Beyond Kin Care? Institutional Facilities in the Imaginations of Older Presbyterians in Southern Ghana

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Abstract:

In rural towns of Ghana’s Eastern Region, older adults express curiosity about Western facilities for seniors such as care homes—where older adults reside permanently—and senior day programs—where they come for the day for activities and meals. This paper argues that aging is a site of cultural innovation; in this case, ideas and practices imported from abroad like care homes are reworked in local imaginaries to speak to local concerns, including a critique of the state. Supporting James Ferguson’s recent argument that new social welfare practices and rights are gaining traction in Africa, it illustrates how older adults in Ghana are articulating a vision of a caring nation, as they confront the aging process and cope with changing aging trajectories and intergenerational reciprocities.

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We don’t have someone to live with us to take care of our food and wellbeing. If we had a place—as there is abroad—where, when you grow old and no one lives with you, you could go live there, like a school where they sent you, where there are doctors, and they cook you food; everything! You happen to meet your classmate, and it makes you happy, and it will make you live a long time. That kind of place is not common in Ghana or our region, so it troubles us.

—older man, Old Tafo, July 11, 2014 (original in Akim Twi)
In my conversations with older Presbyterians in the rural towns of Ghana’s Eastern Region, I was surprised to find that they, like this older man, seemed to consider Western care facilities for older people as a potential solution to some of their quandaries, particularly the precarity of living “alone,” meaning without support for their nutrition and health. These remarks were surprising to me because of the state’s explicit reliance on kin care and of many middle-aged Ghanaians telling me forcefully, as I discussed my research with them, that Ghanaians care for their aging relatives. I argue that older people’s interest in care facilities does not reflect the modernization of the African family, or a sense of individuals being solely responsible for their own wellbeing, but rather a moral critique of the communities to which they belong—the nation of Ghana and the Presbyterian church—for ignoring and abandoning them, despite their contributions to these communities. Institutional facilities, as imagined by older Presbyterians, become a visible and public way that the state and their church could, and should, care for them.

Older people are thinking about the cultural practices there might supplement or replace kin care, when kin care is not viable or falls short. As Livingston (2005:3) points out, “Debility, like other bodily states, triggers the imagination”. Ideas and practices constructed as from “abroad” feed into such imaginings as part of the global horizon in which Ghanaians place their own nation (Graw and Schielke 2012). In their discussion of how models travel, Behrends, Park and Rottenburg (2014) focus on the importance of the token, which symbolically represents a particular social order and set of arrangements. In order for a particular model to travel, the token has to be adapted to mean something significant in the new context, without the institutions and social networks built up which supported that model in the original context. Institutional facilities for older adults serve as a token of a model of elder care, which is transformed in older
Ghanaians’ imagination to address their particular needs. Thus, as the quote above illustrates, they imagine these institutions as promoting their goals for a comfortable and happy old age, in which food, medical care, friendship and public recognition are highly significant. Furthermore, they are using these foreign institutions symbolically, to critique the current state of affairs, and as a lament to incite others to action, as, according to Cattell (1999), older people in Kenya also do.

Based on focus group discussions with members of older people’s fellowship groups organized by the Presbyterian Church in Akim and Kwahu, and casual conversations with older Presbyterians in Akwapim, this paper argues that ideas and practices coming from abroad are reworked in local imaginaries to speak to local concerns. Thus, the paper provides an example of how a model of care travels as part of globalization, through the agency of different actors. Arjun Appadurai (1996:205) expresses, “Lives today are as much acts of projection and imagination as they are enactments of known scripts or predictable outcomes”. Cultural resources in the form of ideas and practices are necessary for the acts of projection and imagination that Appadurai discusses. Globalization allows ideas and institutions to travel, but in order to be picked up, they have to be translated into the local context and thus are transformed. “While the token enters into a new setting with a different ontological and epistemic background, a different institutional setup and technological infrastructure, it needs to adapt to these new circumstances in order to connect to them. So the first thing that changes is the travelling token” (Behrends, Park and Rottenburg 2014: 3). Sarah Lamb (2016:183) illustrates this point in her research on how the idea of institutional facilities for aging adults have traveled to India, despite representing “alien, Western-inspired institutions”. They have been adapted to the local context, becoming equivalent to ashrams where older adults can withdraw from the bustling world to focus on their spiritual
development or like joint-family households, with a middle-aged couple taking into their home a small number of older adults for extra income and calling them grandparents as if they were family members.

