Not a Nurse, Not Househelp: The New Occupation of Elder Carer in Urban Ghana

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Not a Nurse, Not Househelp:
The New Occupation of Elder Carer in Urban Ghana

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As Ghana goes through a demographic transition, in which people are living longer and with long-term, chronic diseases (de-Graft Aikins et al 2012), families are experiencing a growing strain in caring for their elderly and frail members. Reciprocities across the generations are changing (Aboderin 2006, Apt 1996, Dsane 2013). There is a growing demand for elder care providers to supplement the direct care of kin busy with work and school in Ghana and abroad. Middle-class households in urban and peri-urban areas tend to use the labor of househelp and fostered adolescents for this purpose, while wealthier households and middle-class urban households with access to migrant remittances increasingly turn to carers hired through commercial nursing agencies, who supplement the work of househelp and fostered adolescents and work alongside them in households. Thus, changes in ageing in Ghana have generated a new, emergent occupation: the elder carer. Although the occupation is modeled after its counterpart in the United Kingdom and other Western countries, I argue that it is understood in relation and opposition to recognized social roles in Ghana, in particular those of daughter, househelp, and nurse.

Changes in household work often reflect wider social changes. In particular, because household work instantiates the inequality that exists in particular societies (Rollins 1990), changes in social inequality are reflected in changes in domestic labor. An expansion of wealth or the growth of a wealthy class brings new kinds of servants and new varieties of domestic services (Colen and Sanjek 1990, Sassen 1998). In the United States, with increasing income inequality, the growth of commercial elder care services in the past two decades has enabled a re-flourishing of gendered,
racial, colonial, and class hierarchies (Glenn 2010, 1992). In urban Ghana, with a more prosperous middle class after years of strong economic growth (Lopes 2015), and with remittances flowing from established migrants abroad (Orozco et al 2005), the new role of carer is a sign of emergent forms of social inequality. Social changes in ageing are thus not only resulting in changing intergenerational reciprocities between parents and their children but also creating new hierarchical relations within households. These new hierarchies build on and reconfigure previous hierarchical domestic relations between kin, fictive kin, and non-kin.

Based on ethnographic research and interviews with carers, clients, and nursing agency owners and staff, this paper examines how the young women and men who work in this new occupation are confused with their adjacent roles—namely, nurses and househelp. These confusions with adjacent roles have repercussions on carers’ status, pay, and treatment in households. As a result, I argue, carers attempt to navigate their status in relation to the adjacent roles: they position themselves as professionals like nurses against the category of househelp through wearing uniforms, sharing biomedical and scientific knowledge, and showcasing their educated status. However, these forms of cultural capital are not always recognized or valued by elderly clients and other household members, including househelp themselves and kin of the client. This paper, by examining a new kind of care worker, explores how new configurations of inequality emerge for young people, within the context of an ageing population and changing intergenerational reciprocities.

The Significance of Adjacent Relationships and Cultural Capital in a New Occupation

In earlier work (Coe 2013a, 2012), I discussed the significance of adjacent or contiguous relationships in a social field, in allowing people to change the obligations of relationships in contested situations. In that work, I was particularly interested in how child slavery, child pawning, and fosterage were adjacent relationships in the southeastern Gold Coast in the late nineteenth and
early twentieth centuries. Each role was associated with a different status and set of rights in the household economy, but they were similar enough in some of their tasks and norms that participants could define a particular situation differently; they could elide the differences in these relationships. My thinking about adjacent relationships owes much to the work on adoption by Melissa Demian (2004) who insists that “it is frequently difficult to single out an ‘institution’ because it often emerges from shifts in other, disparate relationships” (p. 100). Here, I want to use the concept of adjacent relationships to understand how a new occupation, like carer, is understood in light of other occupations or roles and is built out of those understandings of other relations, through opposition and similarity simultaneously.

One concept critical to thinking about the status of various roles and positions in a situation of inequality is that of cultural capital, developed by Pierre Bourdieu. After reviewing the range of meanings of cultural capital in Bourdieu’s work, Michele Lamont and Annette Lareau (1988) define it as high-status cultural resources that affect a person’s inclusion or exclusion from high-status positions, including the ability to garner economic resources. Bourdieu (1977) developed the concept of cultural capital through his work among the Kabyle in Algeria, and, later (Bourdieu 1989, 1996), turned to how cultural capital functions in the intergenerational transmission of social class, particularly in France, arguing that the domestic transfer of cultural capital through a family in the dominant class shapes the bodily performances and personal inclinations—the *habitus*—of its young members (1996, p. 273). Cultural capital is key to the intergenerational transmission of prestige and status within an unequal society.

Yet some social theorists have argued that cultural capital is more fluid, even in Bourdieu’s analysis, than is suggested by its use in explaining the reproduction of prestige across the generations. John R. Hall (1992), in his critique of cultural capital, argues that “cultural capital is good only (if at all) in the social worlds where a person lives and acts, and the value that it has
depends on sometimes ephemeral distinctions of currency in those particular social worlds” (p. 275).

Different people define what qualifies as cultural capital variously and thus how much economic and social value to place on a particular skill, connection, or experience. Furthermore, similar kinds of cultural capital may be valued differently in diverse social fields or markets, such as education, employment, and marriage (Brown 1985). These differences are themselves subject to social tension and conflict, as different groups seek to convince others to recognize what they value. Mikkel Rytter (2011) notes that Bourdieu recognizes that “the rate of exchange between the different forms of valid capital is the result of an ongoing symbolic struggle between more- or less-powerful actors in the social field” (p. 207). These issues are critical to understanding the status and roles of a new occupation and its positioning in a hierarchical social field of differently-valued occupations.

