The enchantment of neoliberal education: a healthcare certificate, youth aspirations, and an elusive adulthood in Ghana

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The Enchantment of Neoliberal Education:
A Healthcare Certificate, Youth Aspirations, and an Elusive Adulthood in Ghana

It is well-known that contemporary African youth struggle to attain adulthood, associated with a middle-class status. However, less often discussed are the mechanisms by which that marginality is produced. In particular, I argue that the changing role of the state in relation to the middle class affects young people’s precarity. I explore a healthcare certificate offered by private schools in Accra, Ghana as an example of those changing relations. Based on ethnographic research in a healthcare assistant school and the private healthcare market, and longitudinal research with the graduates of the school, I use Bourdieu to analyse the contradictory, confusing role that education plays in contemporary Accra in generating enchantment among young people for an adulthood that proves elusive.

Keywords: health care; adulthood; neoliberalism; vocational education; youth

In a private school located in a rented house on the outskirts of Accra, Ghana in May 2015, fifteen young people—fourteen women and one man in their twenties and thirties—learned about entrepreneurial skills, mathematics, and anatomy as part of a healthcare assistant training (HAT) certificate program. The healthcare assistant certificate was developed for care workers (or carers) in an expanding private market providing home care services to aging adults in Accra and other urban areas of Ghana. However, many of the young people hoped to become nurses or nursing assistants in hospitals. The director of the National Vocational Training Institute, the government agency supervising the certificate program, said that students see “care as a stepping stone to nursing. It is not.” Similarly, the owner of a home care agency, which employed many graduates of this program, said that the young people want to “show off” and are “excited to work in hospitals.” However, “they are being deceived because there is no work for them.”

As Christiansen, Utas and Vigh (2006) point out, “Since the early 1970s, many youths in Africa have aspired to come of age in often volatile or precarious
circumstances and have had to shape their lives and strategies accordingly in their attempt to generate meaningful lives for themselves” (9). As a result, young people are presented as in “a state of flux: dislocated, marginalized, open to political manipulation, forever in a state of becoming (yet never arriving)” (Porter et al 2010, 796) or remaining in a state of “prolonged immaturity” (Masquelier 2005 60). Less well discussed are the specific conditions by which such precarity is produced and the role education plays in youth aspirations for the future (for exceptions see Mains 2011 and Martin et al 2016). Young people’s desires and engagements are an important window onto the social realities of their lives (Martin et al 2016).

The healthcare assistant school speaks to the ways that neoliberal forms of education enchant students with dreams of stable professional positions which were produced by previous state investment in a middle class. New educational programs, designed for private labour markets, mobilize the infrastructure, labour, and visions developed by the developmentalist state, because the private sector only offers precarious, service-oriented labour to those with secondary education in Ghana. These new forms of education marginalize students, stripping them of limited resources as they attempt to secure an adult future.

By educational enchantment, I mean the ways in which schooling becomes the vehicle for fantasies of the future. As Martin et al (2016) note, young people appear to be unshaken in their belief that going to school and university will help them to rise socially (see also Laube 2016 and Maurus 2016). I am not so much referring to the mystical or occult forces that Comaroff and Comaroff (2001) see as mobilized to explain millennial capitalism, but instead the hopes engendered by schooling, despite the social realities faced by educated youth. Berlant (2011) discusses the powerful forces that lead to misrecognition, in which “fantasy recalibrates what we encounter so
that we can imagine that something or someone can fulfill our desires” (122). In this, I mean an everyday desire to be enchanted and have hope, born out of struggle and the need for direction and movement. Although Appadurai (2013) distinguishes between fantasy and the imagination, in which fantasy is individual and imagination is collective, I find it difficult to differentiate between the individual and the collective, because of the ways that persons take up hegemonic imaginings for their own personal projects. Not only are educational programs explicitly oriented to the future (Stambach 2017), but they also powerfully shape young people’s aspirations (Martin et al 2016, Mains 2011, Maurus 2016). In a precarious world, all steps feel uncertain and full of risks, and thus enchantment is necessary to move in any direction. Schooling is therefore the same kind of “taking a chance” as van Wyk (2012) describes for gambling in Cape Town, requiring enchantment but also the realization that one needs to engage in multiple options to achieve success, as has been noted in other studies among youth in Africa (Christensen, Utas and Vigh 2006). I would argue that enchantment and disillusion are the major emotional registers of taking a chance.