In the case of southern Ghana, older Presbyterians’ interest in care institutions is predicated on the fact that they have not directly experienced such institutions but only heard about them as common in the West. In fact, they seem particularly interested in the symbolism of care institutions, as a sign of a community’s care for older persons and of their importance, and not solely as a practical solution to aging in the failure of kin care. By using care institutions to lament their current condition, they propose a particular ideal community which takes care of those who have contributed to it in the past. In the process, these older Presbyterians familiarize and normalize what they consider foreign and antithetical to a Ghanaian “tradition” of kin care. Supporting James Ferguson’s recent argument (2015:14) that we are witnessing “new kinds of political claims-making and new possibilities for political mobilization” in Africa, this paper illustrates how older adults in Ghana are articulating a vision of a caring community and nation, as they encounter the aging process and cope with new aging trajectories and intergenerational reciprocities.

The Presbyterian Church of Ghana has provided the forum, but is not the instigator, of this alternative social vision. Religious institutions have historically been significant sources of social welfare in Ghana and other African countries, and they can be important actors in civil society when state resources for care decline or have never existed (e.g., Scherz 2014). At the same time, this paper illustrates some of the problems with care organized under the auspices of religious institutions, as they may be as reluctant as the state to provide care to aging adults.
After discussing my methods and sources, I discuss the ideal of kin care, as articulated by southern Ghanaians. Then, I turn to the ways that the state and the Presbyterian Church are considering providing care for aging adults. Because of their relative silence and ambivalence about doing so, discursive space is provided for older persons to use their imaginations to articulate other kinds of solutions and pick up tokens of models from “the West.” Then, I discuss more extensively the reasons older Presbyterians gave for being interested in institutional facilities, as they localized a model of care associated with the West, thus enabling it to travel.

**Understanding Older Persons’ Reflections on Aging in Ghana: Methodology and Setting**

This paper mainly draws from my conversations with older people who were involved in the Presbyterian Church in three areas of the Eastern Region—Akwapim, Kwahu, and Akim. This paper is based on fieldwork in June-July 2013, June-August 2014, and May-July 2015, about twenty weeks in duration over three years.

My research on changes in old age care was prompted by a visit to the town of Akropong in Akwapim in June 2013, after a four-year absence. During my visit, I learned that the building in progress next to the main Presbyterian church in the town was intended to be a senior day center. The church was already organizing quarterly day-long gatherings of congregants seventy-five years and over as well as sending a nurse employed by the Ghana Health Service to visit older congregants regularly in their homes, to check their blood pressure and blood sugar and give them health advice, free of charge. I was able to attend one of their quarterly gatherings in June 2013 and accompanied the nurse’s assistant as she made home visits on three days in June 2013 and July 2014.
The Presbyterian Church of Ghana has organized fellowship groups for older people in Kwahu and Akim. These areas also have a long history of Presbyterian activity, such that the Presbyterian Church is dominant in these towns (Gilbert 1995, Middleton 1983, Mohr 2013). On Sundays, in all three areas, the congregations are dominated by older women, who are sometimes living with and looking after their grandchildren or great-grandchildren because the middle-aged generation is working in the major cities in Ghana or abroad. Younger men and women were more attracted to Pentecostalism or other new churches with dynamic ministers and founders. I spent a week each in Kwahu and Akim in June 2014, and with the help of the District Minister, attended hour-long programs of several fellowship groups with fifty to seventy-five people in attendance: seven meetings in Akim and eight in Kwahu. Most of the participants were over the age of seventy-five, the definition of “the aged” (as they called themselves) within these churches, although some who had reached retirement age (60 years) within the civil service also considered themselves “aged.” Conversations were in Akim, Kwahu, and Akwapim Twi.

In Akim, these meetings were mainly organizational, in which the ministers expressed their interest in expanding and institutionalizing the program for older persons. I asked the attendees about their problems and their thoughts about solutions to those problems. At one of these meetings, the participants engaged in their regular activity of singing Presbyterian hymns while doing physical exercises (Fig 1). In Kwahu, where the aged fellowship groups met regularly once a week, organized under the auspices of older congregants, rather than ministers, I was less often a participant than an observer to their ongoing programs, which involved singing and dancing, board games, religious sermons, health information, and competitions and debates.
I also explored activities and programs in Accra and its twin city Tema, visiting a senior day center run by the St. Vincent de Paul Society of the Catholic Church several times and four care homes, talking to the organizers and some of the attendees and residents. I also interviewed owners, clients, and workers of several home nursing agencies (Coe 2016). I talked to several founders and the current director of HelpAge Ghana, the major advocacy group on the aging in Ghana, as well as key members at the headquarters of the Presbyterian Church and the Catholic Church, the churches most interested in aging issues.