Academic qualifications are an effort to institutionalize the conversion rates between cultural capital and economic capital and thus reduce the diversity of interpretations about the value of a particular qualification (Bourdieu 1986). Professional organizations, such as doctors’ and nurses’ associations, can also establish the conversion rate of a credential, by maintaining that only people with certain credentials are qualified to assume particular roles in institutions under their authority. However, such power is always under contestation. Having one’s cultural capital not recognized is a real possibility (this is discussed in greater depth in Coe and Shani 2015). In their work on education in France, Pierre Bourdieu and Jean-Claude Passeron (1990) discussed how the entry of low-status persons into an occupational field may result in a decrease in that occupation’s prestige, rather than an increase in those persons’ status as a result of entry into that field. The fact that cultural capital may not be recognized or that broader access to a prestigious occupation may decrease the prestige of that occupation means that investments in certain kinds of skills, educational experiences and credentials are risky. Thus, cultural capital is very much in play and under negotiation by parties with different conceptions of what is worthy and what is of value.
The new occupation of the carer is emerging at a time in Ghana when norms of cultural capital are shifting and multiple occupations are undergoing changes in their prestige levels, due to changes in education, economic trends, and migration. Although “household work always operates in situations of inequality, and . . . through household work the multiple axes of inequality dividing household workers and employers intensify and harden” (Colen and Sanjek 1990, 10), those axes of inequality are constantly being negotiated and contested in everyday life (Adams and Dickey 2000). The position of carer provides an opportunity for young people with a “carer” credential to raise their status in the eyes of other household workers, the client and the client’s relatives, and the carer’s own family, friends, and neighbors. This article explores how their cultural capital is deployed by carers and the nursing agencies as a claim to be not househelp, but rather a nurse, and how such claims are interpreted by clients and other members of clients’ households.

Understanding the Role of Carers in Urban Ghana: Methodology

This paper is based on fieldwork in July 2013, June-August 2014, and May-July 2015, about twenty weeks in duration over three years. During this period, I interviewed seven owners of commercial nursing agencies which employ carers, three of the nurse managers at these agencies who directly supervise the carers, ten elderly clients or the relatives of clients, and sixteen carers, most of whom were employed by these agencies but two of whom I met independently of the agencies. I also visited twelve client households briefly, accompanying the nurse manager or owner on their visits to supervise the carer or assess the client’s home for the first time. I also attended two weeks of classes and three days of final exams at one school for carers run by a nursing agency, and attended a morning class at another school. Particularly on the exam days, I was able to chat with teachers and students at a range of different nursing schools in the northern suburbs of Accra.
Finally, I interviewed the head of the National Vocational and Training Institute and a deputy at the Nurses and Midwives’ Council about the course for carers.

Home nursing care provided by commercial agencies is a change in the elder-care landscape in Accra. It is a small phenomenon in terms of prevalence, but interesting because it reflects a widespread sense that families are struggling to take care of their elderly. The agencies represent a growing commercialization of care, an amplification of the far more common, quasi-commercial arrangements of househelp that have emerged under the aegis of kin fosterage. As a result of commodification, the role of kin—particularly adult female children—changes, from being direct providers of daily care, to being the financial sponsors and self-appointed supervisors of those remunerated others who help the elderly get through their day.

It is possible that the six nursing agencies still in operation whose owners I interviewed represent all the nursing agencies currently providing services in Accra. At least, I have not been able to discover any others, although a few may not publicly advertise and rely solely on individual referrals and recommendations.¹ Five are run by women in their fifties or sixties, and the sixth is run by a male nurse; the seventh which went out of business was owned by three brothers. Some agencies are fragile and short-lived; for example, four which started in the late 1990s went out of business quickly. Others have figured out how to combine a profitable school for carers and an agency to survive; still others drop the strenuous demands of training their own employees and hire carers trained by other agencies.

The oldest of the six agencies started in 1997, the latest in 2012 (see Table 1). The smallest served six clients in June 2015 and did not think it had the capacity to expand beyond ten clients at

¹ These six were the ones mentioned to me in interviews and conversations with owners of nursing agencies and friends in Accra who had explored private nursing care for their relatives.
any one time; the largest and oldest served 45-60 clients. The six existing agencies served a mean of nineteen to twenty clients, mainly in the greater Accra-Tema metropolitan area, but were also receiving requests from other cities and large towns like Begoro, Cape Coast, Nkawkaw, and Sunyani. The small number of nursing agencies operating in Accra and the small number of clients they serve may suggest that the phenomenon of private nursing services is marginal or not relevant to elder care in Ghana. In my view, however, this new industry provides a window onto broader social conflicts and changes in Ghana, including both class and intergenerational dynamics. Although potential clients cannot always afford the services, there is great interest in them, speaking to the difficulties people are encountering in caring for their aged relations. Furthermore, given youth unemployment and under-employment in Ghana (Baffour-Awuah 2013), young people are looking for a way to make a living, and one way to do so is by providing services to middle-class and wealthy families.

The carers are mainly young women in their twenties, with a secondary school diploma, although a few young men also work in this field. Many of the carers lived in or grew up in Accra prior to entering this field, although they tend to live in the poorer sections of Nima, Teshie and La Paz or the outskirts of Accra. When they have children, many drop out of the profession, as they find it difficult to continue to care for their children and work simultaneously. The agencies vary in how much they charge clients and how much supervision they provide, but in all cases, they take a large cut and carers’ pay is severely reduced by the cost of transportation.

Private nursing services constitute a luxury commodity. The clients are either wealthy themselves or have a child abroad. Some clients are return migrants, who returned to Ghana from

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2 At the most, the number of clients served by the agencies at any one time was approximately 145 people, out of a total population of just less than 127,000 people older than age sixty-five in urban areas in the Greater Accra region (Ghana Statistical Service 2012).
abroad when they became sick, injured, or frail, because greater kin support and cheaper care services were available in Ghana. Clients' households tend to be concentrated in the wealthy neighborhoods of Accra and Tema: Dzorwulu, Ringway Estates, Tesano, East Legon, and Labone. Most elderly people in Ghana do not have a paid carer, and most will never enter an old age home, but many find the thought of both attractive and worth exploring (Coe 2015, Van der Geest forthcoming), and if they had the financial resources, more households might well turn to them. India has experienced rapid growth in the provision of elder care services like old age homes (Lamb 2009), and while it is tempting to project future growth in this field in Ghana, following the case of India, I do not think it wise. Rather, I treat the growth of home nursing agencies and the occupation of carers as an experiment, as one response to what people perceive as a “crisis of old age” in Ghana. It is a response that brings young people into unfamiliar, upper-class households in a new role, as carer.

