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Book section

Original citation:

Originally published in: Hoffman, Jaco; Pype, Katrien, (eds.) *Ageing in Sub-Saharan Africa: Spaces and Practices of Care*. Bristol, UK, 2016, Policy Press, pp. 115-136.

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Available in LSE Research Online: August 2016

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Emily Freeman

Introduction<1>

Political and academic concern that care for older adults in Sub-Saharan Africa is insufficient and under strain in light of changing demography and society is long standing (UN, 1982), but poorly set out. Questions remain unanswered: What is meant by ‘care’ and what is the care that older adults need? Do (all) older adults want this (undefined) care? If they do, when do they want it and from whom? Much of the established discourse implies incapacity in older age, a burden of care to be shouldered by family, and a homogenised “elderly” who want, and sometimes successfully motivate, care.

In 2008 I started a conversation with older men and women in rural Malawi about their experiences of ageing. Care giving and receipt was a recurring narrative in our discussions, and at the heart of their understandings of older age. ‘Care’, ‘help’, ‘assistance’, ‘support’, ‘looking after’ and ‘keeping’, were used interchangeably in conversations to refer to a wide variety of practices, from assistance with washing, mobility and feeding (‘basic activities of daily living’) and farm- and housework (‘instrumental activities of daily living’), to gifts of maize, clothes and money, as well as vigilance to need, for example, by regularly visiting to monitor a person’s welfare as they aged. Some older adults were receiving this broadly defined care, and from those they expected it from; some were not, left without care because of poverty, HIV, poor planning or just bad luck:

A lot of people passed away, so the ones who are left behind cannot care for the old people: that old person complains, ‘it would be better God took me’. Then there are

other old people who have children, who have gone to school and are working, so when that old man is ageing, the children assist him. And there are other old people who suffer, even though they have children.

[Estina, female, 55]

As might be expected, and found elsewhere in other settings (see Van der Geest, Chapter One), care was inconsistently presented, even within a single interview. Sometimes participants would talk about the care they received and at other times deny receiving any help at all. Sometimes participants centred discussions of care only on the giving and receiving of larger resources (for example maize, school fees, building or repairing a house, digging a latrine) or on farming assistance given by someone who would not eventually share the produce. At other times smaller resources (salt, analgesics, a few Kwacha) or help with housework (fetching water, cooking, sweeping) were included in conversations about care. Sometimes participants did not mention non-financial care if it was given by or to their parent or child, but at other times, it was these relationships that made the care salient and the subject of conversation. Assistance for the sick or frail, such as help bathing or with getting around was usually always referred to as care, but if the assistance was given by a spouse, or was received by a participant in response to older age rather than (non-age related) illness, it was not readily discussed unless we asked about that specific care practice. How and if care was discussed by participants differed depending on the context of the care in question (whether it was care given or received by the participant, the type of care, the actors involved, the circumstances in which it was given) but also on the context of the conversation: that is, what else we had discussed that day.

Despite these differences in receipt of care and the way that care was (not) discussed, there were patterns in the way participants used the concept of care in their conversations. This chapter focuses on those patterns. It argues that research conversations about care

became a discursive space in which participants explored what the giving, receiving and needing of care meant for their sense of selves as they aged. All participants presented their experiences of care in ways they understood would demonstrate positive self-identities. They talked much less about availability of care, and much more about what the giving and receiving of care ‘said’ about them.

Drawing on sociological theories of identity, this chapter considers the implications of the meanings associated with different types of care for older adults’ age-related identity scripts. Receipt of care in response to vulnerability or from those who could not easily provide it was framed with reference to overwhelmingly negative, body-centred understandings of old age that presented a challenge to older men and women’s central identities as ‘adults’ – defined by participants as valid members of the social world. Emphasis on self-care and reciprocity in older adults’ narratives can thus be considered strategies to maintain positive ‘adult’ identities.

The implication of care for participants’ identities was a salient part of their wider ageing experiences, but is infrequently discussed in the political and academic conversation around ageing and care in Africa. Anthropological work excepted (for example Cattell, 2002; Van der Geest, 2002a, 2002b), much of the research on African ageing carried out in the social sciences since the late 1980s, primarily concerned with producing insights to inform policy responses to ‘the problem of ageing’ in the face of under-explored social change, has focused on *provision* of care for older adults: whether or not older adults are (still) receiving care (Stroeken, 2002). Evidence and explanatory frameworks that take into account motivations for providing and receiving care and older adults’ strategies to respond and adapt to their changing situations are needed (Aboderin, 2004; Ferreira, 1999; Peil, 1987). This chapter contributes to attempts to incorporate older adults’ *experiences* of care – needed, given and received – more fully within representations of ageing in Africa.

