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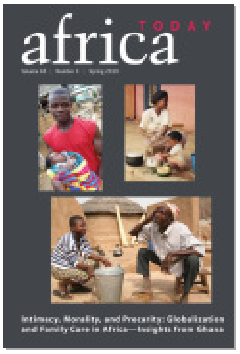

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Avoided Family Care, Diverted Intimacy: How People Living with HIV/AIDS Find New Kinship in Two Ghanaian Hospitals

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This article aims at nuancing the discussion of processes of globalization and change through ethnographic research on caregiving in Ghana. It points at a cautious but remarkable shift from traditional family care to care outside the family setting and raises the question how this shift is linked to external and internal processes of change. The presentation of an extended case of avoiding family care by people living with HIV/AIDS serves to suggest a more complex interpretation of social change than is implied in the concept of globalization.

The stigma attached to HIV/AIDS in Ghana induces infected people to hide their condition from their families and seek help from professionals and fellow sufferers. We describe this process through the examples of two Ghanaian communities and two hospitals where two of the coauthors conducted anthropological fieldwork. In hospitals, people living with HIV/AIDS find new (quasi) relatives, to whom they divulge their secret and with whom they freely discuss their problems; these new relatives are other people living with HIV/AIDS, volunteers, and health workers. Strangers thus become safer and more trusted caregivers than family members. We describe in detail how this development precludes the practice of family care.

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Introduction

Since the mid-1990s, global flows of communication, migration, international politics, and economic forces have been regarded as key drivers of change worldwide (Appadurai 1990, 1996; Ellwood 2010; Giddens 1992; Hopkins 2004). Observers agree that such international flows are not new but, as Appadurai (1996) remarked, they had never occurred with such intensity and forcefulness before. It has been pointed out that globalization is not a one-directional phenomenon (Ellwood 2010; Hopkins 2004; Kearney 1995). Asia, for example, has exported numerous artistic and religious traditions to Western countries (Harper 2004). Nor is globalization a matter of exact copying. Modern ideas and practices from elsewhere are reinterpreted and transformed when they are received and integrated in new contexts (Ellwood 2010; Kearney 1995).

Developments in healthcare tend to be regarded as prominent examples of globalization due to the overbearing influence of biomedicine through international organizations such as WHO and UNICEF, medical schools, hospitals, medical technology, pharmaceuticals, and migration (Biehl 2016; Brown, Cueto, and Fee 2006; Hochschild 2000; Janes 2004; Janes and Corbett 2009; Mattingly, Grøn, and Meinert 2011). This article takes changes in family care as a case to analyze the role of globalization in caregiving in Ghana.

Intimacy, affection, and kinship solidarity are seen as the ideal virtues of family care in Ghana. Care by non-kin (strangers) is therefore often looked at askance as a dubious Western practice and a moral shortcoming of the family. For those diagnosed with HIV/AIDS, however, family care is often avoided, as will be shown in the ethnographic centerpiece of this essay. We look more closely at the development of dwindling family care and growing involvement of others in care activities by positioning our research in the context of other Ghanaian studies of care. The process of shifting care practices is seen as the outcome of a mix of developments that reflect changes within the heart of Ghanaian culture and society, due to the specific care problem at hand and to globalizing forces intersecting with local transformations. The extended case of avoided family care by HIV/AIDS patients and the other ethnographic examples are used to propose a more nuanced and complex interpretation of social change than is suggested in the concept of globalization, the overarching theme of this special issue.

In the discussion, we look at several family-care processes that form the wider context for the avoidance of care. Migration reduces the availability of relatives who are traditionally responsible for providing care to children, the elderly, and the sick. Instead of giving direct care, migrant relatives may send money to attract others (more distant relatives or non-kin) to provide care. Imagined views of family and home affect relations of affection and trust between supposed caregivers and care-receivers. Fictive kinship allows for transforming non-kin into quasi-relatives who replace biological kin in care activities. Reciprocity, finally, determines entitlements to care. These processes and concepts enable us to better understand dwindling family care in the context of wider processes of change.

The ethnographic data in this article derive from anthropological observations and interviews. The extended case is based on a multisited research project by the second and third authors about how people living with HIV/AIDS in Kumasi and a nearby rural community managed their lives under the threat of severe stigmatization and exclusion. The fieldwork took place intermittently between 2007 and 2011, about fifteen months in all. Kwansa (2013) carried out participant observation in two communities, one urban, one rural, and focused on how people living with HIV/AIDS and their relatives and neighbors went about managing the stigmatizing secret of the disease.[1] Dapaah (2012) did parallel and similar research in two hospitals in the neighborhood of the communities where Kwansa worked. The purpose was to meet and follow as much as possible the same people in two different contexts.