Although faith in schooling has been present at least since the time of independence in Africa, particularly in its instantiation as transforming society (Vavrus 2003), neoliberalism is revitalizing educational enchantment. Neoliberalism is the doctrine that valorises private enterprise, to the extent of advocating that the state be run like a business, and the practices associated with this doctrine (Ferguson 2009). Although neoliberalism has been discussed in relation to the role of the state in Africa, its influence on education, particularly private education and certificate programs, has been less often explored. Neoliberalism leads to enchantment of schooling because of the growth of private educational schools and services, which require an enchanted clientele and create longings for various futures through advertisements (Nisbett 2013).
In many ways, these neoliberal dreams mobilize a nostalgia for a past that did not exist, in which education leads directly to state employment, a developmentalist model of the relationship between the state and the middle class, which is reinforced in school textbooks (Maurus 2016). Although this developmentalist model never truly worked in reality, neoliberal educational dreams rely on one aspect of this model—that schooling promotes social upward mobility to the middle class. As such, it scavenges the developmentalist infrastructure of what it aims to replace through the market. The precarity and flexibility promoted by neoliberalism can make some people reject schooling (Esson 2013; Langevang 2008), but others are even more enchanted, ironically investing even more in it, as they seek linear trajectories into the future, as promised by such educational programs (Laube 2016, Mains 2011).

I conducted fieldwork on the emerging care market in Accra and the occupation and education of care workers during twenty-five weeks over five years (2013-2018). The longitudinal nature of the fieldwork allowed me to explore the relationship between young people’s aspirations and the elusiveness of adulthood. In addition to speaking to government officials, nursing school heads, managers of home care agencies, and home care workers, I followed fifteen students in one school offering the HAT certificate. I was present at the beginning and end of their course and followed up with seven of them twice — six months and two years after they had passed the examination. The students ranged in age from 23 to 38 years of age. All were women, except for one man. Two were from the more economically deprived North, and the rest came from the South. Four were married (two with a husband abroad), and three had children. Some students had worked in the informal sector since completing senior high school two to five years before; others had worked as a ward assistant or office secretary for several years before deciding to pursue a new occupation. One was a domestic servant, whose
employer was paying for the course. Most had graduated from senior high school. The students’ class positions thus varied a great deal, from impoverished to middle class.

The healthcare assistant certificate in Ghana reveals how young people’s futures are lost and social precarity is (re)produced (Cooper and Pratten 2015; Gupta 2012). An institutional contestation, generated through competing visions of the state’s relationship to the middle class, resulted in a limited exchange value of the healthcare assistant certificate in the employment market. As I show below, various state and private sectors tussled over the meaning and value of the educational health care program. This case reveals the contradictory, confusing role that education plays in a context of neoliberalism, in which education, through enchantment, is a source of extraction of value from those aspiring to adulthood associated with the economic ability to maintain dependants. Neoliberal processes have introduced new dynamics in education but are not completely dominant, because they rely on the infrastructure of the developmentalist state to generate value. Instead, neoliberal processes are assembled through and entangled with an older model of the social order, which does not go away entirely.

Elusive Adulthoods and Changing Relations between the Middle Class and the State

Young people in many African countries face difficulties in attaining a respected adulthood associated with the middle class, with research particularly focusing on the problems of young men (e.g. Durham and Solway 2017; Mains 2011). Although the students in the healthcare assistant class were in their twenties and thirties, some with small children, they were positioned as “young people” because of their student identity and their inability to support their dependants, the sign of adulthood in Ghana. They had
gone through several vocational programs prior to the healthcare assistant school, and would do so after the program ended.

What I want to focus on here is that this attainment is made more difficult by the multiple models of middle classness in tension in Ghana, with different implications for state investment and regulation, education, and gender. These are models of the relationship between the middle class and the state; the reality is more messy, with multiple middle classes, movement between the public and private sectors by individuals, and movement in and out of the middle class across the life course (Kroeker, O’Kane and Scharrer 2018). One model is a developmentalist middle class shaped by the state, from state-provided formal education to employment, because it is constructed as critical to national progress (see Maurus 2016). The neoliberal middle class, in contrast, is engaged in entrepreneurship, connected to global capital, obtaining short-term instrumental or practical education, and dependent on the state’s promotion of private markets. These different middle classes as routes to the good life represent “different visions of the state, different modes of capitalist reproduction, and different forms of subjectivity” (Heiman, Freeman, and Liechty 2012, 14).

These two models also have different views on the role of education. Ideally, the developmentalist state supports the middle class to obtain many years of schooling, which is then rewarded with government employment, and amenities like transportation and housing, stable employment, and status, in part because of the legacy of colonial administrations (Kuklick 1979; Oppong 1974). Education has long been key to middle-class status in Ghana (Budniok and Noll 2018). The neoliberal middle-class model, on the other hand, values shorter-term instrumental schooling, so that a flexible labour force can meet the needs of an ever-changing private market. Technical skills are purported to be of higher value than educational credentials. Furthermore, the individual
chooses his or her own educational path based on imperfect knowledge, and thus may invest “irrationally,” that is, in skills not desired by the current labour market. For these many reasons, the exchange value of education is precarious and fleeting in a neoliberal order.