Methodology <1>

I spent 12 months between 2008 and 2010 living with and talking to older adults in Malawi in order to understand their experiences of growing old and of HIV infection. Constructivist grounded theory (Charmaz, 2006) was used to carry out the study, privileging what older adults themselves presented as the salient elements of their experiences. Our conversations included relationships, politics, death, sex, love, having HIV and growing old. This chapter presents my analytical account of their understandings and experiences of care in older age.

In-depth interviews were the primary method of generating data to access people's thoughts on unobservable, multi-layered, complex and emotionally-charged experiences and behaviours (Sommer and Sommer, 1991). Participants were initially recruited from those who had taken part in the Malawi Longitudinal Study of Families and Health (Anglewicz et al, 2009). Knowing something about potential participants before approaching them meant that an ongoing theoretical sampling strategy could be used, with each person recruited based on characteristics (for example, age, HIV, gender, living arrangements) likely to be important for exploring analytical ideas being developed about data generated. Further participants were recruited from the families of existing participants' (parents, children and spouses), HIV support groups and the local area (for example, healers).

This chapter draws on data from interviews (N=135) with 44 men and women living in approximately 25 small, rural villages in or close to Balaka District, southern Malawi. They were relatively evenly spread between approximate ages 50 and 90 years. It is a weakness of the study, aiming as it does to prioritise participants' concerns and perspectives rather than mine, that this chronological age range had little significance for them: many did not know their birth year and some did not self-define as 'older'. Nevertheless, this sampling

frame meant that a wide variety of experiences and understandings of ageing could be elicited from a population that represents that which policy makers and much of the academy refer to when they talk about old age in Africa (WHO, 2001). Although approximations of chronological age are given alongside quotations reproduced in this chapter, participants' understandings of their age were used in the analysis.

Interviews presented here were carried out in Chiyao or Chichewa with the help of local research assistants between March 2009 and May 2010. Most participants were visited three or four times for audio-recorded interviews typically lasting one or two hours, although some were much longer. Analysis of these interviews was additionally informed by analysis of data from observations made during visits to participants' homes throughout fieldwork, group interviews with older adults with HIV in Balaka (N=3) and initial exploratory in-depth interviews with older adults (N=42) conducted between June and August 2008 in all three regions of Malawi.

The corporality of care in Balaka<1>

Balaka is one of the poorest regions of Malawi, one of the poorest countries in the world (UNDP, 2010). Almost 85 per cent of Malawians, and over 90 per cent of Malawians aged 50 and older, live in rural areas (NSO, 2008) as small-holder subsistence farmers (Chintsanya et al, 2010). Livelihoods in Balaka centre on self-sufficiency in maize production. They featured heavily in older adult's narratives about a wide range of issues, including care.

The dominance of livelihoods in research conversations reflects daily routines, but also high levels of food insecurity and widespread poverty. Along with their families, all participants experienced food shortages, at least during the annual 'hunger season'. Almost all older men and women continued to farm, some supplementing this with inconsistent and

modest earnings from the sale of cash crops of cotton and tobacco, reed mats they had woven or snacks they had made (older women only). Two older men variably ran businesses in the trading centre while their families farmed — a tea shop and an ‘electronics shop’ with a refrigerator selling cold drinks – although these were a no more reliable source of income.

There is little formal care provision in Malawi. Typically, when individuals lack the capacity for (mainly) agricultural self-sufficiency, temporarily or permanently, the family is called upon to provide care. As explored in this volume by De Klerk (Chapter Six) and Van der Geest (Chapter One) in Tanzania and Ghana, participants’ care-giving relationships were not innate, based on pre-determined roles, but continually evolving social processes formed and shaped through daily interactions. Their experiences and expectations of receiving care were situated within a complex web of support networks, based on a principle, if not practice, of reciprocity.

