprised us by refusing to answer our questions about her children and siblings. We first asked how many siblings she had and whether they were still present and she answered: 'I have two'. We asked whether there had been more siblings and she replied angrily: 'what is the use of writing them. Are they here? They are not here anymore. Are they going to help me? It is best to leave them, but if you want to write a number, write two'. Questions about her children she dismissed by saying: 'that is what I do not want to talk about'.

Photo 4.1 Child hanging onto a gravestone, where laundry is drying in the sun, in northern village on the border of Uganda



At the time of that visit, in July 2003, only two months after I had arrived in the village, I thought that Mae Adventina had expected to be enlisted for NGO support and stopped talking when she realised we would not do so. We left the interview and Mae Adventina's home at that point. We would greet her when we passed her house, but we never really came back to talk with her or grasped the implications of her silence until some three months later, when, by chance, passing her house, Gussy heard her crying. An outsider, Gussy approached her door, and spoke quietly, offering consolation and advice. Mae Adventina invited her in. While sympathetic, Gussy urged her not to cry, arguing that weeping would debilitate her and would eventually lead to health problems like high blood pressure and even stroke. Holding it together, being emotionally strong was practical advice. Only much later did I realise how much of a breakpoint Mae Adventina's refusal to talk had been for my understanding of loss in the village.

One strategy for coping with the monumental losses older women face involves an active forgetting or a willingness to consciously suppress traumatic memories. While this may ease emotional duress, it is also strategic and pragmatic, as Gussy pointed out, because it allows one to focus on the present, and to attend to the daily challenges presented by providing care, and the ordinary necessities of living. Moreover, 'forgetting' is an essential Haya practice with regard to death; untying the bonds between the living and the dead, in that way allowing for the continuity of kinship relations (Weiss 2007). But this practice has some unexpected consequences, too. Not only does putting this emotional baggage aside help older people to manage their emotions, it allows for more flexibility in the present, and allows older people to engage in relations.

Mourning experiences are often physical: Within the body the loss, sorrow and the broken connection between the body of the deceased and the bereaved is manifested (Klaitis 2005: 48). Death and bereavement, as Goody argues, throw light on relations between members of a social group, living or dead (1974: 452). The physical presence of a deceased body in the land around the homestead connects generations to a specific place (Weiss 1996), but in an era with increasing dispersal of kinship relations, with many marriages that are not official, with children not officially belonging to their father's clan, there are increasingly uncertainties as to where bodies belong (Whyte 2005) or where children belong, visible in inheritance discussions.

Mourning and bereavement can either be analysed from individual grief or from the mechanisms to redress this grief (Beatty 2005). In this chapter I am less concerned with analysing the specific emotional states of older men and women as a result of adult death, than I am with emotional practice (Beatty 2005),³ following Klaitis' argument that there is no clear distinction between bereavement

as a private emotion or as a public ritual, because through remembering the emotional and bodily condition of the bereaved is shaped in public acts. Remembering, he argues, is an act as well as a feeling as it allows survivors to re-evaluate ongoing relationships (2005: 49). Equally, forgetting is the active not-thinking about the deceased is an act of memory 'work' (Fabian 2003: 491). Lambek argues that both remembering and forgetting are part of moral practice and are in that sense identity building acts (Lambek 1996: 249).

Remembering can be dangerous, as is visible in the advice Gussy gives Mae Adventina: It can affect the physical health of older people and brings out the tensions in the relationships that remain. Klaitz argues that remembering in Botswana, is a style of behaviour; by remembering people 'think about the past in such a way that the act of recollection affects their sentiments, conduct and physical well-being' and can therefore be dangerous (2005: 48). This brings up the question how within the context of increased death, and the excessive costs and time involved in funerary rites which affect the spaces for bereavement (Kilonzo & Hogan 1999), older men and women maintain their physical and emotional well-being, while being continuously confronted with memories of their deceased relatives.

This chapter focuses on the way older people experience and handle emotions about the death and memories of their children in such a way that they are able to re-institute themselves as social persons within their networks of social relations after bereavement. In this respect it is important to focus on processes of aging, both physically and socially, and how bereavement reflects what is at stake for older people.

The consequences of bereavement for older people's ability to forge relations of support are a forgotten element in the literature on older caregivers. There are references in existing literature that indicate the presence of psychological problems following the death of relatives, stating that older people experience stress, anxiety, inability to sleep and health problems (Akinsola 2000; Ssengonzi 2007; Seeley *et al.* 2008), but how these psycho-social consequences affect older people's physical and mental ability to engage in relations is relatively unexplored. Moreover local practices to express and contain emotions in response to grief are often framed in the literature by resilience or coping, thereby employing a western style psychosocial paradigm, with too little attention to what local resources and mechanisms for support are present (Igreja 2003).

The core of the chapter comprises an examination of a common expression that was used to advise bereaved older people. This term was *kwegumisirisa*, a Haya term which stemmed from the verb *kuguma* and can be roughly translated as: Being healthy, being hard. In the village *kwegumisirisa* was translated as tolerating and, for that reason, this term will be used in this chapter, but the

English meaning of the term is closer to 'putting up with'. How old people put up with the pain of loss, and why putting up with is central to survival, is the subject of this chapter.

Older people's conceptions of AIDS death

In the village death has, in the past 25 years, become a frequent part of the lives of older men and women, to the extent that older men and women address death as 'normal', referring to the constant confrontation with death.

'We are all going to be finished', Ta Stephen said to me when the news of yet another funeral reached him, reflecting a notion of a societal shift that is seen as irreversible. Another saying some older men and women used was a Kiswahili proverb. *Kifo cha wengi ni harusi*: The death of many is a wedding, which referred to the constant presence of people at funerals, to the extent that funerals often were social occasions at which people met and exchanged news.

Also at the village kiosk, where the men of the village gathered in the evening to listen to the BBC news, death was a common topic for discussion especially in December when the short rain season has stopped and the hot season is beginning. The shopkeeper, keeping track of the general topic of discussion on two nights related two conversations about death. 'There is a lot of death nowadays', one older man said in December 2003. 'I think God just wants to finish his list for the year', another replied, 'he saw he had not yet finished all and that is why death has increased so much'. 'But why is there such a problem with older people and small children nowadays', a third man asked. 'It is malnourishment. In this month there is not sufficient food. So when the bodies get a simple disease they cannot resist'. A week later, the discussion focused on the accidents in the period of December. 'Some of the people are sinners and God does not want them to enter into the New Year with their sins', the group of older men argued. 'But accidents also happen because everyone is travelling home for Christmas and the drivers are speeding'. God's will, sin, weak bodies and the dangers of mobility, and its associations with death show the dangers embedded and felt in present society.

Death in the village does not just occur due to AIDS. Mortality rates show that malaria is the number one cause of death, especially for young children (Tubeti 2007, quoted in Rugalema & Mathieson 2009). In 1999 El Nino, and the rains that came with it, caused a malaria epidemic of such a scale that emergency relief organisations set up camp in Rubya hospital. The increase of tarmac roads and the busy travel between villages and cities is the cause of many road accidents. In the rainy season many older people become sick with flu and common colds.

'Death is normal nowadays', both young and older villagers told me. When I asked older men and women specifically why people said this, they replied that it

was a phrase that was usually uttered by young men and women, who were already infected but that it was 'just the mouth talking'. 'Death is normal' referred to the inevitability and the frequency of death. What changed in the past 25 years is that death among young adults has increased. 'Death was always there', Ta Cyriacus says, 'but before they were small children or the older people. Nowadays it is the young adults'. Twenty-two of the 47 older people in the village had lost children to AIDS and two people had lost all their children to AIDS.

Older men and women have been and are repeatedly confronted with death. Mae Tibaigana a 65-year-old woman who had lost her husband and daughter to AIDS in 1987 and 2002, lost her daughter-in-law (sudden illness), and her son-in-law (plane crash), the son of a befriended family (AIDS), her mother-in-law (old age), a child of a sister-in-law (convulsion), a member of her parental family, and she attended eight funerals in the first year of this research. The constant presence of bereavement in each family has changed the narratives of blame as became apparent during a conversation with our neighbour:

Mae Sofia (55): You know, in the past you knew that everyone came to look at you, to see your misfortune and they would laugh at you. But now that has changed; everyone has the same misfortune. Now the people just come and comfort you.

These deaths often had serious effects on the social position of older people. Especially when a woman lost her husband her social position often seriously changed, even more than when an older person lost a child. The current climate of land scarcity and economic difficulty often provoke serious disputes in families over inheritance of land, and court cases around land grabbing abound. When older women do not have access to land or possessions their possibility to engage in relations is seriously diminished.

Despite the seriousness of losing a husband, older women are particularly concerned about losing their children. In Haya culture, a person continues to live after death through remembrance. Losing your children means that no-one will remember you. Mutembei (2001) explains this meaning of death in relation to Haya concepts of death and time. In Haya culture when a person dies of old age he or she becomes an ancestor. Death and life are a process which you start even before your birth and which continues after death. You live through your children. If you haven't had children, as is the case for many young adults who die, you become extinct. Older people refer to their children: 'It's finished, she has gone'. What is at stake for older people is therefore remembrance as an ancestor, an enduring legacy to the community (Mutembei 2001). The phrase 'who will bury me' was often used in reference to the death of adult children. Mae Maria, from *Kiziba* explains why:

- Josien: We have heard many older people ask: Who will bury me. Do you know why they say this?
- Mae Maria: Those who say this do not know if those children will be left at the time the parents died. So you find that the parents bury all the children and the parents become young again [without children], and when they die there are no children left.

In this sense adult children and their success 'makes' the older person. Children are extensions of their parents. This was mainly visible in the highly affected northern area amongst older people who had lost all their children as the story of Ta Athumani shows:

- Josien: Is your position in the community different? Like did the respect decrease?
- Ta Athumani: This can happen. They see you stay like this. They scold you. My respect has decreased because I lost my children.
- Josien: When did this happen?
- Ta Athumani: Since I stay alone, the respect is not the same anymore as it was before. They know that there is no child to come and fight with them. Young people pass without greeting; they know there is no one to fight for the father. If they knew there was a child to fight for they would not do so.

The death of adult children has a meaning beyond the physical death; it represents the disruption of a normal aging process in which the children's accomplishments reflect on older men and women, robbing them of the possibility to 'die a parent'. To die a parent is to die when your children surround you, to have the drums playing and the grandchildren dancing on your grave¹, not to die as Mae Maria says: 'as if you never had a child'. For many this ideal is unattainable; children die before their time, grandchildren are raised by their parents and older people perceive care in contemporary *Buhaya* as uncertain: 'You give birth to children who beat you like animals; it is better to be chased out by your children than to be beaten'. Mae Maria (76) who lives alone states in a conversation with Mae Elesta (78) about dying a good death, how to make sure to gain respect after death:

You have to be sure to be with a *mkeka* [woven mat, *ks*], so that when you die they can lay you on it and bed sheets so that they can wrap you in it and blankets because this can even help when you are sick. These things are very good to be with so that at the time that you die they can help you get respect, because your body is covered well.

The increase of death then threatens the core elements of what is considered a good old age: Care, remembrance and to some extent old age identity. The death of children in *Buyaha* has an added layer of tragedy because of the meaning of

¹ This is a particular Haya practice where grandchildren, the alternative generation, invoke the memory and authority of the deceased grandparent during the funeral by dressing in his or her clothes and dancing the Ngoma drums. This practice has often been abandoned in the era of AIDS as the grandchildren are raised by their grandparents and resemble the ascending generation too much (Mutembei 2001). I witnessed one such event when a family matriarch of a wealthy large extended family died at an advanced age (over 80 years of age), dying what is considered a 'good death'.

death and death's legacies. Following on from Sagner's notion of a relational self as a core element of old-age identity (2002), I argue that the loss of children provokes extreme anxiety, not just in terms of old-age care but also in terms of old-age identity. In the village there were elaborate mechanisms to manage the consequences of the loss of relatives. This included formal mechanisms to manage funerals as well as adaptations in bereavement practices. These adaptations make it possible for older people to contain both their anxiety and be able to socialise and engage in relations.

Spaces for emotions: Formal bereavement practices in Buhaya

Biehl *et al.* argue that the key to understanding a social drama is by explaining what they call 'key emotional and inter-subjective constructs' (2005: 10). For older men and women, the social drama in their lives refers to the loss of images of a 'good old age', remembrance, care, but also what they see as the institution-alisation of relations of care at funerals, the amendments to mourning practices that are inevitable and necessary in response to death but that are also less spontaneous. Sociality in mourning is achieved through sharing, encapsulated in the term *comforting* – showing compassion, sharing stories of loss, wailing and touching the bereaved person. At the same time this practice is taxing on older people's health as it reminds them of their own emotions, which are considered detrimental to physical and mental health.

In the village the increase in funerals and the associated costs have led to dramatic changes in mourning practices to allow for the increase of death and to allow people to attend many funerals in a row. These are practices such as the duration of the funeral, which decreased from 6-7 days to 3-4 days. One older woman explained that she had saved the funerals of three people that were not very close to her for Sunday. Taboos on doing work changed as well. Family members, close friends and neighbours used to sleep in the house of the deceased and spend the entire six days there, but nowadays family members often sleep at the funeral but travel to work in the daytime as Mae Tibaigana, 65, explains:

It is impossible to be away all the time; you will lose your job, so he compromises and sleeps at the funeral just like Korokora (Mae Tibaigana's son).

Whereas death used to bring a halt to activities of all villagers, as a result of the increase in death it became localised. News of a death would not reach the entire village and had become an affair of the extended family, immediate neighbours and the members of the self-help groups. Visible markers of grief, such as practices of women shaving their heads or wearing black clothes for a year have been largely abandoned.

Another practice has changed as well: The functioning of the burial groups. Funerals are expensive² and labour intensive occasions; all the people who come to 'say *pole*'; to offer their condolences, need to be seated, received and fed. Food needs to be cooked, water needs to be carried, firewood needs to be collected and a grave needs to be dug. These are all tasks that the bereaved cannot possibly perform on their own. In the village funeral assistance is provided through the burial group. When a household member of a group member dies, the household receives assistance from all the groups of which the group member is part. The group members dig graves, and contribute money, food, firewood, grass to sit on and sheeting to protect the mourners against the rain. The group also accompanies a member to the funeral of a close relative even if the funeral is in another village. The type of contribution depends on the status of the different groups. Women's groups also cook for four days for the bereaved. Besides, practical support groups also provide social support such as accompanying the father or mother to the actual place of burial. When a married daughter dies, she is usually buried in the village of her husband and the burial can therefore be held far away from an older person's home village. Group membership is central in the village and every older man and woman in the village is at least a member of one burial group.

There are several types of burial associations in the village. The main one is the *bujuni* (funeral association of men, *kh*) (Dercon *et al.* 2006). In the sub-village where I worked mainly this was *Tweyambe*, with 198 members, which covered most of the sub-village but also included members from other sub-villages. Membership was open to men and single women (divorced, widowed or unmarried). That meant that most households in the sub-village (in 2002 I counted 105 households) were represented in the *bujuni*. It is also possible to be part of a *bujuni* when you live in Dar es Salaam. Many young men who have migrated are still part of the *bujuni* and contribute money so that when their older parents experience a death, the household is covered. The following fragment shows the functioning of the main burial group in the sub-village for single women and men, *Tweyambe*.³ This included all the older widows and divorced women and their households.

4th October 2002: House of Mae Elesta's son

Burial of Vedasto. Many people have been present since morning. The burial was held at three in the afternoon. Most of the people showed their sadness. Present are the leaders of the Women's Group, the Unity of the Sub-Village group and the organisation which assists dur-

² Haram (2010) refers to a WorldBank study from Kagera Region in the late 1990s, which estimated that households spend an average of US\$ 104 on death, US\$ 40 on the illness and USD60 on the funeral (though unevenly distributed according to the economic capacity of the household).

³ The regulation of *Tweyambe* was that men and single women could become members. The group is not for married women. The group pays towards the funerals of direct relatives (partner, children)

ing funerals. All have made announcements and given contributions for the bereaved. The contribution of the Women's group was grass for people to sleep on at night, and they prepared food for after the burial. They arranged work shifts for cooking for the duration of seven days. The women of the sub-village contributed ten fingers of banana [one finger is one plantain], money and beans each. All the sub-villagers, every household contributed firewood and money for the funeral. The Union Group: *Muungano* [including some households in other villages] contributed bananas and money for the bereaved, and they contributed pots, pans, plates, lamps and large sheets to shelter the people from rain during the funeral.

Apart from burial organisations that are solely focused on assistance upon death, other support groups, such as religious groups,⁴ women's groups and clan groups often assist during funerals, as well as a women's bank. The coverage of these groups can be extremely local (on sub-village level) or can cover several villages. Some groups are formed in response to a certain problem, for example during El Niño. Besides more or less formalised large groups, there are many small informal groups. Many of these voluntary groups are of a recent date.

The interesting aspect of the burial groups is their level of organisation. Dercon *et al.* (2006), writing about Tanzania and Ethiopia, argue that these types of risk-insurance associations are fundamentally different from loosely organised informal risk-insurance. All funeral groups have common elements. First of all there is a group-membership for which one has to apply, and which is restricted and very formal. Insurance schedules are based on certain conditions, for example only when a household member dies. The form of payout is organised in cash, goods and labour. There are rules and regulations, which are often written down and fines when contributions are not met. Groups have a governance structure in the form of a chairman or a committee and lastly groups have a large spread. Often there are many groups in small communities and members are part of several groups.⁵

A historical timeframe is necessary to understand the development of groups. Dercon *et al.* (2006) argue that burial groups are neither informal, because there are strict rules, nor traditional (because their emergence is recent). In Tanzania the self-help groups evolved as independent institutions after a period of intensive state-rule with forced group-forming under Nyerere's presidency in the 1980s (Dercon *et al.* 2006).⁶ This is visible in Table 4.1, where the only group that started before 1980 is Tweyambe, the *bujuni* of the sub-village. Before 1975,

⁴ Especially Islamic support groups were seen as highly organised 'cooperating nicely', mainly by Christian villagers.

⁵ For more information on the difference between Ethiopian and Tanzanian funeral groups, see Dercon *et al.* (2006)

⁶ De Weerd, in a historical analysis of the Union Group in one community in Kagera, shows how the creation of the Union group was part of the socialist politics of Nyerere to establish newly formed administrative villages. The group had an economic function and later on became a political movement (2001: 5).

Table 4.1 Types of group assistance for funerals

Type of self-help groups that help in funerals	Examples of names	Example regulations	Example of contribution
Special burial groups	‘Tweyambe’ (let us help ourselves, <i>kh</i>) ‘Otangalana’ (do not worry, <i>kh</i>) ‘Tumwambembele’ (let’s first help her, <i>kh</i>) ‘Twambangawe’ (we help each other, <i>kh</i>)	Men and unmarried women. When a member loses a partner, children, father or mother, they contribute	2 hands of banana or 1 kg of ugali, or 200 shillings and an additional 100 shillings
Clan-based groups	Abayango clan-group, for all the members of this clan	They go to the house of the deceased and contribute the same day; the next day Muungano takes over	200 shillings, 20 fingers of banana, 4 pcs of firewood, 1 bowl of beans, 1 basin of water
Religious groups	Catholic, Lutheran, Muslim	They come to the house of the deceased and help organise the funeral and contribute	Varies per group
Women’s groups	‘Poa Tupo’ (Rest/calm, we are here, <i>ks</i>), Muungano The united women’s group, umbrella of 7 smaller groups	Contributes when a member loses a husband, children, father or mother and organise the funeral and perform all home activities	Bringing water, food, grass, beans and 3,000 Tsh. They have a basket fund for funerals in which they contribute 200 shillings every month.

when the ruling TANU party of Nyerere created pressure on women to unite in *Umoja ya Wanawake* (Union of the Women, *ks*), group assistance was largely informal. Co-operation existed between households in case of death, sickness or calamities, but there were no fixed rules or contributions. The experience of formal arrangements through the UWT group made women realise the strength of formal institutions. The women then used the experience to unite on the level of their ‘felt’ community rather than the administrative ‘imposed’ community (de Weerd 2001).

The form of practical assistance during funerals in *Buhaya* has therefore responded to the increase in death and political and economic change over the past 25 years and self-help groups have rapidly developed. When I asked the chairmen/women of the self-support groups why the groups had been formed,

food shortage was an issue that was mentioned mostly. Food shortage meant that funerals could not be easily organised anymore and it also meant that the voluntary assistance of neighbours had decreased. In a context of increased sickness and economic deprivation, it makes sense to organise formally. Group evolution is thus related to what is needed in the community and this explains why burial societies are so strong. New groups are also constantly formed in response to urgent issues. The chairman of *Otakangalana*, 'do not worry', a group developed in response to a malaria outbreak in 1999 explains:

During el Niño there was a great hunger in this area and outbreaks of many diseases such as malaria, so this group started as a redeemer/liberator. During that period so many people left other groups because of hunger, lack of money and many sicknesses. For example in my household I had four children sick and when I took them to Rubya (hospital) they had malaria. So, in this group, when we started, we allowed the people to bring anything they had (rather than having fixed contributions): Cassava flour, maize flour and potatoes, so this helped in that period. This group was very strong from the beginning and until now it is very strong and many people want to be part of it.

Over the more than 20 years of existence self-help groups have developed into well functioning social security mechanisms to such an extent that no person dares to not be in a group. A funeral without a group is impossible. If a community member were to lose a relative but not be in a group, or did not perform his or her group duties properly, sanctions would be undertaken. Community members would, for example, dig a grave of 20 cm deep or a women's group would not give food, which left the humiliating task to the bereaved family of performing heavy work alone or going out in search for food for the visitors in the midst of severe grief (de Weerd, personal communication). But also not giving contributions is penalised, which leaves some group members searching frantically for money to contribute when a relative of a group member has died.

The above quotes show however, that though groups are perceived as indispensable, they can also be a burden. Some older people, especially older women have left in recent years because of weakness and their inability to pay the contributions. Other older women leave the group as soon as their son marries and the daughter-in-law takes their place in the group instead. A few older people leave the group when all their close relatives have died because they 'did not see the point of being a group member anymore'. The leaders of the groups emphasise the importance of the groups compared to the past but also acknowledge that it was more and more difficult to pay contributions due to the food shortages and *shamba* sizes. Despite these problems they maintain that there is no life without groups.

One important aspect to this discussion involves the organisational level of social assistance around funerals, an example of how moralities of care are adapting. New social configurations mobilise resources, and alter the spaces of

participation in familiar rituals, changes which older people view with ambivalence, perhaps in part because it is death, loss, and a bleak outlook that is driving the change. It is a social obligation of group members to assist, both practically as well as in comforting the bereaved. The organisation of comforting is something which has changed, according to older men and women; whereas in the past neighbours would assist each other voluntarily in food and kind, nowadays this voluntary assistance is impossible to give as death has increased too much. Hence groups were formed.

The older men and women in the village often spoke about group-assistance both in terms of pride as well as in terms of loss. Pride because everything was now well-organised; loss because ‘voluntary’ assistance and ‘compassion’ in relations of care had decreased.

Forgetting the dead: Emotions and remembrance

What the amendments to funerals have not changed is the experience of loss, nor the norms and rituals in relation to how to show feelings of loss. Mae Sofia, the wife of Ta Stephen makes this very clear:

A death is still a death. The loss of a child or someone near leaves a scar on your heart and you can never forget that – not after 50 years, not until the day you die. What has changed is the way we deal with death.

Though this may be true in practice, as the previous section showed, norms about proper bereavement mean that those older people who do not observe the norms are scorned and gossiped about. As Haram argues, mourning is gendered: It is a woman’s social role to make sure that the deceased are properly mourned (Haram 2010). If a mother is too active at a funeral or does not show that she is sad, neighbours will talk for days about her improper behaviour. Over the months of research I jotted down some comments of village friends and of Gussy relating to funerals. ‘She did not look very sad; she was even laughing when she received the gifts’. ‘The neighbours complained that the mother was helping to cook and running around’. ‘When I arrived at the funeral the mother had gone to the market to buy *konyagi!* (locally brewed gin, *ks*). She even changed her clothes so that the neighbours would not recognise her as the one who had lost a child. That shows how people do not care about death anymore!’ The concerns which are voiced are concerns related to treating death too normally.

When someone dies, even in the middle of the night, the women of the household start to wail, a sign for everyone that someone has died. Before the actual burial the mother sits next to the body of the deceased. The body is wrapped in white cloth and placed in the backroom of the house. Visitors wail outside and then enter inside and kneel next to the body. Whilst crying the mother will show the face of the deceased person, often touching the body. After

burial the mother is not supposed, nor able to do anything; everything is taken care of by the groups and by friends. Other women advise the bereaved mother, support her, bring her something to eat and force her gently to eat. When new visitors, especially good friends come, there are often bouts of crying followed by comforting. Usually a bereaved mother should wear the same clothes until the beer ceremony in which the 'black clothes' are traditionally taken off, six months to a year later and she cannot engage in leisure activities for at least a few months. Acute bereavement and sadness should be shown, and is expected to be seen. The mother is expected to share her worries, to feel numb, whereas later, after the bereavement period is over, she will be expected to control herself and her emotions, to forget the deceased.

Both Weiss and Mutembei discuss forgetting as a central element of mourning, as this allows the deceased's authority to be invested in ascending generations (Weiss 2007: 169); forgetting in this way makes remembering possible (Mutembei 2001). In the mortuary rituals disconnecting the dead from the living is a central element (Weiss 2007: 169). The funeral usually begins with wailing and the wake around the body of the deceased who is covered in a white shroud, followed by the actual burial and the funeral which can last between 4 to 7 days. On the final day when the funeral is officially 'finished', only very close relatives remain. On the 40th day the inheritance is settled. During these days the practical issues related to the death of the person are arranged. A major issue is inheritance, often a source for family feuds, in particular when the deceased left children who are to inherit his land. A year after the death the mourning is officially closed off with a beer ceremony: The 'taking off the black clothes'.

I feel happy like now when we are talking here. I am happy, I am always happy but I was sad when my brother died in December. I was thinking, who will bury me, my siblings are all dying. Who will help me? But now I am happy; I have forgotten. (Ta Athumani, northern area of Kiziba)

It is important not to situate forgetting in a frame of denial. Forgetting is closely associated with remembrance and is a way to allow the living to continue their lives independently of the deceased while remembering the intentions of the dead for those who remain (Weiss 1997a). Forgetting as a practice is a normal response in *Buhaya* to situate death within broader kinship relations, and connect the living and the dead.