Most of the studies of elusive adulthood in Africa have focused on young men, yet it is important to also understand the experiences of women aspiring to middle-class adulthood. The different models engender the middle class differently. In Ghana, the overwhelming majority (90%) of civil servants and those employed in the formal sector are men (Heintz 2005). Although women in Ghana work at levels comparable to men, they dominate the informal sector in trade and marketing (Clark, 1994; Heintz 2005). Nursing, alongside teaching, has provided one of the few routes by which women can obtain a civil service position within the developmentalist middle class. The flexible labour market promoted by neoliberal processes, on the other hand, is open to female employment, in part because it is oriented to the provision of services associated with feminine skills (Freeman 2014), and because it overlaps with informal markets in Ghana.

The developmentalist middle class seems to be deteriorating in Africa, while the neoliberal middle class ascends (Spronk 2014), but the reality is more complicated. In Ghana, neoliberal structural adjustment reforms in the 1980s and 1990s resulted in a decline in civil servants’ status into a lower-middle class as they were retrenched and their wages and benefits eroded, and intensified the economy’s dependence on resource extraction. Half of Ghana’s economic growth (at 15.2% in 2011) has been driven by mining and oil extraction (Baah-Boateng 2013). The extraction economy does not produce a local middle class because it employs few Ghanaians, nor did neoliberal reforms promote an indigenous entrepreneurial class (Opoku 2010). Ghana’s economic
boom was used to support the developmentalist middle class, with the civil service expanding enormously since 2005 (Economist 2016). Nonetheless, a recent loan from the International Monetary Fund accompanied pressure to reduce spending, with the Ghana government announcing that in 2017 there would be no openings for government positions, with a few exceptions (Anon 2016a). The developmentalist and neoliberal middle classes currently co-exist uneasily in Ghana.

In the past few decades, nursing and medical personnel were somewhat sheltered from other public service cuts, as the Ghana government considered health services to be critical to national development and tried to stem the international migration of government-trained nurses (Abuosi and Abor 2015). Although nurses feel underpaid for the hard work they do (Böhmig 2010), their salaries have risen since 2005, and are at about $400 a month (Darko 2015). As its benefits, status, and pay have increased, and because it serves as a stepping stone to international migration, nursing is an increasingly popular profession among young Ghanaian women.

As a result, there is great demand for nursing education. Entrance to government nursing schools is extremely competitive, with 3,000 applications for 250 positions. To be admitted to a nursing program, students need to have a high enough score in three core subjects (English, Integrated Science and Mathematics) and three elective subjects on the secondary-school examination (WASSCE). Less than half of secondary school graduates taking the WASSCE in 2016 passed, with pass rates in the subjects of integrated science and mathematics particularly abysmal (Anon 2016c). Many students re-take the exam over several years to try to improve their scores.

After the government allowed private nursing schools to open in 2003—to help address the nursing shortage, reduce the high population-to-nurse ratio,¹ and meet Ghana’s Millennium Development Goals, particularly in the areas of infant and
maternal mortality—Accra and other urban areas witnessed an explosion of private nursing schools. In Ghana, as in other parts of the world, private schools have focused on vocational courses of study oriented towards seemingly fast-growing and attractive careers like IT and healthcare. Private schools in Ghana are founded by entrepreneurs who see them as a profitable venture, and they have grown increasingly popular at all levels of education in urban areas. Whereas during the 2010-2011 academic year, there were thirteen public and four private nursing colleges (ISSER 2013), the number had doubled to twenty-three public and ten private nursing colleges, along with twenty-five unaccredited nursing schools, by 2016 (Anon 2016b; National Accreditation Board 2016). Many schools offer not only nursing programs, but also programs for lower-level positions in healthcare, including the two certificates for healthcare assistants described below.

The attraction of both healthcare assistance certificates among students is due to their association with nursing. Many healthcare assistant students would like to become nurses and fantasize that healthcare assistance is a step in that direction. However, as in the United States (Ducey 2009), where the further training of lower-level healthcare workers does not count towards course work in nursing and medical education, a year or two of healthcare assistant training has no exchange value for further education as a nurse. Students who want to pursue nursing would be better off re-writing the relevant examinations of the WASSCE to obtain a higher score than enrolling in a healthcare assistant certificate program. These contradictions mean that young women are enchanted by the occupational promises of the certificate.