**Kin Care of the Elderly in Ghana**

Adult children are deemed particularly responsible for an older person’s care because of the contributions parents have made to their children’s biological and social personhood (Coe 2011). A Twi proverb reflects this reciprocity of relations, as expressed by one grandfather in Akropong:
If your mother or father or someone looks after you while your teeth are coming in, when it comes to the time where his or her teeth are falling out, you look after him or her.

Isabella Aboderin (2006) has noted that this onus on adult children constitutes a shrinking of the network of responsibility for care and is connected to changes in inheritance in the second half of the twentieth century which increasingly privilege children over other members of extended kin. As Ghana goes through a demographic transition, in which people are living longer and with long-term, disabling and chronic illnesses which require home management (de-Graft Aikins et al 2012), the sense of an “old age crisis” generates a particular narrative which focuses attention on adult children’s failure to meet their caring obligations and older people’s risk of neglect and abandonment (Aboderin 2006, Apt 1996, Dsane 2013). For example, in the national press, Professor Mate-Kole, the founding director of the Center for Ageing Studies at the University of Ghana, called aging “an emerging epidemic” in Ghana in which older adults “have been left basically to rot” (Anon 2018). At the more local level in the social circles of my informants, a play performed by one of the Kwahu fellowship groups illustrated the problem of an older couple who supported their children to go to school, only to be abandoned by them when they migrated to the city. The children did not visit or send remittances, and ultimately accused their parents of witchcraft (discussed in Coe 2017).

Concurrent with the strong critique of adult children, however, are other discourses, particularly among older women in Akwapim, which urge acceptance of children’s financial and emotional limitations and express an openness to alternative arrangements, including domestic servants and institutional facilities as solutions to the problems older people face (Coe 2018,
2017). Alongside the discourses of critique of the next generation, there was a willingness to experiment and engage imaginatively with different possible futures, including ones which were perceived as foreign or even antithetical to Ghanaian ways of life. Urban and international migration, lower birth rates, nuclearization of the family, and longer life spans all make the issue of elder care a significant national conversation.

**The State and Elder Care: Maintaining Kin Care**

Government policy documents on aging uphold Ghanaian families as the proper site for the care of older adults. The state drafted its aged policy around a traditional, idealized Ghanaian family, and highlights the expense, foreign-ness, and inappropriateness of other countries’ approaches (Government of Ghana 2010). As a result, successive governments, since the 1990s, have explicitly advocated against institutional facilities. As in India (Cohen 1998), Sjaak van der Geest (2016) has argued, this approach seems to ignore the plight of the aged in Ghana and presents the government as needing to do little to support the aging population. One indication of the government’s lack of concern for older adults is that although it drafted an aged policy almost ten years ago, Parliament has still not passed this policy (Anon 2018). Instead, state resources in Ghana seem to be concentrated on the futures of the young (Doh 2012).

NGOs like HelpAge Ghana, affiliated to the international UK-based NGO HelpAge, have played a major role in shaping government policy in this area in conjunction with government ministries and the World Health Organization (WHO). A locally-based grassroots NGO is working with HelpAge under the framework of the “social franchise” model in which international NGOs partner with a local NGO. One of the founders of this local NGO, Dr. J. B. Asare, a psychiatrist, told me,
To remove the old people, segregate them and put them into a place: one, you are going to put them in an unnatural environment. Number two, we think that they cannot be looked after very well [in these environments]. Thirdly, they will have to pay a lot of money to do it, unless government supports it, and we are against even government providing such facilities, unless that person is severely ill and infirm and has to be in a facility. Even that one, we would still want the person to manage at home. (interview, June 2013)