In the current situation of increased death, bereavement is however continuous: Older people are constantly confronted with death because they are not just bereaved themselves but also have to fulfil different social roles in bereavement practices as members of the community – roles that are increasingly prescribed, as I argued in the previous section. These roles depend on the relationship that they have with those who mourn and what is at stake for them in that relation-

ship. An older person may have lost a child two weeks ago but, as a member of the burial group is required to attend a funeral of a neighbour. Mourning in this sense is about affirming the relationship with those who remain. For older women mourning rituals are particularly visible, because they require physical expression. As a mother losing a child, an older woman is expected to wail and cry at death and for the duration of the funeral, other older women touch her, sympathise with her and tell similar stories to show her that she is not alone or tell jokes to make her laugh. After the funeral she is urged to push her grief away, though the official mourning period usually ends with the commemoration service, one year after the death. In the role of a neighbour an older woman is supposed to visit the bereaved and comfort them. In the role of a sibling an older woman is supposed to go and stay with her bereaved sister for a month. In these different roles there is a constant negotiation between wanting to forget memories of loss and social obligations to comfort, a practice in which older people tell each other to 'forget', but in that process are reminded of their own loss. Bereavement then is an emotional practice in different social spaces *through time*, not just practices related to actual funeral rites and not just isolated events. This requires a constant moving between different roles and obligations. The factor of time, the fact that older people have different roles in the mourning process or are at different stages of mourning which are not yet finished when they have to engage in different roles, makes it however, hard to forget and remember the deceased in a healthy way, as older people are constantly reminded of their emotions. In the next section I present the case of one woman who navigates between different social roles and in that process explores a core narrative in the village: Tolerating death.

Tolerating to avoid memories of death: The different roles of Mae Tibaigana

Everyday reminders

Mae Tibaigana usually was a cheerful woman, always joking. She had told me already that she had lost her husband and her two daughters, and had shown me their graves in the plantation next to the house. That information was given in a rather matter-of-fact manner, so I was slightly unprepared when one day I found her sitting on the sofa with a photo of her daughter in her hand, dressed in a black and red cloth which I had not seen before. 'Today it is two years since Rosa died. I remembered her today'. I sat down and asked whether I could look at the photos. Together we went through them and Mae Tibaigana told me how Rosa came to visit and fell ill with malaria, how she took her to the hospital and how she was discharged but died of the complications. She then points to the cloth

around her shoulders and explains that it used to belong to Faustina, her eldest daughter.

She came for the burial of Rosa but she was already sick and she did not go home again. She died just three weeks after Rosa. She was my eldest daughter. Two daughters in one month (...) It is three years now since they died and I am a bit better. After the death of my daughters, my brain was down (I was unable to think). I do not know (...) I could not talk for a year, but after a year I had to move on. I had such a pain in my head that I thought my brains were out of my head so I went to the doctor to have an X-ray and he told me that it was because I could not sleep because of the worries. He told me to drink some alcohol before sleeping so that I can sleep. So since then I take a little bit of *konyagi* (locally brewed gin) at night. My medicine!

Memories about death of a loved person can cause problems in functioning in daily life. As long as Mae Tibaigana talked about her daughters in general terms she was able to tell stories. But when I asked more detailed questions, the memories became painful. Several times, an event that reminded her of her own children made her go out of the room to cry. Memories also prevent Mae Tibaigana from sleeping. Memories of grief and worries were often a physical experience. 'I feel weak, my pressure is rising, Mae Tibaigana would often say when an event reminded her of her loss.'

Other older men and women complained of strokes and of high blood pressure and all these physical complaints were directly associated with grief. Several times I have heard older people say that it was possible to die from grief. Worries caused insomnia and all sorts of illnesses related to high blood pressure and heart failure. Old people often directly connected these problems with emotions. 'Look at Mae Erenesta. She is a strong woman; she lost so many children, but she has heart problems because of the grief'. Memories and the emotions associated with them are threatening the continuation of life and survival. They cause health problems, sleeplessness and ultimately loss of hope. The best way to deal with memories is to temporarily move the memories aside. Mae Elesta 72 just focused on food, a symbol for daily survival:

Nowadays the problems have increased much in people's heads. We have said it all and we have finished talking about it. You tend to think about where your life is going to and how it is going to end. But you have nothing to add. The mind is empty. And we others, we no longer are with any mind [we lost the ability to think about the future]. The mind is finished and we are only left to eat. When you get food it is ok.

Memories of deceased loved ones are an everyday presence in the lives of older men and women. Graves are next to the houses and often an older woman would point outside to the graves and say 'the one over there', or 'the one who is buried there' when they were speaking about their deceased children. Graves trigger memories, but daily events do as well. The story of neglect of the children of an AIDS-patient reminds Mae Tibaigana of her worries about her own grandchildren. Other women, especially those who depended on their own failing

strength for survival, often started crying as soon as we talked about how deceased children had assisted them. Especially in *Kiziba* the area where AIDS hit hardest in Kagera Region, older women's stories would often focus on a particular child, as the following story of an 82-year-old woman shows:

One died here in this house, one died in Kanyigo and one died in Kihanjo, Bukoba Rural. I had bought a *shamba* there. The first one was staying in Bukoba rural where I had bought a *shamba*. When he became sick he went to this house and when the condition became worse I brought him to his father's home in Kanyigo where he died. The second one was already buying a car; he brought it here; he has gone; what can I do? He was a businessman, so he studied a lot and attended courses and then he went into business. He has gone. My child. What can you do? He was sick from here and I decided to take him to Bukoba rural where he died. He died. '*mimi ni mama bure*' [Proverb: I am a mother of nothing/no-one, *ks*]. The third one was not yet married and he was 37 years. He stayed here. (...) What I pray for is not to give myself poison (...) to find that you get something (children) and then you lose it ...

The anniversary of a death is also an occasion on which memories thoroughly upset the daily living and well-being of older people.

The conflict between different roles as comforter, community member and being a parent becomes especially apparent in the case of Mae Tibaigana. Through her narrative we see how she is moving between different roles. First of all she is a mother; she had lost two daughters within one month in the fall of 2000. It took her a year to resume her life. She is afraid of losing more relatives, a threat that became reality in the year I followed her life. Forgetting is the best remedy against painful memories. Trying to push the thoughts about a deceased person to the back of your mind is of central concern to older women and men. Such need could provoke conflict between their different roles. At the same time, the experiences of death and grieving have drawn out a critical, reflexive perspective in Mae Tibaigana. More than personal resilience and ingenuity brought about by necessity, these challenges and personal traumas seem to have opened a space to criticise a loss of values such as *huruma* (compassion, *ks*) as an intricate part of the morality of care or suffering as a part of parenthood, and as such open a possibility to engage in shaping relations.

Making yourself tolerate: Avoiding, praying and socialising

'Shall I take you to the funeral of *shangazi* [father's sister]?' I ask Mae Tibaigana. It is a bright and cold May morning in the middle of the long rain season and the road is covered in mud and wet pools. *Shangazi* [an aunt from father's side in Kiswahili], a senior member of the clan, died a week ago and today the funeral period which lasted six days will be officially closed. 'No, I will stay here; I do not feel well today. Florida's brother died today: The same father, the same mother. The burial is today and that house is close to the house of *Shangazi* so if I attend the closing ceremony I would have to go there as well'. Florida is one of Mae Tibaigana's closest friends and Mae Tibaigana is a family friend. 'No, I will not go', Mae Tibaigana repeats with determination. 'I do not like to attend funerals of young people. They make me remember my own children and instead of crying for the deceased I find myself

crying for my own children'. She points to the two graves near the house, both covered with pink flowers in which her daughters are buried. 'So these kinds of things I do not like to go to. I will go tomorrow'.

Later that day I paid Mae Tibaigana another visit and while we were talking, Grace, her daughter-in-law came in. She had just come from the actual burial of Henry and elaborated extensively on how the orphans were crying above the grave of their father asking their father to take greetings to their mother, who had died two weeks earlier from AIDS. Mae Tibaigana stood up and silenced Grace with one dismissive wave of her hand. She then walked away into the side-room and when I followed her I saw her sitting on the bed crying.

In order to tolerate her loss Mae Tibaigana tries to avoid being confronted with sickness and death in a direct way. Mae Tibaigana had a vivid way of expressing how she dealt with the death of her daughters. She portrayed it as a box in which she 'stored' memories and that box was not to be opened. During the time I spent with her, she refused to go to actual burials or to visit sick patients. It reminded her of the children she had buried and it caused her grief. Only when the deceased was an old person or a child, and only when she was directly related, would she go to the actual burial. Even for one of her best friend's brothers, she refused to go to the actual burial – she went a day later. 'I find myself crying for my children, instead', she said.

Another way to continue living was to try to stop thinking. The death of her daughters had caused her to develop high blood pressure, she told me, and thinking about them she felt her blood pressure rise. On those occasions I found her in bed. On the advice of the doctor she drank a glass of alcohol every night, without which she was not able to sleep. To tolerate the loss she not only avoided occasions that reminded her of her deceased children, praying was also extremely important to her. She always quoted passages from the bible and when I phoned her in the summer of 2004 to offer my condolences after her son-in-law died in a plane crash, she literally said: 'I try to tolerate. I pray for God to put my worries at ease, but so far it has not happened'. Moving out of the room when her daughter-in-law was talking about Henry's death was such a tactic.

But also visiting neighbours 'for normal talks' was an often used tactic. Avoidance has therefore to be seen as an active tactic in a situation where death is repetitive and where old people live with the anxiety that they cannot be sure whether remaining children and close relatives will survive. Avoidance is therefore not equivalent to denial; it is an active focusing on the here and now, the relations that are there.

Making others tolerate: Comforting and being comforted

'We have become *Kiziba*'. Mae Zulia, a Muslim neighbour and friend of Mae Tibaigana, is sitting in the front room of her house. Outside is a fresh grave; ten days earlier Rhamadani,

Mae Zulia's son was buried after an exhausting sickness. He died only a month after Mae Zulia's husband died. The two women are sitting close to each other on a woven mat that is rolled out for the guest. Mae Tibaigana takes Mae Zulia's hand in hers in response to the comment about *Kiziba*, the district in Kagera Region which is known as the place most affected by AIDS. 'Even when I am in bed I cannot sleep', Mae Zulia continues. Mae Tibaigana comforts Mae Zulia by telling her that it is normal not to be able to sleep: 'It is true: It is still early; at first, right now, you will not have many thoughts – you will get more thoughts when these people go home and you are alone. The sleep will fail totally'. Mae Zulia responds to Mae Tibaigana's comments about sleepless nights and worries by telling her that she will manage the loss of her son better later on, and that fortunately he did not leave her with small grandchildren. 'I will forget, like I was able to forget my brother. This one, I will also forget, especially since the child he left me with is already big', Mae Zulia answers. She is silent for a while. 'Because you see, before this son, his older brother died and also his younger one, the one who follows him. They are in the same line. We parents will have tears all the time. I do not know whether I will stay with the rest or whether they are in the same way.'⁷ We parents, Mae Tibaigana, are in problems. I had ten pregnancies and I am left with only four children. Three died younger, but these others were adults'.

The two women sit together and talk some more about Ramadhani and then a young woman arrives to pay her respect and the discussion quickly moves to another subject. Towards the end all women, including Mae Zulia, are laughing and Mae Tibaigana leaves the house. The worries of Mae Zulia have been discussed and she is comforted, but on the road back home Mae Tibaigana discusses the precarious situation in which Mae Zulia finds herself. 'You know these Muslims, they have tough hearts they got from God. *Kuvumilia*, to tolerate. This woman has so many problems. You see that she does not look sad – she was just laughing but she has many problems: She lost her children and her husband even if he was an older man. You see that the house is falling down. Where do you think she is going to live in future life? She does not get sleep (...).'

The above event, registered by Gussy, as she happened to bump into Mae Tibaigana just when she was leaving to go and say *pole*, followed upon Ramadhani's death. In the weeks before his death, the family had been subject to much discussion; Ramadhani was suffering immensely, apparently covered in sores and had tried to kill himself twice, succeeding the second time. We had already noticed his death because of the group of Muslim men coming from the house on the day of his death; according to Islamic custom he was buried on the day of his death. His widow, from another tribe, had left the village immediately after the burial, taking all her and Ramadhani's belongings with her. Mae Tibaigana went to give condolences to his mother on the day of the funeral but also went to visit several days later, and Gussy decided to accompany her.

The account above is a typical example of how comforting works. A central aspect of comforting in the village is sharing *mawazo* – thoughts or worries (*ks*), with friends and neighbours during the four to six days of the funeral rituals. Family, friends and neighbours gather in the house of the deceased in order to pay their respect and comfort the bereaved. A funeral is a space where loss is shared. It is shared by crying together and by sharing experiences of loss, all with

⁷ Here Mae Zulia implies that she is afraid that her other children have AIDS as well.

the aim of reminding the bereaved mother or father that experiences of death are not a personal misfortune, but that everyone in the village has experienced the same thing. The stories are often about other losses as was related in response to my question about comforting to a group of four older women in the village:

A woman will tell you a story about how she lost six children, and you look at her and you see that she is nicely dressed and she tolerated the pain while taking care of herself and it makes you decide to tolerate the loss as well. And another mama will tell a funny story so everyone is laughing.

It is both looking at others who are in the same position and who also manage to endure loss, as well as the realisation that it is not specifically you on whom misfortune has befallen that makes comforting by sharing stories of loss important.

Though the funeral is the site to talk about death and loss, it is also the site at which parents, in their role of neighbours and friends, cannot avoid thinking about their own losses. Gussy notices this in her description of Mae Tibaigana at the funeral of Mae Zulia's son: 'sitting with a bent head as if she is having many thoughts'. Funerals are therefore a source of conflict. The comforter gives advice to make the bereaved tolerate but is herself or himself confronted with memories about loss.

Well-being and relating after death

'Tolerating' was the word English speaking Haya used to translate the Kiswahili word *kuvulimia*, but which usually suggests less 'openness and acceptance of difference' and more 'putting up with'. Tanzanians use the verb *kuvumilia* generally to discuss the challenges of everyday life, but the verb is not specific to the region or to older people. As discussed in Chapter 2, however, older women in particular use the value for implicit criticism of the demise of social relations. In relation to death and personal loss *kuvumilia* has taken on a second meaning, and refers to pushing grief and other emotions away to the back of the mind in order to be able to continue with daily life. The Haya equivalent of *kuvumilia* conveys this meaning even better than the Kiswahili word. *Kwegumisirisa* stems from the verb *kugumu*, which literally means 'to be strong/healthy', but which others translate as 'being hard'. *Ugumire*, a Haya greeting, stems from the same word and literally means 'are you strong/healthy?' *Kwegumisirisa* is said to a person who has encountered a big problem and means: 'try to view this problem as small, try to control yourself, be strong'. The Haya word thus conveys the importance of shielding and comforting yourself against grief and loss. In the north of Kagera the Kiswahili verb *kusahau*, 'to forget' is more often used. Tolerating is not only mentioned in relation to the death of children, it is also the most common way in which older people deal with other misfortunes such as lack of care, lack of food and health problems. Tolerating is a way of dealing

with grief based on notions of self-control, preventing a person from acting rashly and threatening remaining relationships (cf Bhagilishya 2000) and is an essential element of bereavement practices.

The emotions that loss provokes are potentially dangerous, because they often are about underlying tensions in kinship relations. Anger of older people was often related to *shamba* conflicts, inheritance quarrels, thievery or misconduct, loneliness was often connected to the absence of people in the house and disappointment about care, and grief was related to loss of remembrance, and failed expectations, or in other words the social disconnectedness of older people as a result of death, whereas older people referred to the presence of people to speak with or visits of children when they mentioned happiness. The emotions around death seriously affect the well-being of older people as Mae Maria from northern *Kiziba* states during an interview about the loss of her children:

Mae Maria: The person himself can become a mad person. It is an amazing thing to see you have four or five children and they die and you look at the place where they were and you find it is open. It is shocking.

The defined social spaces for bereavement as outlined in the case of Mae Tibaigana make it difficult to voice these feelings *outside* those spaces and could be detrimental to social relations as the continuation of the conversation with Mae Maria shows:

Josien: Did your respect decrease?

Mae Maria: At that time people said: 'ah, are you going to that family? You will find that she is going to talk to you about her problems. So the people will not talk with you'.

After death and after the funeral, older parents say that they are not able to speak with anyone because everyone has the same problems. People say, 'It is better to keep problems to yourself.' In the villages in *Kiziba*, the comparative site, the inability to speak about problems was expressed even more strongly. A number of older women stated that they would be socially isolated if they were to speak about their worries. In the village I observed reactions to uncontrolled behaviour which also show the importance of self-control: A woman who ran through the village, upon hearing about the death of her two children, shouting that she would question God about his behaviour, was said to be a mad woman; it clearly was not good behaviour.

The practices around good care in relation to bereavement such as comforting and the underlying values such as compassion and endurance/tolerating, place a high demand on the physical and mental health of older people. Most older women complain about sleepless nights, like Mae Tibaigana or lose all interest in living as Mae Elesta's statement about the finished mind shows. Physical problems such as strokes are attributed to grief and anxiety around death as are

heart conditions, high blood pressure and general bodily weakness. Loss in this sense is embodied, expressed in the potential weakening potential on already aging bodies (cf Scheper-Hughes 1992).

As the previous chapter argued, good health and related independence is central to survival in a climate of uncertainty, life itself depending on the ability of an older person to keep on engaging in relations. Endurance and tolerating, if done properly, can counter the detrimental effects of emotions on the health of aging bodies and minds. Countering the bodily aspect of emotions is, as the dialogue between Mae Adventina and Gussy which opened this chapter indicates, vital for the survival of older people.

A focus on emotional practice in new situations of care, in this case, mourning and bereavement opens the way to how older people experience their old age in the face of their growing responsibilities. Emotional practice in the form of tolerating and forgetting makes sense in the context of the continuous insecurity and bereavement that is part of a long-term epidemic. Older people become more dependent on remaining relatives and on their social standing in the community for engaging in relations. In this context of shared mourning, to keep on engaging in the social relations that remain, it is only possible to share individual mourning in regulated spaces. Zarowsky argues that personal suffering has the potential to disintegrate and fragment moral webs and have adverse effects on the emotional health of individuals '(...) narratives which were considered salient were those that indicate-and thus help to create and maintain- an individual's position within the community' (Zarowsky 2000: 399).

The narratives in the village are somehow along these lines. 'Bear the pain, endure, tolerate' are all narratives that point to the importance of continuing life, of pushing pain towards the back of your mind, in order to live, in order to forget the dead in the sense of making sure the living are disconnected from the dead in order to continue living with those who remain.

Conclusion: Being hard, being healthy

Old people in northwest Tanzania handle grief about deceased children by enduring it, trying to move on. The death of young people is an event for public discussion in which all issues that are at stake in the lives of older people come to the forefront. Grief and anger are logical emotions when confronted with the death of an adult child. But the discussions around the loss of a young adult in the community point to more than grief. AIDS death represents the disruption of the lives of older people: Through loss of remembrance but also sometimes loss of position as a result of death. For older women in particular the loss of a husband and the loss of a child who had supported them extensively could mean an enormous change in living conditions which affected their social contacts and

standing. The latter loss is not just material as older people also see their children as extensions of themselves. Emotions around death contain all these insecurities: Grief over the loss of a loved person, anxiety over future living conditions, food and care, worry over the fate of other children and over decreasing strength as a result of aging and the physical effects that are attributed to grief, and are in this sense responses to challenges of belonging in kinship relations.

Emotions around death have the potential to create conflict in remaining relationships, within the family when older people are confronted with the loss of possessions and support or inheritance conflicts around clan land. But they also have the potential to create conflict in the community, especially when older people talk about problems that everyone has. In a context where death is present in each family, a space to discuss and accuse has been lost. Older people mention that they cannot discuss their worries with anyone; they only seek distraction from worries by talking about everyday life with neighbours or by having a drink in order to sleep. Worries can only be discussed with close family and friends, mainly daughters.

In the village handling emotions is encapsulated in the concept tolerating, or putting up with death, which refers to being healthy and being hard which can be reached by actively not thinking about death. In this respect older people use the Kiswahili verb *kusahau*, to 'forget'. Grieving is largely restricted to the private sphere, except for on certain set occasions, like funerals. Not showing emotions is seen as healthy; it prevents older people from becoming literally ill from emotions and it maintains their social position; personal control in every sense is highly valued. Through practices of self-control, older people can fulfil the different roles that bereavement practices demand of them, and be a mourner and a comforter at the same time, roles that trigger memories of personal loss, but roles that have become more and more institutionalised and rigid in response to the increase in deaths.

Sociality in mourning is made through sharing, encapsulated in the term 'comforting': Showing compassion, sharing stories of loss, wailing and touching the bereaved person – in short, proper mourning. These practices which are gendered and part of a morality of care which reflects older women's concerns about contemporary social relations. Proper mourning practices are, however, also taxing on older people's health as it reminds them of their own emotions, which are considered detrimental to physical and mental health.

The concept of tolerating, as well as the notions of concealment in the following chapter highlight the importance of self-control in the face of chaos and highlight the role of older people in creating cohesion in new constellations of care, but also show the consequences for individual experiences of loss. The control of emotions and the attempts to normalise death make it possible to connect

with those who remain, but also to face the changes in life after the loss of relatives: Not relying too much on those who remain, maintaining physical health, caring for other relatives who become ill and raising orphaned grandchildren. Practices around death and bereavement have the potential to restore social cohesion and the possibility of older men and women to continuously engage in relations of care by their focus on survival.⁸ This is the subject of the next two chapters where I show how older people, within the context of these physical and emotional aspects of the experience of aging in the era of AIDS, engage in practices of relating in two completely changed ‘fields of care’: Care for dying relatives and care for grandchildren without parents.

⁸ Zarowsky (2000) in writing about Somali Ethiopians and emotions in relation to trauma has been influential in redirecting my thoughts toward trying to see what the overriding concern in a society is. As was the case for Ethiopia, survival seemed to be the primary issue for older people in the village. The experience of war, argues Zarowsky, is ‘an attack on webs of relationships through which individuals, families and groups have immediate or potential access to the material, social and political resources which allow survival’ (Zarowsky 2000: 398).

Caring through concealing: Older caregivers and dying patients

Introduction

Scène one: Sleeping patients, exposed illness

It is a hot afternoon in July, the long rainy season has finished and the paths winding through the banana groves are dusty. I have just come home from a walk to the roadside with my 25-year-old neighbour. It has been four months since my arrival in the village and I have been feeling a bit uncertain lately. Though death has been present in many conversations, AIDS illness has, so far, been invisible to me. It is this invisibility that triggered the question I asked my neighbour: 'Do you know who has a patient in their house right now? I never met anybody, it seems as if AIDS is not present at all.' My neighbour points to a house not far away. 'In that house there is a patient, but she is not yet sleeping'. She uses the word 'sleeping' as many people do when they want to indicate that a patient is close to dying. 'And the daughter of Ta Stephen, she is in Rwantege (dispensary) now; they brought her this morning.' I am surprised; even though I have known Ta Stephen for four months and have seen him almost every day, I had no idea he had a patient in his house. My neighbour was surprised as well because I did not know what everyone knows. 'He has not told me anything about it', I said to her, and she answered; 'He can't, he can't. It is very difficult to say that and it is also very painful.' 'But is it certain that it is AIDS?' I asked. My neighbour is certain. 'Yes, she was admitted in Rwantege dispensary and it is serious. The mother slept there last night (implying the patient is close to dying).'

In northwest Tanzania, those who suspect that they may be infected with HIV and their close relatives usually keep their suspicion to themselves. Even when the terminal stage has been reached, silence around AIDS illness is generally maintained. Results of tests are not always told to patients, and when a villager meets someone in whose house a patient is dying, there will be respectful enquiries after the condition of the patient, without references to what is wrong with the ill person. At funerals the cause of death is also hidden, or phrased as 'ill

Photo 5.1 Father with daughter after her discharge from the hospital



for a long time'. Because of this silence, AIDS is at first sight invisible, but for villagers who are ill or who might be ill is a subject of public speculation.

When patients reach their terminal stage both silence and speculation increase. Someone who is very ill sometimes hides or is hidden by the family. Visitors are told that the patient is sleeping. But public discussions in such a phase intensify and often include the caretakers as well. Intimate feelings and emotions, relations between parents and children, the social status of the family – all these private issues are made the subject of public scrutiny when a patient becomes seriously ill (cf Mutembei 2001).

The discussions take place in bars, on the road, in houses and on the paths through the banana groves where villagers meet. News is exchanged and stories from different sources are evaluated. Often these discussions do not have malicious intent; it is the usual way to discuss everyday events. The stories around the terminal stage of AIDS illness expose what for a long period of time has been concealed, and in that way provide an entry point to understanding the rationale for silence and concealment within care giving relationships from the perspective of caregivers.

I became intrigued by these different modes of communication when I realised that I was excluded from an intricate knowledge in the village. People knew who

was ill and discussed their situation but in concealed ways. When I asked older caregivers, they shared their painful stories of losing patients, even indicating that their relatives had died of 'this disease of ours'. By living in the village I had to adhere to its unwritten codes; there were limits on the social spaces I had access to, and to the questions I could ask.

In this chapter I examine how tactical silences employed by older caretakers, patients and those outside the family over the course of a dying process, relate to notions of good care. In providing care older men and women are, while growing physically older, constantly confronted with expectations about good care, expectations that are physically taxing and that they cannot always fulfil, but that have always been paramount in how they view 'normal' relations. How this balancing act works out in practices of care is the subject of this chapter. In this chapter I focus on both older men and women and their respective caring role in AIDS illness, as the role of men in care giving is often denied (Knodel & Ofstedal 2005). This denial obscures the broader family dynamics in patient care.

Giving care to dying patients is often framed in discussions as to whether the extended family is able to cope with the increased demands on its resources (Ankrah 1993; Seeley 1998). What is as yet unexamined is how care and 'good care' are enforced by the community and shape the way that caregivers and those around them deal with the increasing demands. The element of relationality poses new questions, the main one being: What is at stake in certain relationships because of AIDS illness and how does silence or concealment 'work' herein. Relations of care are negotiated within a certain local moral world, where things that really matter are at stake (Kleinman 2006; Yang *et al.* 2007). To understand how AIDS illness might create distortions in the relations of caregivers, current analyses around stigma and how stigma is embedded in social relations give some directions.