We first briefly present five studies that describe a variety of relevant traditions and developments in the field of family care in Ghanaian society, followed by the extended case of HIV/AIDS-related care.

Ethnographic Observations of Developments in Family Care

Elderly Care in Teshie

Sarah Dsane (2009) studied changes in care for older people in Teshie, a Ga-speaking patrilineal community near the capital, Accra. In the past, when an older man became sick and frail, he was taken from the place where he normally stayed with his wife (or wives) and children to his maternal relatives' compound, where female relatives took care of him; they bathed, dressed, and fed him and gave him medicines. His wife was not allowed to care for him; she could only visit him. The reason, according to Dsane's aging informants, was that the wife could not be fully trusted, and competition between cowives could have a negative effect on his well-being. A similar decision was taken when an older woman became weak and dependent and needed special care: her maternal family would appoint an adult female relative as caregiver. That person could be a sibling, a cousin, or a more distant relation. All these options emphasize that only relatives were to be trusted to provide proper care for the older person. Even a partner could not be fully trusted. Today, however, that custom has changed. Particularly in the case of well-to-do parents, children and others who expect to inherit from them see it as their responsibility to provide care. By doing so, they also secure their inheritance. Those who do not have properties to be inherited, or family members who may have benefited from their investment, may be left without any formal or supervised care.

Vicissitudes of Elderly Care in a Kwahu Rural Town

Sjaak van der Geest (2002) explored experiences of growing old and practices of care for older people in a rural town in the Kwahu area in the Eastern Region of Ghana. One of his objectives was to discover who would be the likeliest to care for older relatives. The outcome of his research was more complex than one might expect on the basis of the widely held assumption that close family members take up that responsibility. He found that two principles were the best predictors of caregiving: practicality (who happened to live in the same house as the older person) and reciprocity (in the positive and negative meaning of the term). Older people were paid back for what they had given to their children, partner, and other relatives during their active years, but no iron law guaranteed that these principles would indeed be applied. Reciprocity, for example, could fail if the children were too poor to provide the material care and support that their parents deserved because of their good care for their children in the past. Geographical distance (which had formerly hardly existed) could be compensated by sending money (if these relatives could afford it), and lack of time could be solved by employing another relative. Shifting priorities in the new generation of parents (own children first, older parents second) were also pertinent (Aboderin 2006). Finally, children's "bad character," according to some older people, explained the failure of the reciprocity principle.

Negative reciprocity often led to divorce or separation at an advanced age. If a woman felt that the husband or (in an informal relationship) partner had not been taking care of her properly, she could decide to return to her own maternal family and leave the old man alone. During the first stage of this fieldwork, only three of the thirty-five old people who were interviewed were still married and living with their partners. Five had lost their partners through death. All the others had divorced or were living apart.

Grandchildren and Grandparents in Nzema

Douglas Frimpong-Nnuroh (n.d.) carried out anthropological fieldwork in Nzema society in the extreme southwest corner of Ghana. He was interested in care arrangements between children and their grandparents in families where the middle generation of parents was absent because of work and migration. Grandparents, who become parents again to care for their grandchildren, have frequently been studied in societies affected by HIV/AIDS, where many of the parental generation have died. In Nzema, however, the researcher focused on the mutual care between grandparents and grandchildren. Grandchildren in this case were not just a burden of care to grandparents: they were a source of joy and support. Young grandchildren brought the happiness that only small children can produce. When they grew older, they helped in the house, on the land, or wherever something was to be done. Thus, the balance of mutual care gradually shifted from the grandparents to the grandchildren. Another feature of mutual care and reciprocity was that the absent middle generation sent money to their parents, who in exchange took care of their children's children.