Not a Nurse: A Credential's Lack of Cultural Capital

There has been an explosion of private nursing schools in Accra and other urban areas over the past decade. Two different health assistant certificates—the Health Assistant Training or HAT supervised by the National Vocational and Training Institute (NVTI) for carers and the Health Assistant Clinical or HAC supervised by the Nurses and Midwives Council—exist. Both are available as a one-year and two-year course (certificates 1 and 2). To enter these courses offered by the two different associations, students have to have completed secondary school. About a hundred schools in Ghana, mainly in Accra, offer the HAT through NVTI, which has offered this certificate since 2003. The general public and students alike experience confusion between the two certificates, as one would expect given the similarity of their acronyms, and the kinds of employment these certificates enable. The reason why there are two different certificates is that the Nurses and
Midwives’ Council refused to oversee the training for home carers (around 2002) and wanted to keep the distinction between nurses and healthcare assistants very clear. HACs may be employed as assistants to registered nurses in public hospitals; HATs trained by private schools under NVTI are only eligible to be employed as ward assistants in private hospitals, a job previously available to men and women with low or no education. As a result of the confusion between HAC and HAT, the manager of a school which offers the HAT called students “victims of circumstance.” The owner of a nursing agency said that the students at the private schools want to “show off” and are “excited to work in hospitals.” However, “they are being deceived because there is no work for them.” Most HAT graduates would rather work in a hospital than in home care. The nursing agencies do hire HATs, although some owners prefer to hire those without the credential to train them the way they would like.

Many of those pursuing the HAC or HAT ultimately want to be nurses who work in a hospital. However, in order to enter nursing school, neither the HAT nor HAC are helpful; instead, students need to have a high enough score in six key and elective subjects on the secondary-school examination (WASSCE) to be admitted to a nursing program. As in the United States (Ducey 2009), the training of lower-level healthcare workers does not count towards further education for more high-status professions of nurses and doctors; their year or two of healthcare assistant training counts for nothing towards nursing school. Instead, nursing students—even those with previous healthcare training or experience—have to start over at the beginning, which in the case of Ghana, means improving their results on the secondary school examination and enrolling in a registered nursing program. Students who want to pursue nursing would be better off re-sitting the relevant portions of the WASSCE than enrolling in a HAC or HAT educational program. But many students only become aware of these issues once they have already enrolled in a HAC or HAT course,
thinking that they will be trained as nurses through this program. The director of NVTI said that students see “care as a stepping stone to nursing. It is not.”

I spent two weeks observing the lessons of a HAT certificate 1 class in one of the private nursing schools attached to a home nursing agency. I also accompanied the fifteen students for the two days of written examination and one day of practical examination. The students in this class mainly wanted to be nurses and work in a hospital, rather than in home care. They had done two weeks of clinical training in a hospital in addition to two weeks of home care. The syllabus and the examination for HAT 1 emphasized hospital care, rather than home care. Questions on the examination were oriented towards general healthcare—like malaria prevention and maternity care—rather than the care of the elderly. In general, then, the course oriented the students as if they would be nurses working in a hospital, with the status and authority of that role, rather than working in home care assisting the elderly.

The students in my class were enamored with their hospital clinical. They felt that a hospital offered more opportunities to learn—such as to insert IVs or ride in an ambulance—and a greater variety of cases. They were eager to expand their knowledge. One student told me that during her clinical in a private hospital, she was told to give an injection by a nurse, and she did it, without instruction. She had watched the nurse do it, so she thought she could (on the significance of imitation in education in Ghana, see Coe 2005). She also dressed wounds that were much worse than those she had dressed at home while caring for her mother. The owner of the school observed that the students want to work in the hospitals, because they like their freedom, do not want to work hard, and do not want a boss or supervision. Supporting the owner’s point, another student said she wanted to work in a hospital because they close at two in the afternoon, whereas in home care, one works much longer hours.
As they reached the completion of their year-long training, the students were beginning to realize the limited employment opportunities available to them. After they had completed their written examination, as they were studying for the practical portion of the examination, the students began to discuss their futures:

Florence said anxiously, “Mibia [I need the] certificate.”

Bella said, “I don’t want to resit [the certificate if she fails].” Bella said she would not go on to do the certificate 2; rather, she will re-sit the WASSCE and do general nursing. She explained why: “Carer nyƐ effective uƐ Ghana ba. WọbƐbrƐ saa ara. Ghana nye [Being a carer is not effective in Ghana. You will be so tired (in doing the work). Ghana is not good (in terms of remuneration for employment)].” In Aburokyiri [abroad], on the other hand, she felt it was okay to do carer work, because you would be better paid.

Millicent said that with a certificate 2 [HAT], the hospitals will take you, like Nyaho [a private hospital]. Another student is doing her attachment at Nyaho, she said.

Bella said, “They call them health assistants [meaning, they are not nurses]. The best thing if you get the chance is to be a community health nurse or a general nurse.”

They then discussed the respective pay of a community health nurse and general nurse.

On another day, a student looked up the word “carer” in a nursing dictionary bought for the course. She read aloud to the others, “Carer: A non-professional” and commented, “It’s a pity-o.” As they approached the end of the course and their exams, they realized that their credential had little cultural capital: their best option was as a ward assistant at a private hospital, or in a government hospital outside Accra. Thus, for insiders to the field of healthcare, the credential of HAT carries
very little cultural capital at all, even though outsiders consider it impressive as a “nursing credential” and the school they have attended is a “nursing school.”

