Transnational Migration and the Commodification of Elder Care in Urban Ghana

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Transnational migration and the commodification of elder care in urban Ghana

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Abstract

Over the past twenty years, organizations to provide commercial nursing services, mainly to the sick and debilitated elderly, have sprung up in Accra, Ghana. This article assesses the degree to which transnational migration has generated social changes in aging at the level of everyday practices. It argues that a range of social actors differently involved in transnational migration has created and sustained a market for home nursing agencies in Ghana through diverse processes involving the imagination of care work abroad, complex negotiations between the elderly at home and their anxious children abroad, increased financial resources among the middle class, and the evaluations of Western elder care services by return and current migrants. These dynamics illustrate the complexity of the role of transnational migration in generating social change and highlight the significance of the needs of local families and the role of the imagination in shaping social remittances from abroad.

Keywords: transnational migration; Ghana; elder care; markets; social remittances

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Introduction

“I thought Africans looked after their old, but since doing this business, I see that they don’t.”

—the owner of a home nursing agency, Accra, August 2014

Over the past twenty years, private agencies which provide commercial care services, mainly to sick and debilitated elderly, have sprung up in Accra, the capital of the West African country of Ghana, created by Ghanaian return migrants or health care professionals. Six agencies currently provide nursing services in clients’ homes. Four small residential facilities are also operating in Accra and its outskirts. The interest in commercial elder care services is high among middle-class urban families, which are mainly concentrated in Accra and its neighboring port city of Tema, but some of the agencies send paid caregivers outside of the greater Accra-Tema metropolitan area.¹

As the quote above suggests, many Ghanaians consider the use of commercial care services to be un-“African” and implicitly a sign of “modernization”. The notion that family life changes with modernity, becoming more nucleated and with narrower relations of solidarity, is a central tenet of modernization theory. Because the institutionalization of the aged is considered one outcome of modernization, care practices for the aged are a key symbolic distinction between “modern” and “traditional” societies in everyday discussions and policy documents (Cohen 1998; Lamb 2009; Thelen and Coe n.d.).

One source of modernizing social change in family life is posited to be transnational migration. Transnational migration refers to the maintenance of cross-border social and emotional networks and identifications when people migrate across international borders. These social and emotional ties usually involve the communication of ideas and experiences and the
exchange of financial resources and goods across borders. This article examines the ways that ideas and practices associated with other societies are adopted and adapted by various social actors. This is a study of social change assessing the degree to which transnational migration has driven the commercialization of family life.² On the basis of my research, I argue that the commercial care market in Ghana is generated by a conjuncture of experiences, interests and dreams of differently positioned persons. I focus on three categories of persons: clients and their families who procure and pay for these services, owners who have created these care services, and care workers who contribute their labor. These social actors are differently affected by ideas and practices coming from abroad and have different kinds of transnational relationships.

Two theories within the sociological literature speak to the issue of how transnational migration might contribute to the commercialization of care in Ghana. One is the concept of global care chains (Hochschild 2001), in which paid domestic labour in households in wealthy countries is performed by female immigrants who left behind their own families in their home countries. The commercialization of care in wealthy countries generates a “care deficit” in countries that are the sources of migrant domestic workers. In these women’s absence, their households may experience pressures to outsource care, such as hiring a poorer, more rural migrant as a caregiver. However, commercial care services are not primarily the result of global care chains, as not all or even most Ghanaian migrants are care workers abroad.

The second is that of social remittances (Levitt 1998). In Levitt’s initial conceptualization, transnational migrants loomed large as social change agents, bringing new expectations of democracy to organizations and politics in the Dominican Republic, similar to the way that they sent money back home as remittances. More recently, similar to the way that research on financial remittances has illustrated their complexity, flowing not only from
migrants, but also to migrants (Mazzucato 2008), Levitt’s ideas on social remittances have been tempered by an acknowledgment of the ways that social actors and the local context in the home country affect the ways that ideas from abroad are implemented and institutionalized at home (Holdaway et al 2015; Levitt and Lamba-Nieves 2011). Thus, rather than Western ideas and practices transforming societies through the social remittances of transnational migrants, instead, those ideas and practices are shaped by individuals to fit the local context.