Students of the healthcare assistant program were mainly young women. Enchanted by a vision of becoming nurses, young women invested their kin’s financial resources in a neoliberal educational program. They found the only labour market
willing to employ them was a private one, associated with the informal sector which
women already dominated and precarious, low-wage work. I now turn to the
institutional conflicts which generated this elusive adulthood.

**A New Care Market, a New Credential**

The genesis of the healthcare assistance certificate derived from the emergence in the
late 1990s of a new private care market created by entrepreneurs, mainly return
migrants, who saw urban families in Ghana struggling to provide care. The care market
was prompted by the needs of already working, middle-class and elite women, whether
in Ghana or abroad, who could not personally care for their aging parents. In response
to this demand, using capital earned abroad, entrepreneurs founded agencies to provide
home nursing care. The first home care agency in Ghana was started in 1997 by a
retired nurse, a return migrant from the United States. The emergence of other agencies
in the late 1990s and early 2000s was part of an overall marketization and privatization
of healthcare in Ghana to serve wealthy and middle-class urban families (Dekker and
van Dijk 2010).

The new private, completely unregulated market in care sought the assistance of
government agencies and professional bodies to create standards for the new occupation
they had created, to help these entrepreneurs establish a high reputation, market their
services, and pay their employees an attractive wage. Esther, the owner of one agency,
worked to create a credential for carers as part of her efforts to legitimize the work and
quality of her agency employees and differentiate them from untrained domestic
servants, whom families were also using to provide senior care (Author 2016). Esther
told me that she went first to the Nurses and Midwifery Council, but they told her they
did not consider care to be part of nursing. She then turned to the National Vocational
and Technical Institute (NVTI), which supervises certificates in construction, mechanics, electrical engineering, auto repair, dressmaking, and hairdressing. Part of NVTI’s mandate is to partner with private industries, and thus NVTI represents a neoliberal wing of the Ghana government. Esther worked with NVTI from 2005 to 2008 to develop a one-year curriculum, and she was also involved in writing and grading the examinations. However, Esther found that what she had originally set in motion became completely different as NVTI increasingly drew on the expertise of four nurses—who worked in hospital settings and did not understand home care—to write the curriculum. The examinations for Health Aid (Carer) in May/June 2004 that Esther had devised—and which she showed me—focused on communication, skin care, diet, wound healing, and laying of beds. However, the examinations changed under the nurses’ expertise to make them similar to those for nurses, including examples based in hospital settings and familiarity with medical terms (e.g., cerebrospinal fluid). The certificate’s name also changed, to Healthcare Assistant Training (HAT).

Esther’s frustrations with the hijacking of the credential she had created led her to reject it as meaningful. Despite her concerns, she found training her own students to be too much effort and began hiring HAT graduates from other schools or even people without certificates. Although potential employees with HAT certificates present themselves as “nurses” to her, she found that they could not answer her specific questions about care. She preferred to hire those with “a warm heart,” whom she could train as she liked, who are not “arrogant,” and whose misguided training she did not have to undo. Other agency owners also discounted the HAT certificate, preferring to give a brief orientation and relying on employees’ existing skills learned from caring for their frail or sick relatives at home.
The new credential did not address the needs of this market, because it socialized students into hospital-based nursing, not care in the home. The focus of the curriculum shifted because NVTI sought to give the certificate greater cultural capital. The director of NVTI told me that about 110 private schools offered the certificate in healthcare assistant training (HAT) in 2016, mainly in Accra. The schools pay a fee to NVTI as part of their accreditation; one school director complained that NVTI wanted many schools to offer the certificate because of the money from the fees. Since NVTI began offering the certificate in 2003, by its own estimation, 1000-1500 students have received this certificate. By using nurses as experts, NVTI responded to students’ dreams of becoming nurses, not low-status care workers in other people’s homes, and private schools’ desire to attract students.

In the meantime, the Nurses and Midwifery Council (N&MC) sought to delegitimize the popular HAT credential by distinguishing it from nursing. In response to NVTI’s credential, the N&MC developed its own certificate for nursing assistants, known as the Healthcare Assistant Clinical (HAC). Some schools offer both the HAC and the HAT as one-year and two-year courses. The HAC course is more expensive than the HAT (Ghc5200 vs Ghc3600 respectively in August 2015 for the one-year course, equivalent to $1300 vs $900 at the time). These programs are advertised on the radio and television, as well as plastered on vans which serve as public transportation and on fences and walls on public streets. Word-of-mouth advertising through existing clinics and hospitals is also important. The students I met through my fieldwork heard about the certificate courses from relatives or spouses, some of whom already worked in health care. Students’ tuition costs were paid by these key figures, in addition to remittances from migrants and the sale of other economic resources, such as land.
Due to the N&MC’s pressure on government hospitals, HACs may be employed as assistants to registered nurses in public hospitals, but HATs may not. HATs are only eligible to be employed as ward assistants in public hospitals, a job previously held by men and women with little or no education, or HATs may work in private hospitals, if they have the social networks to find employment there. HAT students are also prohibited from doing their clinical training in government hospitals. The Nurses and Midwifery Council thus views the HAT certificate offered by NVTI as a threat and maintains the privileged niche of nurses by limiting who can be employed in government hospitals. NVTI is in a defensive position: it wishes to accommodate N&MC’s concerns but also continue the certificate program.