Ironically, some home nursing agencies do not consider the HAT and HAC to be useful for home care. They may accept someone with that credential, because it helps convince clients and their relatives that their carers are “nurses.” However, they consider other qualities above and beyond the credential to be more significant to the quality of care a carer will provide, such as “a warm heart,” in the words of one agency owner. The HAT and HAC credentials therefore have little cultural capital in both hospital and home-based care, although many with that credential turn to home care when they cannot find work in a hospital.

Those working as carers were generally perceived by their friends and neighbors as being nurses. Some hid their actual profession as a home care worker out of shame; others did not. One middle-aged woman working as a carer did not tell her friends and neighbors the exact work she was doing, and she said that they think she works at a polyclinic. Another young woman working as a carer said that people around her think she is a nurse, because of her uniform. They turn to her as a medical expert, asking her about what they should do for headaches, for example. She has not bothered to explain her occupation to them. In both cases, immediate family know the actual work of these carers. A third carer said about her father and friends: “They see you as a nurse.” The uniforms help in this regard, which they wear as they come back and forth from work.

Househelp and Fostered Adolescents as Elder Caregivers

Discourses about the crisis in old age, as noted above, posit that modes of family caregiving are breaking down. The growth in nursing agencies suggests that as a result of that breakdown, daughters and wives are being replaced by carers, the employees of the nursing agencies: mainly young women, paid by the hour or day, non-kin, and somewhat trained in biomedicine. However, I
want to trouble this narrative a little, by positing another development that eases the transition between family care and trained nursing care, a quasi-commodification of caregiving that occurs in the transformation of extended kin and non-kin fosterage into domestic service.

In my research with the nursing agencies, carers supplement or replace care not only of daughters, wives, and younger sisters, but also that of more distant relatives, domestic servants, and househelp. Although the care of a daughter, wife, or sister is idealized, her care has long been supplemented by adolescents fostered in the household, women hired informally, and more distant relatives. Generally female, the fostered adolescents are kin who have been taken into the household and are providing domestic service, in exchange for some promised support in the future such as apprenticeship into a trade like sewing and hairdressing or current support for school fees (Goody 1982, Sanjek 1990). Fosterage relationships have themselves been becoming more commercialized, particularly in urban areas. From the 1960s onwards in Accra, non-kin or more distant kin have replaced nieces and nephews as foster children and have been treated more like domestic servants, sleeping and eating separately from children of the household and more liable to be exploited or abused than kin foster children (Ardayfio-Schandorf and Amissah 1996, Oppong 1974; for a discussion of a similar process in Benin and Cameroon respectively, see Alber 2013 and Argenti 2010). Furthermore, with the expansion of free education in Ghana, it has become more expected for all children to continue their schooling, making children less available to foster. The age of domestic servants has therefore risen to late adolescence (16+ years, after the completion of the basic nine years of schooling) and young adult women in their early twenties. These older domestic servants expect more, particularly in requesting monthly pay rather than a bulk reward like a sewing machine at the end of their service. I met a number of young women from Akropong in the Eastern Region who had worked as domestic servants in Accra and Cape Coast while they were in their late teens and early twenties, for distant kin and non-kin. Although domestic service was previously seen
as a stage in the life course appropriate for childhood and adolescence, women at different stages of
the lifecourse are now entering domestic service and, for a few, it may become a career, signaling a
hardening of class divisions in contemporary Ghana. In some ways, too, as they have aged, domestic
servants have gained greater rights and negotiating power in the last few decades, although they are
usually positioned as “junior” in age, no matter their actual age, to household members.

Currently, even in small towns in southern Ghana, because adult daughters living in the
larger cities have competing responsibilities, and because they have access to cash to hire domestic
servants, daughters may act like sons in delegating the work of daily elder care—from
companionship to cooking to more strenuous household tasks like clothes washing—to more
extended kin or househelp, whether an adult woman or adolescent girl. For example, I encountered
the household of Mama Adelaide in Akropong during my fosterage survey in 2008 in Akropong,
Akuapem (for more of a discussion of this research, see Coe 2013b). Mama Adelaide was a seventy-
-eight-year-old woman who could not walk easily. She was living with Esther, the fifteen-year-old
grand-daughter of Mama Adelaide’s maternal uncle. Mama Adelaide called Esther her great-grand-
daughter; Esther called Mama Adelaide her paternal aunt (sewaa). In exchange for her domestic care,
Esther’s junior secondary school fees were paid by Mama Adelaide’s four adult children living in
Accra. Esther had come to live with Mama Adelaide from a village near Suhum in Akyem, where her
father grew cocoa and she had gone to primary school. Mama Adelaide’s adult children (two men
and two women)—a trader, a bar owner, a nurse, and a car alarm installer—sent Mama Adelaide
money, supporting both Esther and Mama Adelaide. That Esther was in her second year of junior-
secondary school at the age of fifteen indicated that her education had been disrupted or she had
been held back a year, an all-too common occurrence for rural students in Ghana (Ministry of
Education 2013). After school each day, Esther went to the market and cooked the main meal;
during my interview with Mama Adelaide one morning during the school holidays, Esther was washing clothes in the courtyard.

Another elderly woman in Akropong, whom I asked what she would do in the future if she became more frail, said that, rather than her daughter returning from Accra to live with her, her daughter would probably hire another woman to take care of her. A retired nurse in Awukugua, Akuapem sent her foster child, a twenty-eight-year-old young woman who was not her kin, to be trained as a nurse’s aide so that she could care for the nurse’s mother who was in her nineties and very frail. Thus, a growing trend in Akuapem seemed to be elder care by fostered young women or hired help.

Thus, what makes nursing agency carers “new and different” in the provision of care is therefore not their non-kin status, for non-kin are already providing elder care in some households. Furthermore, carers’ age and gender—most are young women—is similar to that of fostered adolescents and househelp. Rather, what makes them different is their rate of remuneration, their biomedical training, and their supervision and management by an outside agency, rather than by the household members, particularly the most senior woman. It is precisely these issues which form the basis of conflicts in the exchange of care services. For example, although households expect househelp to modify their norms of cleanliness and conduct to meet the household’s expectations, carers see themselves as having forms of expertise about biomedical knowledge and proper care which family members are not expected to possess. Thus, unlike househelp, carers attempt to set the care standards in the home, although they are not always successful because they are instead treated as househelp who should conform to the household norms.