Mrs. Ollennu, another founder, said more diplomatically, “HelpAge is not keen to establish homes. Rather, they should stay with their families, whatever family is available, because it is not easy” (interview, May 2013). Nana Araba Apt (1996, 1991), a prominent sociologist of aging in Ghana, also considers institutional facilities to be antithetical to Ghanaian kinship, as well as too expensive for government budgets. She was active in shaping government policy and HelpAge’s advocacy during the 1990s and early 2000s, including writing a draft aged policy for the government in 2002. In an earlier report to the Department of Finance and Economics (Apt 1991), she said that institutionalization of older adults should be the final alternative and that emphasis should be placed on community-based alternatives. The World Health Organization (WHO 2015) similarly promotes healthy, active aging and ‘aging-in-place’ initiatives, in which community health workers, volunteers, and comprehensive health services play a major role. Influenced by the experiences of other countries in which institutional facilities often lead to poor care and neglect as well as high healthcare costs, HelpAge’s articulation of policies Ghana should avoid is clearer and stronger than their proposals for alternative pathways the Ghana government should take.
Kin care is thus the orthodox position, in the terminology of Bourdieu (1977), meaning that it is the conventional, formulaic, and normative position. It is the only position articulated and promoted by the state and NGOs which advocate for older adults and with whom the state has written its unenacted aged policy. It coincides with local discourse, which similarly emphasizes the morality of kin care. However, in Bourdieu’s discussion, what is articulated as orthodoxy can also be challenged by alternative constructions, which he calls heterodoxies. These are positions which are not shared by all and not even intended to be legitimized as such, but are nevertheless shared by some. In contrast to the orthodoxy of kin care, institutional facilities became constructed by state policy as heterodox, and as “Western” and “foreign” in contrast to the “Ghanaian tradition” of kin care.

Although HelpAge Ghana was strongly against the establishment of institutional facilities, it did set up several senior day centers in the capital city Accra in 1992 and 1993 in conjunction with the Catholic Church (Ayete-Nyampong 2008; Dodoo et al 1999; Father Andrew Campbell interview, June 2014). These centers provided a hot meal, activities like games and songs, a nurse on site to conduct medical checks, and occasional excursions for participants, funded by the Catholic Church. Of these centers, all but one in the Osu neighborhood of Accra are now defunct because of difficulties participants had getting transportation to the facilities. These centers in Accra, and the occasional media attention they garnered, served as the inspiration for the construction of the senior day center by the Presbyterian Church in Akropong.

Similar to my discussions with aging Presbyterians, Van der Geest (2016) noted an openness to institutional facilities in his discussions with older people in Kwahu, where he has long done research. The negative construction of care homes as heterodox by government policy
and NGOs means that the model of institutional facilities is available to be picked up by interested actors who are frustrated with the current situation (as discussed further in Coe 2018). This means that policy documents disseminate the model of institutional facilities in the process of dismissing it, making it available to travel when other actors re-interpret the heterodoxy as having positive implications. It is precisely because the social norm of kin care is perceived as not working and the government has no alternatives beyond kin care that there is some agentive space for older people to develop heterodox discourses and practices. The current government policy promoting kin care appears to aging adults to disregard them. Thus, they are free—or perhaps forced—to imagine their own solutions beyond kin care. To some extent, they have also been pushing other institutions, like their own churches, to come up with solutions. Within this quest for alternatives, institutional facilities are elaborated upon and gain traction as a potential solution to the problems of elder care.

**Churches and Elder Care**

Churches have historically been and still are a major provider of social services in Ghana. Furthermore, churches are important sites for the creation of fictive kinship and social capital (Adogame 2014, Meyer 1999, Mohr 2013). Thus, for those thinking about alternatives beyond kin care, it is natural to think of churches as potentially playing a major role. Advocates for older persons have directed some of their energies to churches, particularly within the Catholic Church, the Presbyterian Church of Ghana, and the E. P. Church of Ghana, all mainline churches in Ghana which are therefore more likely to serve older populations and to have had a history of supporting schools and hospitals.¹
The towns in the Eastern Region where the Presbyterian Church of Ghana is dominant have a higher proportion of older persons than in Ghana as a whole, mainly because of the migration of the youth to the larger cities and the region’s better access to health care relative to poorer parts of the country. The E.P. Church of Ghana has also formed aged groups for exercise, self-help, and health promotion, and whose congregations in the rural towns of the Volta Region also contain many older adults. According to the 2010 population census in Ghana, those over the age of 65 constitute 4.6% of the population, or about one million people out of a total population of 24.7 million (Ghana Statistical Service 2012). Fifty-seven percent of these are women; forty-three percent are men. The Volta Region has the highest proportion of older persons in Ghana (6.4% of its population is over the age of 65), followed by the Eastern Region (5.7% of the population). But in the North Akwapim district, 8.18% of the population is over the age of 65; in Kwahu South and East, the districts of the towns I visited, the proportion was 7.35% and 8.14% respectively. In the three districts in Akim that I visited (Akim East, Akim West, and Kwaebibirim), the proportion was lower, at 5.51%, 6.7%, and 4.85% respectively, but still included a higher proportion of older adults than in Ghana as a whole. This demographic shift may account for why it is the Presbyterian Church of Ghana and the E. P. Church which have launched new initiatives for older adults, in comparison to most of the other churches, particularly the “new,” more Pentecostal churches which have attracted much younger congregants.