Negative Reciprocity and Reluctant Minimal Care

Bridgit Sackey starts her article on care for sick people in Fante families in Accra and Cape Coast thus:

> The care of the seriously ill may either highlight family solidarity and integration or magnify existing dissensions and rancor within families, as the question of who takes care of the sick sometimes becomes extremely contentious.... What happens when no family member is willing to take on an additional arduous responsibility of caring for a patient who has been "declared by the doctor to go home and die"? (2009, 188)

She provides five cases of family care, one of which is about a sixty-six-year-old man whom she calls Tom, who came from a large family of twelve children. Tom had spent more than thirty years, which he considered the best years of his life, in Liberia. During all those years, he had not communicated with any of the siblings or the children he had had with different women. Nor had he sent any money to his ailing old mother. When he suddenly came home, sick and needy, the relatives tossed him about. No one wanted to care for him. His senior brother, who was particularly resentful about Tom's behavior, reluctantly gave him the minimum of care. Tom's health deteriorated. He became bedridden and died shortly after. His uncaring life had resulted in a noncaring family and a miserable death. Sackey's description confirms the observations around reciprocity by Van der Geest in Kwahu.

The Mercy Home Care Centre in Accra

In 2013, one of us (Sjaak van der Geest), together with Sarah Dsane, visited the Mercy Home Care Centre, a residential home for older people, in the outskirts of Accra. As far as we knew, it was the only such home in the country. It had been founded around 2012 by a Ghanaian couple living in Switzerland, who emphasized that it is not a commercial enterprise and that payments made by families—370 Ghana cedis per month, about 100 euro in 2013—did not cover the costs of residence. At the time of the visit, the home had nine residents, but it had room for thirty. One condition for acceptance was that families would visit their older relative at least once a week. The four staff members, at the level of clinical health assistant or below, lived in the building and were permanently available seven days a week, day and night. The elderly residents admitted that they had not been happy when they had been brought to the center. To be handed over to unrelated caregivers was felt as a shameful thing—for their family, who had failed to do their moral duty, and for themselves, who had been victims of that failure. But now, they said, they understood the decision of their children who were too busy to take care of them properly. Some residents stayed only for a short period, while their caregiver at home was not available. The center was neat and simple and clearly not meant for families affluent enough to hire professional help to stay with them in their own houses.

These observations—in addition to the other contributions in this special issue—show a kaleidoscope of changing care arrangements in the context of societal developments. But before reflecting on the circumstances of these arrangements, we shall present more extensively the ethnographic showpiece of this article: the avoidance of family care and its intimacy by people living with HIV/AIDS.

Avoided Family Care, Diverted Intimacy

This description of people living with HIV/AIDS will serve as a vantage point from where we look at the wider issue of avoiding the intimacy of the family as a source of care. The first section deals with care (or its absence) in family and community contexts; the second describes care relations in hospitals.

Living with HIV/AIDS at Home, among Relatives and Neighbors

Almost all the HIV-positive persons whom the researcher in the community met kept their status hidden. They were mainly those who had been diagnosed when they were relatively healthy. The majority decided to follow the ART regimen, which might help them to manage the situation and thereby conceal their status. Due to the absence of overt symptoms or progression of the disease, little change occurred in their everyday lives after testing positive. They were therefore not compelled to reveal their status to those in their environment.

Those who were married or in a sexual relationship, especially women, often did not reveal their status, not even to their partners. They knew what the consequences could be if their partners were to find out: breakdown of the relationship and divorce, loss of financial support, and disclosure to unwelcome others. More than 80 percent of the HIV-positive people followed in the community had not disclosed their status to their family or friends. For those whose status was disclosed to relatives, two consequences were possible: exclusion or collective concealment by the family, to prevent what Goffman (1968, 44) has called courtesy stigma—stigmatization by association.[2] A severe example of exclusion and collective concealment to prevent courtesy stigma was the case of a gravely ill woman whose relatives refused to spend any money on her when they found out that she had tested HIV positive. "She was going to die anyway, and the money would go waste," a nurse explained. About three weeks after the researcher met her, he saw her obituary notice all around the community. A grand funeral was held for her. To avoid the shame of AIDS, the family had rejected the live body, but celebrated the dead one. In a clear act of collective impression management, the funeral was the family's strategy to keep the real cause of the woman's death private, even though many in the community were probably aware of the fact that she had died of AIDS.