3 The young woman was attending the school for carers I observed, and after the course had ended, I visited the nurse’s household and briefly interviewed the nurse and met her mother.
As has been noted in care work in other parts of the world such as the United States (Buch 2013, Stacey 2011), kinship idioms are used to incorporate and domesticate paid carers into the household into hierarchical relationships, as is done for househelp also. For example, one elderly male client I visited said that his carer, a young woman, was “like family.” On hearing this, his carer laughed, as if she did not think it was true but did not want to contradict him. He continued, calling her his great-grand-child. One of his complaints about one agency he used was that they continually rotated their carers, which made it difficult to become familiar with the carers and make them “like family.”

Although kinship idioms are used to naturalize the hierarchical relations between carers and their clients, carers do not put much effort into distinguishing themselves from family members (“daughters”). Instead, they focus their energy on showing their difference from the adjacent role of househelp. Furthermore, househelp are important in terms of carers’ experience of working in households, and carers strategize about how to maintain good relationships with them, as I discuss more fully in the next section.

(Not) Househelp

Are Carers Like Househelp?

Two elements of care work stigmatize carers: one, the nature of the work and two, the location of their work in other people’s homes. These characteristics affiliate carers with househelp, befitting an uneducated young person, whether a child or adolescent. In terms of the nature of the work, carers lift clients from the bed or a seated position; they bathe them; they clean them after toileting; they change beds and clothes; they clean the client’s room and area; they help feed them; they give them medication; they provide companionship through games, prayers, or conversation; and they are at the client’s beck and call during their shifts, whether day and night. Roger Sanjek and
Shellee Colen (1990) note, “Household work in all class societies results in a measure of stigma. Household labor. . . is seen as lowly, devalued work, associated with dirt and disorder” (p. 5). The tasks carer perform is “dirty work” (Palmer 1989), and as such degrades the performer of these tasks. Likewise, hirers of such workers can avoid the degradation of “dirty work” and maintain their status.

The location of the work further stigmatizes carers. One agency owner said about her employees,

They are expecting to work in a hospital, and it is hard for them to work in a home. It is also about status. They want to work in an environment recognized by others. If they are asked where they are working and they say “Korle-Bu [Hospital, the most prestigious hospital in Ghana],” then the response will be “Oh, Korle-Bu” [said with appreciation and respect]. But if you are working in someone’s home, then it is like you are a maid or househelp.

Even if they are doing the same kind of work—cleaning and feeding people—in a hospital, being able to say that they work in a hospital allows the respondent to imagine a more prestigious occupation. Work in a person’s home, on the other hand, is associated with domestic service and the degraded status of househelp.

In fact, carers frequently express that they are viewed as househelp by clients: they claim they are not respected as human beings or for their work, not trusted, and given tasks which they feel are unsuitable for their role. One agency owner complained that her workers were treated as househelp by clients, meaning that they were not treated with respect. For example, they were not given sachets of treated water in the household, but rather told to “drink from the tap.” Or the clients served them cold porridge, the remains of what they had eaten. A carer from this agency reported the same concern about sachet water, telling me in an interview, “I challenged [the client]: ‘You [yourself] are
not taking the tap, but you want someone to take care of someone, and what happens if I am sick?”

The provision of food and drink which is the same quality as the client’s is a key symbol of respect and appreciation. Fostered children similarly use food and drink to determine whether their foster parents care for them (Coe 2013).

Carers also report a lack of respect for their work by clients. In a discussion I had with two carers, they said:

Agnes: Clients can ask, “Why are you doing this job? Go to nursing training.” It discourages you.

Florence: They look down on you.

Agnes: I say [to the clients], “This is what I want to do.”

Florence: In this part of the country, they don’t know what it means to be a home nurse. They don’t understand.

Thus, carers and agency owners feel that they have to educate clients about the nature of their work and roles. As one carer said, “[Only] a few people understand that care is a profession. A lady said, ‘I can have four housekeepers, but I still need a carer for my mom. The cook will not see how the grandmother was breathing badly.’” She felt that this female client understood and respected her work, unlike many others, because she could see she needed a carer in addition to her househelp.

Carers are often asked to also perform the tasks of househelp. One carer told me, “As a home care giver, you do certain things in the house. They ask you to heat this for me. They take advantage of you. They can be abusive.” An agency owner said,

Sometimes clients want caregivers to be househelp. I let them do some light cleaning here and there, but not for the whole house. We had a situation where one of our best caregivers was doing some housework but wouldn’t do all of it. The client’s relative said that she [the carer] should not step into the house again. When I
protested, saying she was one of our best caregivers, the relative said that she hadn’t swept under the table in the kitchen or cleaned the fridge well enough. We took the caregiver away. The client [the mother] asked about her when the new caregiver showed up, saying that the first caregiver was very patient. She wanted her to come back. So we spoke to her daughter, and the first caregiver came back, and another caregiver did the housework. The relations think the caregivers are there for them also, not just the clients. It is a challenge for the caregivers and very frustrating. It is hard to distinguish caregivers from househelp.

A carer in this agency spoke about a similar situation, where she was doing the cleaning for a client who was also very heavy and hard to lift. She complained to the client’s daughter:

“Are you going to pay me extra money for the housework?” Because I was asked to take care of the mother. I want to have time for the person. If I do this [house]work, I won’t have much time for the client. The daughter told me, that she is grown [older] more than me, and so it is not fair that she should sweep and mop when I am there. She could have given birth to me, she told me. I told her she had to hire househelp, but because I needed this job and I didn’t want to stay at home [not working], I said yes. I agreed to do the housework.