In the development of commercial care services in Ghana, I argue that return migrants, as Levitt (1998) initially suggested, play an outstanding role in translating eldercare ideas and practices from abroad. However, the commercialization of elder care is also dependent on two other kinds of social actors who are affected by transnational migration differently. Nursing agencies can exist because they have willing employees—unemployed and underemployed young women and men who are attracted to what is otherwise undesirable employment by imagining this work as a springboard to migration to the Gulf States, Europe and North America. This group of social actors—the carers—highlights the significance of the imagination of transnational migration (see Appadurai 1996). In general, the role of the imagination in adopting new ideas and practices has been overlooked in the literature on global care chains and social remittances.

Commercial care providers are also dependent on clients and their families. 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—poor and wealthy alike—are experiencing a growing strain in caring for their elderly and frail relatives, leading to concerns about elder loneliness and abandonment (Aboderin 2006; Apt 1996; Dsane 2013; Sanuade and Boatemaa 2015). The fact that many households are struggling to care for their elderly relations
makes them open to new ideas about elder care (Coe 2015). The needs of families are a feature of the local context accounted for in Levitt’s later analysis, but do not feature significantly in Hochschild’s global care chains, in which the needs of families in wealthy countries drive the process of social change.

A further complexity is that, as Hirsch (2003) emphasizes in her study of changing expectations of romance in Mexico, we should not overstate the effect of transnational migration on changes in social norms, which may be changing alongside, rather than because of, transnational migration. The emergence of commercial care services in Ghana arises not only from transnational migration but also from the current and historical prevalence of domestic service and fosterage in urban Ghana (Ardayfio-Schandorf and Amissah 1996; Coe 2017; Goody 1982), ongoing changes in care reciprocities across the generations (Aboderin 2006), and increased wealth among certain strata in Ghana (Lentz 2016). The growing commercialization of elder care in Ghana, and perhaps more generally across the Global South (Lamb 2009), I would argue, is the result of a combination of local economic growth, the increased participation of women in remunerative and formal employment, transnational migration, and a larger population of frailer elderly. This study focuses on the local context affected by out-flows of migration and the contributions of people there, rather than on the countries to which people migrate and the agency of migrants, which have been over-emphasized in the migration literature.

Examining a range of social actors—including clients and their relatives, paid carers, and the owners of the nursing agencies—I argue that transnational migration has helped create and sustain a market for home nursing agencies in Ghana mainly through the evaluations of eldercare services associated with “the West” by return and current migrants as suggested by the initial conceptualization of social remittances. However, it is also sustained by carers’ dreams of
migrating abroad and by complex negotiations between elderly persons and their anxious children about needs, obligations, and resources. Thus, social remittances—in the sense of bringing social expectations of aging from abroad—are significant, but are shaped by the dreams and negotiated needs and resources of those in Ghana.

**Methods and setting**

My data comes from fieldwork in July 2013, June-August 2014, and May-July 2015, twenty weeks in duration over three years, in order to track the viability of this market over time. It includes interviews with six owners of commercial nursing agencies which employ carers and four owners of residential facilities, 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, sometimes accompanying the nurse manager or owner on their supervisory or assessment visits, and sometimes coming on my own to spend an hour or two with the client and carers. These visits allowed me to supplement my interviews with observations about care practices and relationships between carers and clients, which I have written about elsewhere (Coe 2016). I also attended two weeks of classes and three days of final exams at a school for carers run by a nursing agency, and attended a morning class at another school. I had conversations with middle-class elderly and their children who were not using these services about the phenomenon of these agencies and residential facilities. Although these numbers may seem small, I interviewed the entire universe of owners of nursing agencies and residential facilities currently operating in Accra and 5.7% of clients, as far as I can tell (see Tables 1 and 2) [insert Tables 1 & 2 around here].³
This market is surrounded by a much larger, less commodified market in which middle-class households contract directly with individuals or their families to provide elder care as “helpers” or domestic servants, in exchange for much lower wages. The prevalence of domestic servants in middle-class urban households means that home nursing services are far more accepted than residential facilities, and indeed the agencies are older and serve more clients than the residential facilities. Home nursing care reduces some of the stigma and conspicuousness of having a non-relative care for one’s relative, which care in a residential facility would make visible (Van der Geest, Mul, and Vermeulen 2004). As the larger and more long-standing phenomenon, I focus on the home nursing agencies, rather than the residential facilities, for the purposes of this paper.