Care was discussed in the context of this socio-economic structure of subsistence agriculture and familial safety nets. In older adults’ narratives, care implies survival through providing for oneself (self-care) and for those less able to support themselves. It is exclusively discussed in terms of the provision, need and receipt of physical assistance rather than emotional support. The body is central to such care. In the absence of other opportunities for employment in this rural setting, for both younger and older adults the body’s capacity for physical labour – farm work, housework, or “bedwork” (marital sex) – is essential to be able to care for oneself and secure reciprocal care from others:

For your daily life, you have to work. You have to work for the life you are living. There is a saying which goes ‘he who does not work should not eat’.

[Lyness, male, 68]

The body's capacity for all types of work is determined by its fluids. All fluids (blood, sweat, ejaculate) contain a life force – a quality of 'being alive', translated as 'power' or 'strength'. This life force is strongest in the blood. Subsequently, participants typically referred to all bodily fluids and the body's power as 'blood'.

The lifecourse is understood to be a linear trajectory of diminishing blood (power/strength) until death. However physical labour requires a lot of strength so 'uses-up' an individual's broadly finite store of blood, hastening their decline. Support relationships involve the giving and receiving of blood. Bodies without sufficient strength cannot perform self-care, nor can they care for others. However, since care is reciprocal, as long as some of a body's blood has been used caring for others, in principle that individual can expect to receive care.

Although older adults called upon extended family, friends or community groups at times of crisis (for example bereavement, severe but short illness, theft of maize), adult children¹ and spouses were the most important exchange relations when longer-term, regular care in older age was needed. Van der Geest observes in Ghana "there may be some rules about who should care for the old, but that does not yet predict unambiguously who will actually do the caring" (Van der Geest, 2002a: 23). Similarly, while these relations did not necessarily provide care to participants, it was these relations - or the absence of them - that they referred to most often when discussing the management of current or expected age-related declines in ability to work. They prioritised these relations in research conversations because of the level of investment they had made in them — or could have made in them. This principle of care 'investments' — food provided, physical care given, money spent — played out daily and over years, has been described in many African settings (for example Cattell, 1990; Schatz and Ogunmefun, 2007; Hoffman, Chapter Seven; De Klerk, Chapter

Six; and Van der Geest, Chapter One). Here, investments were explicitly body-centred, tied to exchanges of blood.

For example, in participants' narratives conception, pregnancy and childbirth are presented as having used a substantial amount of a woman's finite blood (and in the giving of semen, a smaller quantity of a man's blood). Children are expected to 'repay' the strength contained within this blood by caring for their mothers in later life:

When I am careful with [maize] it takes me through the year. But if things are not well, it does not last me a year... I tell my children that my food is finished ... and the children assist me ... Because I know that they are the ones I shared my blood with. I tell them because there are no other people who can assist me apart from them. They understand because I am their mother, I gave birth to them and I suffered a lot for them.

[Lizzie, female, late 50s]

In participants' narratives, those who have not made sufficient investments cannot expect to receive support from their children in older age. Robertson's case highlights this well. Recently re-married, Robertson was living in his wife's village, a few miles from his first marital home. He saw little of his children, who had yet to visit him at his new home. He explained that although he might like to, he knew he could not complain about this and did not expect them to care for him in future because, having left their mother and them while they were young, he had not met the conditions of reciprocity:

No, the children I have... don't come to visit me here... No, when I go there to visit them they are happy, when I ask them why they are not visiting me here they say they will come, 'sometime'. I stop it there. I did my job, that's all ... I produced them [but didn't raise them] ... It would be different if I had paid lobola² – I would be worried

then because they would be living with me here [and receiving support] and if they would not support me then, I would be worried.

[Robertson, male, 80s]

Robertson wasn't concerned. He had his new wife, a strong and vibrant village head, should he need care in the future. Indeed, marriage is important for giving and receipt of non-intimate and intimate care. In contrast to caring in Tanzania discussed in this volume, this elder to-elder care was a well-established social norm, presented as the preferred option when older age care was needed by older men and women as well as their children (see Van Eeuwijk, Chapter Three). While unmarried or recently-married participants discussed the benefit of new partnerships for securing care in older age, it was longstanding spouses that were most prized, specifically because of the length of time over which bodily investments in the relationship – years of farming, cooking, sharing sexual fluids (see Freeman and Coast, 2014) – could be made. For example, Rhoda explained that her older husband's declining productivity was a result of having shared his blood with her and her co-wife and was quick to affirm her intention to reciprocate his care:

[My husband] is not working much as compared to those days when he was energetic... The time he was coming [to marry me] I had no kitchen but he constructed the kitchen, toilet and put up the fence. But nowadays he cannot manage to do that. He is unable to provide us with money. I understand the situation is that he is ageing... so I just say let us just be keeping each other.