In the case of the healthcare assistant certificate, the professional organization was powerful enough to reduce the value of the HAT credential generated by a government agency working with the private sector, thus limiting a neoliberal orientation in favor of a privileged group of nurses tied to state institutions. Meanwhile, private schools and NVTI tried to uphold the credential’s value through providing hospital- and nursing-oriented curricula and clinical experiences and giving students a uniform similar to nurses, in order to continue to attract students. Some teachers and school owners assumed that N&MC would ultimately lose its battle against the HAT certificate, as private hospitals would seek to reduce their costs by employing lower-paid healthcare workers in place of nurses. As one would expect, given the similarity of their acronyms and names, the general public and students alike are confused about the difference between the two certificates and the kinds of employment these certificates enable. Poorer students are more likely to pursue the cheaper course.

The credential emerged from an assemblage of neoliberal processes, including the creation of a private market for home senior services, the effect of transnational
migration on kin care, and the increasing presence of private schools within a neoliberal educational context. However, the story of this credential also illustrates the limits on neoliberalism in its efforts to put pressure on civil service wages and in the creation of a private educational market. Nurses unfamiliar with home care services became the experts in setting the curriculum and examination for the HAT as NVTI sought to raise the cultural capital of the credential, thus orienting students towards the most valued places of employment: government hospitals. At least for the moment, professional organizations like the N&MC control the kinds of credentials accepted within the government hospitals, thus limiting the value of the educational program developed by private schools. Thus, students were trapped between, on the one hand, the exuberance of private schools and a private care market eager to expand, and, on the other hand, a professional organization closely tied to the most preferred employer, the state, which could guarantee a middle-class status for its members.

The Social Life of a Credential: Forms of Capital in the Making of a Middle Class

In June 2015, I was at a secondary school on the outskirts of Accra, sitting with a teacher in the shade of a pavilion in the center of several classroom blocks. Inside the classrooms, hundreds of students from different healthcare assistant schools were writing the examination. Having observed a class in one school, I was pleased to talk to a teacher from another school about her students and her sense of the curriculum, to compare my fieldwork insights against her more extensive experience. In the course of our conversation, she commented that the students were “victims of circumstance.” She explained that the students were able to pay for their education and were eager to learn, but there was no work for them. As soon as she said this, she backtracked from the forcefulness of her statement as if she found it too depressing, saying that students were
in fact learning useful skills that would help them in their own households or as mothers. Pierre Bourdieu’s conceptualization of the forms of capital is useful for thinking through the value of the healthcare assistant certificate, as this teacher sought to do.

Bourdieu (1986) distinguishes between different forms of capital—economic (income and wealth), cultural (cultivation and credentials), social (connections) and symbolic (status)—and illustrates some of the mechanisms by which one is converted to the other. Although the exchange value of capital can be broadly recognized as valuable in certain periods, such value is usually the result of fierce negotiation. “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” (Hall 1992, 275). Furthermore, “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” (Rytter 2011, 207). For example, in northern Nigeria, a previously valued and respected status—like Qur’anic student—became stigmatised in the face of new forms of education associated with modernity (Hoechner 2015). Histories of Western workers find that wage and status bubbles are generated by particular arrangements that temporarily value an occupation highly, until the owners of capital find a way to reduce the value of that labour, such as through outsourcing or mechanisation (Sewell 2005).

Academic qualifications are an effort by actors to institutionalize the conversion rates between cultural capital and economic capital and thus reduce the diversity and dynamism of interpretations about the value of a particular qualification (Bourdieu 1986). To the extent that the state is the major employer of educated persons, as in the developmentalist middle-class model, the state provides the equation for converting an
academic credential (cultural capital) into a position providing symbolic, social, and economic capital. The formation of a privileged middle class such as nurses or civil servants is dependent, in part, on state political concessions and legal niches that protect this class and distinguish it from others (Berger 1981; Klocka 1981). Considered the primary source of potential opposition in Ghana, the urban middle class has historically won numerous political concessions, such as low food prices at the expense of farmers, and engaged in strikes to maintain civil service wages (Opoku 2010).