**Transnational migration and commercial care services**

Transnational migration contributes in complex ways to the commodification of elder care. Many nursing agency owners are return migrants. They aim to institutionalize ideas and practices from abroad, in part because their institutionalization enables them to reside in Ghana. At the same time, owners adjust these ideas based on their personal experiences.

However, a care market also requires clients and workers. The children of elderly clients face certain care needs out of the contradictory conditions of transnational migration which allow them to pay for luxury services but prevent them from being present to provide care. Finally, eldercare workers are stimulated to enter this field by dreams of a life abroad. Transnational migration is significant not only for the transfer of ideas and practices—but also in pragmatically changing resources of time and finances for care in families and in broadening the horizons which stimulate new life trajectories.
Return migration and entrepreneurship

Three of the six owners of nursing agencies currently in operation had previously lived abroad (in the United Kingdom or the United States), and the business was necessary for their return migration to Ghana. Living abroad gave them capital with which to start their business; the agency was their route to making a living in Ghana. It also gave them cachet among their clients and employees as having a particular kind of expert knowledge. A fourth, who had worked with a nursing association in Ghana, had traveled extensively for international conferences as part of her work, and she told me that she wanted to help her country with the knowledge of nursing and hospital practice that she gained abroad. The fifth, a healthcare professional, had worked briefly with international development organizations on the Millenium health goals in Ghana. The sixth was a nurse in a hospital in Ghana.

Most owners talked about their role as cultural change agent in creating a new market. The owners of the home nursing agencies were a conduit for new ideas of how elder care might be organized socially and politically, and were testing those ideas in conjunction with clients and carers. Their knowledge and perspective from their experiences abroad also prompted a critique of Ghanaian government policy, which had essentially ignored the new market, leaving it completely unregulated, because of the government’s emphasis on the role the “traditional” family plays in taking care of its elderly members (MacLean 2002, Van der Geest 2016).

Owners who had traveled abroad varied in their assessment of the elder care arrangements of the West. This variation seems partly explained by the work that they did abroad. The two who were trained and worked in elder care abroad were more enamored of what they learned there, more so than one owner who worked in retail abroad and was simply exposed
to elder care by being a UK resident. For example, Stella⁴, an owner of a nursing agency, got four weeks of training in home care in the UK after completing university studies in Ghana. She then worked in a residential home for the elderly in the UK and “loved it.” Following that experience, she did community care, working in people’s homes to support them to live independently, simultaneously pursuing her social work degree. For ten years, she told me, she worked with a range of (in her words) “vulnerable populations”: people with learning disabilities, physical disabilities, mental health, and the elderly. Her experience abroad functions as the gold standard for her: “Some people tell me I brought London to Ghana,” she told me proudly. She wants to reproduce what she learned abroad in Ghana. For example, she would like a regulatory body for agencies and a criminal background check for her employees. At the moment, she sends employees to get their fingerprints taken at the police station, but admits that this measure mainly makes employees afraid of committing an offense rather than actually checking their criminal records. Furthermore, she is looking for a supervisor trained in the UK, because she says, “The Ghanaian educational experience does not provide the right skills to do the job. They are not trained in home care settings.” A year later, she felt even more strongly: “I am reluctant to take a nursing professional from here in Ghana to join me.” By May 2015, she had hired a Ghanaian-British nurse with a strong British accent who had returned to live in Ghana.