[Rhoda, female, 56]

Both older men and women provided personal care for their spouses when it was needed. Some of this care, such as bathing, involved intimate contact with naked bodies. Participants' sexualised understandings of their bodies partly underpinned their universal

preference for spousal rather than child carers, and then gender-matched carers, regardless of investment made in relationships.

The corporality of identity<1>

The familial support system was rarely enacted as smoothly, deterministically, or reciprocally as this however. Children and spouses died, leaving older adults without support they expected to receive, as well as heartbroken. Relations contested investments made and support due. Children migrated and “forgot” their parents. Families argued and broke apart. Participants bemoaned adult children who through habit or laziness still relied on them for support. Given high levels of food scarcity and poverty, care was only given or expected from kin who could afford the resources or time to provide it, regardless of investments made. Moreover when those providing care discussed their motivation, love and familial bond was as important as any sense of investment or payback. But while the rhetoric of blood given and repaid did not always line up with the practicalities of everyday life, it is this body-centred understanding of care that underpinned its consequences for older adults’ identities.

For participants, the body’s ability to perform care – that it, to support oneself and others through the various practices outlined above (farm work, housework, personal care and so on) – demonstrated an individual’s status as an ‘adult’: a socially-valid person. As observed in other settings (Comaroff and Comaroff, 2001; Guillet, 1992; Cattell 2002), in the social and structural context of rural Balaka, an individual not only secures their and their dependants’ survival through performing care, they produce their entitlement to membership of the social world of ‘adults’. Those who are not able to perform care are excluded. These individuals, rarely young, were defined in opposition, as ‘children’. The production of the adult identity is therefore embodied in the act of care.

Here sociological theories of identity provide a useful analytical lens³. Role identity theory, the theory of Possible Selves (Markus and Nurius, 1986) and Identity Control theory (Burke, 2006) encourage us to consider *how* performing care and adulthood are linked for older adults and *why* identities are so important in shaping experiences of care. They inspire reflection on the ways participants maintained positive identities even as they described age-related changes that would challenge those identities, extending existing academic understandings of ageing and care.

According to role identity theory, people derive individual-level social identities from the roles they play within the social structure (for example, teacher, mother), based on the socially-constructed shared meanings and expectations associated with those roles and their performance (such as ‘knowledgeable’ for the teacher identity, ‘caring’ for the mother identity) (Burke and Tully, 1977). These role expectations form a set of ‘identity standards’ that guide behaviour. That is, “in order to be (some identity), one must act like (some identity)” (Burke and Reitzes, 1981: 90). This process is reciprocal. Individuals classify themselves as having a particular identity based on their behaviours, and behave in ways they believe reinforce and confirm that identity.

A role identity is arrived at when:

- an individual identifies with a socially-recognised role,
- others identify them as occupying that role,
- they achieve gratification by performing in that role, and
- the demands of a particular situation make enacting the role socially appropriate and appreciated (McCall and Simmons, 1966).

Having a particular identity involves coordinating and negotiating with individuals with related, complementary, or counter roles (for example, teacher-pupil, mother-child). It is only

during this interaction that an individual identifies with their role identity (Burke and Reitzes, 1981; Stets and Burke, 2000).

In participants' narratives, to have the role identity 'adult', one must act in ways that are interpreted by oneself and observers as being able to care for oneself (at least partially, in not being wholly dependent), and as being able to care for others (at least partially, in making some contribution towards others' well-being). Since physical labour – 'work' – is understood to be the only behaviour available through which to perform care, for participants, to be an adult an individual's behaviour must be recognisably work: working is the identity standard for the role identity of an adult. The performance of care through physical work therefore reflected and shaped participants' identities as 'adults'.

Participants drew on their interactions with others in the context of performing care to establish their adult role identities. In the following excerpt, Lyness refers to the reactions of those around him to confirm that his behaviour demonstrates his identity as an independent, contributing – caring – adult. He distances himself from the counter-role occupied by those "who don't work":

I am old and people respect me. Other people take me as an adult, not an old man, because I am working and have power... You know I am working ... This makes me have some money to support myself and my family. There are others who don't work but are staying at home... They may look older than me [because] they don't have proper care... Because I am working, my friends look at me as someone different. When they come to me, they know that they can ask for help.