Posel argues that an analysis of emotions around sex, death and embodiment are central in any analysis of stigma (2004: 5). The terminal stage of AIDS illness, implies a slow degeneration of the physical body (Henderson 2004), often leading to feelings of disgust and shame (Posel 2004: 8).¹ AIDS illness then often leads to a social death that precedes the actual biological death (Niehaus 2007). This social death that is related to feelings of shame and disgust can damage relations of AIDS patients and their caregivers. Secrecy and silence are then seen as responses to shame and disgust (Posel 2004: 8) as a mechanism to protect patients (Emlett 2008: 712).

¹ Posel (2004) argues that shame is in essence a social emotion related to judgments of value, in the eyes of others. Also Schwartz (1988: 23) argues that shame is necessarily related to social life; it is an actor's response to wrongdoing.

In this chapter I build on these arguments by analysing how tactics of silence and concealment contribute to what is considered good care. This is a somewhat reverse angle: I do not take the patient, or stigma as such, as a point of departure but the caregiver and their care giving activities. I see illness events as moments which open up debates about morality and praxis,² in this case in care. Tactical silences and concealing, then, can be framed as responses to such moral breakdowns (cf Zigon 2007). Following Iliffe (2005: 363) I argue that concealing in relation to AIDS illness functions as a core praxis to protect the honour of individuals, an honour which frames what good care is. Notions of masculinity and femininity are tied in with good care. Concealment then, contrary to what public health literature frames as denial, is central to practices of relating in a local moral world.

Experiences of caring for dying AIDS patients were not easy to articulate for those whom I interviewed. The more I became familiar with certain older people the more they preferred silence. Talking about those who were gone was too painful and only came up when patients in neighbouring houses were about to die or when death could not be avoided at a funeral. Talk about loss had its space but silence prevailed. As such I base this chapter on a combination of sources: Conversations with older people who had lost and cared for relatives dying of AIDS; observations of what was said and not said; four case studies of patients in their terminal phase; gossip about patients and caregivers; and responses to direct questions about AIDS and the issue of silence. Analysis of this material shows the nature of intimate relations between older parents and their dying children, as well as the paradoxically supportive and conflicting relations between families and the community. In two follow-up one-week visits in 2005 and 2008 I traced the events in the ten families and observed the manner of speech around AIDS. These brief observations indicated that older men and women were still losing relatives to AIDS³ after the introduction of ART and that general modes of discussion around AIDS had not changed.

² Zigon (2007: 140), in suggesting an analytical framework to study morality, argues that the key to understand local notions of morality is to look at the moment of moral breakdown, when people are forced to step away from the unreflective, embodied everydayness of morality. In these moments an ethical demand is placed on persons to return to the everydayness of moral dispositions. In return local conceptions of morality become visible.

³ These observations parallel those of Kastelijns (2009) – patients generally went to hospital only in a very advanced state of illness and hence often died, despite treatment.

‘This disease of ours’: Silence in an advanced epidemic

‘*Bantaho olugambo*’: They have put words on me.
(*Haya metaphor: Aldin Mutembei 2001: 71*)

‘They have put words on me’. This sentence quoted by Aldin Mutembei conveys the action present in speech and the dangers in that related to AIDS. Putting words onto someone means that someone is positioned into a certain being, an ill person (Mutembei 2001: 71). Despite its long presence, there is a sense of danger surrounding AIDS illness in the village. Amongst older men and women there is a general sense that AIDS is inevitable. Long illnesses are attributed to AIDS, and older men and women have become adept in recognising the signs and symptoms of AIDS:

My son died from this *Mugendelanwa* [going together: That the thing came to you and you have to go with it, *kh*]. Nowadays you do not have to ask what someone died of. He was married and left one child, but even the wife had already died. Their child stays with the uncle of the wife in Mwanza. My son and his wife stayed in Dar. He arrived already sick, stayed two weeks and died. We took him to Rubya hospital where he died. I cared for him in his house, then in Rubya hospital. About seven years passed since he died. (Berina, aged 78, is left with one unmarried son)

Older men and women see AIDS as a disease of sexuality, something that belongs to ‘those who go in those ways’. Though there are some cases of AIDS associated death amongst older people, like the husband of a 60-year-old woman who died at the age of 66, in general older men and women do not associate themselves with the illness. This is also related to the history of responses to AIDS.

Messages about AIDS in Kagera have come from a variety of sources. Whereas the Catholic Church emphasises the importance of abstinence until marriage and faithfulness within marriage, the Lutheran Church also promotes condoms and has active HIV prevention programmes. Other sources of information about AIDS include workshops and training which village leaders attend as well as resident AIDS counsellors from World Vision and Wamata⁴ and messages from radio and television, oral poetry (Mutembei 2001) and popular music. Older people, however, are often excluded from prevention messages and are not seen as possessing relevant knowledge, even though some attend training seminars. Their ways of caring and advising when AIDS is concerned is often not appreciated by younger relatives. However the death of relatives close to them has shaped their understanding of AIDS. ‘I am not infected myself, but I am infected through the death of my children’ a statement of a 72-year-old woman which

⁴ These counsellors are chosen by the organisations that they work for and usually have to cover an extensive area. The counsellor of Wamata for example had not been paid in a year and two other counsellors had stopped. The village has around 900 households. She was responsible for six villages. She also had 16 children, a business of beer making and a household to attend to.

conveys the deeply felt presence of AIDS in the everyday lives of older men and women.

In their references to AIDS, older people often refer to a moral punishment; '*gharika*' (Noah's flood), referring to the history of commercial sex work in the region, mobility and the often shady business deals with which the first AIDS victims were associated. Other narratives voiced defeat and too many deaths, too often. In stories about AIDS illness of relatives AIDS is referred to as 'the man which came to finish us', or '*rumala*', (the disaster). Or as a 78-year-old man put it: '*watu wote tumedudulika*', literally meaning 'all of us are insectised'(*ks*), using the metaphor of an insect to indicate the inevitability of infection. In some ways AIDS has become a disease of everyone in the three decades of its presence. The concept of time, the fact that this is an advanced epidemic, is therefore central to an analysis of secrecy and silence, and how these forms of communication have evolved through experiences with the epidemic.

In the village there was some openness about AIDS. AIDS is usually referred to as 'this disease' to which often the adjective 'of ours' is added. Villagers state that AIDS has become accepted to some extent and that overt exclusion or gossip about the family of a patient has decreased.

You can't talk about anything; nowadays you don't ask anything to your friend. When you find your friend s/he will tell you that s/he is in the same situation as you. She will tell you that maybe two children of his/hers have already died. Others tell you that four children have already died; you find another one telling you that her children are sick. Nowadays we are no longer talking about it because nowadays we are all in trouble due to this disease. (Elesta, aged 70, lost three children and a grandson and is left with four children)

Yet personal experiences with AIDS are often met with an uneasy silence. Let's consider a conversation in *nyakitaba* (*kh*), the business centre of the village. The village chairman, aged 43, and I, sitting on a wooden bench in front of the village office are watching the bustling street life and I bring up attitudes towards AIDS in the village. 'Nowadays we are open about *ukimwi* (AIDS); we can speak about it', states the chairman. I decide to make it personal: 'so if your brother dies of *ukimwi*, can you say that to the people at the burial?' The chairman shakes his head vigorously: 'Oh no no no, it would cause many problems in my family, no, it is impossible (...).' He thinks for a moment and then laughs at me. 'There you've got me'. There are spaces for silence and spaces for public discussion.

AIDS patients themselves often refer to experiences of both covert and overt exclusion. A 59-year-old woman with a history of *umalaya* (commercial sex work, *ks*) was thought to have AIDS and narrated how her family members with whom she had a conflict over land had shouted at her. 'You, your head is full of virus! You are a dead (person)' and referred to her own experiences of isolation as well as those of other patients in the village.

Yes, I was isolated. Take the daughter of Ta Stephen. She wanted to sell *mandazi* [doughnuts] but people were afraid to buy from her. (...) Some older people think that the patient was asking too much. One old man said, when his son came back from Bukoba with AIDS: 'do not disturb me; you went yourself to Bukoba to find this disease'.

The broader framework of silence, the sense that AIDS is there and inescapable, and that accusations are pointless, combined with association between AIDS, sexuality and inevitable death, shape the practices around care for AIDS patients in the village. I started to see the different ways of being silent and the different social spaces in which silence was required. Older caregivers talked about the difficulties of care giving in a circuitous way. Families hide the patient in the house and look away and to the ground when talking about the strain of care giving. Stories about families who were giving care also reflected concealment: The stories were told only to particular persons and the story tellers often used secretive modes of speaking: Whispers, heads close together, and reflective pauses. To understand these practices of silence and concealment around AIDS illness I propose a framework of relationality: What does silence protect in the context of interpersonal relationships of older caregivers?

There is no compassion nowadays: Generations and care in the era of AIDS

'It would be better if God let him rest. Where will I get the money? I am tired'. With tears in her eyes Mae Elesta, a 72-year-old mother discusses the intense care demands during the final stages of her son's illness. It is September 2002, her 48-year-old son has been 'sleeping' since April 2002 and his mother moved to his house to take on his daily care. I read the story in the diary Mae Tibaigana kept for me in my absence on her visits to caregivers on a weekly basis. In the diary there are sober notes on everyday life: The house has become dirty; there is no time and energy for cleaning. There are also notes on how the older mother is involved in doing casual labour on the farms of others and therefore has no energy to sow her own beans, leading to food insecurity. And lastly the diary sheds some light on how care giving is shared in households: How the eight-year-old son of the patient is spoon-feeding his dying father and is scared to be alone, while his grandmother is out working.

The above sketch points to a reality of intergenerational care that brings up questions of meaning amongst older men and women; what is happening to the world that demands situations such as these, what has happened to children, to relations between parents and children, relations between women and their family members? Older men and women are extremely concerned with relationships of today. Stories of conflict, of witchcraft and use of herbs, of jealousy, of rape and theft, and of young people 'running around in the village', are rife. The

AIDS epidemic triggered new questions, mainly questions of control and connection. Older men and women have lost many relatives but only the village has become a place where it can be 'known' whether a person is likely to have died of AIDS. In the death histories the knowledge of the sexual networks of the deceased and the attempts to control by checking for bodily signs is visible.

Her husband died away from here, so you cannot know. But did you see the black spots on her hand? I wonder ...

The statement voices a lack of control amongst older people, an attempt to make sense, through commentaries, of the felt chaos of contemporary social relations. In particular, commentaries are directed against the current generations of young people who, following their desire for wealth, *tamaa ya mali*, brought back a disease, causing anguish and an extra burden. As a result, in the eyes of older people 'compassion', *huruma*, was lost in contemporary *Buhaya*. As is often argued in recent literature on AIDS in Africa, narratives around AIDS in the village point to chaos and distortion in social relations within Haya society and in that sense trigger actions to restore social cohesion (Dilger 2010: 10). *Huruma*, a core value of social relations is part of *ustaraabu (ks)* – proper, dignified, honourable behavior.⁵ *Huruma* in intergenerational relations pertains to a sense of closeness, a good *roho (ks)*, 'nature'. *Huruma* is about care and caring relationships. Daughters and women are said to have *huruma*, but sons often lack *huruma*. Daughters are the ones who, not out of obligation, but out of love assist their elderly parents. These values are also reflected in messages of Churches and Mosques. In Church congregants are urged to take care of each other, to not denounce the ill. In every service those who are ill are named and prayed for. There are special services in the village for those who are too old to walk to the church or too ill. This morality of care is reflected in older people's care practices around AIDS in which values like *huruma* are emphasised, thereby reflecting values that they thought had been lost in the current generation of young people.

This concern with relations has everything to do with the way the epidemic demands care roles that are unexpected, and hence stretches the relations of older men and women over prolonged periods of time, due to taking care of different relatives. Older people have occupied different roles in care giving often involving wider family members. Mae Tibaigana's husband, for example, fell ill in 1987 when she was working in a nearby city. She earned money for his care but her parents-in-law took on the physical care for him in the village.

He went to the mines near Geita. He did not want to be a schoolteacher anymore. I went to work in Muleba at the district and I took five of the seven children with me. I raised them alone. Then he came back and I took one look at him and I thought: 'eheh'. We went to the village and we got out of the *dalla dalla* (minibus, *ks*) and his father did not recognise him.

⁵ Moyer, personal communication.

So he stayed there while I worked during the week to earn money and he died and he was buried near his father's house.

When her daughter became ill in 2000 Mae Tibaigana nursed her herself. The presence of AIDS for 25 years has affected different historical generations. In the table below we see that most of the older men and women have cared for their children, but that a substantial part of the men have also cared for their siblings and that some older women have cared for their spouses.

Table 5.1 Care for relatives with AIDS (according to old persons) amongst 21 older people above 60*

	Women (13)	Men (8)
Partner	2	1
Children	14	7
Sibling	3	5
Siblings children	4 **	4
(Adult) grandchild	1	1
In-laws	1	1

* In this table only the deaths in which older people mentioned that they gave active care are mentioned.

** One childless woman lost three children of her sibling.

The physical experiences of care giving might be similar, but the material consequences of losing a husband versus losing an adult child working in the city can be quite different. Patients who return from the city are the patients of whom older caregivers had hopes and expectations of financial support, which is emotionally challenging for older caregivers. At the same time patients who become ill at home in the village are often cared for over a longer period of time, demanding more from their older caregivers, materially and physically than patients who return from the city in an advanced stage of illness and were also often those who provided practical support.

Mobility is important in more than simply the return of patients from the city. Often caregivers also travel to the marital homes of their daughters or sisters. In this sense family care is not bound to a specific locality: It contains the rural-urban relations between older people who remain in the villages and expect and hope for support from their kin in the city, but also the home-marital connections between women of different generations in a family that transcend one locality. Mobility then is not just responsible for distortions in relations of care; it is also a core aspect of continuity in family care relations.

The relationship between caregiver also matters in terms of how older people experience the impending death of a patient. Though older people do not only

take care of their dying children, the experience of caring for a dying child is the most disruptive:

I lost my father-in-law: Normal. I lost my husband [to AIDS]; somewhat normal. But to lose your child [to AIDS] at the age of 43? Not normal. (Mae Tibaigana, aged 65, lost her husband and daughter to AIDS)

AIDS illness therefore poses fundamental questions about Haya motherhood and fatherhood and about the role of an adult man in the broader extended family. Older men and women bring up a story about a divorced widow returning home from the city to die, to discuss a shift in time between ‘when conditions were still good’ and the time when the world changed. There are implicit judgments in stories about an adult grandchild, dying because of ‘running around’, representing a generation out of control. Whyte *et al.* (2008: 16) refer to these concerns as generationcentrism: To bring out how morality and virtue are spoken about in different generations. These conflicts play out in the everyday practice of care and support.

In the village the question is not whether families can cope with increased care demands. The issue is ‘how’. How are everyday practices of relating: Visiting, touch, feeding information while maintaining enclosure, and ways of eating and of assisting shaped by long-term care of ill patients? In this capacity care demands bring up not only assessments of current relations and relating but also questions of morality.⁶ Who should care for a specific relative? What is ‘good care’? How are new moralities around care giving relations formed in a village affected by death? These questions feature in the next three sections where I return to the day on which I found out that the daughter of my neighbour was close to dying to explore two ‘social spaces’: The relation between caretaker and patient and the relation between caretaker and visitors, to understand what is deemed good care and how this shapes practices of silence and concealment in the terminal phase of AIDS. I specifically single out the relation between older parents and dying children, because it is a relation which is rife with mutual expectations about care.

The morality of silence: Concealing to create spaces for compassionate care

Care giving for prolonged periods of time, can strain relations of caregivers within families. Previous tensions and conflicts in families come to the fore when older women become worn out and tired, when resources are sold and when

⁶ Dilger (2010b: 108-109) distinguishes four verbs that comprise the experience of caring in the era of AIDS: *kutunza/ kuhudumia*, to guard, protect and keep safe; *kujali*, to give honour to, referring to the quality of care; *kutenga*, to separate, referring to dissolution of kinship relations.

demands are made of relatives who are struggling themselves (cf Kastelijns 2009). Over time, as the process of care unravels it makes visible what is normal and abnormal care and how relationships between caregivers and patients work out. Acts of care giving also often interplay and have to be balanced with other demands of care such as burials in the village, taking care of orphans and periods of sickness or weakness of the older person him or herself. To understand concealment and what it protects in relationships between caregivers and patients, I start by examining the shifting power balances in families when a patient reaches the terminal stage.

Scene 2: A father's duty

The same evening that we heard about the illness of our neighbour's daughter and her admittance to the hospital, we went to pay a visit. When we arrived in his house around 7 pm we found him sitting in his living room; he had just returned from the hospital and his wife was still there. Ta Stephen was glad to see us and invited us to sit down and a conversation ensued:

- Ta Stephen: Thank you; it is really a problem. Right now, I have just come back, but her condition is not good.
- Gussy: We got the news – a woman who came to our house told us the news, but we did not know that her condition was this bad and my fellow [Josien] was not there; she came yesterday. We were planning to go and visit her tomorrow.
- Ta Stephen: Her condition changed yesterday noon. Her condition is not good at all, because her entire body has become swollen. They say that if you swell up, it is because of a problem with the kidneys. Therefore her condition is not good.
- Gussy: But is she conscious? Can she talk?
- Ta Stephen: Very little.
- We: And can she eat and drink a little?
- Ta Stephen: Very little.
- We: Since when has she been ill?
- Ta Stephen: She started to be ill from last year, in the eight month [August]. She used to live in Bukoba, but we took her to Rubya Hospital. There she got some relief but she did not return to Bukoba. She started to live in a house behind this one. But her condition was so so. Now she has returned to be ill again. Her condition is not good at all and now you see that I cannot leave from here because we are awaiting any news from there [the dispensary]. Every three hours we receive news from the dispensary and right now a boy will come to bring news from there.
- We: But have they checked what is wrong with her? What are they saying is wrong with her in Rwantege?
- Ta Stephen: You know her problem is her kidneys. But if you look at her, if you investigate her, you will see that together with the problem with her kidneys she has H I V [he pronounces each letter carefully, bending forward, looking at us].
- We: *Pole sana, pole sana* [we are very sorry, ks].
- Ta Stephen: Yes. HIV is dangerous, but what can you do?
- We: Since when have you known that it is HIV?
- Ta Stephen: Since she returned the first time. That is the reason why I prevented her from going back to Bukoba.

Somehow this moment of illness marked a change in our relationship and from that moment onwards Ta Stephen was remarkably open. He explained how his daughter, Elida, who is 36 years old, was married in another region. After her divorce from her husband due to 'grave misunderstandings' she went to Bukoba, the regional capital, leaving her young son with her husband's family. In Bukoba she had another child, from an 'unknown father'. A year earlier in 2002 she came home to the village and was admitted in Rubya hospital. He immediately 'knew' that she was suffering from HIV, which he related to her stay in Bukoba:

You know, there is something else that is very difficult to explain but it is obligatory [*lazima, ks*] that I tell you; there is no other way [*hakuna jinsi, ks*]: You know if a person leaves from here, and goes to Bukoba, she goes to do work. And at that time she does not have a specific job, so it is a problem. It is dangerous.

It is dark now and Ta Stephen switches on the light. He has one of the few houses with electricity in the village. The atmosphere is intimate and what I hear Ta Stephen talk about, in subtle terms, are failed expectations: His daughter divorcing, leaving him with the burden of her two children. We don't discuss AIDS; we discuss how subtle expectations within care and support relations have changed. Ta Stephen, as a relatively wealthy man and a clan elder, relates how he keeps on caring for sick relatives, providing financial means, taking care of transport to hospital, buying medicines and food, arranging for funerals and making decisions about the fostering of orphans. Ta Stephen has been doing this since his first son died in 1996.

You know my other child has died already, the one who was born from my first wife. He was born in 1963 and died in 1996 and his wife followed, and he left a child, who disturbed me very much. He died last year in the tenth month. Because he had no father and no mother and his grandmother was ill, I was the one who cared for him. I took him to Rubya, Ndolage, Rwantege [hospitals, between three and 30 km away]. In Rubya he stayed for two months for TB treatment. And I was the only one looking after that child. No-one else assisted me; sometimes I had to beg someone else to help care for the child.

An important aspect of the care of ill relatives is that care is mainly organised in the immediate family, in this case (grand)parents and siblings and that there is one decision maker (cf Janzen 1978). When Elida came home with suspected HIV, Ta Stephen as head of the family made the decisions and instructed the other family members what to do. What is also visible in the above story of family care is that care is a reflection of close relations. Often in caretaking previous tensions play out as is clearly visible in Elida's mother's refusal to take care of the grandchild of her co-wife. Also in the story Ta Stephen tells about Elida: Indirectly he blames her for divorcing, coming home with an illness and leaving her parents with the care of two grandsons who need schooling. Moreover, the length of illness, with bouts of illness and periods of good health, in Elida's case over a year, is taxing on close relationships. This issue of time, in

the sense of prolonged illness is important as care for an AIDS patient often interplays with the other obligations which older people face. Especially older men, as heads of clan families, have many responsibilities. Besides the care for sick relatives Ta Stephen is also responsible for his elderly parents, who are still alive at 86 and 92 years of age and need full-time care and he needs to provide for the schooling of his children and grandchildren. These burdens of care differ from those of Elida's mother who is present at her daughter's side, sleeping with her, cooking for her and cleaning her, providing all the physical care tasks needed when a patient becomes confined to bed or admitted to hospital. These multiple obligations over prolonged periods of time make care giving a strenuous affair.

Being a good parent: Care giving in the terminal stage of AIDS illness

In the care giving stories such as Ta Stephen's story what is striking is the way the relation between caregiver and patient is as much as possible maintained throughout the process of the different illness stages until finally the terminal stage has been reached. In the above case Ta Stephen evokes a sense of duty towards his family; he provides and arranges where his daughter will live, and he cares for his small grandson. In taking up this care there are implicit assumptions in relation to how to act as a caregiver.

As discussed in the previous chapter, social relations in Haya society are deeply informed by the *ekibanja* system, the system of clan land, which structures generational and gender power (Setel 1999; Weiss 1996). Relations between parents and children are relations of provision and authority (Whyte 2004: 85). Whereas parents are supposed to provide for their children by schooling them, providing them with land and opportunities, and good behaviour, children are not 'obliged', *lazima*, to provide for their parents in later life. This is considered *wajibu*, out of respect and gratitude for mothers who suffered for their children.

These relations are also visible in how care for AIDS patients is organised. Within care giving others are always involved, mostly immediate household members or close kin, but caring for patients is almost always a family affair. There are clear gender roles in care giving (cf Dilger 2010b), both in terms of work division and in terms of what is 'good' care. Older women are expected to provide the physical care for patients whereas men are expected to provide financial and practical support. When a widow is caring for a dying relative she either sells assets, works where possible as a casual labourer or receives assistance from male relatives, sons, or brothers.

Care responsibilities for older men therefore extend to more kinship relations than just children and grandchildren, but also vertically to sisters and sisters'

children as the story from Ta Athumani, aged 59, who provided active care for two sisters (who died at the ages of 62 and 54), two children of sisters (who died as young adults) and two of his sisters' grandchildren (who died as young children):

The first one who died was called Alida; she was 54 years old. She was married and divorced and had one daughter. After divorcing she went to Musoma and Arusha to enter prostitution. Then she came back with the money and bought a *shamba* nearby and built a house and stayed there. She became ill when she was here. She was ill for about two years. She was ill and then became better and then became ill again, for about two years. I cared for her until she died. I cared by buying household goods, kerosene, salt, milk and *mboga* (a side dish, *ks*) because you know that when someone is ill they are in need of good food to eat. So I was buying that for her.

What about caring like cooking, bathing, washing clothes and helping her to go outside to the toilet, you were doing that yourself?

That was done by her daughter and our mother. When her condition became worse I brought her to my home.

This 'duty' of men to provide is also visible in the story of Ta Stephen who occupies a central role in arranging the practicalities and making decisions on care, whereas his mother is in the hospital sitting vigil with her daughter.

Caring for AIDS patients is a lengthy process taking place over a period of time, with patients becoming better and ill all the time. Both patients, primary caregivers and the close family care circle attempt to maintain the relationship of mutual care for as long as possible. Elida for example attempted to set up a business; in other cases a daughter would still bring her mother beans a month before her death. A son would tell his mother: 'Let me tend to the *shamba* while I still have strength'; a daughter would give her mother 100,000 shillings (100 US\$), without mentioning her illness. These references indicate that there is a certain amount of communication between caregivers and patients about the illness.

Strains on parent-child relationships

AIDS illness changes experiences of parenthood. In *Buhaya* parenthood is about provision in both ways. Parents are good parents when they make sure that their children have a good life, by providing them with an education and with land to build a house. And when children grow up and go to the city, buy a car, become employed and have children, parents are proud. When parents discuss the death of their children they often focus on one child. Invariably this was the child with the best opportunities for making a better life or the child they felt closest to.

AIDS illness subtly changes the relationships between caregivers and patients. Personal experiences of patients and their caregivers often reflect ambivalence, a search for a redefinition of positions and emotions, from anger to grief to shame. Expectations of relations have, in essence not changed, nor have practices of

parenting and consolidating relations. Yet care giving demands extraordinary efforts of older people. This dualism – a search for maintaining relationships as they ‘should be’ in a new situation – is what creates pressure on older people. Caring for dying AIDS patients should be understood in this context; it is a period where all the expectations, the hopes and the investments in relations become an entangled mess, and patient and caretakers have to negotiate their relationship again and uphold the standards concerning good care in the community. Silence is about this negotiation: It is to ensure that parents maintain the humanity of their dying children.

Elida’s father revealed her illness to us in an intimate setting, when we all expected the news of her death, but in later conversations AIDS was never mentioned again. Elida knew that she was dying but never spoke about it; her mother did not speak about it either and only mentioned her loss after Elida had already died. In this way they not only protected their dignity as caregivers but also the dignity of the patients. Villagers assessed the behaviour of both parents in the different stages of illness which exposed the relationship between Elida and her parents. They commented on what they did not consider to be *huruma*, compassion, where they thought a parent’s duty failed. In these assessments notions of female and male honour were core.

Creating ‘loving’ care

In the previous section I showed how patients and caregivers, through everyday living together, attempt to maintain their relationship. Fathers and mothers perform their parenthood through providing and suffering for their children. Children suffering from AIDS provide for their parents within their possibilities. Concealment makes this generational care possible. Yet this relation subtly shifts when the patient becomes more ill and confined to bed. Other elements of relational care also explain why concealment is considered an element of compassionate care. One of these is the emotional relationship that often exists between caregivers and patients. To ask for care, i.e. to become totally dependent is often the outcome of a shared personal history of patients with their caregivers.