In both cases, the carer and agency capitulated to the client’s requests, because of the economic capital of the client, but with tension and resentment. It is important to note that the client’s daughter used her seniority in age in her argument that the carer, a young woman, should do the dirty work. The carers’ relative age positions them as like househelp or young people of the household, who should do the “dirty” and most physically strenuous tasks.

It is not only the performance of household tasks that rankle carers, but also the fact that clients and their families can order them to do things in the house, as they would househelp. A carer
said, as a home carer, as opposed to a hospital worker, “You have to abide by their rules” in the house. For clients and their relatives, the position of “nurse” is associated with ordering others around. One client’s daughter reported that her mother was “furious and angry” when she and her siblings first discussed hiring an agency. “She’d heard that the nurses control you and order you about.” The daughter told the nursing agency, “Get me somebody who won’t [try to] control her.” In general, she is satisfied that the carers do not behave like nurses in trying to dominate the situation and her mother.

Finally, carers, like househelp, felt that they were not trusted by household members. Agnes, for example, said, “They think you want to steal or take advantage of them.” One carer I knew was fired after a robbery of the house where she was working, probably because she was considered to be collaborating with the robbers. The trust at stake—a concern for property and money—arises from the anxiety generated by vastly different social and economic positions of the househelp, carers, and clients. In particular, poorer persons are living in the intimate spaces of much wealthier persons: in their houses, their wealth is visible and on display, provoking jealousy or greed on the part of those who do not have it, and poorer persons have access to the money or precious objects of another. Clients position carers in an economic and social strata similar to househelp and feel some of the same class anxieties about them.

The confusion between carers and househelp mean that within the household, one of the key relationships that carers have to manage, in addition to that with the client and his or her relatives, is with the househelp.

Rivalries with Househelp

In many households, carers are interacting with househelp, in addition to the client and the client’s kin. As one client’s daughter astutely noted, there are rivalries between househelp and carers,
with petty jealousies, gossip, and tale-telling to the client by both parties. Unfortunately, I do not have the perspective of househelp, only those of carers and clients. Many househelp are similar in age to carers, as young women; although occasionally, there are differences, as when househelp are much older than carers. Furthermore, carers are more educated than househelp, who are more likely to have only completed junior-secondary school.

The client’s daughter noted above observed,

If one party is not cooperative, they get very particular about who is supposed to do what. No one is willing to go the extra mile. There is some rivalry too: they are the same age. But the nurses [carers] are glorified househelp. [She raised her arms and elbows in front of her, like a powerful chief, to indicate their sense of themselves as persons of high status]. The househelp get upset when the nurses won’t wash their own plates.

From the perspective of the client’s daughter, the source of the tension between two similarly situated groups—househelp and carer—was that the carers thought that they were better than the househelp.

The carers’ perspective on this same tension is that one, the househelp feel anxiety that their jobs will be taken away, because the carers will replace them in the household; and two, that the househelp have knowledge about the family and its habits that the carers do not have, which puts them in a superior position to the carer. One carer said that in one household, the househelp refused to cook for her, so she had to bring her own food. The househelp refused to do so, the carer explained, because she worried that the carer would take away her job, even though the househelp was kept on and her salary remained the same. Sometimes the same househelp refused to help this carer lift the client, because she did not feel that it was her task to perform. The carer said that she
knew that lifting was her job, not the househelp’s, but lifting can be difficult and give you pain in your back, and it would be nice to have some assistance once in a while.

Another carer talked about how she handled the relationship with househelp, so that these rivalries did not arise and househelp cooperated with her. In particular, she addressed the househelp’s concern about job security directly, did not gossip with them, and respected the househelp’s knowledge about the family based on long-term joint residence:

First, we [carers] washed [clothes, in the household]. When you do their washing for them [the clients], then they will let their househelp go. You spoil someone’s job, and that is her daily bread. They [the clients] treat you anyhow, just as they treat you like the househelp. [Now] I tell the househelp, “I am not coming for your work. My job is your Madam. You are doing your own thing. If you prepare the food, you do it and I feed her. Yours is the washing and ironing.” So though we are in the same place, there is different work. You don’t go to them conversing and gossiping about their Madam, [and] you will be fine. They know a lot. They will tell you a lot about the person. They will take your insults to them [the client]. They didn’t go to school. They see you, “Eh!” they are [feel] betrayed. They will do whatever it takes to destroy the relationship. You take them as a colleague, but not so you insult people to them [which the househelp is likely to report to the client]. You go professionally; then you are free.

Another carer said about househelp, “They think they know better because they have stayed with them for a long time. The agency tells me not to be close to the househelp, so I am not free with them. Sometimes they watch you from a distance and then decide you are okay, and then it is fine.” Another carer said that if the househelp knows the client very well, she would “lower yourself to learn what the person knows,” so she could do the job better. When I visited one client’s household
with the nurse supervisor of the agency, the househelp, a woman in her thirties, said that she had been in the household for ten years and teaches all the carers who come what to do and how her client likes things. Her greater knowledge of the client, as well as her older age, helps her manage the carers who cycle through.

Thus, there can be conflicts between househelp and carers because of the confusions between their respective roles over job security, respect, and intimate knowledge of the household. Carers have to manage their relationship with househelp carefully, so that they are allies, not enemies, in accomplishing the work well and pleasing the client and family, on whose approval their continued employment depends. At the same time, they do feel superior to househelp, and signal such status through their dress, education, and deployment of biomedical knowledge and discourse.