In some households, a family that learned from the hospital that a relative had been diagnosed as HIV positive would mistreat that individual. In one case, the family of an HIV-positive woman kept her in a room and barred her from speaking to anyone. No one could visit her, not even her own children or the staff of the hospital. One day, the researcher and a nurse demanded access to her room to check on her. When the relatives vigorously refused, the nurse decided to make a scene by shouting and accusing them of preventing them from seeing their sick family member. Only after this did they allow them to enter the room. The woman was lying on a mat in a virtually empty room, with only a few cloths for cover, two eating plates, a cup, a tablespoon, and a chamber pot. She explained that she had seen the nurse and researcher every time they had come by the house and been refused entry and had not traveled anywhere as the relatives had claimed. She had been denied any visitors and saw the world only through the doorway to her room. Considering such possible consequences of revealing their sickness, it is hardly surprising that few HIV-positive persons willingly disclosed their HIV status.

Though the people living with HIV were usually likelier to trust people in their own household than others with their private affairs, they were nevertheless not inclined to inform them if they were receiving treatment for HIV/AIDS. They kept all medical records in their possession—hospital cards, prescription forms, and even their medicines—away from prying eyes. One woman explained that she hid her medicines in a locked suitcase; one man concealed his pills under the family sofa. After a hospital visit, some patients disposed of the antiretroviral packages and leaflets even before they left the building. Another strategy was to scratch off the writing on the containers or put the medicines into a different box altogether.

In some cases, the family did not want to know the diagnosis of the disease in an attempt to protect both the patient and themselves. The sister of one infected man insisted that his disease was spiritual. She helped her brother with fasting and prayers and took him every Wednesday to a prophet, since "no one knew what was wrong with him, and only God can help out." He, by not disclosing his sickness, and she, by deliberately remaining ignorant of it, managed to maintain their mutual relationship of care and support.

In another study, a middle-aged man explained to the first author that he worried about his reputation if his status were to be revealed:

> If they get to know about it, they will no more respect me. When I call them, they will not mind me. They may not like to come near me. Because of the disease they will call me names and tease [harass] me.... But if I don't tell people that I am sick, I am respected and regarded.... If I disclose it to people,

> they may even stop giving me some assistance because they will assume that I will die very soon. (Van der Geest 2015, 269)

The examples and quotations above demonstrate to what extent the home—ideally a safe place, where privacy is guaranteed—can turn into a dangerous environment, where intimacy becomes a liability. If even one's closest relatives and friends pose a risk for people living with HIV/AIDS, it is no wonder that they look for another category of people to share their secret with. Hospitals turn out to be places where the most trustworthy confidants can be found.

New Kinship in the Hospital[3]

A hospital at first sight looks like an unlikely choice for people infected with HIV/AIDS to seek safety. It is a risky place because it is public. Patients can be spotted by neighbors, relatives, or others who know them. Their presence is likely to raise questions about what is wrong with them. If they are seen in or near the department for people living with HIV/AIDS, rumors will start, and the secret of the infection may become known. It is for this reason that people with the disease may avoid going to a hospital at all. Or they use tricks—as they do at home—to avoid the risk of being recognized and betrayed. Some may travel a long distance to a hospital where they hope that no one will recognize them.

Fear of the hospital because it may cause unwanted disclosure is one reason why many people refuse to get tested or to accept hospital treatment. Those who do—eventually—accept hospital treatment face two more risks, apart from being spotted. One is that staff members may talk. Although they assure confidentiality, doctors, nurses, or counselors may be careless and unintentionally reveal the fact that someone is HIV positive. Such a piece of information may spread through the gossip network and reach relatives, neighbors, and others in the community.

Another risk of hospital treatment is that the staff not only pressure HIV-positive clients to inform relatives, in particular partners, about their status, but also oblige clients to find a buddy or adherence monitor, whose task is to help the client strictly follow the medication regimen and other treatment rules. When the researcher asked a patient why she was reluctant to bring a monitor for adherence counseling, she said that, for this disease, it is better not to talk about it with relatives: "The moment you tell one relative and bring that person along to the clinic, other relatives would hear that you have it [HIV/AIDS]. And they will start avoiding you for bringing shame (*animguaseɛ*) to the family." Health workers told the researcher that some clients just pick someone from the street, someone they do not know, to avoid the risk that relatives will hear about their treatment. One client explained:

> I cannot trust any of my relatives to come with me for counseling. I do not want to bring my wife either, because she does

> not know that I have this disease. My fear is that if I bring a relative and he gets to know that I have this disease, my wife and other family members will hear of it. My wife would divorce me, and I would lose the respect I have in the family as an immoral person. So, I felt that I should bring a stranger who does not know my wife or any of my relatives.