From my conversations with ministers and elders within the Presbyterian Church of Ghana, religious leaders are deeply ambivalent about their aging programs. Most congregations do not have strong social welfare missions, but instead are influenced by the Prosperity Gospel promoted in the Pentecostal churches, in which wealth is a sign of God’s blessings (Mohr 2013).
To that end, church construction seems a major goal of many congregations. Many congregations in these towns have re-built their older, modest churches and ministers’ residences (manses) into spectacular buildings with tiled floors, glass windows, and wooden ceilings to showcase their power and wealth, as a sign of God’s blessings (Fig 2).

Figure 2: Old church, new manse, Abetifi, Kwahu, July 25, 2014

Accompanying ministers in Kwahu, I noticed that when two Presbyterian ministers met one another, they quickly entered into a conversation about construction, discussing the price of cement, for example, or commenting on the aesthetic of the floor tiles in another’s church. Within an environment focused on church building, supporting older congregants looks solely to be a drain on church financial resources. Furthermore, church leaders are interested in attracting young and middle-aged people into their congregations, because they are current income earners who can contribute to church finances, while older women are stereotypically portrayed as devout but impoverished, putting only small coins into the collection boxes. In fact, one minister
in Kwahu told me that the reason to start an aged fellowship group was to remove the older
generation from the men’s and women’s fellowships groups, because their middle-aged children
would have difficulty belonging to the same fellowship groups as their seniors. Thus,
paradoxically, according to this minister’s analysis, the aged fellowship groups were not a sign
of the inclusion or increasing significance of older congregants, but of their marginalization
within the church, so that middle-aged congregants could take leadership positions on
committees. Thus, “Celebrating the Aged,” as the Akim fellowships’ t-shirts proclaim (Fig 3),
may in fact symbolize older persons’ segregation into less important arenas of the church.

![Image: "Celebrating the Aged" t-shirt of the New Tafo aged fellowship group, July 11, 2014]

Nonetheless, for the past five years, a senior day center has been in the process of being
built on the grounds of Christchurch in Akropong, its construction dependent on the remittances
of the town’s migrants abroad and in urban areas of Ghana (Fig 4). These migrants are one of the
important mediators of the traveling model of institutional facilities, because they cannot provide
daily care to their aging parents since they are far away and they have the financial resources to
support the church’s aging initiatives. However, they were not the initiators of the idea of the senior day center, which came from within the church leadership in response to the needs of their older congregants. Many transnational migrants work in elder care in the United Kingdom and the United States and, having witnessed institutional facilities firsthand, are not strong supporters of them. However, they are willing to support the center given their concerns about their aging parents in Akropong. A senior day center represents a compromise between a full-time residential facility and kin care at home. Promoters of the center hope one day to be able to serve a hot lunch, have a nurse present, and use the church van to pick up parishioners daily. However, they also worry that the church leadership will use the building for some other purpose and argue, at the least opportunity, that the building is a message that caring for older people can raise money for the church and enhance its physical profile. The fact that the building was completed in late December 2016 but was still not functioning as a senior day center by May 2018 speaks to some of the ambivalences within the church leadership about the church organizing an ongoing program to support older adults. Furthermore, as a two-story building without a kitchen, it has not been built as a senior day center serving potentially disabled adults. Instead, its façade looks more like a standard contemporary mansion.
In a religious environment in which the mainline churches have lost their younger members to the newer churches, the Presbyterian Church of Ghana is competing with the more popular churches by becoming like them in its rhetoric and programming. Thus, while the Presbyterian Church might be a source of new programs to support older persons, its voice is muted by competing demands and goals, including the concerns about financing new programs. There are ministers and elders in the church who advocate for support of older adults, including in its leadership, but there are others who find the focus irrelevant or indeed distracting from the long-term survival and growth of the church, which relies on the youth and those in middle age. The Presbyterian Church does not articulate a clear, strong discourse on solutions when kin care fails because of its own ambivalence about social welfare for older persons. However, it has generated new spaces—through the aged fellowship groups—for older Presbyterians to articulate and share their experiences and concerns.