Carers’ Biomedical Knowledge, Dress, and Education as Uncertain Cultural Capital

Agency owners report a number of strategies they use to differentiate their workforce from househelp. One agency owner makes sure that her clients are not paired solely with one carer, which encourages the clients, she feels, to forget about the agency’s role and treat the carer like a househelp. Another agency makes the carers’ food the responsibility of the carer, rather than the client, since clients provide food to househelp. Many agencies require that carers wear a uniform to differentiate them from househelp. One agency owner said, “Sometimes they look to us as the househelp or maid. This is why all my caregivers have uniforms, to distinguish them from a maid or househelp.” The uniform was usually a blouse or top, printed with the agency name, rather than an entire outfit. This sartorial distinction seems to help clients recognize the professionalism of the employees. A client’s daughter said critically about one agency she used, “At one agency, the girls were just like househelps, dressed in their own clothes.” She was not happy with this agency for
many reasons, including the lack of supervision and the high costs, but the regular clothing also suggested a lack of professionalism in her eyes. A uniform thus serves as a kind of cultural capital, for the carers, clients, and agency.

Carers often report using their biomedical knowledge, completion of secondary school, and nursing certificate as forms of cultural capital in their interactions in the home. These forms of knowledge are not always recognized in households, which causes agency owners and carers to complain bitterly. Carers’ knowledge is set in contrast to the knowledge of fostered adolescents and domestic servants, which they learn from their families of origin or become versed in through their years-long stay in a household. Ironically, in carers’ practice of care, their training and education may matter less than their warmth, patience, knowledge of the person’s habits and tastes, and previous experiences of caring for a sick or elderly person in their own families or households. Quite a few carers had in fact taken care of a sick relative, whether a father, mother, or grandmother, before being hired as a carer or entering healthcare training. Many of their own relatives have suffered from a stroke, which is also a primary reason why clients and their relatives seek an outside agency’s assistance with care. Although the carers often relied on informal knowledge to actually accomplish their work, they positioned themselves as having access to a privileged biomedical knowledge because that was key to their status in the household.

Nursing agencies trade on biomedical knowledge and other forms of knowledge to raise the status of the carers as a profession, vis-à-vis other kinds of household workers. The conflictual process of raising the status of the female-dominated nursing profession has been documented in the United States and France ((Reverby 1987, Schultheiss 2001) and has been dependent on the creation of a strict hierarchy within the nursing profession, in which a few have gained high status and pay but in which many lower levels of nurses do not. Similarly, in Ghana, the training of carers justifies the higher pay and status of the carer in comparison to “uneducated” and “rural” househelp,
and sometimes in relation to the client and their kin, for example, in giving carers authority to dictate
care practices to family members rather than being ordered to perform certain tasks. For example,
owners of nursing agencies emphasize, as part of their marketing, that as a result of carers’
knowledgeable practice, clients live longer than they do under the care of househelp.

Biomedical knowledge and training are critical to the carers’ sense of professional self. The
key ways that they deployed biomedical knowledge was in terms of using equipment like latex
gloves, writing notes, using medical terms for diseases and bodily processes, and having some
information about diabetes, strokes, and blood pressure, but they were not as fluent in these matters
as trained nurses are. The training in biomedicine helps them feel pride in their work and gain status
in clients’ homes as well as among their family members. A carer told me,

In the olden days, if someone is ill, the aunty [who] is in a village somewhere not
doing anything will come and take care of the person. So they have the perception
that the work is not for those who are educated. They think you are not educated,
because you are changing a diaper. We had to let them know that this is not just
someone from the village, but we learned something from the class. You have to
wear uniforms, and you have to wear gloves to change a diaper. We know the
medication. They realize they [we] are not villagers. They know you are a
professional caregiver. You sign in and out, and write what happened that day, so the
next carer comes and reads [what happened on the shift].

Biomedical training is the key distinction between carers and their adjacent relationship, househelp,
and it brings carers closer to the adjacent relation of nurses. Because training and education are key
to status enhancement, they can also be cited in the degradation of carers, when clients or their
relatives are angry at them. One carer talked about a difficult relative of a client, who insulted her,
“You are nothing! Where is your certificate! Where did you train!” Feeling that these sentiments of
clients were not always articulated, carers explicitly emphasized their training, literacy, and use of biomedical equipment like latex gloves in the home to bolster their position and sense of self-worth.

One carer reported feeling respected as a medical professional in a household where she worked. In a household in the middle-class neighborhood of Mamprobi, she reported, the client’s relatives called her to tell a neighbor’s child about “this or that,” for example, about drinking cold things when one has asthma, using the carer as an authority figure to support the child’s mother’s instructions. The client’s sister also asked the carer to check her blood pressure. Another carer said that he managed to convince another househelp of his status by talking about his knowledge and showing his certificate to her. The co-worker househelp was a young woman of about twenty, who just completed secondary school and cooked for his client. He reported, “She doesn’t respect us [the carers].” She told him, concerning home care, “This work, I would never do it, even if I had no job.” He said he became angry with her: “She thought we were nobody.” Later, he was teaching the client’s son and his wife, who live in the client’s house, about hypertension and medication. The cook asked him, “Do you want to go to nursing school?” He told her, “I have completed nursing school,” by which he meant school for the HAT. The client, overhearing this, was also surprised and asked to see the certificate. The next time the carer went to the house, he brought his certificate. He reported that the cook started showing him more respect (although the client did not).