Professional organizations, such as medical and nursing associations, have also historically been involved in establishing the exchange value of cultural capital, by maintaining that only people with certain credentials are qualified to assume particular roles in institutions. One of the main targets of neoliberalism has been occupational self-regulation, with Milton Friedman writing an early book about the medical profession (Standing 2011, 39). Credentialing was used to professionalize nursing in the United States and create privileged positions for some, while simultaneously creating subordinate positions to do the “dirty” work of nursing, such as changing beds and cleaning patients (Reverby 1987). As discussed previously, nursing in Ghana is for the moment a privileged niche, which the nursing association in Ghana protects by controlling entry into the profession, as seen in the N&MC’s pressure against the HAT certificate. The state has been a key actor to the making and unmaking of the middle class in Ghana through its employment practices, and in setting the exchange value of the forms of cultural capital in which middle classes invest (see also Subramanian 2015 for India).

Young people preferred hospital-based work—associated with the developmentalist state and its middle class—to private care for several reasons. First, working in a hospital gave one status whereas working in someone’s home was similar
to domestic service, a denigrated status in West Africa (Gardini 2016). Hospitals are associated with educated professionals, and domestic service with the uneducated (Author 2016). Nurses and carers act differently in relation to patients. Nurses in Ghana are known to be rather abrupt and curt, giving orders which patients must obey (Böhmig 2010). In most hospitals, family members, not nursing staff, provide the most menial care of changing clothing, bathing, and feeding. At home, in contrast, carers must follow the household rules and patient’s wishes and perform feminized labour.

Secondly, rates of remuneration differ, with hospital staff receiving a monthly salary, a sign of stable professional work, and carers a daily rate associated with a precarious, informal workforce. Nursing assistants in hospitals were paid a monthly wage of Ghc800-900 (or about $200-225 in August 2015, or $1.67 an hour for a 40-hour work week). In contrast, in 2015, carers were paid a daily rate of around Ghc20 (or $5 for 10 hours) or Ghc30 (or $7.50 for 24 hours) and some receive Ghc500-700 a month if they work many days. Because of the monthly salary, hospital workers are seen as more autonomous in their schedules, important for young women with childcare needs. One student said she wanted to work in a hospital because they close at two in the afternoon. Although nurses work in shifts, this schedule is what she imagined from her internship with a hospital, and the day shift has the largest workforce. She imagined working much longer hours in care. Commenting on the difference between the expected work conditions and her students’ hopes, the owner of the same school said, “They like their freedom and they don’t want to have to work hard. They don’t want a boss or supervision.” Although both nurses and carers work under supervision, students saw nurses as having much more authority and control over the nature of their work than carers.
Bourdieu (1996) argued that although educational credentials served as an important form of symbolic capital when they were exchanged in the labour market, their significance was to obscure and validate the embodied cultural capital transmitted through the family. Furthermore, he posits that the transfer of cultural capital through a family in the dominant class cultivated particular bodily performances, aspirations, and personal inclinations—the *habitus*—of its young members, which in school were valued and converted into the cultural capital of grades and credentials. I would argue that it is important to tease apart embodied cultural capital from the exchange value of an educational credential. The healthcare assistant credential gave students embodied cultural capital temporarily, demonstrated everyday through their uniforms and subjectivities, during the period of their education, as in the developmentalist middle-class model of education. However, its exchange value was ultimately determined by the state’s negotiations with professional bodies and the private sector. Through the contradictions of the state’s competing developmentalist and neoliberal orientations, young women’s futures as middle-class adults were both made and lost.

**Embodied Cultural Capital**

The healthcare assistance school gave young people embodied and symbolic cultural capital during the time they were in school. They had status as students, legitimating their mobility outside the house and giving their activity purpose and meaning, which is particularly important for young women (Maurus 2016, Porter et al 2010). The daily activity of going to school gave young people a feeling of agency, authority, and status. Moving around the city for school gave a sense of making progress in the world, as has been noted in other work on youth in Africa (Mains 2011, Porter et al 2010). Full of purpose and progress, education was enchanting. The key features which gave HAT
students this sense of identity and status were their uniforms and their healthcare knowledge, both of which were used by the schools to attract young people.

The National Vocational Technical Institute (NVTI) required HAT students to wear a uniform. The white uniform with green trim was very similar to that of nurses in Ghana. This uniform gave them a public identity as they commuted long distances across the congested and sprawling city of Accra to and from school. They reported being viewed as nursing students by their friends and families, and they were asked for medical advice. This public identity also spurred them to identify as nurses and with the mission of nurses to train and help the public. For example, one morning, when Millicent arrived at school, she recounted to the other students an accident she had seen on her way to the school that involved a motorbike, At first, the students discussed the prices of motorbikes, an increasingly popular mode of transportation in Accra, although car ownership is—and has been historically—one of the paradigmatic signs of middle classness. Then Bella said, “As a nurse, you have to get down.” Mary illustrated what a nurse should do by calling out, “Driver, wait! Let me help!” They thus developed “a heart for the work” (Wendland 2010), in which nursing was a calling to serve the public. HAT students were treated and came to see themselves as persons-on-the-way-up, even though their course did not qualify them to move up.