Another owner of a private nursing agency, Esther, also lived in Britain for many years, working in credit collection for a retail company. She was successful in this line of work, but returned to Ghana when her mother was diagnosed with cancer. She was more selective than Stella in adapting home care to Ghana. Giving a guest lecture on hospice to a group of students at the School of Social Work in Accra in July 2014, she emphasized, “We should not look for
everything British and American.” She told me she decided not to “take from the outside world because the situation is different here. We pick from the developed world, but it is not practical and it doesn’t work here. I tailored it.” One of the ways that she has tailored her business is that she gives a lot of budgeting and practical advice to her students, because the income of carers is so low. Furthermore, she is less worried about carer abuse of clients and background checks for employees, than client abuse of carers, because many people treat carers as househelp. Rather than learning about elder care through formal training in Britain, as Stella did, she said she learned a lot from caring for her own mother as she died of cancer in Ghana. She was primarily interested in the hospice movement, which formed the impetus for opening a private nursing agency. She was motivated to serve others with a dying parent, allowing them to continue working, as she wished she could have. She would like to ultimately open a hospice center, but in the meantime trains her students in hospice techniques and provides home nursing care services.

Some owners of nursing agencies press for an expansion of social welfare programs in Ghana. Stella wishes that pensions could pay for nursing aides, the way that Social Services helps the aged in the United Kingdom. Another owner made a similar comment in connection to Denmark. Obviously, it is in the interests of home nursing agencies to promote Western-style social welfare policies. If governments pay for these services, these services can be provided beyond the more limited pool of people who can currently afford them.

Owners of home nursing services are therefore active brokers of knowledge from abroad, drawing on their transnational migration and experiences abroad, but also on their other experiences, including caring for elderly relatives in Ghana. They thus serve as conduits through which knowledge and information about Western models of elder care—social remittances—
flow. They use that knowledge to create an elder care market in Ghana and hope to expand that market by pressuring government agencies for the regulation and support for their services, without much effect thus far. Their knowledge is refracted through their varied experiences, which shape owners’ evaluation of how useful those programs are to Ghana’s aging population.

**Adult children abroad: able to pay and seeking reliable care**

Another major actor in the creation of a care market are the consumers of these services, primarily composed of elderly people with children abroad, including elderly return migrants whose children remain abroad. It is important to note, however, that usually not all of the adult children of elderly clients of nursing agencies are abroad: according to the owners and the elderly clients I interviewed and the households I visited, many elderly clients have children living in Ghana—perhaps even in the same house—in addition to a child or two abroad. The children living in Ghana work outside the house and are not often present during the day, thus necessitating the need for paid care. The child (or children) abroad tend to shoulder most of the costs of commercial care.

That children abroad are paying for these services means that they are accessible to a broader group of people than simply the Ghanaian elite, but include retired teachers and mid-level civil servants who also have children abroad. Nursing agencies have become one strategy by which children “care at a distance” (Baldassar, Baldock, and Wilding 2007). Transnational migration has therefore created and helped sustain a market for these services, by generating a group of more anxious and resource-rich clients who need to care for elderly parents across national borders and find commercial care services more trustworthy than househelp or distant kin, even if they are more expensive. Unlike the owners of commercial care services,
transnational migration has not affected families’ ideas of proper practice. Commercial care is a pragmatic response to a time crunch experienced by many professionals around the world—in Ghana as well as abroad—and to an expansion in financial resources.

Elderly clients themselves usually expect that their children will care for them in their own homes and resist the notion of paid care. The impetus for hiring an agency comes not from them but from children who feel over-burdened or anxious. A woman described how her mother, debilitated by a stroke, would prefer her own children’s care, but the daughter told her mother that she is fifty years old and has a career she does not want to leave. After six years of using paid carers, her mother remains unhappy about, but resigned to, the situation. Another woman said that her partially blind mother was “furious and angry” at the notion of an agency when it was first floated by her children. “She’d heard that the nurses control you and order you about,” so the woman warned the agency to send someone who would listen rather than command, and as a result, six years later, her mother has accepted her carers, in part because they allow her to live in her own home where she can move around despite being blind, rather than having to move in with one of her adult children living in Accra.