Despite these dangers lurking in the hospital, many people living with HIV/AIDS find a safe haven there. Once inside, they meet companions in misfortune and caring nurses and peers (also living with HIV/AIDS) who are involved in the treatment and education of other patients on a voluntary basis. All these people know the patients' secret and thus form a safe audience to speak to. Stigmatized individuals view those who share their particular stigma as their own; they belong to the same in-group, in contrast with those who are ignorant or hostile toward HIV/AIDS patients. Experiencing severe stigma created a strong sense of solidarity among the clients, and health workers sympathized with them and supported them. Health workers were adopted as parents: nurses became mothers, who helped them take decisions on treatment and marital problems; peer educators became uncles and aunts, who advised and assisted where needed. Clients shared with their fellow patients, as siblings, their worries on a wide range of issues.

One man described his fellow clients as sickness relatives (*yareɛ abusuafoɔ*). He freely interacted and conversed with them—which, he explained, helped release stress he had being going through at home. A twenty-five-year-old woman said that sometimes she came to the clinic just to hang around and chat with her fellow patients and to share her own experiences: "Some of the cases they tell me are worse than what I went through before I started treatment here in the clinic. These sometimes serve as encouragement for me to feel that in my case things were a little better, and there is still hope for me in life (*anidaso wɔ hɔ ma me*)."

Clients thus created a space to live a more fulfilling and less stressful life; they fraternized, shared worries, sought advice, and settled disputes. They felt love and affection from health workers and their peers, something they had not experienced in some instances for a long time. In fact, the clinic served as a refuge, affording a respite from the problems they were going through at home. Contrary to Ghanaian norms and values that emphasize the home as the proper place for care and intimacy, these people, suffering from the physical, social, and emotional effects of HIV/AIDS, turned to nonkin for assistance and care.

Discussion

The ethnographic observations about variations in family care and the extensive case of HIV/AIDS patients seeking support and care outside their family homes demonstrate the complexity of processes and contexts that affect changes in care practices in Ghana—and elsewhere, as can safely be assumed. In this brief reflection, we try to shed more light on the entanglements of changing family care. Our purpose is not only to offer a more nuanced understanding of these changes, but also to illustrate the different processes that are conveniently put together under the umbrella of globalization.

Migration

Migration is one of the most obvious components of globalization, necessitating rearrangements of care and solidarity in Ghanaian families. Migration takes away relatives who are expected to take the responsibility of care and companionship for sick and frail members of the family, but it may bring new caregivers, who will fill the vacancies left by the original ones. These new caregivers can be grandchildren and grandparents from within the family, as is shown in the Nzema case (Frimpong-Nnuroh n.d.), or professional caregivers in a nursing home, as in the Mercy Residential Home. The new caregivers can themselves be immigrants, in which case we speak of a "global care chain" (Hochschild 2000). This concept refers to the migratory processes of women who leave their own families to provide care in other families in a more profitable setting. In their own homes, these women are replaced by other women with similar intentions, and thus a chain forms. Absent migrated caregivers are supposed to fulfill their original task by sending remittances—another form of diverted care—that help the family at home provide the necessary care by buying materials, hiring outside help, and paying for funerals, which is also part of the care arrangement. In this way, migration eases and promotes the inclusion of nonkin caregivers—a contingency that was otherwise regarded as a moral shortcoming of the family. Migration thus leads to new moral pathways related to care. Sending money may even be morally valued above being physically present (Coe 2019).

A last arrangement to be mentioned in the context of migration is fostering, which is not entirely new but reactivated by migration. Ghanaian migrants leave their children in the care of relatives, as they believe that education and upbringing in Ghana are preferable to the system abroad (Coe 2014, 87–114). Coe (2014) studied Ghanaians in the United States who find it difficult to combine work with looking after their children; the costs of professional day care are too high, and the values being taught in school lack the respect that they regard as being of ultimate importance. Sending the children to Ghana to stay with relatives therefore seems the best option, despite the emotional hardship it may cause to parents and children. The foster arrangement is also used in the case of internal migration within Ghana (Ackah and Medvedev 2010; Badasu 2004; Frimpong-Nnuroh n.d.).

Family and the Family Home

Family and the family home repeatedly cropped up in our ethnographic examples. Their prominence is obvious in studies of caregiving, since the family and its residence are usually marked as the ideal environment for the intimacy, solidarity, and privacy that proper care needs. In Sarah Dsane's research about past care traditions in Teshie, informants emphasized that proper care for the elderly could be trusted only to the maternal family. Ursula Read and Solomon Nyame (2019), in their contribution to this issue, describe the struggle of families to keep their mentally ill children, but remark that it is mothers, not the family, that are really concerned over time.