Through their course of study, HAT students came to identify with nurses in hospitals. For example, although students had clinical experiences for two weeks in home care and seven weeks in a private hospital, they spoke only of their hospital clinical in their conversations in the classroom, unless prompted otherwise by me.

The students were enchanted by their hospital experience and spoke often of their former colleagues during informal conversations in the classroom, even though
They had been insulted by the nurses, who had shouted at them and used them as low-status errand-runners for food and lab results.

They talked about a nurse [they met through the clinical training], who is now training to be a doctor. They did not like her because she was arrogant. She told Bella to fetch doughnuts from a place far away. She told Brilliant to go to the lab to check the results, and Brilliant refused, so the nurse complained to Brilliant’s supervisor. Brilliant told her supervisor that when the lab staff had the results, they sent them back, so it was no use going to the lab to bother them. The supervisor, impressed, asked what Brilliant would like to do. Brilliant said she would like to follow the doctor on rounds. When she did so, she learned a lot about different cases. Bella responded by saying that she did not think this nurse had the heart to be a doctor.

Observing the healthcare professionals around them carefully, they were choosing whom to model themselves after. The nurses seemed part of the middle class, because of their autonomy, status, and power in the workplace, in contrast to care, which looked more like being a domestic servant working for the rich and powerful. Such talk about nurses whom they had met at the hospital was an important part of their occupational self-identification.

The students said they wanted to work in hospitals because it was a place where they could learn many things from those around them and through the variety of cases they encountered, which would not be possible from taking care of one patient at home. They could continue learning and “move ahead.” They hoped to move up in the hospital hierarchy through their skills, in neoliberal fashion, since they lacked the right credentials. One student told me proudly that during her hospital clinical, a nurse told
her to give an injection to a patient. Although she had not received instruction on this technique, she had watched the nurse do it, so she said she could do it and did so (on the use of imitation in modern schooling in Ghana, see Author 2005). She also dressed wounds that were much worse than those she had dressed at home while caring for her mother. The pursuit of knowledge through imitation, rather than credentials, enchanted them during their training. They oriented themselves to working in a hospital, as a place that would reward this more informal pursuit of knowledge.

Recalibrations of the Future

As they reached the end of their year-long training, the HAT students became more concerned about the limited employment opportunities available to them. The anatomy instructor, a midwife, reminded them that they were going to be “healthcare providers,” so they have to collaborate with the nurses, but would not be in control as nurses are. A student responded, “That is why we have trouble getting jobs.”

After they had completed their written examination, and were studying for the clinical examination, the students shared their future plans, using a mixture of English, Ga, and Twi, as is common among senior high school students in southern Ghana.

Florence said anxiously, “Mihia certificate no [I need the certificate].”

Bella said, “I don’t want to re-sit [the certificate if she fails]” or do the second-year HAT course; rather, she would re-sit the WASSCE and do general nursing. She explained why: “Carer nyɛ effective wɔ Ghana ha. Wobebrɛ saa ara. Ghana nye [Home care is not financially viable in Ghana. You will be so tired (doing the work). Ghana is not
good (in terms of remuneration for employment)).” She felt it was okay
to do home care abroad, however, because one would be better paid.

There are no recruitment agencies for domestic work and nursing abroad in Ghana,
unlike in the Philippines. Although many Ghanaians in the UK and US work in home
care (Author 2019), their credentials do not transfer transnationally. Towards the end of
the course, students socialized one another to dampen their aspirations and plan other
courses of study, as a result of peer and teacher comments.