[Lyness, male, 68]

Individuals have numerous positive identities, and rely on them at different times as a particular identity becomes relevant in a social situation (becomes ‘activated’) (Burke, 2006). Older men and women in Balaka presented themselves as occupying a range of identities: fathers, daughters, good Muslims, competent lovers, jokers. However, the ‘adult’ identity and the behaviours understood as standard for that identity (bodily capacity and production) dominated research conversations about ageing. Of all participants’ identities, the ‘adult’ identity formed a central, salient identity in our conversations, activated by talking about needing and receiving care.

Threat to the adult identity presented by needing and receiving care in old age<1>

Through decreasing blood, ageing was understood to undermine an individual’s ability to care for themselves or others. At its culmination, this inability produced dependent behaviour that, for participants, was incompatible with the adult identity. The ‘childlike’ old become “useless”:

The aged walk like children, senseless things. Yes, they don’t take care of themselves and we take care of them. To say let us take care of the aged, because she is now useless. So we fetch some water for her to bathe. Cook the food and give to her so she doesn’t get worried ... [At that stage] there are a lot of problems you face: you crawl and at times you are pushed by children, because you are useless.

[Ethel, female, late 80s/early 90s]

Throughout this volume the gradual decline in bodily strength (De Klerk, Chapter Six) and ability to work (Obrist, Chapter Four) are presented as key experiences of ageing. The following interview extract and field note highlight the process of non-adult identity formation associated with these experiences. Wyson’s mental and physical health had

declined. Aged around 85, he lived with his sister, her husband and children. He presents his behaviour in ways that mirror their observations, highlighting how his inability to care for himself through farm- or housework removes him from the social world of adults (“men”).

On this first visit to his home we were greeted by his sister. We explained we had come to visit Wyson to talk with him about our research. She seemed amused that we thought we would learn from him and warned us that he was “just like a child”. Other members of the household came over to talk to us. His 48 year-old nephew was concerned for our research, telling us we would learn more by speaking to another member of the household. I am sure that Wyson, sitting close-by, could hear this conversation.

Interview

I So at first you should please tell more about yourself

P My family ended some time back. And at this time I have nothing to do with marriage. Currently it is my sister and my in-law who are taking care of me

I So what do you do here at home?

P ... I do nothing. I stopped my hands. I can't do any task

I OK. So in this community, do they use you as a very old person to perform some duties?

P I do nothing.

Participant's sister (S), calling across the compound: He does nothing!

P I just stay

I Mmm

S I am just feeding him!

I [To S:] Would you please allow that all the questions should be answered by your brother?

S OK

I Do you farm?

P No I don't cultivate, I stopped

I Do you do any business?

P Nothing. Aah I just stay idle

I May be cooking when your sister is not here?

P No I can't.

I OK. Do you take yourself as an old person?

P I am an old person no doubt about that

I OK. Thank you grandfather. So since that time you were born, up to this time, what has changed on this earth, in the world, but also in your life?

P ...What has changed is that I am not able to do things. I am not a man enough.

On hearing his family's description of him prior to the interview, Wyson immediately directs the conversation to his inability to work, evaluating his behaviour as falling short of the identity standard for an adult - "a man". He returned to his physical ability and inability regularly in subsequent conversations, reflecting the salience of these corporeal changes and their meanings to his identity.

For participants, autonomy and ownership were the domains of the adult. They understood inability to care for oneself in old age to undermine these basic privileges. They

frequently commented on the powerlessness of the very old who “just stay” awaiting care.

Wyson’s loss of agency characterised his experience of receiving care from his sister:

There is a difference. This time there are rules. Those days I was the one making rules, [but now] I cannot, it is not my house. There is no way you can order them to give you water to bathe.

Other participants simply feared this experience:

[Getting older] is not good because you become a child, when a person is old they just wait to be fed, people to do things for them. Eeh, it is a bad thing, because you become a child, and the things you used to do when you were young, you cannot do them because you do not have the strength... it will be painful ... because a person can do something for you which you didn't want, in so doing you start remembering what you used to do in the past while you were strong.

[Ethel, female, late 80s/early 90s]

Ability to perform care and avoid childlike dependence is universally referenced in participants’ descriptions of a good or a bad old age.