**The Attractions of Institutional Facilities**
Institutional facilities are “good to think with,” but have not been experienced or seen. There are four actual residential facilities for older adults operating in Ghana, to my knowledge, three in the capital Accra and one on its far outskirts. They are relatively small; the largest had eighteen residents in January 2017. They are all heavily subsidized by their owners. Although the facilities are run partially as charitable ventures, most of the owners ultimately hope to make the homes commercially viable. Owners report that the cost of care is the biggest barrier to their use. As a result, the main clientele are return migrants or those whose children are transnational migrants, who can afford such care. Despite the small number of care homes which are operating in Ghana, and their difficulties with financial viability, there is considerable discussion of them as an imagined or potential institution amongst those concerned about older persons. Some owners of home nursing agencies and the current manager of the St. Vincent de Paul Center in Tema, affiliated with the Catholic Church, are eager to begin providing residential care. Additionally, the Kwahu Presbytery of the Presbyterian Church of Ghana is thinking of building a residential facility.

The facilities operating in and around Accra are not known to the older persons I spoke to in the Eastern Region, nor have they visited them. Instead, they imagine institutional facilities operating in other countries. Their source of knowledge does not seem to be Ghanaian migrants who work as nursing staff in institutional facilities in the United Kingdom and United States, because migrants’ representations of these care environments tend to be quite critical and even horrific. Presbyterian congregants’ knowledge of care homes arises from highly generalized discourses in Ghana in which “We Ghanaians take care of our own older relatives, unlike you [foreigners] who put your older relatives in an institution.” Institutional facilities are discursively set up as the heterodoxy to the orthodoxy of kin care (Bourdieu 1977). This heterodoxy is
therefore available for aged persons to think with and re-imagine. An institutional facility becomes a symbolic representation or token of a model of care for older adults, but the apparatus generating and maintaining that model—the healthcare institutions, experts, state support, and commodification of care by market-based care providers—are not visible or widely available in Ghana. Residential facilities are therefore amenable to the imagination and to idealization; they can become a solution to Ghanaian Presbyterians’ dilemmas precisely because they are only a token and not a reality.

The use of facilities to think through the problems of aging means that older Presbyterians situate themselves and the responsibility for their care in comparison to other countries. Within this wider horizon, Ghana is positioned as imperfect within the social field of nations where other nations are symbolically considered more advanced, for the purpose of criticizing the inadequate efforts of the Ghanaian government and the Presbyterian Church. The unfamiliar and “the modern” thus becomes an important hook through which they can imagine a good old age where older adults are dutifully respected, fed, and attended to, even though many older persons in the imagined countries do not experience aging in this way.

Institutional facilities were re-worked in several ways. First, they were seen as places of sociability, where older people could gather to talk to one another. The children of older people in these towns had migrated to the cities or abroad, a situation which congregants constructed as living alone, although few lived in completely solitary conditions. Instead, they lived with the grandchildren they were looking after, or in compounds with more distant kin. They were speaking, thus, to their sense of not being cared for, attended to, or respected, even when one lives with others (Van der Geest 2004). “Our children have grown and left us at home,” said one older man, and “we are alone.” Loneliness was considered a major problem for aging adults,
causing illness, depression, and ultimately death. A man said, “Sadness. . . kills people.” A woman said, “If you get something to amuse yourself, then you won’t be thinking too much.” Another man said, “Staying in one place . . . is bitter, and a person’s spirit declines. Maybe all his classmates have died, all of his contemporaries.” Being “alone” at home was associated with thinking too much and worrying over one’s current finances and previous losses. Sociability, amusements, and moving around was the cure for this worried and worrisome kind of thinking, in distracting older adults from their concerns. Being with others “enlivens” you, as one man said.

Secondly, institutional spaces were associated with a free cooked meal. Food was taken as the *sine qua non* of good care more broadly in Ghana. Its discussion in my interviews and public meetings signaled that many older persons were seen as going hungry, a sign that they were badly cared for (see also de Jong et al 2005). A man said, “Hunger is always there and it makes you worry, and these things also make you sick.” A woman described another man who lives alone without anyone looking after him, and therefore has difficulty getting food. The nurse’s assistant in Akropong said she had met some congregants who did not receive good care. What she meant was that they were not given a well-balanced diet, instead eating simple carbohydrate-based foods such as maize porridge or *kenkey* (a ball made of cooked fermented maize flour) with hot pepper but no fish. Abandoned and neglected elders were viewed as eating plain cooked rice, without stews or sauces containing fish or meat. Protein-rich food represented good care and attention in general, including cleanliness and medical attention.