Carers contrast what they learned at school to caring knowledge acquired by other means to shore up their precarious position in clients’ homes. I was able to see this dynamic in action one day when I visited a client of a nursing agency, an elderly man who had suffered from a stroke. His carer was a young woman in her early twenties who had been working with him for less than a month; this was her first client after completing HAT school. As I talked to her in the client’s room, we were joined by an older woman in her fifties, a housekeeper who cooked the client’s food. It turned out that she had been taking care of the elderly man since he had had the stroke, a year and five
months before, until the man’s children had hired the agency four months ago. The carer was eager
to show off her medical knowledge—of catheters, for example—and also to learn medical
information from me, which I resisted, as I was unqualified to give it. As we continued our
conversation, the carer and the housekeeper began to spar over what constituted proper treatment
of the client. The housekeeper emphasized her long-term, personal knowledge of the client in
making her arguments. For example, she said that these days—during the rainy season, in July—the
weather was cool and he could sleep well, but when the weather was hot he itched a lot, and she has
a cream which she gives him. The housekeeper continued by saying that when she took care of her
grandfather, her mother taught her medicines which took care of bedsores. The carer challenged her
on this issue, saying that she learned in school that bedsores are avoided by the sheet being flat and
without any particles like sand on it. She stood up to brush the client’s sheet to demonstrate.
Looking at me for confirmation—unfortunately, I found myself nodding—she went on to say that
bedsores were avoided by having a “hygienic environment” and changing the client’s position. The
carer was impressed with the way the blood pressure medication kept the client very healthy—she
checked his blood pressure regularly—whereas her own father, also a stroke patient, took many
different medications without positive results. The client has not gone to the hospital all year, she
said, which she attributed to the blood pressure medication. The housekeeper thought that perhaps
the client should reduce his medications, since he is now feeling better, but the carer argued in
response that it was the medications which were keeping him healthy. They also had a more minor
disagreement about salt in the client’s food. From my vantage point, the different caregivers in this
household seemed to be competing with one another over the proper forms of care, and who was
better qualified to take good care of him, with the much younger carer using her school-based
knowledge to her advantage. Although she managed to silence the much older housekeeper, at least
in my presence, it was not clear to me that she had necessarily convinced the housekeeper that her
medical knowledge was superior to the housekeeper’s home-based remedies and long-term knowledge of the client.

The training and certificate are attempts by carers to position themselves as educated and medically trained “nurses,” rather than as “househelp” and occasionally, these efforts are successful, generating requests for medical advice and respect within their clients’ households. Some clients, as the quotes above illustrate, call carers nurses and consider them like nurses. At the same time, the nursing profession has pushed back against the definition of carers as nurses, limiting the cultural capital of their credentials. The credentials of carers make it hard for them to find work in hospitals, where “real nurses” work, and the unavailability of hospital-based work makes them turn to home care work.

Conclusions

This article speaks to the struggles of young, urban, secondary-school educated, mainly female Ghanaians to find work with status, respect, and pay to support themselves and others. In the context of demographic changes and new forms of wealth, a new kind of work is emerging that is open to young people: elder care. Positioned between the low-status, poorly educated, young, rural-in-origin role of househelp and the high status and authoritative role of nurse, the occupation of carer employed by nursing agencies is ambiguous for carers, their friends and family, and the clients and their relatives alike. Who are these young people? What can they do? How valuable are their knowledge, attentiveness, and warmth? Is the work skilled or unskilled labor?

Carers and agency owners tend to position carers as similar to nurses, with the cultural capital of biomedical knowledge and education. This positioning happens not only among friends and family but also to the significant members of the households in which they work—clients, their relatives, and househelp. The characteristics of being like a nurse are signaled by their uniforms,
professionalism, the possession of biomedical knowledge, and the use of biomedical equipment. However, the adjacent role of househelp constantly threatens the occupation of carer: the kind of work performed and the location of work make carers seem very similar to househelp. Furthermore, the age of carers also means that they are often junior to clients and their relatives, and similar in age to househelp. Because they seem like “glorified househelp” to some clients, carers often do not receive the respect and status they feel that they deserve. Their cultural capital of education is not valued, or not as valued as they would like.

This research speaks to two important phenomena that are occurring in Ghana and in some other countries in Africa more widely. One is the growth of a middle class with greater resources, some of which is due to economic growth on the continent. It is also the result of a growing diaspora abroad which continues to funnel resources to the continent. This social class has new demands for goods and services—including elder care—and is creating new employment opportunities for young people. These employment opportunities have the potential to complicate hierarchical and social class relations within households. Household labor is being re-organized among mainly younger and older women in different social classes and roles: middle-aged and wealthier women with elderly and frail parents are shifting some elder care work to younger and poorer women, both househelp and carers. New social class hierarchies are changing domestic labor and are reflected in social inequalities in households.

Secondly, this research speaks to the options for young people with a secondary-school education, and the disjuncture between their aspirations and the employment available to them. The forms of cultural capital in which they have invested their time, energy, relatives’ capital, and dreams disappoint. As noted in research on young men in Ethiopia (Mains 2011) and in a fishing village in Ghana (Lucht 2012), disappointments with the local employment market create a desire to go abroad (Graw and Schielke 2012). As carers in Ghana find that their expectations for employment
are not met by reality, they begin to idealize work abroad, as a place where they imagine carers of the elderly are better compensated and treated more like nurses. Thus, their work in Ghana may position them somewhere between househelp and nurse, but their disappointments with the cultural capital of the position of carers may propel them into a position of servitude in a new social hierarchy abroad.
Acknowledgments
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References


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Table 1. Home Nursing Agencies in Ghana

<table>
<thead>
<tr>
<th>Nursing Agency</th>
<th>Dates of operation</th>
<th>Number of clients</th>
<th>Work Background of owner(s)</th>
<th>Residential Facility?</th>
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<tr>
<td>1</td>
<td>1997-</td>
<td>2014: 45-60</td>
<td>oncology nurse in the US</td>
<td>Facility acquired; waiting to open</td>
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<td>2</td>
<td>charitable, 2003-2010; paying, 2007-</td>
<td>July 2014: 19</td>
<td>retail in the UK</td>
<td>Land bought for the purpose, but currently under litigation</td>
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<td>3</td>
<td>2004-</td>
<td>July 2014: 20</td>
<td>public health; worked for nurses’ association in Ghana</td>
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<td>4</td>
<td>2007-2010</td>
<td>5 clients at the end, in 2010</td>
<td>3 brothers were owners: 1 medical faculty in Ghana, 1 pharmacy faculty in US, 1 in Canada (not in healthcare)</td>
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<tr>
<td>5</td>
<td>school 2008-agency 2012-</td>
<td>July 2014: 12</td>
<td>social work and nursing; worked for midwifery association in Ghana</td>
<td>has 4-bed facility: 2 clients in July 2014, none in June 2015</td>
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<td>6</td>
<td>2010-</td>
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<td>7</td>
<td>2012-</td>
<td>May 2015: 27</td>
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