The hallowing of the family (*abusua* in Twi) and the home (*efie*) started long ago, when functionalist anthropologists were writing about the harmony of African households and expressing fears that social changes such as urbanization and industrialization might lead to the breakdown of traditional family life; they were interpreting intrafamilial conflict and friction as temporary crises, which would lead to the reestablishment of harmony. Ghanaians themselves have been equally active in praising the peace and warmth of their families, often in reaction to Western family life, which they believed cold, selfish, and conflictual. Examples of Western families handing over care for their aging parents to strangers were popular proofs that underscored their disapproval. Religious and political leaders were eager to keep that romantic image of the family alive, the latter in particular to economize on state funding of care for the elderly, disabled, and chronically sick (Van der Geest 2016).

Skeptical observations regarding family and family life also exist. Beneath the apparent peaceful relations, family members may worry about the dangers of *bayie* (witchcraft), which is nearly always linked to envy between close relatives. Family-based envy is probably common to families everywhere, but its intensity is particularly strong when it is expressed and experienced as an evil, destructive, and potentially lethal force. The intimacy that exists in the family is its greatest vulnerability. The enemy within knows the weakness of others and has easy access to them; eating, conversing, and sleeping together—a sign of close companionship—facilitate the practice of *bayie*. Familiarity breeds not only contempt, but also insecurity, vulnerability, and fear. Relatives telling the researcher in confidence about their fears often supported their information with proverbs such as "If a tree is near another tree, they rub each other" (*Dua a ebɛn ne yɔnkɔ na etwi*) and "It is the insect in your own cloth that bites you" (*Aboa a ɔhyɛ wo ntoma mu, na ɔka wo*).[4]

The ambivalence and hidden insecurity of the family home should also be taken into account if we try to understand that people in certain situations avoid the privacy and intimacy of their own family and seek help from outsiders whom they trust more than their relatives.[5] In one of the first elaborate ethnographic accounts of HIV/AIDS management in Ghana, before the availability of antiretroviral treatment, Maud Radstake (2000) showed that people living with HIV/AIDS were desperately trying to keep hospital personnel away from their homes to protect the secret of their disease. The case of the clinic as a home presented in this paper shows the intersection of global and local developments. The rejection of family care derives from long-existing ambiguity and tension at the heart of Ghanaian society but is also prompted by the global advent of a highly stigmatized disease whose transmission is widely associated with illicit sex or promiscuity. Privacy is at risk where it is supposed to be most secure.

Fictive Kinship

Fictive kinship refers first of all to the language used to transform nonkin or strangers into relatives and thus uphold the ideal of family care when the family cannot provide that care. Interestingly, and as shown in the text above, persons living with HIV/AIDS appropriated the literal use of kinship terms in reference to doctors as fathers, nurses as mothers, educators as uncles and aunts, and peers as siblings. This practice carries a strong emotional message: kinship terms may express deep feelings of friendship that surpass the affection one feels for real kin (Van der Geest 2013), as is shown in the ethnographic cases presented above. In a recent publication, Cati Coe draws attention to the fact that caregiving activities by nonkin or distant kin have a long history in Ghana. The present trend, in which families increasingly recruit outsiders to care for relatives, was preceded by involving slaves and fostered children in care labor—which Coe calls care-scription. These nonkin helpers were often given fictive kinship terms to salvage the ideal of family care. She concludes:

> These entrustments change over time, as different obligations—such as schooling or debts from marital disputes—gain force and as new routes to defer commitments emerge. Care-scription is sensitive to changing economic and social circumstances, including the economic migration of women, increased educational expectations, the allure of urban areas in providing economic and educational opportunities, and longer lifespans with more chronic illnesses. (2017, 150)

Reciprocity

Reciprocity runs through all the cases presented above. It is probably the strongest, oldest, and most widespread principle determining the quality and quantity of all kinds of care, and, as we have seen, it continues to do so. Life is an incessant investment in social relations, long-term and short-term, a game of giving and receiving. Those who fail to give will not receive. Earning social capital is a condition for a successful life. Reciprocity is the cement of social relations. The case of Tom, who returned sick and destitute from Liberia, is an example of a failed and bad life in the eyes of his family. It is no wonder that his relatives were extremely reluctant to welcome him and take care of him: he had refused to invest in social relationships and had to bear the consequences. For the same reason, fathers who have not cared for their family during their active years face loneliness and poverty at the end of their life, as partners and children leave them (Sackey 2009; Van der Geest 2002). But reciprocity is not an iron law; circumstances can lead to deviations from the rule. Poverty or the inability to pay back can be one such reason, but people can usually find alternative ways of paying back, such as showing respect, gratefulness, and submissiveness.