Whereas care is sometimes given out of obligation, because there is simply nobody else present, in most cases those who provide care often share a long history with the patient and care deeply for the patient. This is the reason why an elderly childless aunt takes in three of her favourite nephew’s dying children: She had raised them since childhood. This is also the reason why an elderly grandmother moves to the newly established home of her grandson and his wife to take care of him during his illness. She raised her grandson, bought him land, and will continue to support his widow and the small great-grandchildren. The loss of someone with whom one had a close connection often creates emotional

tension. Caregivers can be angry at patients for bringing home a disease: Behind that are anxieties over lost expectations. The presence of AIDS has profoundly changed the experience of being an older person and a parent.

When the terminal stage has been reached and the strains of care giving increase relationships change into total dependency on the older caregiver. The symptoms of AIDS in the terminal phase are extremely painful to witness and can also lead to feelings of disgust (Livingston 2008). Henderson (2004: 3) argues that a body's disintegration interweaves with a disintegration of social relations. Bodies decay, are covered in sores, patients often have continuous diarrhoea and some lose so much weight that their entire physical appearance changes. The state of a relationship, how intimate the caregiver is with the patient, is a way to overcome these feelings of disgust (Livingston 2008). Acts of care giving are therefore not isolated from broader family biographies and kinship dynamics. On the contrary these biographies are embedded in the way care is provided (Dilger 2010b: 110).

For older women good care involves intimacy and closeness – showing love to a patient. In doing so, touch and physical presence are essential, such as washing and feeding a patient or braiding hair. To show love requires hard physical work, in particular in the terminal phase. Patients often have terrible symptoms: Continuous diarrhoea, open sores and are physically unable to walk. As toilets in the houses are outside and patients are usually cared for on a mattress on the grass floor, these symptoms require the older person to use an enormous amount of physical effort. To cook the food a patient needs, older women need to collect firewood, buy eggs or milk and sometimes work on the land to buy necessities. And then there is the strain of living with a terminally ill patient who may die at any time. It involves sitting up at night, spoon feeding a patient. As Mae Tibai-gana, aged 65 said about the care for her daughter:

It is hard. You know where you are sitting now (on the sofa, with a cup of tea in front of me) – if the patient is terminal she cannot even reach for that cup of tea. You have to place it in her hands. And then the patient wants an egg, so you go to the neighbours and buy an egg and send a child to collect firewood and light the stove and cook the egg, and then she says, no, I am sorry I am not hungry, maybe some milk, so you go to the neighbours to buy milk. It is very tiring (...) and sometimes you get angry but you excuse the patient as she is ill.

This physicality of care is particularly taxing on older women as they are simultaneously confronted with aging bodies which become worn out from care giving. The emotions of losing a loved person adds to older people's wariness. The certainty of death and the intense physical experience of care leading to anxiety, stress and sleepless nights leads to feelings of grief and anger. The association of AIDS with imminent death is often unbearable, especially in a parent-child relationship such as Ta Stephen describes. This bodily experience of care triggers concerns about the prospect of physically aging while having to

manage failed expectations of children who are dying. These concerns are particularly rife in the terminal phase of illness.

The danger of emotions

A second trigger for conflict between patients and caregivers is the association of patients with immoral behaviour, and the disappointment of older parents in patients coming home with an illness from which parents tried to protect them, as is clear from the case of Elida. Ta Stephen for example is explicit: He only discusses the illness with family members and only when in the context of problems that need to be solved.

I told my family members. I made a small meeting and explained the problem and how we should handle it. And maybe I can tell a good friend. He will ask 'how is the condition' and I will say 'it is so and so'. But to say it is AIDS is not possible, for the following reasons. First of all if you say she is suffering from AIDS, she now knows that she is going to die, she is already dead and she can kill herself. And secondly, it is shameful, because it comes from prostitution. So to speak about it you are gossiping about your own child and when she hears she will leave the house and not speak to you.

The moral thing to do in response to an ill child is to protect a patient from gossip and from losing hope. Ta Stephen indicates that the only reason to talk about AIDS is to make practical arrangements. Concealing protects the relationship between the caregiver and the patient: Open discussion can potentially culminate in accusations between parents and their dying children. During my stay in the village, one man killed himself by taking an overdose of malaria tablets and panadol, after a heated argument with his mother. I asked his mother, about a month after his death, what had happened. She explained how she, as a caregiver, was seeing all the problems, the end of future security and having to support those who will be left behind, the grandchildren. She answered:

No, it is true. You feel angry because you find that the disease enters the head of the sick person and all the time he will force you to say something that is not there because his mind is not well. He will force you to sell the *shamba* [land]. Like Athumani. He wanted me to sell the *shamba* so I could bring him to the traditional healer. And when a patient is sick he does not remember his children. (...) God sent us this disease but it is really paining us (...) Nowadays mostly there is this disease. Normally when a child was growing up you were sure that he was not going to die and now you see the child growing up, growing up for death (...).

To lose a sense of continuity was defining for the experience of older caregivers and could, in the care giving period cause explosive situations. One old man, who had lost nine of his 11 children started to shout when I asked him whether he had been angry as well as sad:

Angry?! Of course I was angry! *You* come home. *You* are ill. *You* did not listen. Now it is *your* problem!!

Through concealing, these emotions are contained, hidden and a relationship of inclusion is made possible whereby the illness does not become a concrete

reality. Concealment serves an important function in maintaining a sense of closeness in an extremely emotional experience.

Concealment here ensures that parents maintain the humanity of their dying children. Elida's father revealed her illness to us in an intimate setting, when we all expected the news of her death, but in later conversations AIDS was never mentioned again. Elida knew that she was dying but never spoke about it; her mother did not speak about it either and only mentioned her loss after Elida had already died. In this way they not only protected their dignity as caregivers but also the dignity of the patients.

Whispered morals: Concealing to enforce compassionate care

In the previous section I argued that whereas tactile silences and active concealment make possible the inclusion of patients in the family, they at the same time contain emotions, and add psychological and physical strain to caregivers. In this section, I show how caregivers and in particular mothers, are observed and judged constantly, sometimes explicitly, sometimes implicitly. Caregivers as well as patients have close relationships with friends and neighbours, relationships that extend the family and in which trust is a key-word. In these relations they also constantly shift between containment and sharing. Tactical silences play a role in maintaining the dignity and position of the caregiver and the family, but also create intense feelings of loneliness amongst caregivers.

Scene 3: A mother's lack of love?

The next morning Gussy and I decided to go to Rwantege to visit Elida. We were curious to see her situation because there seemed to be a paradoxical difference between the way Ta Stephen discusses the care for his daughter and the stories Gussy has overheard in the village. She told me:

They were speaking about it all the way down to Maria. Maria said that she had heard that the daughter of Ta Stephen was seriously sick and I told her: 'Yes, I got that information from her mother yesterday'. Maria said that the people were laughing at the mother, because she did not care at all for her daughter, that she neglected her. They were speaking bad words about the mother. I asked why and Maria said: 'I do not know but she did not care for her at all. She went there yesterday when the condition became worse'.

This comment, I realise, is a serious allegation. The care of a mother in *Buhaya*, is the best and most important form of care. Without that care a patient will suffer. To indicate that a mother has not slept next to her daughter in the hospital, implies a lack of love.

When we visited Elida that morning in the dispensary we found Sofia, her mother and several siblings gathered around her bed. Elida was looking ill and was lying down; her mother was sitting on the bed drinking tea and eating bread,

and was happy to see us. She related how Elida was confused in the night and wanted to get out of bed and laughed when she explained this. She also said that she had not slept the whole night and that she failed to take a planned trip to Dar es Salaam on account of the patient. The main point of discussion was where to take Elida. The clinical staff of the dispensary had said that they could not help her anymore and referred her to Rubya, but Elida knew that she was dying and just wanted to go home. When we left a priest came in to deliver the last sacraments. Gussy, who trained with one of the nurses at the clinic walked with her outside the clinic and the nurse shared her doubts about the sincerity of the care of the family.

The siblings are crying, but it seems that they do not really show love to her.

I am intrigued by these words. What exactly do people mean by showing love? According to my observations Elida had hospital care, food, family around and later when she returned home and we visited her I saw a mattress, cups with something resembling milk porridge and *mandazi* (fried bread rolls, *ks*) on a plate. Elida herself seemed to have improved after the hospital admittance and we joked and invited her to visit us at home as soon as she is better. We also saw her nine-year-old son who was sleeping on the sofa in the adjoining room. He had lived with the family for a few years. Elida explained how she would really like to see her firstborn. He was two years old when she left him at his father's family and he was now 15 years old, but she had never seen him again. He lived far away in another region and it was not likely that he could arrive on time. When we left, Gussy remarked:

She will improve, but many times you see that people neglect the patient because they do not want to spend money all the time, when they know they are going to die.

When I came to visit a week later, it was clear that Elida was dying. She was unable to sit up straight but she was happy to see us. We talked about the concert of Saida Karoli, a popular singer, who performed in Bukoba a week earlier. While I talked of drumming, dancing and songs, Elida lifted herself and asked me to tell stories of Bukoba and we left with her promise: 'I will come to your house when I feel better'. She died a few days later.

Concealing not to expose the inside

Conversations around care giving in the village are tied to events, like the news that a patient is bedridden or hospitalised. Conversations are held in specific places and always when family members of the patient are not present. It is mainly women who engage in storytelling, especially stories on social relations and conflicts in other families (Stadler 2003). Older women hold discussions on the roadside and during funerals, watching the behaviour of mainly mothers, or

in houses visiting each other. A hospital nurse assesses the way a family cares for the patient and talks to a befriended nurse. Through the practice of sharing information neighbours, nurses and community members evaluate how the illness is handled by the family. In these evaluations important elements of care emerge. From the story of Elida it is clear that there is more to care than acts; it is the intention behind the acts that is evaluated.

The comments around Elida's care contain references to what constitutes compassionate care. A mother is supposed to show love. Gender is important here; whereas Elida is in the hospital surrounded with siblings and her mother, and her father is at home, the criticism of neighbours is geared towards her mother. What is interesting is that those commenting observe something subtle: Elida's mother cares but does not show true affection. These evaluations of care might strain relations between caregivers and visitors. The following conversation shows how an older mother uses silence to maintain her dignity as an older woman, who 'just keeps quiet', instead of picking a fight when she overhears visitors speaking 'bad words'.

- We: When the people were coming here to see the sick, what did they say about your family and the sick?
- Mae Elesta: Did they come?!! Could they come everyday to visit you?!! [rhetorical: Meaning no-one came]
- We: It didn't happen that you heard that people were talking about your family?
- Mae Elesta: That you cannot listen to. If you listen to these words you find that you are fighting with these people.
- We: But there were some talks?
- Mae Elesta: Ehemmmm, they said. You know the people, when they see someone that is sick, when they see someone that is in bed, they talk, but you do not mind. If you find that the people are talking, you let them talk. Even if they ask you, you don't explain anything to them.
- We: Did they ask you in terms of a joke?
- Mae Elesta: Yes. Some come to laugh at you; some just come to investigate, to see which stage you have reached, but as we are older we just let it go.
- We: There were bad reactions, but were there good reactions as well?
- Mae Elesta: There were some people who came with good reactions, but you cannot know what is inside the people.

Important in this conversation is the way Mae Elesta protects the patient through silence, but also that she as an old woman, knows better than to fight with people. In the community, the role of older women is to counsel younger women and men about fights, jealousy and conflicts, and their general advise is to ignore gossip and to keep quiet at all times. This is what dignified behaviour of older women is about.

These notions of dignity are related to a core orientation in Haya society: That of enclosure (Weiss 1996). Weiss argues that this orientation is visible in everyday practice: from wrapping/enclosing baskets and bunches of banana to closing the doors when eating, and opening only certain spaces for visitors (*Ibid.*).

Elida's mother was not quiet. She laughingly told me, her visitor, about the confused state of her daughter, about not being able to go to Dar es Salaam, even though she never mentioned the illness of her daughter. Visitors reacted to this by analysing the amount of 'real love'. Concealment is therefore normal practice, a disposition, in *Buhaya* and the way older caregivers in relation to AIDS function and what they consider 'good behaviour' very much fit what is virtuous as older women: Being quiet and contained, suffering for your children.

Having visitors is therefore dangerous. Mae Elesta, in the quote above, wants visitors to come, but at the same time states that you never 'know what is inside people'. There was a general sense amongst older people that in contemporary *Buhaya* society trust had disappeared. Old people related the increase of suspicion to poverty and a struggle over resources, especially land and an increase in *fitina* (envy) between people. The lack of trust was related to the *roho*, the 'inside' of people living in contemporary *Buhaya*. As Mae Nyakato, aged 59 said while I asked her to reflect on the core problems of old people nowadays:

The true problem of this village is that people do not want to help each other: Their *roho* [inside/nature] is bad.

In two lengthy discussions with a group of older men and a group of older women, mistrust emerged as an important element of social life.

Before, they were trusting. If you could go and tell someone your secret, they kept it. Now when you tell someone your secret and ask him not to tell anybody, after leaving there she is going to tell it to everyone. Within three days you find your secret has spread all over the village, so there are no secrets anymore. If you say your secret you allow it to be spread yourself. (Mae Fatuma, aged 78, married with a rich son in Dar)

Mae Fatuma makes an important statement in the above narrative: Even close relations or friends can no longer be trusted with a secret, as secrets spread as soon as the person who hears the secret leaves the house. In later discussions the older women related the lack of trust to *fitina* (envy) and related to that an increase in witchcraft in the last few years. Patients often stated they had been bewitched, out of jealousy and also within families, within close relations, mistrust was highly present and there were some older women accused of witchcraft, or they accused their daughters-in-law of claiming their sons. Caregivers therefore only trust selected people with their secrets even within families. In the next section I look at how caregivers employ tactical silences to find, on the one hand support from visitors and on the other hand protect their social position and the dignity of the patient.

What is the use of telling them? Concealing to protect the position of caregivers

In times of illness it is essential for caregivers to receive company, friends and neighbours who come to visit, and who, by sitting in the front room even without

saying much, provide solace. Neighbours, visitors and friends also often lend assistance by bringing some small gifts such as eggs. In the experience of care giving again, this visiting is essential to comfort caregivers, especially older women when they are confined to the house. As Kastelijns (2009) shows for Uganda, in times of illness the social life of caregivers diminishes greatly. Yet as the above sections show, receiving company is potentially dangerous for the social position of caregivers.

To prevent people from spreading information about HIV, caregivers therefore employ different ways to conceal the situation. Sometimes patients are hidden in a side-room or hide themselves and caregivers invite the visitor, stating that the patient has 'just gone to rest'. At other times the patient is present but silence is maintained: Almost all older caregivers said something along the lines of:

The signs and symptoms were seen, so there was no need to say anything. The people could see for themselves.

In this way older caregivers can share some problems without speaking about it and visitors can observe the state of a household. With other trusted neighbours and friends caregivers do share personal stories of the strains of care giving. Trust is an essential element in these assessments.

Amongst older men and women there is a strong sense that talking about problems means asking for pity and assistance and this might affect one's respect in the community. Especially in the current market economy, older people more and more need to engage in work to earn money, employing already worn out bodies to be able to provide care (cf Kastelijns 2009; Ssengonzi 2007). The increased care demands take place in a situation of fragmented land due to inheritance problems and little to no formal employment opportunities in the area, which adds an additional strain to intergenerational relationships. Many young people do not consider themselves very 'capable' financially and hence have trouble living up to older people's expectations. Kaijage (1992) has argued that a reorientation is taking place in Haya society towards the nuclear family. Many older men and women struggle with anxiety over their future situation because adult sons and daughters move away to the cities and the fishing islands, or start a life elsewhere in the area.

There are modes to discuss issues with visitors, specific visitors and specific phrasings. With others older people merely seek distraction and go for 'normal talks'. And as care is strictly related to the family domain, especially in the areas of food and money (two areas which indicate the social standing of a household), it is not useful to discuss problems. 'Will they help me in anything?' was an answer I heard many times. Older caregivers therefore often remain alone in their care giving. 'In *Buhaya* you die with your worries in your heart', was an often dismissive end to a conversation on support. Concealment in this sense serves to

navigate a social situation where care givers cannot lean on family relations *per se* and personal relations of trust are scant and have to have been built over a longer time. Concealing in care giving then serves to maintain a family's dignity to the outer world (cf Iliffe 2005). It protects the family's affairs and especially their social-economic status from public scrutiny.

As the above two sections show, the 'inside' is also an ambiguous domain, making it possible for visitors to enter. In the next section I show how visitors enforce concealment in care giving through their observations of the 'inside'.

Silent discourse: The ambiguity of the 'inside'

'When bad news hits the village, people have a lot to say' is a Haya proverb paraphrased by Mutembei (2001). The death of Elida shows how visitors and community members discuss matters to make sense of what happened with her care. These discussions do not take place out of the blue. Those who enter into the homes of families with patients are often good friends of one of the people in the family – be it the patient or the caregiver. Neighbours for example, often know details about the life of caretakers. The Haya word for neighbour is *omu-taani*, 'those who enter with each other' (Weiss 1996: 47).

Inside and outside should not be equated to the anthropological public-private dichotomy. Each relationship contains an inside and outside – concealment. Haya therefore actively conceal and reveal at every moment, towards each person, including family members. Social relations are surrounded by secrecy, and trust within relations is slowly built by giving small pieces of unimportant information and checking how that information is handled. Conversations that take place around AIDS in the village are therefore often framed in an intricate social knowledge about the family history of the caregiver and the patient. Because the people commenting on practices of care giving often have specific relations of friendship with either patient or caregiver or are a long-term neighbour, which allows them inside the household, stories also become very much personal stories of the storyteller. Zeitlyn (2003: 620) argues that 'talk' functions to manage interpersonal relations; visitors have a role in that they observe what is ongoing in the privacy of a household.

Older men and women in the village can also have different roles at the same time. They can be an active caregiver going to visit a friend who is also involved in care giving or may have lost a relative not long ago. These positions shape the stories that are told. The stories often change slightly over time or are triggered and reframed by other events. This is visible in Gussy's comments on Elida's care: 'Often you will find that a family does not want to spend resources', based on her observations of care as a nurse and an individual who has experience with losing friends and relatives.

The importance of personal histories in dissecting stories became even more apparent in a series of conversations I had with two older women whose life history I knew. They started to comment on the care for a patient in a neighbouring house. Over the course of two weeks, from the moment the patient had attempted suicide until his death two weeks later, two narratives emerged. One woman, the friend of the patient's mother discussed the extraordinary effort of care; keeping vigil all night, taking the patient to the hospital, and having to cope with his anger and shouting. The other woman was a friend of the patient's first wife. At the moment of our discussion about care, she was specifically concerned about care for patients as she was coming to terms with having been ostracised by her own family because she, as an older person, with a history of *umalaya*, was suspected to be HIV positive. This process shaped how she looked at and talked about certain events. She ranted about the quality of care that the patient's mother provided.

His mother? Ah, that one is a *jambazi kabisa* [total thug, *ks*]. She uses money for *pombe* [local beer, *ks*]. She did not care for him at all. I went there and he had the electricity [shingles] and I said: 'get him some medicine!' And she said: 'medicines for AIDS?' You do NOT say that when the patient is in the other room!! (...) so as not to cut his *tamaa* [desire/hope for living, *ks*].

It is therefore very difficult to maintain an inside, especially when different family members have different relations of trust and when there are conflicts within the family as in the above case. For caregivers it is difficult to assess how visitors might frame information. In the intersection between caregivers and others there is therefore a concealed discourse; people speak, but there is no overt reference to the illness. Concealment is therefore never complete silence. Van der Port calls this the eloquence of silence. Drawing on Taussig's (2000: 229-230) concept of implicit social knowledge he argues that silence is not necessarily the absence of speaking. References to AIDS are present. If a close friend asks a parent: 'how is the condition?' and the reply is: 'we were up all night', the neighbour knows enough. The core of concealment between visitors and families is uncertainty about how information will be used and whether people would link promiscuity, adultery or prostitution to their patients, or comment on their practices of care and how this might shift the power balance between families and the community.

The discussions around illness events in this sense have a moral activity: The core elements of compassionate care were voiced. This compassion between patients and especially their mothers is visible in tactility, presence and kindness. Compassionate care requires concealment and silence from both parents and patients in order to hide emotions that could compromise the relationship. A second element is about giving hope to a patient, by concealing the possibility that a patient might die. Visitors not only discuss but sometimes enforce norms

around compassionate care, exposing caregivers who do not care properly to the community.

Whereas concealing within the relation of caregiver-patient functions as an inclusion mechanism to safeguard against the potentially destructive emotions resulting from failed expectations, in the relation between caregivers and others around them it functions as a way to normalise an extraordinary situation: Older people continuously switch between their role as caregiver and their role as older person within a network of kin relations who will remain when the patient has passed away. In this sense the network of kin represents a sense of continuity and these relations have to be carefully maintained.

Conclusion: Enclosed patients, disclosed values

In this chapter I have explored how tactical silences make possible ‘good care’ for patients dying of AIDS in northwest Tanzania. In the advanced epidemic of northwest Tanzania, AIDS illness exposes social relationships in families and brings out moral concerns. Not whether care is given, but how care is given to patients is the issue that occupies the minds of visitors. Illness events trigger questions that go beyond the specific illness of a patient but also pertain to the own experiences of visitors and to general evaluations of practices of relating. Compassion, *huruma*, is an element of social relations that is at stake in contemporary *Buhaya* according to older parents. Compassion in relation to caregiving for terminal patients is geared towards the inclusion of patients and maintaining dignity.

Compassionate care is a moral construct which is made and remade constantly in response to illness events. In the village there are strong notions as to what is considered to be ‘good care’. Practices of good care include tactility, closeness, love, duty and suffering. These are values that are ingrained in the generation of older men and women and that they feel are lacking in the younger generation. It is therefore important for older caregivers to continuously enforce these values through visits and through discussions about illness events. Emotions form an essential element of care giving: There are often close and loving relationships between patients and caregivers.

A core element of compassionate care is concealment. Concealment is neither denial nor completely explicable by stigma theories, but is a ‘core orientation’ or a ‘language’ in a society with a strong focus on enclosure and concerns about trust and social position, and concealing is therefore ingrained in everyday practice – it is honourable to not expose internal affairs. In relation to AIDS illness, concealment creates spaces for compassionate care. AIDS illness reconfigures care relations within families, and with that exposes a family and its internal affairs to the broader community, because of its visibility. Concealment

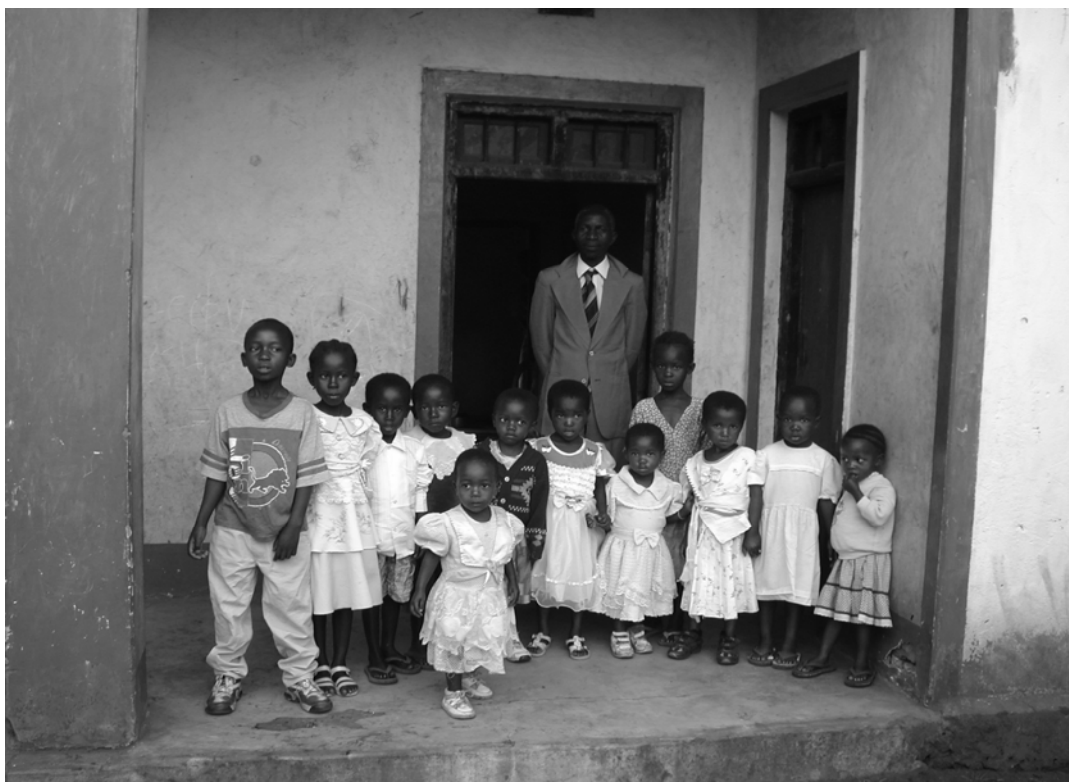
prevents the potential harmful exposure of conflicts and emotions between caregivers and patients and hence protects the social position of caregivers. Visitors, in a way, 'stimulate' compassionate care, in the sense that they gossip about caregivers when these caregivers discuss the illness of patients and hence deny them hope. In this way concealment enforces compassionate care.

At the same time concealment has another side where it hides the interpersonal tensions that AIDS illness brings into families. Illness serves as a trigger that enlarges already existing social conflicts, including witchcraft fears and allegations. By concealing anxiety, stress and anger are contained but not gone. Concealment in this way hides the broader power plays in family and community, leading to dignity of the family but loneliness amongst caregivers. The 'morality' of care giving in this advanced epidemic is geared towards inclusion of patients; silence is a protection mechanism against exclusion. This stance contradicts recent discussions on openness and disclosure in debates on AIDS, in particular discussions on the relationship of disclosure with social support. Strategies of silence and secrecy have often been described in reference to stigmatising conditions such as infectious diseases. AIDS is no exception, but the fact that it often leads to death has made the condition extra stigmatised. Stigma in much of the disclosure literature is often seen as an obstacle to health promotion and treatment. An assumption in this literature is that disclosure leads to better social support.