A good old age, I do put it at the stage, where one is still able to do some work, not just being kept in the house, that kind of old age is not good... We had a certain old man, he just died recently. He couldn't walk out of the house by himself, he couldn't do things on his own. His grandchildren would pick him [up] to go outside to have the sun, he could be crying. So when we saw that the old man, [we thought] that old age is too much. He was not eating by himself because he was just like a child. He was just like a child, he could even fear a goat, when it is [only] a goat!

[Alick, male, early 50s]

More intensive physical care needed by older adults who cannot care for themselves tests the strength of reciprocal support. Participants expected that carers in this situation would be more likely to demonstrate feeling burdened by providing inadequate care:

I Have you ever seen somebody very old who was being taken care of?

P Yes, my grandmother

I How old was she?

P I don't know... but she reached a point that when she has slept she could not wake up alone

I How was she taken care of?

P She could be carried from the house to the veranda, cooking for her

I Bathing her?

P Yes, and washing her clothes

I The time these people were helping our grandmother, were they happy or not?

P They could complain because they were troubled

I What were they saying?

P ...Sometimes you can tell because of how the people are behaving. Let's say the time she wants something, you found that there was no one to provide that thing

[Susan, female, mid-60s]

Exceeded investments for intimate and non-intimate care are most likely when the only carer available is from outside the immediate family. Although a number of participants spoke with tenderness about having given care to friends (for example, one participant talked of caring for her best friend before she died of AIDS, another of how, as a younger man, he

had provided intimate care for his former employer, whom he continued to respect) they rarely ground narratives about receiving care in their own experiences as caregivers. As Obrist observes (Chapter Four), participants instead reported that prolonged dependency on those outside the family would become socially unacceptable:

There is an age where a person can be respected, even though they are old. Mainly that will happen when they have children who can support them. Even if they become very old, they will have the support they need. But if you don't have children to support you, and you depend on other people to help you, you don't get respected.

[Fiskani, male, 61]

Nevertheless, while exceeded reciprocity was more likely with non-familial carers, for some participants, reliance on children presented an equally grave threat to adulthood. In South Africa Hoffman describes how older adults provide care for their children regardless of context (Chapter Seven). Similarly in Balaka, older adults reported that younger generations should always take precedence over their parents. For them, a good parent – and a provident adult – first cares for their children, enabling them to “develop”, and when they can no longer do so, takes less blood from their children than they have given to them. Demanding intensive care from children was understood to prevent them from working to improve their own lives and was incompatible with the behaviour held within the adult identity standard.

Of all the behaviours compromised by the ageing body, it is incontinence and inability to provide intimate personal care for oneself that presented the greatest threat to the adult identity. That receipt of intimate care can undermine an individual's respect (Van der Geest, 2002b) and status as a complete social being (Luborsky, 1994; Schröder-Butterfill and Fithry, 2014) has been observed in a wide range of settings. In the UK, Julia Twigg has observed how personal care “marks the boundary of the wholly personal and individual in modern life.

Having to receive help in such areas transgresses social boundaries and undermines one's status as an adult. These things are normally only done for babies" (Twigg, 2006: 122).

In participants' narratives the meanings assigned to the receipt of intimate care are not compatible with the identity standard of the adult. Need for such care is evidence of lacking the lowest level of self-sufficiency. It requires a level of support transfers that go beyond those covered by the covenant of reciprocity: at this stage, blood received will certainly be greater than the blood given throughout the life course.

The childlike 'possible self' <1>

While some participants were in good health and produced food and resources that supported themselves and dependants, others struggled with limited eye sight, poor mobility and *nyamakazi* [rheumatism neuralgia or sciatica, understood to be caused by blood drying], and were more frequently the recipients than providers of care. However, these participants presented their experiences inconsistently. The following extracts are from a single conversation with Rhoda. Here, as across a further three interviews, her narrative oscillates between losing physical strength and continued ability to work:

P Sometimes I have malaria, plus nyamakazi which prevents me from weaving mats. But it affects me more early in the morning

I What have you been doing during this week?

P I was doing some housework, like sweeping on the ground, cooking relish, nsima, taking water from the borehole.

[...]

I What has changed in your life over the last 20 years?

P My body. The changes which I have seen are that I am failing to do hard work, and when I force myself to do it I become sick... I am failing to do the work... It pains me much.

[...]

I How do you feel about getting older?