The effect of reciprocity on expected care of HIV-infected people by relatives is particularly strong when the disease strikes young people who have not yet had the opportunity to build up the social capital that entitles them to the right of care. Suspicion of immoral behavior may further disqualify them from deserving emotional and financial support from the family. The harsh treatment that some people with HIV/AIDS received from their family and the subsequent fear for family involvement in caregiving would have been less likely if the affected person had built up a sizeable amount of social capital among their relatives. In contrast to dependent older people, HIV normally strikes those who have not yet reached the stage of benefitting from reciprocity.

Conclusion

The ethnographic examples of care practices we presented in this article reveal a kaleidoscope of processes instigated by internal and external pressures. The specific example of family care avoidance that we observed should not be seen as a reluctant giving in to Western practices of outsourcing family care. It is indeed tempting to interpret this process as such, following Hannerz's well-known statement that "the periphery … takes its time in reshaping that metropolitan culture which reaches there to its own specifications" (1992, 238). It is also not a manifestation of localization, a reaction against, or transformation of, forceful international cultural flows (Kearney 1995; Schuerkens 2003; Tsing 2005). Our observations depict an overwhelmingly internal process of weakening family care, linked to local ideas and practices such as honor and shame, stigma, reciprocity, and family-based insecurity. Global processes leading to the avoidance of family care, such as migration, the spread of HIV/AIDS, the hospital setting, and antiretroviral medication, seem less prominent.

To summarize, our article has two related objectives: an ethnographic one (describing changing family care) and a theoretical one (a critical look at globalization, from the perspective of family care). Intimacy, affection, and kinship solidarity are the virtues of family care in Ghanaian households, while care by nonkin tends to be regarded as a moral shortcoming of the family. In the case of HIV/AIDS, however, family care is often avoided. The stigma attached to the disease induces infected people to hide their condition from the family and seek help from professionals and fellow sufferers, largely without the knowledge of the family. In hospitals, people living with

HIV/AIDS find quasi-relatives to whom they divulge their secrets and with whom they freely discuss their problems. "Strangers" thus become safer and more trusted caregivers than family members.

The second aim of this article is to look critically at concepts of change by analyzing a number of ethnographic observations of caregiving. Our argument points at the abiding potential for conflict and failure of reciprocity at the heart of the Ghanaian family, which can affect care. The ethnographic examples demonstrate that the forces of change are diverse and complex and present numerous intersections of global and local drivers, which play out in particular ways in different contexts. The dynamics of caregiving in cases of HIV/AIDS depend, however, more on local circumstances than on external influences brought about by increased global communication, migration, and economic developments.

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NOTES

1. More recent developments, particularly access to free antiretroviral medication, may turn HIV/AIDS into a chronic disease and eventually diminish its stigmatizing character. For the time being, however, this is hardly the case. That a person with HIV/AIDS does not feel sick thanks to the medicine and does not show any symptoms of the disease increases the fear of infection and thus deepens the stigma. The danger has gone underground. For a discussion of the new situation involving fear and stigma in Uganda, see Whyte 2014.
2. Of *courtesy stigma,* Philips et al. (2012, 682) say: "stigmas not only affect the individuals bearing them, but also those who are closely associated with stigmatised individuals and groups: 'the problems faced by stigmatised persons spread out in waves of diminishing intensity among those they come in contact with'" (Goffman 1963: 30), especially family members. See also Birenbaum 1970 and 1992.
3. For a more extensive description of fictive kinship in the HIV/AIDS clinic, see Dapaah and Spronk 2016.
4. See also Mensah Adinkrah (2017, 154–82), who devotes one chapter to witchcraft imagery in Ghanaian proverbs.
5. Huebner suggests the term *professional intimacy* to teach to nurses in hospitals: "Allowing nurses to conduct professionally intimate work will ensure better medical care for patients, which ultimately increases both nurse and patient satisfaction" (2007, iii).

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