In this chapter, I use the perspective of caretakers to explore this assumption, building on anthropological examinations of what 'stigma' entails in social relations. Building on ideas around stigma as resulting from emotions in social relations, I looked at how the event of a patient entering the terminal stage presents a moral breakdown. Care is often the expression of relations that have been built over time (Livingston 2008: 290). It usually takes place within intimate, long-standing relationships. In this chapter I focus on the parent-child relationship between older parents and their dying children. This relationship, which is about providing in dual ways the balance of give and take, is kept for as long as possible. When patients reach their terminal stage the relation shifts towards dependency on older parents who are themselves providing care with aging bodies and can barely manage the care tasks. In this care giving relation the older body is not a given; it is a constant reminder of a potentially insecure future. Older people have to manoeuvre between different identities: That of a caring parent and that of an aging person expecting care. These dual roles often evoke conflicts which are dangerous to kin relations. Concealment as a core praxis of the morality of care is employed to consolidate relations or to enforce the containment of emotions. Values are exposed but patients and caregivers are enclosed. Silence and concealment in this capacity not only protect patients from

exclusion but make inclusion possible and consolidates the position of older caregivers towards those who remain.

Photo 6.1 A proud grandfather



Caring through providing: (Grand)parenting in the era of AIDS

Introduction

February 2004. Mae Elesta, a 72-year-old woman and Gussy are talking inside the house of Mae Elesta's deceased son when Mae Elesta's daughter-in-law enters the house. The two women start talking in riddles, but to Gussy it is clear that they are discussing the granddaughter of Mae Elesta who ran away to Bukoba town with a friend. Mae Elesta relates how Aurelia, the granddaughter, scolded her a few days earlier when she wanted to take some corrugated iron sheets out of the storage room.

I think they have gone to Bukoba or to look for men because a few days past I went there and opened the house and checked on her belongings and only her bedding and one skirt were left; she took the rest. And a few days ago I went to look for my corrugated iron sheet because I wanted to dry my beans on it and I met her along the way with that lady friend of hers; I asked her to open the house for me and give me my iron sheet, and she said: 'you *Mkaikuru* [old woman, *kh*], what are you after me [*wewe mkaikuru unanitakisha na nini, ks*]' . That is when her friend told her to go and open the house for me and give me the iron sheet, and she turned back while saying bad words but in a low voice. (....) She will know herself, I do not care.

Mae Elesta has raised Aurelia and her 19-year-old sister since they were toddlers. Both girls lost their mother in 1992 from AIDS. Their mother had married in a nearby village but the two girls 'had no father' – they were not the children of their mother's husband. For that reason they could not stay in the home of their stepfather, so their mother's mother took them into her care. Now, in adolescence, the girls were giving Mae Elesta trouble. Aurelia's sister had already gone to Dar-es-Salaam in 2002 because, as Mae Elesta put it, 'I cannot manage to give her the money for clothes, soap and body lotion'. It was only a year later when stories about Aurelia began to circulate in the village – stories

about how she was a beautiful girl but had bad manners and how she was walking with boys late at night.

Since the illness of Mae Elesta's son in April 2002, Aurelia had been living on her own because Mae Elesta had moved in with her dying son and his small children to help care for them. Earlier Aurelia had lived with her uncle in a neighbouring house, but because she sometimes stayed away for days without telling anyone where she had slept, her uncle had chased her out. In Mae Elesta's opinion Aurelia had already been spoiled; she had told her grandmother that she had had sex. Mae Elesta had resignedly come to the conclusion that as soon as the child knew that she did not have parents anymore there was nothing one could do; the child would not listen anyway. *'Basi, it is like that'*.

Later during our visit, after her daughter-in-law left the house, Mae Elesta explained to Gussy what had happened:

Gussy, we are in problems, we parents. But you cannot go and tell everything to the people, like: 'look my children did this and this to me'; otherwise you will lose the respect of the people. These children (...) I think you heard when I was talking to Filimon's wife about Aurelia. This Aurelia (...) when my daughter died, she just stopped breastfeeding. I cared for her and she started school and when she reached standard four she refused to go to school. And then she refused to stay with me, saying she did not like staying with me. And now I do not know where she has gone. I fail in controlling my own children, so for grandchildren can you imagine?

This passage gives some insight into how a grandmother experiences relations with her granddaughter. There is conflict, a lack of control and a loss of respect. Mae Elesta expresses the loss she experienced, which she mainly attributes to the fact that her granddaughter grew up without parents and, as a result does not want to listen any more as she is becoming a teenager. The event was even more painful because Mae Elesta had raised Aurelia from infancy. When Aurelia's mother died Mae Elesta's role had shifted to that of a parent; yet the relationship between Mae Elesta and Aurelia was essentially that between a grandparent and a grandchild. The ambiguities that had resulted in their living out these mixed roles had increasingly led to difficulties as both Mae Elesta and her granddaughter aged. As the former lost strength and struggled to take care of a second dying daughter and then her son in 2002, the latter entered adolescence and began to act up. When she took up the care of her son's three young children her capacity to provide for the two granddaughters in her care diminished as a result. Though they were also trying to make ends meet with their young families, her remaining children assisted her to the best of their ability - sometimes helping to discipline the grandchildren, a role that would never have fallen to a grandparent if the parents had still been alive.

This chapter aims to understand how grandparent-grandchild relations have taken shape in the new constellations or 'fields' of family care that have emerged

over the past three decades as HIV has become a reality of daily life and as they are themselves aging, both physically and socially. Debates on AIDS and orphanhood usually focus on changing fostering patterns within kinship systems and whether the basic needs of orphaned grandchildren are being met (Ankrah 2003). Results are inconclusive: Family systems do seem to absorb the increased burden of care, but at the same time more often 'new' fostering patterns are emerging. Families are forced to stretch and re-imagine kinship responsibilities. Examples include orphans staying with matrilineal kin in patrilineal societies (Nyambedha *et al.* 2003), and an increase in fostering by grandparents rather than by uncles and aunts (Foster 2000).

Most children who lose a parent are taken in by other relatives able to care for them, including the remaining parent, paternal and maternal uncles and aunts, or able-bodied grandparents. A study amongst 152 orphans in Kagera Region who had lost both father and mother showed that grandparents and siblings most often took in orphaned children (32.9% of the orphans were cared for by grandparents and 28.3% of the orphans were cared for by siblings) (Ksoll 2007). Whereas the majority were cared for by paternal relatives about 20% were taken care of by maternal relatives (Ksoll 2007: 11-12). Whether an orphaned child ends up with paternal or maternal relatives has important implications in Kagera, because those affiliated to paternal relatives are more likely to have access to land and the security that comes with it in later life. Though the extended family generally seems to absorb orphaned children, some have argued that the quality of care for orphaned children has diminished in the context of HIV. Additionally, as Beegle *et al.* (2006) have shown in their Kagera-based study, having been an orphan can be closely correlated with adulthood poverty. It would also seem that fostering contributes to increased poverty. Studies in households where grandparents provided care to orphans demonstrate that providing care is seen as a significant economic burden and that such households are often impoverished as a result of the need to care for grandchildren (Nyambedha *et al.* 2003; Rugalema 1999).

While it is important to recognise that HIV has dramatically increased the demand for fostering grandchildren, if we focus only on AIDS, we risk overlooking other reasons why grandchildren may live with grandparents, such as divorce of the parents, companionship or assistance (Whyte & Whyte 2004: 92). For this reason I do not speak about AIDS orphans but about children without parents. Recent debates in kinship literature on the experience of grandparenthood point to the importance of analysing the everyday practices of living together as an entry point to understand intergenerational conflict and closeness. Situating AIDS in broader discussions on intergenerational relations raises questions about changing care practices and authority in the grandparent-grandchild relationship. How do older grandparents raise orphaned grandchildren in the con-

text of the broader family care network and what is the role of physical aging herein? Temporality is an important concept, especially in an epidemic of nearly three decades. In *Buhaya* grandparenthood is about growing up and growing old together. Most of the literature on grandparent-grandchild relationships focuses on small grandchildren and rarely addresses adolescent or adult grandchildren and their relationship with their grandparents (van der Geest 2004). Neither has there been much attention to the changing older body over time in discussions on generational authority, especially not in discussions on relations between grandparents and grandchildren.

Important to the grandparent-grandchild relationship are both economic aspects such as material needs and inheritance, and emotional aspects such as joking, closeness and authority. A central point of the chapter is that the value of providing practices of relational care has become central to the grandparent-grandchild relationship in the context of AIDS. In the following section I discuss grandparenting in *Buhaya* in general and how older people see their roles as grandparents. Following that, I describe older people's experiences raising grandchildren without parents, showing that grandparenting does not just involve the grandparent and the grandchild, but also extends to include wider kin networks. This means that care relations must be situated within broader family relations and, further, that these relations are shaped by the identity of the individual older person, making gender, status, and physical capability important. In the final section, I incorporate the concept of time to analyse how grandparents balance the expectations that they had of grandparenthood with the reality of raising grandchildren.

Grandparenting in *Buhaya*

The decision to live with grandchildren often occurs as a normal part of social life for older people (Notermans 2004). In the patrilocal society of *Buhaya*, almost all the older men and women whom I interviewed lived with grandchildren, in a variety of constellations. Very old women, already widowed, often lived with a grown-up child of their son, who assisted them in their everyday needs or would live in their son's household in close connection to their son's family. Other older women lived with grandchildren from daughters and sons who were sent to keep them company, sometimes until they had reached school age, in other times also during their school years. In other cases grandchildren from previous marriages of a son or a daughter would be sent to live with their grandparents. In most of these cases sons and daughters would provide for the grandchildren, in terms of school fees, uniforms, clothes, pens, books and medical costs. Amongst the older women with whom I spoke, half lived with grandchildren.

Living with a grandparent is also desirable for many children; there is often a warm, joking contact between grandparents and grandchildren. Grandparents often call their grandchild, 'my wife' or 'my husband', indicating a close, equal relationship (Weiss 1999). The relationship with grandchildren is, as Whyte & Whyte (2004) note, often an extension of the relationship with children. In *Buhaya*, grandchildren of sons often see their paternal grandparents every day, while they usually only visit their maternal grandparents. Relationships with paternal grandparents are forged on a daily or weekly basis. The importance of paternal grandparents became clear when I asked ten Standard 7 schoolchildren, who had parents, to write about one of their grandparents. Most chose to write about their paternal grandmother and wrote about assisting them to collect firewood, carry water and cook. In exchange, their grandmother shared with them stories about the past and taught them how to do housework. They were also given advice, for example not to steal and fight, to study hard and how to greet properly. While there were more stories about paternal grandparents, specifically paternal grandmothers, there was no discernable difference when the stories were told about maternal grandparents.

Grandparents from the mother's side are often special, especially when they do not live in close proximity to their grandchildren. For example, when I asked one boy why he had chosen to write about his mother's mother he wrote: 'I chose my mother's mother because she loves me and supports me and if I have trouble she advises me'. Grandchildren often have a positive view of their grandparents; they mention the stories that their grandparents tell and perceive this as a central attribute of old age. This view of older people is reflected in the stories of young people about (certain) older people; they are seen as advice givers and conflict settlers, particularly in marriage conflicts because they have self-control and dignity. These idealised images of grandparents may be more common among children who do not actually live with their grandparents as clearly there is a difference in the way visiting grandchildren are treated when compared to how grandchildren who live with a grandparent permanently are treated. Flavius, 12, one of the grandchildren of Mae Elesta gave an example of being angry with his grandmother:

I was angry when *Bibi* [grandmother] told me to leave school and go to the river to fetch water while the children from her other daughter were also there.

Grandchildren who live with a grandparent have daily routines of chores, whereas grandchildren who come to visit help out but remain special visitors, sometimes leading to feelings of jealousy amongst the children living with the grandchildren permanently. While there are more opportunities for disagreement when grandparents and grandchildren live together, my observations of the daily practices of living together and my conversations with grandchildren show that

there is still considerable closeness and warmth.¹ The topic of love was a common feature in stories told about grandparents and grandchildren living together (cf Geissler & Prince 2004: 116). Love is often made manifest through a mix of emotional and material assistance.

It is important to situate the way grandparents and grandchildren negotiate their relations with one another in response to everyday events within the broader social space of family care relations. A grandparent is not isolated but surrounded by different family members, people who can be asked for assistance, and might influence decisions such as schooling and disciplining. In many cases, even though a grandchild stays with a grandparent, his or her parent may live next door, or close by. But also if grandchildren are raised in the household of the grandmother, she may request financial assistance from her other sons who are also often classificatory fathers or uncles. She may also ask them to assist in disciplining the grandchildren. In this sense a 'triangular' image of the relation between grandparent and grandchild does more justice to the reality. It is also important to realise that grandchildren move between households – they may stay for a few years but be relocated when circumstances demand.

Becoming a grandparent is, according to Notermans (2004), a process which is highly gendered. As a woman grows older in her marriage her position in the extended family of her husband gradually changes from a more submissive position to a position of authority over her daughter-in-law (*Ibid.*). As a man grows older his position of authority also changes. He has authority over his sons and is in control of their ability to start making a life of their own by endowing his children with clan-land. By doing this he decreases his authority over his son. This is regained when his son has children, for example through naming practices. In principle, the father's father gives a child a name thereby establishing a child's social identity and place in the generational order of the clan (Weiss 1996, 1999).

Though these practices are important, there are also indications of conflicts as a result of the social transformations described earlier. In *Buhaya* relations between grandparents and grandchildren have, over the last 30 years, been influenced by processes of commoditisation, globalisation, education, migration and AIDS. Literature on grandparents and grandchildren points to contentions about past and present, which are expressed in terms of how different generations relate to each other (Whyte *et al.* 2008: 9). In the experience of grandparents there is a generational gap, in the sense that grandparents in general do not feel that young

¹ Geissler & Prince (2004: 113) argue that sharing is taught from an early age onwards and comprises more than the sharing of material things. The focus on materiality obscures the sharing of many other aspects that build relations such as time, pleasure, presence and touch.

people respect them. For example, one 86-year-old woman who was living with her brother and great grandchildren reported, 'The other day I was really very sad when the grandchildren of my brother's son threw stones at me.' Another older woman who was taking care of six orphans in northern *Kiziba* rather poetically told me, 'Grandchildren? Nowadays, they turn to pee in your mouth'. These statements reflect the different historical eras in which grandparents and their grandchildren grew up. The availability of goods, clothes, lotion, and entertainment such as video shows in the village, radio, and music provide a lifestyle which is alien to that of many older grandparents, and grandchildren recognise this.² For grandparents an important element of grandparenting is installing what Alber *et al.* (2008) call 'virtue, i.e. teaching grandchildren the central values of social relations and the consequences of actions. Similarly, Ingstad (2004) states that, 'grandparenting takes place in a moral space'. Despite the desire to educate, however, older people also feel that they are not able to protect their grandchildren from the new realities of daily life, in particular AIDS illness and death. As one grandfather of 78 put it, 'To tell them about condoms is difficult when I have never used one in my entire life'.

Grandparenting by definition requires intergenerational leaps. This is true everywhere and in all times. I would argue, however, that the AIDS epidemic, in combination with the rapid monetisation of local economies and increased mobility have increased the gap between generations and, further, this gap becomes more problematic when grandparents raise grandchildren without parents.

Raising grandchildren in the AIDS era

In this section I discuss a variety of relations between grandparents and grandchildren, and how kinship expectations, both the contentions in the moral framework of kinship as well as the actual practices of living together and caring, play out in the era of AIDS. The social transformations that older grandparents hold responsible for the conflicts over values between generations in contemporary *Buhaya*, have influenced their experiences of grandparenthood. The dispersal of family care relations, tensions in families over inheritance and ownership of land, the lack of capability of younger people, and the increased frequency in which grandparents stay with and raise children without parents make practices of relating and care between grandparents and grandchildren a subject of discussion. Increasingly, provision of material goods has become part of the grandparent-

² Having said this, there were many occasions when I observed how older women and men were asked for advice, in particular how to solve marital and family conflicts. Young people said that they would seek advice from specific older persons who were good advice givers and respected in the community. The statements above should therefore probably also be read partly as reflections of reality and partly as the concerns of older people.

grandchild relationship. To understand how AIDS in particular has influenced the experience of grandparenthood in Kagera it is important to capture the variety of ways in which AIDS can affect the grandparent-grandchild relationship in a 30-year-old epidemic.³ Often, in the literature on caregivers and orphans, a rather static and simplified image of grandparents and grandchildren is presented. Taking the long presence of the AIDS epidemic seriously allows for examining how grandparent-grandchild relations evolve over time as they grow old together in a changed reality of care. In this section I present four portraits of grandparents and grandchildren in the era of AIDS: A grandfather caring for his HIV positive grandchild, a grandmother worrying about the children of her deceased daughter, a grandmother who loses the grandson she raised to AIDS and a grandmother taking in the children of her deceased daughter. The portraits show that AIDS affects older men and women in very different ways and at different ages, and creates different worries. In that process the role of the extended family is important; the role grandparents and grandchildren have towards each other cannot be seen as separate from broader family relations.

Suffering for grandchildren: The new responsibilities of grandparenthood

Ta Stephen (66, in 2003), my neighbour, is the grandfather of 30 grandchildren, many of whom live around him in the houses of their fathers, Ta Stephen's children. The household is always filled with grandchildren. When I have gone to admire his newborn twins, he proudly counts each of his grandchildren. A small group of his grandchildren always gathers around my house to sing: 'we are still small, we know very little, we greet you aunt'.

Ta Stephen has lost one son to AIDS, a child of his first wife, at the age of 33 and his daughter, who is divorced, is currently ill with AIDS. Her youngest son, aged nine is living in the household of his grandfather and grandmother. Though Ta Stephen describes this child as 'the burden she is leaving me with', he schools the child and raises him. His daughter's eldest son lives with his father's family; after Ta Stephen's daughter divorced she left her son with his father. The grandchild staying with Ta Stephen has no known father.

Ta Stephen's son died in 1996 and his son's wife followed. They left a child behind, a small boy, who died in October 2002 from AIDS. 'Because he had no father and no mother and his grandmother was ill, I was the one who cared for him. I took him to Rubya, Ndolage, Rwantege [hospitals, between three and 30 km away]. In Rubya he stayed for two months for TB treatment. And I was the only one looking after that child. No-one else assisted me. Sometimes I had to beg someone to help care for the child'. The reason for this lack of assistance was two-fold: The child was a grandchild of the first wife and Ta Stephen's second wife did not want to look after him and secondly the mother and father both died of

³ According to national statistics, the Kagera region is estimated to have the highest number of orphans in Tanzania as a result of the long presence of the AIDS epidemic: 200,000 in 2003, which would equate to 20% of youths being orphaned (Kessy 2005: 4). In a tracking survey amongst a specific sub-sample of children who were 6 to 15 in the first round of the survey between 1991 and 1994 and who were traced and reinterviewed in 2004, 18.5% of these children had become orphans between 1994 and 2004 (Beegle *et al.* 2006). There were 235 orphans registered in the village and 2,750 in Nshamba sub-district, the area in which the village was situated. Of these 2,750, 1,479 were registered as AIDS orphans. (Nshamba ADP records, year not given but probably 2001)

AIDS so everyone thought caring for him was useless. 'They sneered at me for caring for him and I felt much pain for that child so I looked after him until the end.'

In many ways it is important to start this story of grandparenting in the era of AIDS with the story of a man. First of all the story of Ta Stephen shows that grandparenting is gendered; as a grandfather he is responsible for his grandchildren's school fees and material needs as well as his medical care. Grandfathers, as central figures in the clan often make decisions on where to bring orphans and on how to deal with the problems of inheritance. Of the 17 older men whom I interviewed, four were or had been caring for orphaned grandchildren. In this case Ta Stephen lives with grandchildren of his son as is the custom and with the grandson of his daughter who was born 'without a father'.

Ta Stephen's position as a clan elder and a relatively strong, well to do, man is important in his experience of grandparenting: His children turn to him for care and for the provision of grandchildren born out of wedlock. Ta Stephen is also able to take up the role of carer because he is the head of the family, irrespective of his second wife's opinion as a step grandmother or the gossip about him taking on care. What is different in grandparenting nowadays is what Ta Stephen calls 'the burden of grandparents' Ta Stephen provides for his orphaned grandchildren as if they were his own children. This 'suffering' for grandchildren is often unrecognised in the literature on older people and grandchildren.

Caring for grandchildren, especially young ones is tiring; they need to be carried and supervised, grandparents wake up at night and if the children are ill, they have to be taken to hospital. 'Suffering' for grandchildren is increasing in the era of AIDS as the strain on remaining kinship relations increases and grandparents receive some assistance, but are for a large part responsible for themselves. For older grandfathers, the responsibility of deciding where children will stay, how land will be divided and safeguarded, and taking in children without a parent, are demanding tasks which normally belong to the role of a parent. In this sense the AIDS epidemic installs a moral framework of caring through providing material needs and future security by grandparents. To fulfil this role, older people need to be strong; the word 'suffering' points to personal sacrifices, in terms of physical labour and investing in material assets, but also in terms of putting one's own life to the side for a moment and be there for the grandchildren. In this sense the idiom that grandparents use to discuss the role of a grandparent raising grandchildren resembles the idiom that they use about raising children.

Keeping an eye out: The role of the maternal grandmother

Mae Tibaigana (65 in 2003), has been living with small children for the past five years. She was born in the north western part of the Kagera region as daughter of a chief, was well educated and lived in different places. She also travelled to Europe. She is an AIDS widow; her husband died of AIDS in 1987 but had left already in 1979 to do business in another

region and only came home to die. In effect she has been raising her children alone. After her husband's death she lived in the nearby district town with five of her seven children; two of the children went to stay with their paternal grandparents in the village. After Mae Tibaigana retired she built a house in the village where her sons and family-in-law are living. Her two daughters married in different regions, and three of her sons married and went to live in different districts in the region. Five years ago her daughter-in-law came to stay with two grandchildren and in the morning she was gone; she had decided to divorce Mae Tibaigana's son and left the small children in her care, so they remained in their father's clan. Later on also the illegitimate child of another son was placed in her care.

When Mae Tibaigana went to visit her eldest daughter and grandchildren who had married in a polygamous marriage in another district Tarime on the border of Kenya in 2000, she found her daughter, husband and co-wife ill. 'I remember my grandchildren walking with me to the bus when I left. They were holding my hands, saying *Bibi* from Buboba, as they could not yet say the K'. Worried, she left for home. 'I saw that they were both ill but I thought that they would get better'. In the fall following that visit her youngest daughter came to visit, contracted malaria and died of complications. Her eldest daughter, then severely ill from AIDS came to the funeral and died three weeks later. This is four years ago and her two grandchildren remained with the husband's family, in the care of the second wife. 'My son-in-law urged her to take care of all the children, as if they were her own children. She is a good woman, a vet, but I do not have any news and I worry. Will they be ok?'

The role Mae Tibaigana assumes in the above account of grandparenting is that of a maternal grandmother. One important aspect of grandparenting which has come to the foreground in the AIDS epidemic is the issue of gender and in particular the role of maternal and paternal grandmothers. Daughters marry into the clan of their husbands and the children belong to the husband's family. When children lose their mother they are supposed to remain in the family of their father. When fathers remarry children are incorporated into a new family with a stepmother, a relationship which is often tense. The maternal grandmother keeps an eye out and I have heard of maternal grandmothers, who, despite physical problems travelling to the former marital home of a deceased daughter to claim her daughter's children. The story of Mae Tibaigana shows how grandparenting in the era of AIDS is an experience that includes more than living with and raising grandchildren but that grandparents feel a responsibility for grandchildren that are raised in other places, and actively make sure that these grandchildren are well, even though they in the patrilineal 'ideology' have no saying over the grandchildren of a deceased daughter. Grandchildren are often seen as extensions of children and keeping them well is a way to remember a deceased daughter or son. Providing in this sense takes the form of ensuring the well-being of grandchildren by holding the main caregiver morally responsible.

Closeness through shared lives: Love in the grandparent-grandchild relationship

Mae Florida was 76 years old in 2003 and lived in her natal home. Mae Florida herself had no siblings; she was an only child, but she had a brother from her uncle on her father's side and was living next to his house. Mae Florida married when she was 21 in a nearby village but when her husband died the clan decided that she should be inherited by her husband's

brother. To escape this, she went back to her natal home. In her marriage Mae Florida had three children. One child died during delivery because she had to have a Caesarian-section, while the two others were alive and had children of their own.

From her son Mae Florida had six grandchildren of whom one died. 'He died of a normal disease; he had a fever for two days and then he died. His wife died while giving birth; she died soon after delivery on the way to the hospital. I stay with one of their children, a great grandson who is in primary school. I care for him in every way, like school expenditure and personal needs'. Mae Florida not only cares for this great grandson; she also provided her other adult grandson, who was already married with children, with half an acre of land which she inherited from her father. She points to the house of bricks that has been built next to her own house. This is where he stays. This grandson assists her when she is ill.

From her daughter Mae Florida had ten grandchildren of whom three died, two as infants and one as an adult. 'He was about 25 years old; he died from that disease which visited us. He left five children and a wife. They stay in Ithongo, a neighbouring village, on a plot of land which I gave to that dead grandson. When he was sick I cared for him a lot. I was going there to stay for a few days or a month, or longer. I covered the expenditure for the household, taking him to the hospital and paying the fees there; he was sick for one year and three years have passed since he died [in 2000].' She sold a bicycle to pay for the hospital. By caring Mae Florida supported her daughter, who was also caring for her son, but had a large family and not enough money and time because she needed to look after her children in her marital home. 'His father did not care about anything; he was very *mkali* [angry, mean, ks]; he did not even like his son to come home to be cared for when he was sick.'

Mae Florida had a very close bond with this grandson. She had raised and schooled him, taking him off her daughter's hands until he started to work as a brick-maker and stopped school. Mae Florida decided to give him land in Ithongo, which she had bought with money earned through a small business. 'So he stayed there. How he got that disease is the problem of children not staying at home, just going outside the marriage. I cannot say the disease was brought by the wife. He was the one running around everywhere in this district'. Mae Florida feels responsible for the family of her deceased grandson. She brings them soap, sugar and money for home expenditure and school expenses. She used to earn money as a casual labourer but since she has lost her strength she depends on her land and the sale of coffee. 'I did not get much this year: Only 8,000 Shilling [7 US\$], which I have to share with my grandson's family and with my daughter as she was here caring for me when I was ill.'