I followed up with seven of the students from the course in December 2016—six
months after they had passed the exam—and in August 2018. None of the fifteen
students I followed actually worked in home care for which they were officially trained,
although the four agencies I followed in Accra mainly employed those with HAT
certificates. Three had found work by December 2016. The best student was working in
a small private hospital recently founded by a surgeon and his wife, but was paid a
small monthly stipend of Ghc200 (about $50) because of the paucity of patients.
Although her salary was very low, such that initially she told me she was paid nothing
at all, she wore a nursing uniform to work and had a high social prestige. She lived with
her family in a suburb of Accra and was supported by her husband, a soldier, with
whom she had recently had a baby. Two other graduates were working in private
pharmacies, one using her social networks and the other with previous experience in a
pharmacy prior to her HAT training. A fourth was planning to embark on another
course, this time in cosmetology, funded by her husband as her HAT training had been.
The sole male student did further training in fire management and showed me photos of
his fellow students posing in macho ways. Two students relied on their husbands’
remittances; one husband hoped his wife would soon join him in New York City to
work in home care. Thus, the youth seemed to have recuperated quickly when
enchantment dissipated, mobilising themselves for another project like marriage, migration, or further education rather than being depressed. As Laube (2016) notes, these other grammars by which social recognition can be given mean that young people do not necessarily experience waithood. Young people were eager to become re-enchanted by another project.

The HAT credential did not have no exchange value, but one needed social networks and prior experience to convert it into employment. The available employment was in the private healthcare sector, whether in home care, private hospitals, or private pharmacies, characterized by low pay and long hours. However, unlike home care, the employment found by the HAT graduates I followed was associated with an educated status and expertise in that one wore a uniform or business attire to work. By pursuing the HAT, young people were socialized into a professional subjectivity and skills associated with nursing, but found they had to turn to the private healthcare market for employment, where they faced precarious employment conditions, long hours, and low pay (similar to home care but with higher prestige). Thus, the private schools cater to a private healthcare sector, creating a parallel system that tries to copy the state system and uses the enchantment of middle-class employment associated with the state sector to attract young people to invest their resources in this pathway to adulthood.

Conclusion: Middle-Class Precarity, Neoliberalism, and Education

In the wake of neoliberal economic reforms, entrepreneurial movements have created a change in the educational and employment possibilities in many African countries. Educational entrepreneurs relied on enchantment, a mis-recognition of the possibilities, using the images of a middle class tied to civil service employment to promote training for precarious, relatively low-paid work in the private sector.
The example of healthcare assistant training in Accra shows that youth uncertainty is produced through relations between private and state sectors. As noted in other studies (Gupta 2012), the state is a many-fingered creature, in which the goals of one agency like NVTI do not necessarily match the employment practices of another, like government hospitals. The state’s promotion of a middle-class adulthood is incoherent and confusing, and speaks both to the deteriorating status of the middle class—in which education and stable employment become disjoined—as a result of neoliberal reforms and counter-attempts to shore up those losses, by limiting employment in government healthcare institutions to a privileged few protected by a special alliance between the state and a professional organization. In this case, the competition of different middle classes with differing relations to the private market and the state produced a certificate with little exchange value to which young people were attracted.

The contradiction of the healthcare assistant credential also speaks to the contradictions of a new occupation generated in the private sector in Ghana, an occupation which promises low-status and precarious work for educated persons. Care work is stigmatized because of its association with domestic service, little education, long and uncertain hours, and lack of a stable, salaried career. An attempt to legitimize the care market created the healthcare assistant credential, but the credential was quickly transformed to become more similar to nursing and oriented to hospital-based settings, and thus more attractive to young people unable to gain admittance into nursing programs. The credential’s popularity incurred a counter-strike by the nursing association and the most sought-after employer, government hospitals, which negated its exchange value, at least at the present time.
This is not a story of the triumph of a neoliberal state and the new middle class tied to it. Instead, the entrepreneurial middle class attempted to mine the social resources and mechanisms for creating value, such as schooling and stable employment, associated with the state-based middle class. Structures, skills, and visions developed by developmentalist liberalism allowed neoliberal education programs to enchant students.

As this article has shown, education plays a contradictory role in the precarity of youth in Africa. The neoliberalizing context which relies on state infrastructure and regulation affects youth aspirations and pathways to adulthood. Although such credentials may not have cultural capital in terms of their exchange value in the employment market, the courses do have significant effects on young people’s subjectivities, status, and knowledge and give them the promise of a meaningful pathway into the future. Education becomes the object of fantasy, swelling dreams and egos, followed by disappointment and recalibration of the future. The HAT course gave youth confidence about their expertise, a sense of purpose that their lives were moving ahead, and a subjectivity of authority and public mission (which some read as arrogance), at least during the time they were in the course. Education creates a momentary status with the promise of stable future but also serves as an instrument for stripping scarce resources from young people, creating disillusionment about one kind of taking a chance, which were soon replaced by new enchantments through marriage, transnational migration, and further education.
References


Author 2016

Author 2005


Notes
As of 2010, there were almost 25,000 nurses in Ghana, with a nurse to patient ratio of 1:971 (Ghana Health Service, 2010, 19).

Although a year might seem a long time given the six-to-fifteen week training for certified nursing assistants in the United States, it is similar to Denmark’s social and healthcare helper course of a year and two months.