Third, these spaces were associated with free medical attention with a nurse on site, although the imagined medical care was often preventative like checking blood pressure or blood sugar levels, such as that provided in the aged programs of the Presbyterian Church, rather than
more intensive nursing care involving drips or physical therapy for stroke victims. Older people can spend much of their time and energy seeking health care, waiting in decrepit waiting rooms in hospitals and clinics where, in their opinion, they are treated harshly and disrespectfully by arrogant medical authorities (see also Böhmig 2010). Some people in my conversations proposed that aging adults should be treated first in hospitals; for example, they should ‘jump the queue’ like pregnant women and young children.² Although Ghanaians over the age of 65 technically have free health insurance, access to health care in public facilities is not entirely free because of costs for transportation, medication, and other basic supplies.

Fourth, institutional space with its loss of privacy and institutional food seemed familiar, particularly for educated older men. They made the analogy between institutional facilities for older people and secondary schools. Many secondary schools in Ghana are boarding facilities, and, while they are associated with physical discomfort, teachers who enact physical discipline, and a strict schedule, they also are associated with deep, lifelong friendships (Coe 2005). Social networks formed in boarding schools enable alumni to navigate bureaucratic and business environments in adulthood. Previous experiences with institutions like schools, particularly for educated men, meant that they saw facilities as having the potential for intense sociality and peer friendships.

Finally, these spaces were taken as a visible sign that a society cared for its seniors. The foreignness of the institution was taken to critique the Ghanaian state among the nations of the world, rather than to bemoan the fact that their children were not Ghanaian enough in meeting their care obligations. The presence of residential facilities for seniors in Western countries was taken as a sign that these societies recognize and have not forgotten their aging adults. In my conversations, just as Egyptians formed a critique of the state around their failing kidneys and
experience of dialysis centers (Hamdy 2008), institutions functioned as a tool of political critique and advocacy to highlight the plight of older persons in Ghana. Older persons were concerned about their low status in society which they felt contributed to their neglect and abandonment: by their children, by their church to which they had contributed over the years, and by the state. Advocating for institutional facilities was one way to make that complaint stronger, by showing that other societies respected their older persons by building such facilities. Facilities were seen as their right from their previous contributions to society. This idea may have been particularly relevant for a generation that grew up in the time of independence, when the state began to fund public health initiatives. If children were not going to step up, then perhaps the state and the church would. Thus, residential institutions became a symbol of respect and recognition, which older adults felt they were lacking in society at large.

Thus, when asked what they would like to have happen, in public fora organized by the Presbyterian church, institutional care was one of the solutions articulated. There was some lack of distinction between residential facilities and senior day centers, where they might go for the day for food, companionship, and medical attention, while younger members of their households were at work or school. Interestingly, they were not concerned about facilities as a response to physical frailty, disability, or ill health, but rather as a response to social abandonment and neglect, by their kin, the state, and the church. Similar to older persons in Burkina Faso (Roth 2005), insecurity in aging for these older Ghanaian Presbyterians was perceived as a social problem, not a physical one. Their openness to institutional forms of care speak to their fears of abandonment associated with poverty and hunger, their positive experiences of institutional residency in the past, and some general knowledge that facilities exist elsewhere, but not a specific and informed knowledge of what they are like in practice. Thus, they adapted residential
facilities in their imaginations to look like secondary schools and to meet their needs for sociability, free food, routine medical care, and social recognition. In the process, they became mediators of the traveling model of residential facilities as a technology by which to provide care to aging adults, and transformed it in the process of such mediation.

**Conclusions: Options Other than Kin Care?**

The discussion of what ought to happen when kin care is inadequate signals the strategic use of complaints by older persons, which is often neglected and overlooked in both scholarship and public discourse. As Jennifer Cole (2013:226) has discussed, we have a “synoptic illusion” that views young people as a source of social change and newness, and older persons as more engaged in cultural preservation and conservation. Yet, as she notes, “the movement toward old age is a profoundly innovative process” for those who are aging and encountering new circumstances of bodily decline and changing social networks. Furthermore, as this stage of life becomes more extensive—lasting a decade or more—new questions about its meaning and practices are being asked by those who are encountering aging for the first time (see Thelen and Coe forthcoming).

Young and middle-aged people were often categorical and judgmental about deviations from the Ghanaian ideal of kin care, telling me, “In Ghana, we do not use care homes” and “We [Ghanaians] take care of our elderly.” Older persons, on the other hand, were more open to other possibilities as they encounter the aging process for themselves and acknowledge that the ideal of kin care seems unlikely to be fulfilled in practice. I heard laments and complaints in my home visits with older adults in Akwapim. I also heard resignation to the existing circumstances which
led to pragmatic solution-oriented approaches and political critique, particularly from older women who were sympathetic to the multiple pressures on their children.