As other studies have shown, the growing care burden is increasingly placed on adult children rather than the extended family, due to changes in inheritance which privilege children over the extended family (Aboderin 2006; Dsane 2013). Wealthy and middle-class families in urban areas are increasingly turning to commercial care services to solve their elder care dilemmas. These new forms of elder care indicate a shifting of roles in which adult children do not provide personal care but instead the financial support for paid caregivers. Families face difficulties in caring for their elderly, but could turn to strategies other than commercial care services—such as domestic servants, extended family, or fosterage, or the migration of the
elderly person abroad to stay with children abroad. And many do turn to these solutions. The commercial care market depends on families with frail elders seeing home nursing services as a feasible solution to their care problems. The “match” between service and need is dependent on complex negotiations about intergenerational reciprocities within households, as well as the financial ability to pay for these services. The role of families as consumers highlights the significance of the local context in the adoption of ideas from abroad: as the local context has been changed by transnational migration, women’s formal employment, and economic growth, some of the same issues which made commercialized care a solution to the time bind in the West are also influencing Ghanaian families.

Care work and the global horizon

Transnational migration generated a care market not only through migrant children wanting and able to pay for care and through return migrants who wish to establish a business in Ghana. Transnational migration also attracts agency employees, the carers. The key problem in care work is the low wage, particularly the net pay for live-out caregivers after the cost of transportation. Accra is a large, sprawling city with snarled traffic. Housing costs are cheaper on the outskirts of Accra, as well as in its slums, where many carers live, and they can be far from the leafy neighborhoods where they work in middle-class and elite households. Thus, commutes can be long and expensive. “The pay is nothing,” said one carer. Another problem is their education, which generally prepares them to work in hospitals rather than home care, except when they are trained by the homecare agency itself. Finally, the work lacks status. One of the owners commented, “They want to work in an environment recognized by others,” like a hospital. “But if you are working in someone’s home, then it is like you are a maid or househelp.”
So they don’t like the status and the pay.” A carer said, “They [clients] don’t respect the work you are doing” and “don’t treat you well.” Another carer complained about how she was not earning enough money from her work to cover childcare costs, and so had stopped working for the past two months. But she was thinking about going abroad to do the same work: “I know that if I go abroad, my husband will sacrifice,” which he is not willing to do so she can work in Ghana. Many carers initiated conversations with me about what care work is like abroad and told me of their dreams of going abroad.

The romance of abroad compensates for the inadequacies of the care market in Ghana. Carers enter the profession in Ghana in part because it is seen as a remunerative profession abroad. They plan to begin work in Ghana, gain some experience, and then migrate, perhaps for the same work or for further education as a nurse funded by care work abroad. The agencies highlight their international connections to attract students to their schools and to the new profession of carer. The owner of a large private nursing school in Accra—with 200-300 students a year—has an exchange program with Denmark, and she trumpeted to me how many of her students were in the United Kingdom and the United States. One graduate of an agency school reported that most of her cohort of students—who graduated three years before—had traveled outside the country, to the United States, United Kingdom, the Netherlands, and Australia. Carers have also gone abroad temporarily with their clients from Ghana on family visits to the United Kingdom and India.

In their interest in going abroad, carers are following the lead of the nursing profession in Ghana, after which they model themselves. Twenty-four percent of nurses trained in Ghana work abroad, primarily in the United Kingdom and United States (International Organization of Migration 2009). Carers are aware that many Ghanaians work in elder care in these countries
(Arthur 2008). When I observed Esther give a lecture about aging to social work students, a young man reported on a phone conversation with a friend who worked in home care in the United States: as they were talking, the student heard screaming in the background. His friend told him that his patient had dementia, a new concept to the student. The student told Esther that he was not sure he had the temperament to do care work, because he is very emotional, and when things are crazy around him, he also goes crazy. Thus, information about care markets abroad—including knowledge of disease states and work conditions—siphons through the social networks of carers and their friends, social remittances which fuel and deter potential care workers.