P I feel good about getting older with my husband, because we work together in our works... I am looking forward to it because I take care of myself and my husband

[...]

P Paining headache, I fail to work most of the times because of that problem.

[...]

I So what do you think is the best time of life for a person?

P It's when you are a girl or when you have 2 children. Because you have full blood in your body.

[Rhoda, female, 56]

Rhoda's narrative is common. At some point during conversations all participants reported working. This was essential for securing their survival, even when care was available. However, their narratives can also be understood to reflect their active negotiation of the challenges to their adult identities they experienced or expected from their ageing bodies.

Despite universal understanding of the inevitability of bodily decline and dependency in old age among participants, no participants identified with the 'child' identity counter-role; even Wyson was not consistent in reports he was "finished". Instead it presented for all

participants a ‘possible self’ (Markus and Nurius, 1986): an identity they may have in the future when the meanings of their behaviour cannot be aligned with those held in the ‘adult’ identity standard.

Although only a few participants had seen childlike old people first hand, all feared this future for themselves. Fear of this possible self was fear of losing oneself; passing beyond what it meant to be ‘them’:

In the future I will not be same person. I will not be able to do the things I am doing now. Time will elapse. By that I mean I will be very old man.

[Rabson, male, 75, (emphasis added)]

This period of incapacity in old age has been usefully conceptualised for Western ageing experiences as a ‘black hole’, exerting a gravitational pull on those too close to this life phase (Gilleard and Higgs, 2010: 125). The metaphor certainly accords with participants’ interview narratives in which they appeared to consistently ‘pull back’ from reporting need for care.

According to the theory of possible selves, individuals are motivated to avoid negative future identities and pursue positive future identities. Possible selves thereby become incentives that guide behaviours, thoughts and strategies (Markus and Nurius, 1986). Older adults in this study were motivated to maintain their adult identities and avoid the ‘black hole’ of the childlike possible self.

They employed two discursive strategies to do this. In the first, participants focused discussion on their continued ability to care for themselves and their families. In the second, they encouraged us to view them over their lifecourse, emphasising their past productivity. The strategies accord with Identity Control Theory (Burke, 2006). It posits that individuals manage their identities in response to threats by first aligning their behaviours with those in

the desired identity standard, then over time, shifting the meanings of the behaviours held in the identity standard so that they accord with their current behaviour.

Continuing to care for oneself<2>

Participants distanced their behaviours from those associated with their childlike possible self. Those not experiencing any significant age-related changes in their bodies did this by stressing their continued – or even increased – physical productivity. Highlighting their success in securing resources, they presented themselves as able to care for themselves and their families.

In this excerpt, Rabson singles out increasing work, wealth and providence as characteristic of his ageing experience. His older age is a period of “growth”, contrasting the period of decline he associates with others’ ageing elsewhere in the interview:

I Now, what do you think has changed in your life in the last 20 years?

P Ah nothing ... I haven't noticed the changes yet ... I feel I am fine at the moment because I am able to work without any problems ... [There is] no difference, and I can say I am feeling better now than before. Very much. You can see all these [points to his cotton garden and maize store]. I have done myself with my hands. I have also grown potatoes, pigeon peas... I am enjoying my growth... Even if the alangizi [Agricultural Advisor] comes today he would recommend my work in my fields. To me good life means being able to cultivate, children not lacking essential things. I thank God for that.

[Rabson, male, 75]

Other participants were experiencing age-related declines in strength that made highly physical work more difficult. Nevertheless, they emphasised the continuation of their adult-

compatible behaviours, distinguishing their “prime” old age from the childlike “very old” age, using a number of rhetorical strategies. Some stressed that they now worked harder to compensate for reduced strength:

Aaa! I do the work while feeling pain. When I am able to move around I force myself to work...I am able to do my household chores. I also go to the garden and cultivate. For the waist and the eye, they have just started hurting... the arm pains a lot.

[Loveness, female, late 70s]

Some qualified their reports of receiving care from their children with reports of the care they offered in return:

Mainly it's when a person is very old that they would need someone to help them, but it should not be in everything ... I am at the prime old person, I have not reached to be very old ... My family benefit from me in many ways. One, they are happy they have a father and they do get support from me. Two, we do assist each other on the work which we undertake in this compound, [because] I act as the foreman.