Mae Florida's story shows how grandchildren are often raised in the same way as *children* irrespective of AIDS. The death of her grandson from AIDS is like the death of her own child. Older people in *Buhaya* usually receive care and support from those with whom they are close. In some cases these are grandchildren whom they have raised. This is also visible in the living arrangements of older people. Both divorced women and widowed women almost always live with grandchildren. Sometimes the grandchildren just sleep in the house of the grandmother and grandfather, keeping them company, but sometimes they are also raised by a grandparent: In the case of children born outside wedlock, children who remain when a divorced father marries again (in the clan system, the female relatives check up on stepmothers) and in this era, AIDS orphans. Amongst 47 older men and women with whom I spoke, 12 were or had been taking care of orphans. When a grandmother has raised a grandchild to adulthood, their bond is often very close, and when these grandchildren die of AIDS, grandmothers often care for their grandchildren and great-grandchildren. Close

relations are forged in proximity, in the everyday practices of daily life, such as touching, feeding the children and being in each other's company.

Mutual care: Crossed expectations between grandparents and grandchildren

'I tell them that we have to stay together, because we are all alone now and only have each other.' Mae Aisha (in her 60s) is sitting on the grass covered floor in her mud house. In the house the only furniture is a stone, an empty rice-sack and a traditional wooden stool; smoke is coming from the kitchen made from banana leaves. Two grandchildren are sitting close to her. Mae Aisha points to their skin; they have a serious skin disease. Their clothes are torn and dirty.

Mae Aisha remained with three children. One son sometimes came to bring her meat, but the other son and daughter did not assist her much. Her daughter lived on the islands in Lake Victoria and her son lived nearby. Later on we found out that both became ill with HIV, her son died in 2004 and her daughter in 2007. The two children who had already died were a son and a daughter. The son drowned in the lake while fishing. About the death of her daughter Mae Aisha was initially secretive. 'She died of a normal disease (...) okay, she died of the disease that came' and then explained how her daughter was married to many houses 'some even I do not know.'

Mae Aisha lived in extreme poverty together with three grandchildren of her deceased daughter, the youngest of whom was 1.5 years old. The children all had different fathers. The eldest granddaughter, a girl of nine years, had been fostered by her paternal grandfather, who lived in a village nearby, but she had run away repeatedly and her father, who was living in another region with his second wife, had allowed her to go and live in her maternal grandmother's house. Mae Aisha: 'she did not like to stay at her father's home, because she stayed there when she was young and they isolated her and she had to sleep in a bad place.'

The relationship between Mae Aisha and her grandchildren is close and loving despite the poverty. At the same time the girl of nine is in effect the household head, begging within the Muslim community for food and clothes, and this has put her in danger several times. She has seen her mother die and explains that she is afraid when her grandmother is feeling sad because of the loss of children: 'I feel sad when *Bibi* is saying things like I can kill myself by giving myself poison, as all my children are dying. Then I always tell *Bibi* not to say so.' Mae Aisha is afraid about what will happen to the children after her death, since they have no father. To provide for them she has signed over her land to her eldest granddaughter.

Mae Aisha's story can be read as an example of the crisis-fostering stories that are often portrayed in the literature: Due to AIDS death of adult children a grandparent assumes the responsibility for orphans. In the case of Mae Aisha the grandchildren were originally assigned to the father's relatives in line with the fostering 'rules' in *Buhaya*. Yet the oldest granddaughter decided that she preferred to live with her grandmother as her mother wanted, and decided to run away. As a maternal grandmother Mae Aisha has taken the children of her daughter into her house. AIDS has created a situation where more grandchildren are fostered by maternal relatives. This has implications for their access to land in later life. Within the kinship system there are regulations in relation to fostering which are related to the *ekibanja* system tying generations together. Sons inherit the land of their fathers, who have inherited the land of *their* fathers. Through the paternal line the clan is therefore perpetuated. Though inheritance

rights for girls were officially established in the 1950s, inheritance in reality is still decided upon in the clan. Moving to a maternal grandparent home would compromise their ability to inherit the land at a later stage. Mae Aisha, knowing this has made a will in which she signs over her land to her oldest granddaughter and has informed her that, should she die, the land belongs to her and she will be responsible for her younger brothers.

Mae Aisha's experience of grandparenthood is one of mutual care; she is disabled and in ill-health, and cannot care very well for her grandchildren. More often than not we encountered the nine-year-old granddaughter begging for money to buy medicine for her grandmother. Mae Aisha acknowledged her dependency on her granddaughter:

I depend on her very much. When she goes there she brings matchboxes, *ugali* and sugar.

In the above story grandchildren are taken in by a maternal grandmother, the oldest grandchild deciding to stay with her maternal grandmother because the relationship was warm and loving, and she felt abused at her paternal grandparent's house. Another factor was staying together with siblings; each of her brothers had a different father and staying with paternal family would mean dividing the children. Mae Aisha's story in this sense is an example of the pragmatic ways in which grandchildren are taken in. Taking in children by maternal grandparents does have implications for their future security, in particular their access to land, the *ekibanja* of their fathers. Mae Florida in the previous story bought land for her daughter's son, and Mae Aisha wrote a will in which she arranged for her eldest granddaughter to inherit the land they lived on and safeguard it for her brothers. In this way Mae Aisha is trying to safeguard her grandchildren's future, and provide for them. Though she is very close to her grandchildren she has little authority over them, because she cannot provide the grandchildren with their everyday needs. Mae Aisha's ill-health is a concern for the future of her very young grandchildren. Madoerin (2008: 2-3), in a report of a local NGO *Huumuliza* that followed three groups of 30 to 40 mostly orphaned grandchildren, argues that the 'migration' between different households, after different sequences of deaths has installed a fear for the future amongst orphaned grandchildren, in particular related to losing the grandparent to old age. Moreover, from time to time grandchildren are asked to care for their ailing grandparent. In Mae Aisha's story it becomes clear to what extent generational authority is connected to physical strength and the ability to provide for the everyday needs of grandchildren. Though there is mutual care, Mae Aisha feels unable to control her granddaughter.

The above stories all show how 30 years of AIDS has affected experiences of grandparenthood in every phase of life. Ta Stephen is incorporating grandchildren into his young family, Mae Tibaigana worries over grandchildren of a de-

ceased daughter, Mae Florida loses a grandchild whom she raised like a child and Mae Aisha depends on her grandchildren. Though there are many elements of what is considered a 'normal' grandparent-grandchild relationship present in the above stories there are also indications of change. Grandparents do not always have the support of their children in providing material needs or exerting authority, mutual care and closeness have taken on new emotional and material dimensions in the era of AIDS, and safeguarding the well-being of grandchildren has a new urgency to it. In the narratives of older people the issue of aging, in a social sense as well as in a physical sense, is an important part of experiencing grandparenthood, socially because of grandparents' attempts to protect their grandchildren from AIDS and physically because the body becomes more and more important in providing.

Experiences of grandparenthood are however not defined by AIDS; they are reflections of broader kinship relations, tensions and histories in which AIDS plays a role. Ta Stephen's 'suffering' is a reflection of his second wife's relationship with her stepson's child, while Mae Tibaigana's experience of grandparenthood reflects the increased mobility of daughters and sons to other regions. Mae Florida's experience of grandparenthood reflects the trend that older people have noticed amongst the generation of their children having many children, and is in this sense a normal aspect of grandparenting: Taking in grandchildren for company and to relieve some of the economic burden of having to raise many children. Mae Aisha's experience of grandparenthood is mostly a reflection of the difficulties that divorced women like her daughter experience when trying to make a living. She, unmarried, had children by three different fathers, which influenced the care for them after her death. Practices of grandparenting in the era of AIDS are characterised by presence, creating trust and intimacy over time, by providing for grandchildren and by disciplining the grandchildren living with them. To engage in these practices of care older people need their physical body; creating intimacy is about touch and physical nearness (Geissler & Prince 2004). Disciplining needs a strong body as well – a strong body, through its ability to provide, exerts authority. This is in many ways a similar authority to the authority that older people exert through their daughters-in-law and sons and marks a change in the grandparent-grandchild relationship.

Madoerin (2007, personal communication), argues that grandparent-AIDS orphan relations are marked by an increasing affection and emotional dependency and at the same time the extension of a lost child; grandchildren represent what is left of their parents. This increasing emotional dependency goes hand in hand with crossed expectations on an economic level and increased mutual care giving relationships. These shifts in mutual dependency as well as changes in generational authority resulting from it increase over time in the process of

growing old together, which increasingly makes older people aware of their aging bodies. In the next section I explore how the care relation between grandparents and grandchildren is shaped over time and how providing as part of generational authority plays out in this relationship.

Growing up with grandparents: Relations with grandchildren over time

Grandparenting children without parents is marked by increased support needs of grandchildren, checking up on grandchildren, even if they do not stay with a grandparent, new forms of caring between grandparents and grandchildren as well as closeness through growing up together. Grandparenting in the era of AIDS poses new challenges. Grandparents talk about carrying a large piece of luggage, sleeping badly as a result of worries about grandchildren's daily needs and future, and say that they are 'suffering' for their grandchildren. As I showed in the above section, providing is not just related to material needs; it comprises well-being and security, and making sure that grandchildren are healthy, go to school, learn how to respect and have a future. In this process time is important; grandparents grow old and grandchildren grow up over time. Maintaining and negotiating mutual care and support relations with grandchildren poses different challenges in each period of life. By contextualising the event with which I opened this chapter – the conflict that Mae Elesta had with her growing granddaughter – I show how this balance is different in each life phase.

Raising them like children: Infancy

Mae Elesta's care for grandchildren started in 1994 when her daughter died of AIDS and two daughters who had been born out of wedlock were given to her. Mae Elesta, then 58 years old took up the care of her two young granddaughters both under five years of age. Mae Elesta, who was divorced and lived next to her youngest son and his family, mainly earned money through beer brewing and her youngest son and two married daughters supported her in small needs. Support was limited though, as one daughter was a widow and another daughter had had twins five times and was barely managing to care for all her children. Another daughter who was married in Mwanza also supported her.

This support stopped when the daughter became ill in 1998 and Mae Elesta travelled to Mwanza to nurse her for six months, leaving the two small granddaughters in the care of their *mjomba* (uncle from the mother's side, ks). Over the years following the death of her second daughter, raising the grandchildren became increasingly difficult and reached a crisis when her son became ill in April 2002. His illness followed the death of his wife and son in 2000. Since taking on the care of her two orphaned granddaughters, Mae Elesta was repeatedly con-

fronted with the loss of her children; every two or three years another child became ill, and needed to be nursed and buried. The illness of her son and the six months of nursing that followed until his death in October 2002 turned Mae Elesta's life upside down completely. As her son, being a widower, had three small grandchildren, aged 12, nine and six. Mae Elesta moved into his house, leaving her two adolescent granddaughters alone in her own house. In the home of her ill son, she not only nursed him but also took on the care of the three small children, cooking, cleaning, advising and earning money through casual labour. Care for the small children was tiring, especially when they were ill and needed medical attention. An ill child meant sitting vigil with the child and trying to obtain money for medicines or hospitals.

After the death of her son she remained living in the house of her son as she and the grandchildren could not stay alone. Raising the grandchildren was tiring, especially since the grandchildren were young, but Mae Elesta's relationship with her youngest grandchildren was good. The grandchildren always were respectful and when they came home they would first run into the kitchen to greet their grandmother. I asked them whether their grandmother ever told them stories. Flavius of 12 replied:

Yes, she tells stories about our clan and she used to advise us when we were younger to come running home if we saw our fellow doing bad and to not throw stones while playing.

While living with the children of her two deceased children is therefore a part of normal grandparenting, there are differences. One of the major differences is that Mae Elesta is the main provider for her grandchildren. She works hard and though the grandchildren help out in the household, by fetching water from the river, collecting firewood and cleaning, they are still young. The role of Mae Elesta as a provider is visible in the drawings of her youngest granddaughter, who depicted her as a tall slender woman cooking and weeding:

Image 6.1 Grandmother goes to the field to weed.



Image 6.2 Grandmother wants to cook maize meal porridge



But Mae Elesta was not healthy. At 72 she suffered from back pains, had lost most of her teeth, and had glaucoma and stomach pains:

I sometimes fail to sleep because of my worries. I think about how my strength will decrease when I grow older and what I am going to do with these grandchildren. I have stomach aches and toothache. And I have no money as I do not have the strength to do casual labour to get money to buy sugar and other necessities. The *very important* thing is to think who will give me food when I have no strength. You know this stomach is really more of a problem to us than anything else in this world. The children become angry when there is not enough food, but when there is food they are happy.

As long as the grandchildren were still young, they were satisfied with food and general care, according to Mae Elesta. I once asked whether they were giving indications of being troubled by the death of their parents. Mae Elesta said:

‘If I were not alive, where would my grandchildren be? And where would they go? Maybe they would have run away when their parents died. So when they come home from school and they find me in the kitchen, already cooking food for them, they are happy’ (...) ‘Do you think they are feeling pain? They are not feeling pain; when they have food it is ok.’

For Mae Elesta, the death of her children is something too painful to discuss. But the grandchildren were troubled by the death of their parents. Especially Flavius was worried about his ability to do well in school when everything he needed such as exercise books, pens and other school items had to be bought with money that was not available, and his uncle only assisted when he had money himself:

I am sometimes angry, for example when I go to *Baba Mdogo* [father’s younger brother, *ks*] to ask for money to buy exercise books and pens, and sometimes he refuses. If my father was alive I would not be in trouble with exercise books.

Raising young grandchildren, as Mae Elesta does, is even more complicated when remaining family members are struggling themselves. Moreover the loss of children every few years means that Mae Elesta is continuously mourning and grandchildren have to adapt to new living situations as well as to the loss of their parents. Parents play an important role in providing security which is not substantiated by other family members after death. Grandparents can take over a large part of the security but they can only provide in the same way as parents when they themselves are wealthy.

In another household Mae Tibaigana (65) teases her youngest granddaughter, who is just five. She clings to me and Mae Tibaigana jokes: ‘are you looking for the breast?!’ at which the child smiles and lets go, shy now. ‘She misses her mother’, Mae Tibaigana says, ‘her mother left her when she was still breast-feeding. But she should not hang onto people’. Small grandchildren living with their grandmothers are often raised in a non-authoritative manner, reprimanded by making a joke about behaviour and often leaning and hanging on the laps of their grandmothers.

Grandparents who found themselves in a similar situation as Mae Elesta and Mae Tibaigana had clear ideas about how small grandchildren should be raised. Raising a child involved some measure of authority, not feeling pity for the child without parents and raising them as if they had parents. This ensured that the children listen:

If you check the grandchildren with parents and those without, those with no parents respect and listen to you more than those with parents. Because they think that if they do not respect you and listen to you, you can throw them out and where would they have to go then! So they listen to you. Maybe [problems arise] if you raised them badly, you know even the way to raise the child can be done in different ways. When you know children have lost their father and mother you have to raise them as your own children so later they will listen to and respect you. If you say when you raise them, 'do not beat him, he is an orphan', 'do not say anything, it is an orphan', or 'do not do this to this one, it is an orphan', they will not listen to and respect you. (Older woman from southern area of *Ihangiro*, 73, raises great-grandchildren, from deceased granddaughter)

Practices of caring for small grandchildren often comprise a mixture of the jokes and closeness that characterise the relationship between grandparents and grandchildren, but at the same time children are taught the '*mila za desturi*' (*ks*), the ways to act and behave properly, for example kneeling when serving food, being silent while eating, greeting in a respectful manner with hands touching the older person's face, and doing chores in a precise manner. Grandparents who also reprimanded and punished the grandchildren and grandchildren themselves were adamant that they expected this of their grandparent. As Mae Aisha's granddaughter said:

I am not angry when Bibi punishes me. She has to punish me and she *must* punish me. If we make a mistake it is *her obligation* to punish us.

The relationship between grandparent and grandchild in this period of living together is then often a mix of mutual care, kind direction and closeness, which creates warmth but also pressure on both grandparents who worry over the future security of the grandchildren and their everyday survival and on the part of the grandchildren who have little time to play and rest, and sometimes care for their ailing grandparent (Madoerin 2008: 2).

Grandchildren are also a source of comfort and remembrance for older people as they are an extension of their deceased parents. Raising small grandchildren often coincides with the mourning period for deceased children or grandparents are confronted with multiple losses in this period and grandparents are often physically as well as emotionally in bad shape. Grandparents are focused on providing and surviving but sometimes threaten to kill themselves or mourn in front of their grandchildren creating insecurity and tension. On their part, grandchildren often need to come to terms with difficult changes such as a move from the city where they lived with their parents to a rural village or a move from a certain

way of being raised by their parents to a different way by their grandparents (cf Madoerin 2008: 2; Smet 2003).

In raising small grandchildren, grandparents argue that grandchildren need to be raised as children. The aim of raising orphaned children in this way is to have children see their older grandparents as parents. In the realities of living together this notion is practiced as providing kind direction, material needs and food. The relationship of care is very much that between grandparents and grandchildren with closeness, affection, touch and jokes at the forefront but within a context of worry, mourning and decreased physical strength.

She will know herself: Adolescence

When grandchildren grow older, the worries and grief of grandparents do not necessarily subside as the story of Mae Elesta shows. Yet in this phase it is important to discipline children.

When Florian (48), Mae Elesta's son, became bedridden and died of AIDS, Mae Elesta had to leave her two adolescent granddaughters at her marital home. Increasingly she had had problems with the older one, Mary of 18, and when she first told her story, in September 2002, Mary had run away because Mae Elesta was not able to provide luxury goods such as body gel. Over the following year, when Mae Elesta was busy raising her three small grandchildren, Aurelia, 16, stayed alone in Mae Elesta's old house, to guard it. 'Alone', however, was relative as a younger granddaughter slept together with Aurelia and the house next door belonged to Aurelia's uncle and his family. Soon Aurelia started to have problems too and Mae Tibaigana reported on her bad manners when she met her on the roadside. Aurelia was reportedly seeing boys and coming home late at night. When the event with which I opened this chapter happened there had been incidents which culminated in the conflict described in the introduction to this chapter and her running away. When Aurelia returned the village chairman assisted in disciplining the girl and negotiated a probation period but the relation between Aurelia and Mae Elesta had deteriorated to such an extent that Mae Elesta wanted nothing to do with her anymore. 'She will know herself', she said, 'I don't care anymore'. Mae Elesta had other problems too, because she had had a falling out with her youngest son Robert who had subsequently moved to another location in the village with his family, diminishing her support system. In this phase of adolescence Mae Elesta is unable to guide and discipline her granddaughters because she is busy with nursing her dying son and raising small grandchildren, and her son is not available anymore. The older grandchildren refuse to listen because Mae Elesta cannot provide them with their changing needs, for 'luxury items', such as body gel and soap. Mae Elesta has given up and has concluded that the 'inside' of the children is to blame.

It is their *roho* [inside, nature, *ks*]. The orphans I have, I have orphans of my son and orphans of my daughter. Those children whom I still expect to be nice children are the children of my son. But the children of my daughters (...) I do not even have one left [it means that those children are already engaged in bad habits]. One you have seen, she is already spoiled [Aurelia]. She no longer listens to anyone who talks to her; she does not listen to anything. She says: 'what are you saying to me? What are you going to do to me?'

In my observations of grandparents raising adolescents it was clear that they were stricter and that grandchildren did more chores in the household. In households where I saw a grandmother joking with her small granddaughters in 2002, in 2008 the now adolescent granddaughters only giggled when they were alone in the kitchen and were demur and respectful around their grandmother, doing a large part of the housework. This respectful behaviour, however, often is not attainable and whereas grandparents try to parent grandchildren, grandchildren do not always accept the authority of a grandparent.

They are saying that, when you raise a child, at the age of 15 you have finished your task: you have to leave him or her and take your hands off of them. You are not allowed to look after them. (Mae Fatuma 73, southern area of *Ihangiro*)

It depends maybe on the age. For example, my daughter left one son, but because he is still young he listens to me. So even if you beat him, or you punish him he still listens. Those who have orphans who are already adults, do not care about anything. They run away, others to the islands; others listen to their grandparents, because they are like the parents that remain. (Mae Sofia, 55, southern area of *Ihangiro*)

Older people had different explanations for these conflicts. One was the time that the grandchild and the grandparent had spent together. If a child had been raised in the city or with parents who raised them in their own way, it was difficult for grandchildren to adjust to living with a grandparent.

I have a son who died and his wife died. They were staying in Mwanza. They are used to town life as Ta Joseph says. So when you bring the child here from there, they act as an adult; he came from there and stayed for some years, so when he comes home he starts to disdain [*kudharau*, *ks*] you. When you tell something to him he just says 'Bibi', 'Babu'. Like a name.

And those who are staying in the village, maybe their father and mother died and the grandchildren migrated to the house of the *Babu* and they shut down the house of the father, while you have already shared the land with your son. After giving your child his own wealth, house and land when he gets married and has children, they raise their children according to their own rules. Then when they come back to you, when you delegate tasks to them, they have problems. For example that grandson, I took him to school and later he refused. I put him in *Huumuliza* [support organization for AIDS orphans in the nearby town] and then he stopped. Now he is away in Muleba and is busy in jobs. *Basi*. Another one is still there. When he remembers his father and mothers he cries. So it is true that it is a problem. (Ta Laurens, aged 68, southern area of *Ihangiro*)

Other older people referred to the different times in which grandchildren were growing up. They did not necessarily see the generation gap as such as a problem, but the fact that grandchildren were confronted with luxuries – clothes, cell phones and bicycles – and grandparents were unable to provide these.

It is not because they do not listen; it is because of the changing of things. Before if you could buy two clothes for the child – one for outing and one to stay at home – the children were satisfied with that. Now, because children see that things are changing, the child can go to the neighbours and find her fellow child has shoes but she does not. So, it is when the children start to think that even me, I could wear shoes. So because of the changing of things you find children are going everywhere to go for things. For example we were in a seminar and other children were telling their fellows that it is better if our fathers die because they see that the orphans get help with shoes and nice uniforms, so at the time they go to school they see the orphans with nice shoes and clothes while they have none. (Woman, aged 58, not living with orphans)

Narratives of conflict are often situational; a certain event happens that creates disappointment like the falling out with a grandchild or a grandchild dropping out of school. This is important to bear in mind when analysing stories of inter-generational conflict. It is all too easy to interpret the relation between grandparents and grandchildren as contentious, but in reality a lack of authority seems to go hand in hand with closeness and sharing. The lack of authority and discipline is mainly related to poverty in a household because of which a grandparent cannot fulfil the changing needs of growing grandchildren, to the strength of the grandmother to discipline and punish grandchildren, and to the presence of classificatory fathers who can assist a grandparent to discipline a child.

Though the ability of a grandparent to provide is lacking, it is the love between grandparents and grandchildren, and the mutual dependency that often compensates for this. In the northern area of *Kiziba* an old man who lost all his children to AIDS, talked with love and affection about his grandson saying that this was the grandson, aged 15, he raised since the age of five years old.

Josien: Do you have any problems with him?
 Ta Said: No, we stay well together.
 Josien: He is like a child?
 Ta Said: There is an element of a joke between us, like a grandparent-grandchild. He is no *mgorofi* [rude person, ks].

Raising grandchildren who have no parents is an experience in which the roles of a parent – providing care, materially, physically, emotionally – and the role of a grandparent – joking and spoiling – is intertwined. Whereas grandparents argue that they should be parents, they seem to remain grandparents, both in the eyes of the grandchildren and in their own eyes. This is what potentially creates problems in the next phase of relationship between grandparents and grandchildren, when grandchildren reach adulthood and grandparents have aged.

He is my husband now: Adulthood

Returning to the village in December 2008 I did not find Mae Elesta at home and the house of her deceased son was closed. Walking the winding paths of the village I reached Mae Elesta's own home, to which she had moved with the children in 2005. I was greeted by Flavius, now a young man of 18 years old. He

was living in the home with his uncle, Mae Elesta's youngest son, and his two sisters, aged 15 and 12. Mae Elesta had moved to Dar es Salaam, for a visit. Her older granddaughter, a daughter of her living daughter had decided to pay for the fare to Dar and had invited her grandmother for a 'rest'. Mae Elesta had left three months earlier and it was not clear when she would return. Later we phoned Mae Elesta, through the cell phone of her granddaughter. Mae Tibaigana spoke with her: 'stay there, rest, become strong again'. Life had continued to be difficult for Mae Elesta in the five years since my departure from the village and this visit. In 2005, when I briefly returned, she had just buried a granddaughter, aged 20, a child from one of her daughters who had been running a roadside shop. The girl had returned to the village when she had become ill and Mae Elesta nursed her and buried her outside her home. She also continued to age and the Dar es Salaam visit was meant for her to regain strength. The grandchildren looked healthy and well fed and Flavius had finished school and I often met him with other young men from the village on the roadside and the market.

A little described aspect of grandparenting in the era of AIDS is the joint aging of both grandparents and grandchildren. Often, older women talked about the grandchildren they raised as having already married and settled into the once empty houses of their deceased parents, having started families themselves.

Grandparents did their best to make sure that grandchildren had chances in life, for example by making sure that they provide their grandchildren with land, either by making sure the children remain on the clan land or by buying land and registering it in the name of the grandchildren. In Mae Elesta's case, her grandson is entitled to a share of the land of his grandfather and father, and he in turn is responsible for his two sisters. Mae Aisha, who takes care of the three children of her deceased daughter, and is divorced herself cannot give her grandchildren access to land through inheritance. She bought land and registered it in the name of her eldest granddaughter. When Mae Aisha died in 2007 and the grandchildren dispersed over the village, the eldest granddaughter who by that time was living in Bukoba town, kept on coming back once in a while to safeguard the land, weeding it and working on it, at the age of 14, also as a means to keep the land for her two younger brothers, then only ten and seven. In the meantime the land was tenanted to a neighbour. A local organisation for older people started to assist older people with will writing and inheritance claims from 2005 onwards.

Here there is another element of providing: Ensuring that adult grandchildren can manage to start a life. There is often an element of advice in relationships between grandparents and adult grandchildren. For example when villagers started to gossip that Mae Florida (68) would chase her granddaughter-in-law off the land she bought for her deceased grandson, Mae Florida advised her to 'stay

quiet on anything she hears the people say'. In the same conversation she emphasised the importance of this relationship:

They support me, but because they are not capable they just care according to how they are. For example when I was ill, they took me to the hospital especially the grandson I stay near-by with. He helped me when I was ill to take me to the hospital. In work not so much, in care my daughter cared for me when I was ill.