Carers are only interested in a Western model of elder care in that it creates an established care market in the West which might provide them with employment and remuneration. Social welfare programs create a larger care market in Europe and North America than is present in Ghana, and shortages in direct-care workers in the West mean that work in this field is available for new immigrants (Institute of Medicine 2008). To the extent that carers attain the goal of exit, they may also reduce the possibility that a home care market will be viable in Ghana. Owners of home care agencies are both pleased that their former students and employees find work abroad and are dismayed that they continue to lose those they have trained.

Graw and Schielke (2012) note that even non-migrants are affected by “the global horizon” or an awareness and imagination of other societies, in which migration looms as the route for success at home (see also Fouron and Glick-Schiller 2002). Like high-tech and factory work financed by multinational capital in the Caribbean or Southeast Asia (Freeman 2000; Sassen 1998), care work capitalized by local entrepreneurs prompts young people’s onward migration, by putting workers in touch with households with migrant connections while simultaneously denying them a good livelihood.
Conclusions

To what extent does transnational migration generate social change, including the commercialization of elder care? Much of the literature on transnational migration has been directed toward its impact on societies and social change. Initial scholarship posited major changes in family life, including gender and parenting roles (Hondagneu-Sotelo 1994; Parreñas 2004). Later work tempered the impact of transnational migration by acknowledging the significance of changes in family life occurring independently of migration (Hirsch 2003) and of familial repertoires shaped by long-standing urban and regional migration, which are then adapted to international migration (Coe 2013; Olwig 2007). This tempering of the effect of transnational migration is paralleled in the literature on social remittances, which has evolved to a much more complex and dynamic model than its initial formulation of transnational migrants as agents of social change. Instead, the complex role of other social actors and institutions is acknowledged, as diverting or modifying the ideas and practices brought by migrants. Similarly, the concept of global care chains needs to be modified so that households in migrant-receiving countries are not the sole engines of social change, but in which the commodification of care is also driven by households in migrant-sending countries, trying to meet their changing needs with changing resources.

This study of the commodification of elder care in Ghana adds to our understanding of the complexity of this question. Although commercial care services might exist in Ghana without widespread transnational migration, transnational migration has helped create and sustain the market for commercial care services through a multifaceted process involving transnational migrants sending money to elderly parents and relatives “left behind,” return migrants who open
new businesses, and dreams of future migration among young people. Return migrants play a pioneering role in introducing and trying to institutionalize new eldercare practices, talking about themselves explicitly as agents of social change. However, they are not united as a body, lessening their impact. As Levitt (1998) suggested, their experiences abroad affect their translation and reflections of these eldercare practices, and they highlight different aspects of “Western” care practices.

It is clear that social remittances include many different kinds of resources. Ideas are the resources usually highlighted, and indeed we see here the significance of knowledge of British and American home care systems and exposure to concepts like hospice, dementia, and background checks. This knowledge does not lead straightforwardly to a positive perception of care practices abroad, as in the social work student’s fear of dealing with someone with dementia or in the nursing agency owners’ evaluations of what to adopt and what to adapt. Thus, people shape these ideas as they share them with others.

In addition, material remittances also shaped the adoption of these ideas, by giving families the ability to pay for commercial services, rather than relying on reciprocal obligations within families, generated across the life course. Resources like time—particularly women’s lack of time—also affected families’ adoption of commercial care services.