In imagining new possibilities for care, older persons draw on the cultural and social resources available to them, including ideas originating outside of Ghana. They have the discursive space to imagine these possibilities because the major producers of public discourse and shapers of social norms—the state and NGOs affiliated with it—promote the orthodoxy of kin care, in part to avoid what would probably become a major financial expenditure, as it is in Western state budgets. Thus, the orthodox discourse in state policy and local discourse is about children living up to their responsibilities for care for their older relatives, with institutional facilities are constructed as the heterodoxy. The leadership of the Presbyterian Church of Ghana recognizes that kin care poses challenges, mainly because so many of its congregants in the Eastern Region are older women, but has failed to articulate a clear response, because of the ways that support for the aged can seem to contradict the church goals of construction, growth, and fundraising. Because of the institutional silence about and lack of attention to aging, older people in Ghana have the space to construct new discourses, however tentative, beyond the orthodoxy of kin care. Because state and local discourses constructed residential facilities as the heterodoxy to kin care, they were available as an idea—a token—to be discussed and revalued positively.

Residential facilities signal, symbolically, the replacement of adult children by the state or the church. The terms by which the state or the church would provide care are similar to those by which children do: the previous work of older persons contributing to the wellbeing of these social entities necessitates the response by these communities, just as the previous care of older persons for their children’s growth necessitates a reciprocal response by the children as their
parents decline in health and strength. This means that the interest in institutional care should not be taken as a sign of older Presbyterians’ acceptance of a “modern” nuclear family or individual responsibility for elder care. The social order which generated institutional facilities in one context does not exist in the other. Instead, as in other traveling models, facilities are re-signified to make sense locally, in which the state or the church replaces the adult child, justified by similar kinds of reciprocities.

Older Ghanaians express interest in institutions that they see as common in the West, in which the state, the church, or outside benefactors might make up for their children’s failures. In other words, they use the foreign figure of a facility as a token to draw attention to their wellbeing within the local social and political context. And yet, facilities can only function in this way because they are strange and not experienced or known; they are only a token representing the model which is relatively unknown. Thus, neither questions about costs nor concerns about neglect are raised, and institutional facilities are envisaged as charitable or social welfare projects by the state or churches. Where only a few, small, and struggling facilities in Accra exist, theoretical support for foreign institutions shows that older persons are open to new ideas. Using their moral imagination, they elaborate on a heterodoxy in the face of changing kin reciprocities and generate new kinds of political claims. However, one should not overstate the impact of their complaints and heterodox visions, as the older persons articulating these visions are not involved in political movements or organized advocacy for facilities. Older Presbyterians claim their right to the state’s care, mobilizing discourses of reciprocity, at the same time as they are mainly unable to enact their vision in the social world or persuade others around them to act on their behalf. Thus, the model does not fully travel, but remains a token and an idea under discussion.
Nonetheless, the complaints of these older people may ultimately result in pressure for the state to provide care for its older people in ways it has never done before. As Ferguson (2015) notes, new ways of expanding social welfare such as through a basic income grant are gaining traction in southern Africa, generating new models for the state’s relationship to its citizens. In January 2018, Kenya was the latest country to launch a social pension scheme, which gives a small monthly income to those over the age of 70 (Burrows 2017). The establishment of cost-free or low-cost care homes for older adults, whether by the churches or the state, would be another form of wealth redistribution, and thus provide another example of the expansion of care for the vulnerable in Africa and elsewhere in the Global South. In Ghana at the present time, solutions to care for older persons seem very much in flux, with a variety of moral imaginings and no dominant patterns of care. Kin care remains the ideal, but in practice is often inadequate, frustrating, and filled with conflict. Older persons, given what is at stake, are willing to imagine and explore solutions beyond kin care and make claims on their church and state through an imagined institutional facility, thereby contributing to a national discussion on the future care of older people.
Endnotes

The Moderator of the Presbyterian Church of Ghana during this time, Rev. Ayete-Nyampong, was very interested in gerontology, having written his dissertation on how the church might care for older persons.

2 Kuwait has instituted a card which gives priority to older adults in clinics and hospitals (WHO 2015, p. 92).

References


Roth, Claudia. 2005. Threatening Dependency: Limits of Social Security, Old Age, and Gender. In *Ageing in Insecurity: Case Studies on Social Security and Gender in India and Burkina Faso*,