Though Mae Florida still has children, a daughter and a son, she was closest to her, now deceased, grandson whom she raised and his widow. The relation of mutual loving care between grandparents and grandchildren often extends into adulthood especially when grandchildren have been raised from infancy by their grandparents.

In the northern area of *Kiziba* this was beautifully visible when we visited Mae Zalia, an older paralysed woman in her late 80s. Mae Zalia had lost her five children to AIDS and lived with the now grown grandson from her daughter, who was born without a father. He had always lived with his grandmother, first together with his mother, until her death and now with his wife, and Mae Zalia had given him her house. He carried Mae Zalia from her bedroom into the sitting room for her to talk with us. When she introduced herself she started to cry and pointed at the graves outside while she said: 'all my children have died'. She then pointed at her grandson and joked:

He is my husband now! My friend is my grandson, he is the one who gives me food and buys me relish.

We asked her grandson who was caring for his grandmother:

Grandson: I am responsible for everything but my wife does the personal care.

Josien and Gussy: Thank you for caring for your grandmother.

Mae Zalia, smiling: You see, I am shining!

Yet at the same time there are also problems in this relationship especially when the health of grandparents starts to decrease and they need to rely on others for care and support. Grandchildren are then faced with caring for their grandparents at a time when they have just started to build their own lives. Here again a specific generational conflict may come into existence that was analysed by the chairman and Mae Tibaigana as maturity – being able to decide as an old person:

If you look at care for older people, for example you have Mae Nuria (aged 86), she leans on her brother (aged 84), so if he hears she is not well cared for he will make trouble. And Mae Dorethea (aged 83) did not inherit as was common in the old days, a relative did. And when that relative became ill, she did not hold a grudge; she took her into the house and cared for her, because she made decisions as a mature person. But if you look at Mae Tophista (aged 86), her grandson (aged 21) made decisions as a young person, so that is where you see the problem is.

Although there were many stories of grandchildren who were not in control, dropping out of school, living alone at relatively young ages and who did not

listen to their grandparents or uncles, in general there were close relations. Usually grandparents have close emotional bonds with the small grandchildren whom they raise; they are in a way extensions of deceased children and provide mutual support. As grandchildren grow up, as in each household, they start to do more and more chores and the mutual support relation changes to that of a parent-child. In adulthood the relation shifts again, towards an expectation of care from grandchildren. Yet in the relationship of grandparents and grandchildren, the grandparent role remains strong as well. Whereas this creates closeness it also can create conflict, especially when grandparents are less well-off. Grandparents as well as grandchildren have emotional difficulties resulting from the loss of their children which influences the possibilities to parent.

Grandparents raise grandchildren with values from their generation, often not being able to tie into new circumstances. In a way it is because grandparents are what they are – grandparents and not parents – that conflicts are able to arise. At the same time, though conflict is present and felt, everyday interaction shows that there have been changes in what grandparenthood itself is about. The new caring relationship can be characterised as closeness through providing with practices of giving care adapting to the natural aging process of both grandparents and grandchildren. In infancy care is about emotional comfort, and providing food, school materials, close physical care and the touch of a grandparent towards a grandchild. In adolescence care is about guidance and providing growing grandchildren with some luxury items. In adulthood care from a grandparent is about advice and securing inheritance. Care by a grandchild is about supporting a grandparent in their everyday needs.

Staying with grandchildren without parents is an experience which changes over time as both grandparents and grandchildren age. Grandparents are aware that their role is supposed to be that of a parent, to care for grandchildren by providing for them, but in reality their relationship is a mixture between authoritative parenting and grandparenting in which relations are not hierarchical. It is this tension, I argue, that is at the core of what is often termed ‘generational conflict’, while at the same time it explains the closeness and affection that make some older people ‘shine’.

Conclusion: Providing grandparents

In this chapter, I explored the changing relationships between grandparents and grandchildren in the era of AIDS. Grandparents and grandchildren shape their relations in the everyday practices of living together. In contemporary *Buhaya* values of grandparents about social relations, such as suffering for children and grandchildren, and compassion, do not always fit the daily reality in which grandchildren find themselves, and whereas grandparents practise their grand-

parent role through advising grandchildren, they feel ill equipped to address grandchildren in what to them is an alien manner, especially with regard to AIDS. Whereas grandparents do feel that their values about good family care relations are not always shared, I have been careful, however, to interpret this in terms of an intergenerational gap. Rather, situations occur that trigger conflictuous situations, but there are many situations in which there is closeness between the same grandparents and grandchildren. These alternations between conflict and closeness occur specifically in relations between grandparents and grandchildren without parents, be it through AIDS death or through abandonment after divorce. In this sense I have argued that it is not just AIDS which marks the experience of grandparenthood; in their roles the broader concerns with the state of current social relations are reflected; the lack of economic capability of adult children who gave birth to many children, grandchildren born without a father, mobility to town and the consequent alienation of city-bred grandchildren coincide with the confrontations of grandchildren with deceased parents.

In these new situations in which grandparents find themselves, grandparenting as an institution is changing in nature, such that grandparenting has become a mix of parenting and grandparenting. Grandparents have always had different roles towards grandchildren, roles that remain partly the same when raising children without parents, but also contain new elements. In these mixtures of roles grandparents become acutely aware of their aging bodies. Firstly, grandparents who live with grandchildren suffer for their grandchildren, something which they have always done, providing them with everyday needs as normal, but now without the financial assistance of living parents, who would have normally contributed. Depending on the economic position of the grandparent, this sometimes requires them to undertake physical labour to earn money and grandparents experience anxiety. The mutual care that is part of the grandparent-grandchildren relationship and that includes both emotional and material elements, was always present in the grandparent-grandchild relationship, but has now become essential for everyday survival in the era of AIDS. Secondly, grandparents who have always watched out over their grandchildren are faced with increasing problems: Grandchildren being abandoned and mistreated in new family constellations. Sometimes grandparents take in grandchildren when they have aged already and are not really ready to take on the care.

Through closeness a grandparent usually provides for grandchildren, making sure they are well. Providing, a core value in relations of care has taken on a different meaning in the above situations of care. This was particularly visible when looking at the relation between grandparents and grandchildren over time, and how they grow up and old together. Providing takes different forms in different life stages, making different demands on the aging body. In infancy, it

is about touch, carrying, waking up at night, nursing ill children and making sure that the children can go to school. Grandchildren keep the grandparent company. In adolescence providing also contains much more authority, disciplining and advising a grandchild, for which a strong body is needed to generate respect, but grandchildren also have different needs: Access to luxury goods and clothes, which a grandparent cannot always provide. Grandchildren perform more and more household tasks and the care relation shifts to mutual care, but conflicts are also very common. Here the fact that grandparents generally provide through closeness, and material providing is less part of their role, becomes the problem. It is precisely the fact that grandparents remain what they are: Grandparents and not parents, that creates what is often interpreted as intergenerational conflicts. In adulthood physicality takes on a new dimension. Closeness through shared living is still present but young adult children are faced with ailing and aging grandparents at an age at which they are themselves often not ready to take on the task of intensive care giving. At the same time the closeness between grandparents and grandchildren through shared lives often creates mutual support far into adulthood and old age. The demands of grandparenting over time make grandparents acutely aware of their aging body as well as their position as older persons in a changed society.

Conclusion

I felt weak yesterday; after all it is the same blood running through the family – Mae Tibaigana about the death of a young child in the family.

This thesis comes to an end where it began, with Mae Tibaigana describing her experiences of loss and uncertainty in this era of AIDS, on the toll they've taken on her body, and the ways they've distorted kinship connections. Mae Tibaigana's expression of despair also alludes to the common anxieties that older people have about the future and legacy of their relations. In their daily lives, older men and women endure tremendous loss and hardship – burying relatives, nursing patients and raising orphans. They make the best of this situation, in part, by trying to secure care, which they do with varying success. Ethnography has proven a valuable tool for capturing the messy attempts of people to make sense of extraordinary circumstances (cf Moyer 2003; Hastrup 2005).

This study is part of a developing field of kinship studies that seeks to provide an alternative to structural perspectives, and to understand kinship relations as continually forged through everyday practice, through living together in the ongoing and unpredictable flux of history. The question I raised in the Introduction was how we could understand the tension between practices of care and processes of aging, while older people are being involved in more care tasks, while at the same time, as a result of their physical aging, it is less easy to provide that care. Care practices magnify relationships and capture some of the fundamental issues that older men and women struggle with in the era of AIDS; they trigger moral questions about social norms and practices around property and gender, and create new forms of belonging within the family.

Through focusing on the role of older bodies in forging relations of care over time I have been able to paint a more nuanced picture of what is often called 'distortions or breakages in care relations', which marked early analyses of the

Photo 7.1 Two older sisters living together in old age, in the visitor's room of their house



epidemic (Ankrah 1993; Williams 2003), following more contemporary analyses which argue that disruption is part of the human condition (Becker 2002: 7). In this sense I situate AIDS in broader concerns about social transformations and their effects on social relations in the eyes of older people. I focus on the creative ways in which persons continuously shape everyday relations, through ‘doing kinship’ (Alber *et al.* 2008; Dilger 2010a) and I show how kin-related care is endlessly stretched, activated and intensified to the extent that certain relations have become even more intensive than before.

Being old in Kagera is shaped by experiences which older people have had while providing care in situations where new modes of caring were required. For the current generation of older men and women in Kagera, having grown up in the pre-AIDS era, AIDS predicated a fundamental break with the past; family care relations and the generational authority and gender roles embedded in them are increasingly contested. Care practices in the era of AIDS reflect contentions about social relations that are rooted in these historical transformations. Practices of care giving by older people created a space for reflections on changing values, in that way providing a possibility to act.

Within the social worlds of older people three factors influence their ability to engage in practices of care. Firstly gender shapes the expected roles and possibilities of care giving and receiving care; secondly material assets and poverty structure the possibilities of older men and women to engage in relations of care; and thirdly a morality of care that has emerged around AIDS influences what is considered good care and how older people should practise this care.

Neither these social worlds nor the factors shaping care, however, have remained the same throughout their lifetimes. Instead, they have constantly shifted and continue to do so. Historical processes of transformation throughout the lifetimes of older men and women have shaped contemporary gender and generational roles and influenced older people's material position. Their life experiences have shaped their values attached to social relations; and the morality of care has emerged and transformed over three decades of AIDS. In short, people change as they age, but so does the world around them.

It is within this ever shifting social world that older men and women practise care and engage in family relationships and try to normalise the extreme circumstances in which they find themselves. Extreme circumstances then do not just shape the relations of older men and women; they become part of the process of aging. This interplay between practices of care in the era of AIDS and experiences of aging are the focus of my analysis. The intertwined physicality of AIDS-related loss and of growing older, work together to shape the dynamics of care practices. The aging body, which serves as the locus for this physical entwinement, is what permits – or challenges – older people to make connections with others and normalise extreme circumstances: New demands are put on the aging body as a result of changed care realities in the context of HIV. Loss and anxiety often have a physical impact, yet older people in particular need their bodies to be healthy so as to be able to socialise and to remain productive while being confronted with declining strength.

Through the analysis of events around care I argue that older men and women do not just live with loss and disruption but actively seek to manage the experienced disruption by making connections with important others in the realm of the family and their close personal networks. In the remainder of this conclusion I discuss how the aging body is instrumental in navigating relations of care and how the ability to do so changes over time as the body grows older, but also as situations within new fields of care change all the time. Bodily transformations conjoin transformations in care relations.

Practices of care with an aging body

Sina nguvu, 'I have no strength', was a common expression used by older people when talking about experiences of old age. Though the older men and women

were generally able-bodied, old age naturally came with a decline of strength: Hearing impairments, old age illnesses such as high blood pressure, diabetes and in some cases heart problems and strokes, but also more general old age ailments such as sore backs, general fatigue and a decline of the teeth, hearing and eyesight. Though these issues are a part of natural aging, they have become more urgent in the current era of AIDS as bodily impairments are magnified in practices of care (cf Ssengonzi 2007; Seeley *et al.* 2008; Ainsworth & Dayton 2000).

AIDS mortality, together with migration and the monetisation of the economy have out-stretched family care networks. Kinship relations have become dispersed or disappeared, and exchanges within relations have become more monetised. More often, support is predominantly provided by the immediate nuclear family. As a result, older people feel that in old age they still have to rely on their own physical strength.¹

Care giving is embedded in family histories, previous expectations and tensions. An older mother is not just caring for an AIDS patient, but for her son of whom she had high expectations. This turns care roles into moral and emotional concerns. Throughout the ethnographic chapters a morality of care unfolded. This is a different morality than that around AIDS, which serves to make sense of distortions of kinship relations and often leads to the exclusion and stigmatisation of AIDS patients (Posel 2004; Dilger 2010a). Though a morality of AIDS is also present in the village, amongst older persons a competing morality of care prevails, centring around three values: Compassion, endurance/suffering and providing. These values are linked to older people's experiences with historical transformations in family care. Upholding these values places a high demand on the aging body, albeit differently for older men and women, and is strongly enforced amongst caregivers who check on one another during visits to homes where patients are dying.

Compassion, or *huruma*, is of central concern to older people, a value which they feel is lacking in contemporary relationships. With respect to care, compassion refers to issues such as closeness and intimacy as well as inclusion. Closeness is related to intimate, bodily acts of caring such as washing, cleaning, and cooking – often the domain of women. In these practices, the older person's body plays a central role. Care giving is demanding, especially in a village context where water and wood must be gathered and food must be farmed. Cooking in this context, in particular, takes a lot of time. Care is not just about touching and physical presence but also about heavy work. Patients in their final stages need to be washed, and are unable to eat independently. Many have food re-

¹ This was especially so for widowed and divorced older women-the majority amongst older women, who were more dependent on these dispersed relations for old age care than older, mostly married men.

quirements that put heavy demands on financial resources and time. These acts of care giving adversely affect the health of older people, women in particular, especially when patients are ill for prolonged periods of time.

Compassion plays a different role in the context of death and mourning when it refers to older people's role as comforter at funerals. In these situations older people's memories of their prior losses are triggered which, in turn, can cause sleeplessness and anxiety. Older people also employ their bodies to create closeness and intimacy as part of providing compassionate care. This is particularly the case in relation to care for grandchildren where physical presence and touch are essential elements. Abnormal situations which are demanding on the body are when grandparents have to take in small toddlers who are still breastfeeding. Care then requires soothing grandchildren in the night and carrying them around, practices which often drain their strength.

Suffering or enduring is the second value associated with good care. This is particularly the case for older women. Because giving care is both confrontational and sad, it is an emotional process. The shock of seeing an emaciated son or daughter return from the city, the pain of having to wash a body covered in diarrhea and sores, the exhaustion that comes with sitting vigil all night or spoon-feeding a relative are practices that remind older people of the expectations they once had for their dying relative and also trigger emotions such as anger and sadness. In addition to these grief-associated emotions, caring for relatives also leads to *mawazo*, or worrisome thoughts, over how to live up to new demands, such as raising grandchildren. Older people consider these worries and emotions detrimental to health. Heart problems, high blood pressure, strokes and anxiety/insomnia are often attributed to emotions around illness and death. Endurance is linked to self-control, a core-value of Haya social relationships and containment of emotions, which if done properly, can counter the detrimental effects of care giving on the health of aging bodies and minds.

A third value of care relations that runs through the chapters is the materiality of care. Care is about providing in different ways. Providing as a value is linked to notions of parenthood – more so to fatherhood than to motherhood – and features in the material aspects of care giving. Older men are involved in the financial and organisational aspects of caring: Mobilising resources, organising transport to the hospital, paying school fees for grandchildren and involving the broader family clan. When women are single, either because they have been widowed or divorced, they are responsible for men's work, and many older women who do not have assets to sell are engaged in casual labour to be able to provide for the costs of medicines for patients and grandchildren and the costs of schooling and feeding grandchildren. Older women often manage this through hiring assistance, or selling assets, depending on their socio-economic position.

They can also draw on the support of remaining adult sons and daughters, but avoid this as much as possible so as not to place too much demand on already overstretched kinship networks and risk compromising their own old age security. The value attributed to providing leads to the older body needing to work into old age. When older men or women say, like Ta Stephen, that they feel that old age is worse than carrying stones on their heads, they are literally referring to demands on their bodies that they can hardly live up to.

As people age bodies change in appearance, but also in the ability to act. The demands on older person's bodies are evoked in subjective experiences of the aging bodies. Older people putting an emphasis on strength when they discuss aging reflects their constant confrontation with their physical body while they age, a balancing act between what is just barely possible and what is not possible at all. The multiple and varied demands put upon the body intertwine with normal processes of aging and make strength a core concern, while also making the physical body the vehicle for interaction. Care in this way transforms together with the body. This opens a second realm in which older people's bodies are important: The way older men and women through their practices of care make connections.

Practices of relating with an aging body

A second level in which the older body is an essential focus is on the level of relating: The way older people, through bodily practice, forge relations with those they care for and with others. Care is essentially intersubjective in that it takes place in the context of social relations, both intimate and broad. Care is both the object and the subject of social relations; through social relations care is provided, while at the same time through care social relations are intrinsically produced. In this section I discuss the way relations of care are reconfigured and how older men and women attempt to normalise an extraordinary situation through their practices of relating. I discuss the relationality of care in three different situations in which relations of care are often strained and result in conflict: The situation of anticipated and actual loss when older people are confronted with dying and death; the situation after death when older people need to navigate relations with those who remain, including other family members, specifically when grandparents take in grandchildren; and thirdly situations where older people imagine the future, and how they try to actively prepare for old age while being confronted with dying, death and new care constellations.

Within these realms it is important to emphasise that older men and women are confronted with shifts in – and hence forge relations – mainly within their close circle: family, friends and neighbours. Experiences of shifting care relations are so potentially disruptive because care mainly takes place between in-

dividuals who are close and often share a long history together. Shared history is an element of closeness (cf Whyte & Whyte 2004). Through the shifts in constellations of family care, several of the relatives and friends to whom older people were very close might fall away and as a result older people will start to rely on some relatives and friends more strongly than on others. New realities of care might then bring some relatives such as grandchildren closer, which creates new forms of intimacy but also generates new conflicts.

In the realm of care, older persons engage with those who will die, often their adult children. The physical body serves as a vehicle for forging relations as older persons sit with patients, and touch, wash and feed them to create feelings of inclusion and closeness, despite the conflicting emotions that arise in caring for the dying. A parent-child relationship is one of mutual provision, and though this aspect of the relationship does not alter when patients become ill, the balance is distorted. An older mother is seen as a source of security; when the mother is present the patient is cared for. During periods when patients feel better, he or she often they tries to assist their older caregiver.

As emotions can be disruptive for both the relationship of the older person towards the patient but also of the relationship between the older person and the community, in particular when the patient is a person supporting the older person very much, an important practice in caring for patients is the concealing of the illness. Older parents avoid discussing their suspicions about a patient's illness openly and carefully choose those with whom they speak, often choosing neighbours and friends with whom they share a history. Even then the illness is only referred to in concealed ways. Such acts of concealment are considered an essential element of compassionate care and affirm the parent-child relationship, because through concealing, dangerous emotions are avoided. In that sense, though expectations of being cared for by children have changed, the relation between parent and child in the context of patient care has remained the same. For example, many women make sense of their caring task by stating that parents suffer for their children. Concealment assists to 'normalise' the extraordinary situation of dying and death in two contexts: Between the patient and the caregiver, and between the older person and the community.

In managing death and bereavement, practices of relating demand engagement with the extended family and community. In moments of bereavement 'multiple selves' are activated; older caregivers recognise the danger of identifying with their bereaved self, fearing that they might cease to exist as a social person. Older persons attempt to push aside the painful memories to balance the reminders of loss with the obligations that are requested of them as villagers: They go to funerals after burials and they silence those speaking about death. In their contact with community members, in their roles as comforter for other bereaved, they are

connected with community members once more. Both concealing and enduring are related to a core value of social relations in *Buhaya*, that of enclosure, keeping things enclosed, as revealing might be potentially dangerous to an individual's social position and that of his or her family.

A second realm where older people use their bodies to engage in making connection is in relation to those who remain. Older caregivers do not provide care in isolation; family members are incorporated in care giving. Older caregivers are not just providers of care but also receivers of care. Similarly others are incorporated in everyday care tasks. This notion of embeddedness allows us to understand the older person within broader family care relations, rather than solely as a caregiver in relation to the person receiving care.

Older people draw on remaining children to assist them with the different care demands, in particular when the caregiver is an older woman. Adult daughters often come to stay for some time to assist in everyday chores, sons may assist in covering material costs, and at other times members of the extended family are asked to assist in transporting the patient to and from the hospital, sometimes at great expense to the older person. But most of the care is shared in the household and sometimes grandchildren are involved in caring for their dying parents as well. After death, funeral societies and neighbours assist in the burial and mourning period, but the many deaths have led to this support becoming highly institutionalised. Within the intersubjective relations of older persons there is therefore a constant negotiation of roles and the need for older persons to continuously 'position' themselves in the realm of family care within the limits of their physical body.

Bodily presence is also a central feature in care for grandchildren. Grandmothers forge relations with grandchildren through touching, closeness and permissiveness but the physical body is also needed to exert authority over grandchildren in different stages of their lives. Grandparents are mixtures of parents and grandparents, but are limited in the extent to which they are able to provide materially and discipline grandchildren. Mutual care between grandparents and grandchildren now has become essential for everyday survival and it is not uncommon for grandparents as well as grandchildren to assume caring roles that heavily challenge their abilities.

Though grandparenting practices have adapted to meet the demands of caring that have arisen in the age of AIDS, the framing of grandparenthood has not significantly altered. The combination of these old frameworks with the decline of physical strength that comes with natural aging, makes it difficult for grandparents to exert disciplinary authority and provide materially, both of which would have traditionally been considered responsibilities of the parents. Here, especially older women lean on remaining adult children to discipline grand-

children, thereby creating another form of 'normalcy', namely that the social role of the older person remains intact as much as possible. For example, involving the brother of a deceased son to discipline a grandchild makes it possible for a grandmother to exercise her authority through the classificatory father of the grandchild. In this way, older men and women use their life experiences and their social status as an old person in practices of relating.

A third realm in which older people need their bodies to forge relations is in the realm of old age care: Their hopes for a future. Within the changed field of care, bodily contact plays a crucial role in consolidating relationships over time. Older persons, especially older women, need their bodies to remain independent, to fulfil the additional demands made on them by raising grandchildren and by nursing, and to make relations, for example, through socialising and being able to give. At the same time appearance is also a marker of social status, and of good care, especially in old age. Old age is marked by care relations that concern very intimate domains of life and the body; good care for an old person involves washing them, clearing feet of sand flees and applying body gel. In this sense 'body work' is part of the old age experience anyway, but in the era of AIDS concerns over good care have deepened.

When the body fails and care is absent, older persons try to build relations of closeness through providing materially (promising inheritance, or investing land or money in other relations) or through other practices, for example by complaining to neighbours about the care of their relatives in an attempt to shame them into caring. In the areas of active care giving, practices of care can therefore be seen not only as ways to consolidate relations of care between the older person and those they care for, but also to those who remain, i.e. a consolidation of relations which older men and women will depend on in old age. Older bodies need to be strong to continuously shape relations that might lead to security in old age. In this sense the physical body is more than a vehicle in shaping relations of care; it also is a marker for the state of an older person's relations. A well-cared for body indicates the presence of those who provide.

Whereas discourses of disconnection between generations are overtly present in the village, actual practices of care and relating of older persons in my view also point towards the making of connections between the generations. Connections are made through concealing or silencing emotions; through physically and mentally enduring emotions around death; through creating closeness in relations that remain; or employing the physical body to forge new relations of care. Through these bodily practices of care it is possible at some level to overcome the inherent tensions that underlie overstretched kinship relations in this era. In this sense we can speak of the aging of AIDS: AIDS has become embedded in social relations of care in such a way that it is made into something of the

everyday, something normal. Care then becomes a way in which older persons continuously forge relations, thereby normalising the constant shifts in care networks. The physical body can then be seen as the core area for the negotiation of forms of normalcy in what older men and women perceive as disrupted relations.

Whereas the aging body does not define experiences of old age, and old age identity solely and good social relations can and often overcome the limits of the aging body, as several authors maintain (Sagner 2002; Livingston 2005), I argue that in the era of AIDS the body increases in importance in experiences of aging. It becomes 'present' (cf. Shilling 1993): older people have to face their aging body and 'embody' their experiences when they speak of aging in terms of lack of strength.

Aging bodies over time

In the ethnographic chapters of this thesis I show that a time perspective is essential if we want to understand experiences of aging, especially in an epidemic of nearly three decades. Care realities and care practices are not static but have adapted to changed circumstances and this has placed a demand on the aging body in terms of providing care and practising relating. A time perspective illuminates how family care networks are adapting as people age and become more dependent. The role of the physical body in practices of care and relating and how this changes over time is a relatively recent focus (Livingston 2005: 28; Geissler & Prince 2010). Not only do older people experience everyday life and enact everyday practices of care *through* their bodies (Scheper-Hughes 1992; Shilling 1993; Nettleton & Watson 1998; Livingston 2005), but the anticipation of aging, of changing bodies is central to their experience of old age (Fairhurst 1998).

A focus on time also illuminates how people 'make historical sense out of their changing bodily experiences' (Livingston 2005: 1). Older people lived through and in a sense embody historical transformations which have changed firstly the position of women and generational authority in family care relations and hence influence the way older bodies can act. Historical transformations have influenced the way older bodies are looked upon, in contemporary society. Older people, despite their efforts to make connection in family care, and despite their important roles in solving family conflicts often feel disconnected from the current era of AIDS. Partly this is related to the fact that they are not seen as 'going in those ways', having sex and hence do not possess the embodied

knowledge young people feel they possess; partly it is related to their feeling of being unable to control their children and grandchildren and keep them safe.²

It is important to recognise that the older persons who provide active care are often the persons who are still able-bodied. The experience of growing old with the epidemic, however, does not stop with the active care giving task. The loss of loved ones has an immediate effect, but also lasting implications for experiences of old age. Over the course of the epidemic, now three decades, older people of today have taken on different roles in family care: Older men and women mostly care for adult children as they die, but many older persons have also cared for spouses and siblings, for example divorced sisters who moved back home or brothers who had led a mobile life. Increasingly older persons now care for adolescent grandchildren and sometimes even great grandchildren. Here the focus on aging places the older person in a broader perspective of how family care relations adapt as new care demands emerge. Older people are then part of constantly and rapidly shifting networks, in which they fear a time when they become dependent. The aging body for a large part frames what older men and women can be in their relationships of care.