[Fiskani, male, 61]

Others stressed that although they could no longer perform some tasks, they continued to contribute to their self-care and household by performing other types of work:

[Since last week] I have met the same problem of failing to walk, pain this side [pointing at his waist] ... additional pain is from here [pointing at his chest] ... I have worked a little. I was working while seated ... I had some reeds for weaving and I was just processing them.

[Charles, male, around 70]

Each of these narratives allowed participants to present themselves as people who, despite declining blood, are not unproductive, entirely dependent or unable to make any contribution to the care of others. In doing so, they managed the interviewer's and their own perceptions of their behaviour, realigning the meanings of their behaviour with those held in the standard for the adult identity.

Emphasising past productivity<2>

Other participants distanced themselves from the possible self by presenting current dependent behaviour within discussion of 'usual' behaviour – that seen over a lifetime. Declines in strength and work were reported with reference to past self-reliance, productivity and care for dependants. Since the capital of a body is its ability to produce, in these narratives, the older body becomes a capital store, able to trade on past productivity. In the following example, Polly normalises her ageing experiences by focusing on care she has given. In doing so she presents the type of person she is: her underlying adult identity.

I You have talked about loss of strength in your body. How does that affect your life?

P I know it's because I am an old person... I used to carry a big bundle of firewood but nowadays I can't carry it, if I dare then I would feel pain in the head, neck, back, legs. Or cultivating, I can't do as I used to. In the past I was cultivating a large area before getting tired... I am not worried because I know I have stayed on this world for a long time. [...] I am used to it now... every period has its own activities. I carry the bundle which I know I will manage... It can't be possible to go back and be a girl again. I was very powerful but I have shared it [her blood/power] with other people so I cannot be worried.

In these narratives past productivity – care – represents the ‘real’ person. Ageing is something that happens to the body, leaving the adult ‘inside’ unchanged – akin to the ‘ageing as a mask’ theories of Western gerontology (Featherstone and Hepworth, 1989). Receiving care in old age – that is, needing care and having care available – is a reflection of high past productivity, rather than a reflection of low present productivity. An individual is only without blood in old age *because* they have ‘used up’ so much of their finite store working hard. They had care available because they had cared for others. The adult identity is un-embodied as participants invite the interviewer to judge them on their past body-centred behaviour to indicate the type of person they are now. The meanings of the behaviour held in the adult identity standard are altered: to be an adult, one can have given everything. The strategy allowed older men and women to position care they needed or received as evidence of the vitality and strength they had invested in their relationships: they required care in later life *because* they were ‘adults’.

Conclusion<1>

This chapter highlights patterns in how older adults in rural Malawi made sense of receiving or not receiving care from their families in a series of conversations about ageing. In their narratives, the national and international construction of an ‘African family’ in which older adults become dependants that are (or at least were) cared for automatically appears to have little salience. Participants instead presented expectations of care in older age that were heavily dependent on notions of self-sufficiency and reciprocity, grounded in rural subsistence livelihoods.

The political assumption that older adults want care from their families doesn't accord with the more nuanced experiences of the older men and women in this study. Desire for familial care to be available was tempered by desire to not need it. Inability to care for oneself was universally referenced as a bad old age. Participants' discussions centred on care as an embodied practice. As those by Obrist (Chapter Four) and De Klerk (Chapter Six), this chapter illustrates how incorporating the body and its meanings into the study of older age care in Africa can increase our understanding of how ageing and care are actually experienced. In Balaka, changing bodies had implications not only for older adults' activities and spaces, but for the self. For participants, inability to care presented a 'possible self' (Markus and Nurius, 1986) they resisted through identity work. Participants embarked on several discursive processes to reconcile receiving care with feeling that they were still 'adults' – participating members of the social world.

Extending consideration of older age care in Africa beyond questions of who receives care and how care is negotiated to questions of how giving and receiving care makes people feel, can enrich the political and academic conversation. Incorporating existing theories of identity into this discussion can lead to fuller understandings of older adults' experiences or expectations of care.

¹ Understood to include biological children and grandchildren, nieces, nephews and others if cared for when young.

² 'Bride price' paid to a wife's family. While common in the patrilineal north of Malawi it is not much practiced in the matrilineal south. Had Robertson paid labola in Balaka, where children belong to their mother's family, he would have 'owned' the children, so that on separation with their mother, they would have left with him and received his care daily.

³ Elsewhere I have also used social psychological approaches to understanding the self to explore how older adults in Balaka based their identities on membership of the social group of 'adults'.

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