Finally, as documented in other research in Africa (Graw and Schielke 2012; Mains 2011), underemployed and unemployed youth see migration as the route to attain success. Many feel ambivalent about care work in Ghana, because of its low pay and associations with domestic service, but the possibility of it being a stepping-stone to migration abroad overcomes the stigma for some workers. Thus, the commercial care market is generated through various social actors finding that it meets some of their needs—to make a living in Ghana on the part of nursing
agency owners, to provide care for an elderly relative without sacrificing a career on the part of adult daughters, and to have hope for future success, on the part of young carers.

This article illustrates a multifaceted and complex process, in which people—as kin, entrepreneurs, and workers—are shaping care practices and relationships through their ideas of how elder care ought to operate, and are using their resources, relationships, and needs to bring those ideas into reality. Elder care markets in Ghana are formed by various actors—clients, employers, and employees—working to ensure their family’s reproduction and care through the ideas and resources available to them, some of which come through transnational migration.

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Endnotes

1 Some of the agencies sent carers outside of Accra to the towns of Begoro in the Eastern Region, Kpando in the Volta Region, and to the cities of Cape Coast in the Central Region, Kumasi in the Ashanti Region, and Sunyani in the Brong-Ahafo Region.

2 Ghana has a relatively high rate of international migration within Africa (International Organization of Migration 2009). It is estimated that between three and seven percent of Ghana’s population has migrated abroad (Twum-Baah 2005; World Bank 2011). Middle-class urban
households, and many households in smaller towns in southern Ghana, have at least one family member abroad.

3 At the most, the number of clients served by agencies and in residential facilities at any one time was approximately 174 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).

4 All names are pseudonyms.

5 However, they remain out of reach for poorer elderly without international connections, as in a study of childless elderly women in Teshie (Dsane 2013).

6 For a longer history of this phenomenon, see Coe (2017).
References


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Health Sector Development in China and India.” *Social Science and Medicine* 130: 268-276.


Ageing and Society 24 (3): 431-450.


The World Bank.
### 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>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1997-</td>
<td>2015: 45-60</td>
<td>oncology nurse in the US</td>
</tr>
<tr>
<td>2</td>
<td>charitable, 2003-2010; paying, 2007-2010; July 2014: 19</td>
<td>credit collection in the UK</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>2004-</td>
<td>July 2014: 20</td>
<td>public health; worked for nurses’ association in Ghana</td>
</tr>
<tr>
<td>4</td>
<td>school 2008-agency 2012-2014</td>
<td>July 2014: 12</td>
<td>social work and nursing; worked for midwifery association in Ghana</td>
</tr>
<tr>
<td>5</td>
<td>2010-</td>
<td>July 2013: 6</td>
<td>home care in the UK</td>
</tr>
<tr>
<td>6</td>
<td>2012-</td>
<td>May 2015: 27</td>
<td>nurse in hospital in Ghana</td>
</tr>
</tbody>
</table>

Note: Four other nursing agencies were started in the late 1990s but collapsed quickly, “within six months” in the words of the owner of the first home nursing agency. Another, whose former owner I also interviewed, was in existence from 2007-2010.

### Table 2. Residential care facilities in Ghana

<table>
<thead>
<tr>
<th>Facility</th>
<th>Dates of operation</th>
<th>Number of residents</th>
<th>Work Background of owner(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2011-</td>
<td>June 2015: 15</td>
<td>Migrant couple in the Netherlands</td>
</tr>
<tr>
<td>2</td>
<td>2011-</td>
<td>Aug 2014: 9</td>
<td>Housewife and student; husband works for international NGO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>June 2015: 4</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>2012-</td>
<td>June 2014: 0</td>
<td>Housewife and politician’s wife</td>
</tr>
<tr>
<td></td>
<td></td>
<td>July 2015: 6</td>
<td></td>
</tr>
<tr>
<td>4*</td>
<td>2012-</td>
<td>July 2014: 2</td>
<td>social work and nursing; worked for midwifery association in Ghana</td>
</tr>
<tr>
<td></td>
<td></td>
<td>June 2015: 0</td>
<td></td>
</tr>
</tbody>
</table>

*Same as #4 in Table 1*