One question which I asked in the introduction after describing Mae Tibai-gana's physical experience of loss was how kin relations can compensate for the gradual physical aging process over time. Can older people manoeuvre the unpredictable chaos of life in such a way that they overcome physical decline, for example through the creative ways in which they make connections with others? Initially I was looking for a key – a way to understand what it is that allows some older people to manage the new care realities while for others old age has become a painful and lonely experience. I found that there is no key. The way older people manoeuvre through this unpredictable chaos is a constant balancing act and the outcomes sometimes seem more attributable to chance than to anything else. The ethnographic method has allowed me to listen to individual older people's stories and lay bare attempts to normalise an extraordinary situation. Through looking at the body, introducing an understanding of old age in this situation of increased care roles as something that has mainly to do with physical capacity, I have argued that caring in the era of AIDS in northwest Tanzania, but also being old in times of AIDS, is essentially about establishing and maintaining close connections through time. Older people's bodies are vehicles to make connections, but are also representations of failure or success.

This thesis reinvigorates a long-standing medical anthropological subject of inquiry, care, and in particular the importance of family care in the management of illness (Janzen 1978; Bor & Elford 1992; Livingston 2005) and shows how in

² It remains to be seen how the new social reality of Anti Retroviral Therapy affects the way of looking at older bodies.

current debates around AIDS, which focus on technology, citizenship and biomedicalisation which are influenced by the rapid developments in AIDS treatment in recent years, family care giving as a subject of inquiry has remained under examined (Sankar 2010). A focus on the body and temporality in analyses of family care in the era of AIDS triggers important questions; around personhood and the limits of the body as the social realities of care around AIDS keep on changing rapidly, and around issues of connection and disconnection between and within generations, as the physical ability of individuals within family relations continues to change.

References

- AKINSOLA, H. (2000), Effects of the AIDS epidemic and the community home-based care programme on the health of older Batswana. *Southern African Journal of Gerontology* 9(1): 4-9.
- ALBER, E., S. VAN DER GEEST & S. WHYTE, eds, (2008), *Generations in Africa: Connection and conflicts*. Berlin: Lit Verlag.
- ALDOUS, J. (1990), Family development and the life course: Two perspectives on family change. *Journal of Marriage and the Family* 52(3): 571-583.
- ANKRAH, M. (1993), The impact of HIV/AIDS on the family and other significant relationships. The African clan revisited. *AIDS Care* 5(1): 5-22.
- BAGALISHYA, D. (2000), Mourning and recovery from trauma: In Rwanda the tears flow within. *Transcultural Psychiatry* 37(3): 337-353.
- BEATTY, A. (2005), Emotions in the field: What are we talking about? *Journal of the Royal Anthropological Institute* 11: 17-37.
- BECKER, F. & W. GEISLER (2007), Searching for pathways in a landscape of death: Religion and AIDS in East Africa. *Journal of Religion in Africa* 37(1): 1-15.
- BECKER, G. (1997), *Mediating disruption*. Berkeley: University of California Press.
- BEEGLE, K., J. DE WEERDT & S. DERCON (2006), Orphanhood and the long-run impact on children. *American Journal of Agricultural Economics* 88(5): 1266-1272.
- BEEGLE, K., J. DE WEERDT & S. DERCON (2011), Migration and economic mobility in Tanzania: Evidence from a tracking survey. *The Review of Economics and Statistics* 93(3): 1010-1033.
- BIEHL, J., B. GOOD & A. KLEINMAN (2005), *Subjectivity: Ethnographic investigations*. Berkeley: University of California Press.
- BOHMAN, D., S. VASUTHEVAN, N. VAN WYK & S. EKMAN (2007), 'We clean our houses, prepare for weddings and go to funerals': Daily lives of elderly Africans in Majaneng, South Africa. *Journal of Cross-Cultural Gerontology* 22(4): 323-337.
- BOR, R & J. ELFORD, eds (1992), *The family and HIV*. London: Cassell.
- BOURDIEU, P. (1977), *Outline of a theory of practice*. Cambridge: University of Cambridge Press.
- BURY, M. (1982), Chronic illness as a biographical disruption. *Sociology of Health and Illness* 4(2): 167-182.
- CAPLAN, P. (1995), The experience of being old in Mafia, Tanzania. In: M. Aguilar, ed., *The politics of age and gerontocracy in Africa: Ethnographies of the past & memories of the present*, pp. 99-124. Trenton: Africa World Press.
- CARSTEN, J., (2000), *Cultures of relatedness: New approaches to the study of kinship*. Cambridge and New York: Cambridge University Press.
- CLIGGETT, L. (2002), Survival strategies of the elderly in Gwembe valley, Zambia: Gender, residence and kin networks. *Journal of Cross-Cultural Gerontology* 16(4): 309-332.
- CORY, H. & M. HARTNOLL (1971), *Customary law of the Haya tribe: Tanganyika territory*. Westport: Negro Universities Press.
- CURTIS, K. (1992), Cooperation and cooptation: The struggle for market control in the Bukoba district of colonial Tanganyika. *The International Journal of African Historical Studies* 25(3): 505-538.
- DAYTON, J. & M. AINSWORTH, (2002), The elderly and AIDS: Coping strategies and health in rural Tanzania. *Social Science and Medicine* 59(10): 2161-2172.

- DERCON, S. J. DE WEERDT, T. BOLD & A. PANKHURST (2006), Group-based funeral insurance in Ethiopia and Tanzania. *World Development* 34(4): 685-703.
- DE WEERDT, J. (2001), *Community organisations in rural Tanzania: A case study of the community of Nyakatoke, Bukoba Rural District*. Bukoba: Economic Development Initiatives.
- DE WEERDT, J. (2010), Moving out of poverty in Tanzania: Evidence from Kagera. *Journal of Development Studies* 46(2): 331-349.
- DILGER, H. (2005), *Leben mit AIDS: Krankheit, Tod und soziale Beziehungen in Afrika. Eine Ethnographie*. Frankfurt: Campus Verlag.
- DILGER, H. (2008), We are all going to die: Kinship, belonging and the morality of HIV/AIDS related illnesses and deaths in rural Tanzania. *Anthropological Quarterly* 81(1): 207-232.
- DILGER, H. & U. LUIG (2010a), Introduction: Morality, hope and grief: Towards an ethnographic perspective in HIV/AIDS research. In: H. Dilger & U. Luig, eds, *Morality, hope and grief. Anthropologies of AIDS in Africa*, pp. 1-18. New York: Berghahn Books.
- DILGER, H. & U. LUIG (2010b), My relatives are running away from me! Kinship and care in the wake of structural adjustment, privatisation and HIV/AIDS in Tanzania. In: H. Dilger & U. Luig, eds, *Morality, hope and grief. Anthropologies of AIDS in Africa*, pp. 102-124. New York: Berghahn Books.
- EMLETT, C. (2008), Truth and consequences: A qualitative exploration of HIV disclosure in older adults. *AIDS Care* 20(6): 710-717.
- FABIAN, J. (2003), Forgetful remembering: A colonial life in the Congo. *Africa* 73(4): 489-504.
- FAIRHURST, E. (1998), 'Growing old gracefully' as opposed to 'mutton dressed as lamb: The social construction of recognising older women. In: S. Nettleton & J. Watson, eds, *The body in everyday life*, pp. 258-275. London: Routledge.
- FEE, E. & D. FOX (1992), *AIDS: The making of a chronic disease*. Berkeley: University of California Press.
- FERREIRA, M. (2002), Towards a cultural and linguistic construction of late-life dementia in an urban African population. In: S. Makoni & K. Stroeken, eds, *Ageing in Africa: Socio-cultural and linguistic approaches*, pp. 21-42. Aldershot: Ashgate Publishing Limited.
- FERREIRA, L. (1996), *Poverty and inequality during structural adjustment in Tanzania*. Washington: Worldbank, Policy Research Working Paper 1641.
- FOSTER, G. (2000), The capacity of the extended family safety net for orphans in Africa. *Psychology, health, and medicine* 5(1): 55-62.
- FOSTER, G., R. SHAKESPEARE, F. CHINEMANA, H. JACKSON, S. GREGSON, C. MARANGE & S. MASHUMBA (1995), Orphan prevalence and extended family care in a peri-urban community in Zimbabwe. *AIDS Care* 7(1): 3-17.
- FRANK, A. (1995), *The wounded storyteller. Body, illness and ethics*. Chicago: University of Chicago Press.
- GEISLER, W. & R. PRINCE (2004), Shared lives: Exploring practices of amity between grandmothers and grandchildren in western Kenya. *Africa* 74(1): 95-120.
- GEISLER, W. & R. PRINCE (2010) *The land is dying: Contingency, creativity and conflict in Western Kenya*. New York: Berghahn Books.
- GOODY, J. (1974), Death and the interpretation of culture: A bibliographic overview. *American Quarterly*, Special issue: *Death in America* (Dec. 1974) 26(5): 448-455.
- HARAM, L. (2010), We are tired of mourning. In: H. Dilger & U. Luig, eds, *Morality, hope and grief. Anthropologies of AIDS in Africa*, pp. 219-239. New York: Berghahn Books.
- HASTRUP, K. (2005), *A passage to anthropology: Between experience and theory*. London: Routledge.
- HOFFMAN, S., M. HESLOP, G. CLACHERTY & F. KESSY (2008), *Salt, shoes and soap for school. The impact of social pensions on the lives of older people and grandchildren in the KwaWazee Project, Muleba district, Kagera region, Tanzania*. London: Help Age International.

- HOOPER, E. (1999), *The River, a journey to the source of the HIV/AIDS epidemic*. Boston: Little, Brown and Company.
- HYDEN, G. (1980), *Beyond Ujamaa in Tanzania. Underdevelopment and an uncaptured peasantry*. London: Heineman.
- IGREJA, V. (2003), 'Why are there so many drums playing until dawn?': Exploring the role of Gamba spirits and healers in the post-war recovery period in Gorongosa, Central Mozambique, *Transcultural Psychiatry* 40(4): 459-487.
- ILIFFE, J. (2005), *Honour in African history*. Cambridge: Cambridge University Press.
- ILIFFE, J. (2006), *The African AIDS epidemic. A history*. Oxford/Athens: James Currey/Ohio University Press.
- INGSTADT, B. (2004), The value of grandchildren: Changing relations between generations in Botswana. *Africa* 74(1): 62-76.
- JACKSON, M. (2002), *The politics of storytelling: Violence, transgression, and intersubjectivity*. Copenhagen: Museum Tusculanum Press.
- JANZEN, J. (1978), *The quest for therapy: Medical pluralism in lower Zaire*. Berkeley: University of California Press.
- KAIJAGE, F. (1992), The AIDS crisis in the Kagera region, from a historical perspective. In: J. Killewo, G. Lwihula, A. Sandström & L. Dahlgren, eds, Workshop, December 6-8, Dar es Salaam: SAREC Documentation.
- KAIJAGE, F. (1997), Social exclusion and the social history of disease: The impact of HIV/AIDS and the changing concept of the family in northwestern Tanzania. In: S. McGrath, C. Jedrej, K. King & J. Thompson, eds, *Rethinking African history*, pp. 331-356. University of Edinburgh: Centre of African Studies.
- KASTELIJNS, M. (2009), They do not like us, they isolate us: The role of HIV/AIDS stigma on caregiving by older women in Uganda. Master thesis in medical anthropology, University of Amsterdam.
- KESSY, F. (2005), *Rural income dynamics in Kagera Region. Report prepared for the WorldBank*. Dar es Salaam: The Economic and Social Research Foundation.
- KILLEWO, J., L. DAHLGREN & A. SANDSTROM (1994), Socio-geographical patterns of HIV-1 transmission in Kagera region, Tanzania. *Social Science and Medicine* 38(1): 129-134.
- KILONZO, G. & N. HOGAN (1999), Traditional African mourning practices are abridged in response to the AIDS epidemic: Implications for mental health. *Transcultural Psychiatry* 36(3): 259-283.
- KLAITS, F. (2005), The widow in blue: Blood and the morality of remembering in Botswana's time of AIDS. *Africa* 75(1): 46-62.
- KLEINMAN, A. (1998), Experience and its moral modes: Culture, human conditions, and disorder. The Tanner lectures on human values, delivered at Stanford University, 13-16 April 1998.
- KLEINMAN, A. (2006), *What really matters: Living a moral life amidst uncertainty and danger*. Oxford: Oxford University Press.
- KLEINMAN, A. & S. VAN DER GEEST (2009), 'Care' in health care: Remaking the moral world of medicine. *Medische Antropologie* 21(1): 159-168.
- KNODEL, J. & M. OFSTEDAL (2005), Gender and aging in the developing world: Where are the men? *Population and Development Review* 29(4): 677-698.
- KNODEL, J. & C. SAENGTIENCHAI (2005), Older-aged parents: The final safety net for adult sons and daughters with AIDS in Thailand. *Journal of Family Issues* 26(5): 665-698.
- KNODEL, J., Z. ZIMMER, K. KIM & S. PUCH (2006). *The impact of AIDS on older-aged parents in Cambodia*. Ann Arbor: Population Studies Center, Research Report 06-594.
- KSOLL, C. (2007), *Family networks and orphan caretaking in Tanzania*. Oxford: University of Oxford. Department of Economics Discussion Paper Series, Number 361.
- KWESIGABO, G. (2001), *Trends of HIV infection in the Kagera region of Tanzania 1987-2000*. Dissertation, University of Umeå.

- LAL, P. (2010), Militants, mothers, and the national family: Ujamaa, gender and rural development in postcolonial Tanzania. *Journal of African History* 51(1): 1-20.
- LAMBEK, M. (1996), The past imperfect: Remembering as moral practice. In: P. Antze & M. Lambek, eds, *Tense past: Cultural essays in trauma and memory*, pp. 235-254. London: Routledge.
- LARSSON, B. (1991), *Conversion to greater freedom? Women, church and social change in northwestern Tanzania under colonial rule*. Uppsala: Almqvist and Wiksell.
- LIVINGSTON, J. (2005), *Debility and the moral imagination in Botswana*. Bloomington: Indiana University Press.
- LIVINGSTON, J. (2008), Disgust, bodily aesthetics and the ethic of being human in Botswana. *Africa* 78(2): 288-307.
- LUGALLA, J., M. EMMELIN, A. MUTEMBEI, M. SIMA, G. KWESIGABO, J. KILLEWO & L. DAHLGREN (2004), Social, cultural and sexual behavioural determinants of observed decline in HIV infection trends: Lessons from the Kagera region Tanzania. *Social Science and Medicine* 59(1): 185-198.
- MADOERIN, K. (2008), *Concept paper: Tatu-Tano. Proposal for implementation of neighbourhood support system for AIDS orphans in Nshamba, Tanzania*. Nshamba: Kwa Wazee Verein.
- MAKONI, S. & K. STROEKEN, (2002), Introduction: Towards transdisciplinary studies on ageing in Africa. In: S. Makoni & K. Stroeken, eds, *Ageing in Africa: Sociolinguistic and anthropological approaches*, pp. 1-18. Aldershot: Ashgate Publishing Company.
- MANJI, A. (2000), 'Her name is Kamundage': Rethinking women and poverty among the Haya of Tanzania. *Africa* 70(3): 482-500.
- MARIANTI, R. (2002), *Surviving spouses: Support for widows in Malang, East Java*. Dissertation, University of Amsterdam.
- MOYER, E. (2003), *In the shadow of the Sheraton: Imagining localities in global spaces in Dar es Salaam, Tanzania*. Dissertation, University of Amsterdam.
- MOL, A. (2008), *The logic of care: Health and the problem of patient choice*. New York: Routledge.
- MUCHUNGUZI, J. (2002), HIV/AIDS and women's land ownership rights in Kagera Region, northwestern Tanzania. Workshop on HIV/AIDS and land tenure. Pretoria, 24th-25th June 2002.
- MUTEMBEI, A. (2001), *Poetry and AIDS in Tanzania: Changing metaphors and metonymies in Haya oral tradition*. Leiden: CNWS publications 101.
- NETTLETON, S. & J. WATSON (1998), The body in everyday life: An introduction. In: S. Nettleton & J. Watson, eds, *The body in everyday life*, pp. 1-24. London: Routledge.
- NIEHAUS, I. (2007), Death before dying: Understanding AIDS stigma in the South African lowveld. *Journal of Southern African Studies* 33(4): 845-860.
- NOTERMANS, C. (2004), Sharing home, food and a bed: Paths of grandmotherhood in East Cameroon. *Africa* 74(1): 6-27.
- NYAMBEDHA, E. (2004), Change and continuity in kin-based support systems for widows and orphans among the Luo in Western Kenya. *African Sociological Review* 8(1): 139-154.
- NYAMBEDHA, E. & J. AAGAARD-HANSEN (2007), Practices of relatedness and the re-invention of duol as a network of care for orphans and widows in western Kenya. *Africa* 77(4): 517-534.
- NYAMBEDHA, E., S. WANDIBBA, & J. AAGAARD-HANSEN (2003), Changing patterns of orphan care due to the HIV epidemic in western Kenya. *Social Science and Medicine* 57(2): 301-311.
- POSEL, D. (2004), Sex, death and embodiment: Reflections on the stigma of AIDS in Agincourt, South Africa. Conference Paper Life and Death in a Time of AIDS: The Southern African Experience, WISER, Johannesburg 14-16th October 2004.

- PRINCE, R. (2008), Struggling for growth in western Kenya: Modernity, tradition, generation and gender. In: E. Alber, S. van der Geest & S. Whyte, eds, *Generations in Africa: Connection and conflicts*, pp. 137-162. Berlin: Lit Verlag.
- REINING, P. (1967), *The Haya: The agrarian system of a sedentary people*. Dissertation, University of Chicago.
- RUGALEMA, G. (1999), *Adult mortality and entitlement failure. AIDS and the crisis of rural livelihood in a Tanzanian village*. Maastricht: Shaker Media.
- RUGALEMA, G. & K. MATHIESON (2009), *Disease, vulnerability and livelihoods on the Tanzania-Uganda interface ecosystem in the west of Lake Victoria. Diagnostic survey of northwestern Tanzania*. Rome: FAO.
- RUGALEMA, G., K. MATHIESON & J. SSENTONGO (2010), Resilience and (dis)continuity in households afflicted by AIDS: Some preliminary insights from a longitudinal case study analysis. In: A. Niehof, G. Rugalema, S. Gillespie, eds, *AIDS and rural livelihoods. Dynamics and diversity in Sub-Saharan Africa*, pp. 29-42. London: Earthscan Publications.
- SAGNER, A. (2002). Identity management and old age construction among Xhosa-speakers in urban South Africa: Complaint discourse revisited. In: S. Makoni & K. Stroecken, eds, *Ageing in Africa: Socio-cultural and linguistic approaches*, pp. 43-66. Aldershot: Ashgate Publishing Limited.
- SANKAR, A. (2010), Oral presentation in session circulating the life course: Towards an anthropology of care and care giving. Annual meeting of the American Anthropological Association, New Orleans, 16-21 November 2010.
- SCHEPER-HUGHES, N. (1992), *Death without weeping: The violence of everyday life in Brazil*. Berkeley: University of California Press.
- SCHWARTZ, M. (1988), Shame, culture, and status among the Swahili of Mombasa. *Ethos* 16(1): 21-51.
- SEELEY, J. (1998), The extended family and support for people with AIDS in a rural population in Southwest Uganda: A safety net with holes? In: R. Bor & J. Elford, eds, *The family and HIV*, pp. 141-150. London: Cassell.
- SEELEY, J., E. KABUNGA, G. TUMEKWASE, B. WOLFF & H. GROSSKURTH (2008), The impact of the AIDS epidemic on the lives of older people in rural Uganda. Norwich: University of East Anglia, *DEV Working Paper 4*.
- SEELEY, J. (2010), The longitudinal picture: What does it reveal? In: A. Niehof, G. Rugalema & S. Gillespie, eds, *AIDS and rural livelihoods. Dynamics and diversity in Sub-Saharan Africa*, pp. 13-28. London: Earthscan Publications.
- SETEL, P. (1999), *A plague of paradoxes: AIDS, culture and demography in northern Tanzania*. Chicago: University of Chicago Press.
- SHAIBU, S. & M. WALLHAGEN (2002), Family caregiving of the elderly in Botswana: Boundaries of culturally acceptable options and resources. *Journal of Cross-Cultural Gerontology* 17(2): 139-154.
- SHILLING, C. (1993), *The body and social theory*. London: Sage Publications.
- SHILLING, C. (2008), *Changing bodies, habits, crisis and creativity*. London: Sage Publications.
- SMET, E. (2003), Take a look at me now: Children's experience and agency in orphanhood. Master thesis in medical anthropology, University of Amsterdam.
- SMITH, C. & L. STEVENS (1988), Farming and income-generation in the female-headed smallholder household: The case of a Haya village in Tanzania. *Canadian Journal of African Studies* 22(3): 552-566, Special Issue: *Current research on African women*.
- SPRONK, R. (2006), *Ambiguous pleasures: Sexuality and new self-definitions in Nairobi*. Dissertation, University of Amsterdam.
- SSENGONZI, R. (2007), The plight of older persons as caregivers to people infected/affected by HIV/AIDS: Evidence from Uganda. *Journal of Cross-Cultural Gerontology* 22(4): 339-353.
- STADLER, J. (2003), Rumor, gossip and blame: Implications for HIV/AIDS prevention in the South African lowveld. *AIDS Education and Prevention* 15(4): 357-368.

- STEVENS, L. (1991), Religious change in Haya village. *Journal of Religion in Africa* 21(1): 2-25.
- SWANTZ, L. (1985), *Women in development: A creative role denied? The case of Tanzania*. London: C. Hurst & Company.
- TAYLOR, J. (2005), Surfacing the body interior. *Annual Review of Anthropology*. 34: 741-56.
- VAN BINSBERGEN, W. (2006), *Manchester as a birth place of modern agency research: The Manchester school explained from the perspective of Evans-Pritchard's book the Nuer*. Leiden: Africa Studies Centre/EUR Rotterdam. http://www.shikanda.net/ethnicity/Manchester_English.pdf
- VAN DE PORT, M. (2000), De welsprekendheid van het zwijgen. *Medische Antropologie* 12(2): 229-232.
- VAN DER GEEST, S. (1997), Money and respect: The changing value of old age in rural Ghana. *Africa* 67(4): 534-559.
- VAN DER GEEST, S. (2002), The toilet: Dignity, privacy and care of elderly people in Kwahu, Ghana. In: S. Makoni & K. Stroecken, eds, *Ageing in Africa: Sociolinguistic and anthropological approaches*, pp. 227-243. Burlington: Ashgate.
- VAN DER GEEST, S. (2004a), They do not come to listen. The experience of loneliness among older people in Kwahu, Ghana. *Journal of Cross-Cultural Gerontology* 19(2): 77-96.
- VAN DER GEEST, S. (2004b), Grandparents and grandchildren in Kwahu, Ghana: The performance of respect. *Africa* 74(1): 47-61.
- VAN DONGEN, E. (2002), Skeletons of the past, flesh and blood of the present: Remembrance and older people in a South African context. In: S. Makoni & K. Stroecken, eds, *Ageing in Africa: Sociolinguistic and anthropological approaches*, pp. 257-276. Burlington: Ashgate.
- VAN DONGEN, E. (2003), 'Dit lewe vat ek net soos ek dit kry. Life stories and remembrance of older coloured people on farms in the Western Cape province. *Journal of Cross-Cultural Gerontology* 18(4): 303-335.
- VAN DONGEN, E. & R. REIS (2004), Editorial chronic illness: Struggle and challenge. *Medical Anthropology* 19(4): 293-297.
- VON FABER, M. (2002), Maten van succes bij ouderen. Gezondheid, aanpassing and sociaal welbevinden: De Leiden 85+-studie. Academisch proefschrift, Universiteit van Amsterdam 2002.
- WEISS, B. (1996), *The making and unmaking of the Haya lived world. Consumption, commoditization, and everyday practice*. Durham: Duke University Press:
- WEISS, B. (1997a), Northwestern Tanzania on a single shilling: Sociality, embodiment, valuation. *Cultural Anthropology* 12(3): 335-361.
- WEISS, B. (1997b), Forgetting your dead: Alienable and inalienable objects in northwest Tanzania. *Anthropological Quarterly* 70(4): 164-172.
- WEISS, B. (1999), Good-for-nothing Haya names: Powers of recollection in northwest Tanzania. *Ethnos*: 64(3 & 4): 397-420.
- WEISS, B. (2003), *Sacred trees, bitter harvests: Globalizing coffee in northwest Tanzania*. Portsmouth: Heinemann.
- WHITE, L. (1992) *The comforts of home. Prostitution in colonial Nairobi*. Chicago: Chicago University Press.
- WILLIAMS, A. (2003), *Ageing and poverty. Ugandan livelihoods in a time of HIV/AIDS*. London: Ashgate Publishers.
- WHYTE, S. (2005), Going home? Belonging and burial in the era of AIDS. *Africa* 75(2): 154-172
- WHYTE, S., E. ALBER & W. GEISSLER (2004), Lifetimes intertwined: African grandparents and grandchildren. *Africa* 74(1): 1-5.
- WHYTE, S., E. ALBER & S. VAN DER GEEST (2008), Generational connections and conflicts in Africa: An introduction. In: E. Alber, S. van der Geest & S. Whyte, eds, *Generations in Africa: Connections and conflicts*. Berlin: Lit Verlag.

- WHYTE, S. & M. WHYTE (2004), Children's children: Time and relatedness in Eastern Uganda. *Africa* 74(1): 76-94.
- YANG, L., A. KLEINMAN, B. LINK, J. PHELAN, S. LEE & B. GOOD (2007), Culture and stigma: Adding moral experience to stigma theory. *Social Science and Medicine* 64(7): 1524-1535.
- ZAROWSKY, C. (2000), Trauma stories: Violence, emotion and politics in Somali Ethiopia. *Transcultural Psychiatry* 37(3): 383-402.
- ZIGON, J. (2007), Moral breakdown and the ethical demand: A theoretical framework for an anthropology of moralities. *Anthropological Theory* 7(2): 131-150.
- ZEITLYN, D. (2003), The talk goes outside: Argument, privacy and power in Mambila society. Towards a sociology of embedded praxis. *Africa* 73(4): 606-622.

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